This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0074 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2022 2:48 pm] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: Contractor use only

number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(3) Settled with Audit

(4) Reopened (5) Amended

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HEALTH NETWORK, INC. (15-0074) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR			ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Hol	ly Millard	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Holly Millard			2
3	Signatory Title	SVP FINANCE			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	691, 262	-627, 717	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing Bed - SNF	0	0	0		0	5. 00
6.00 Swing Bed - NF	0				0	6. 00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200. 00 Total	0	691, 262	-627, 717	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0074 Peri od: Worksheet S-2 From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1500 NORTH RITTER AVENUE 1.00 PO Box: 1.00 City: INDIANAPOLIS State: IN 2.00 Zip Code: 46219 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V 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 HEALTH 150074 26900 07/01/1966 N 3.00 NETWORK, INC. 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 10.00 Hospi tal -Based NF 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) 01/01/2021 12/31/2021 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. Did this hospital receive a geographic reclassification from urban to 22.04 Ν Ν rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N 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.

25. 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 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. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 3, Medicaid	0	0	0	0	30,	0	40	25. 00
	HMO paid and eligible but unpaid days in column 5.				Urban/Ru	ral S	Date of	Geogr	
					1. 00		2.0		
26. 00	Enter your standard geographic classification (not wa		it the beg	inning of the		1			26. 00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status a r "2" for rur ication in co	al. If ap olumn 2.	pl i cabl e,		1			27. 00
35.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of p	eriods SC	H Status in		O			35. 00
	perred the the cost reporting perred.				Begi nni		Endi		
26 00	Enter applicable beginning and ending dates of SCH s	tatus Subser	int line	26 for number	1.00)	2. (00	36. 00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.	•			0			37. 00
	is in effect in the cost reporting period.		,						
37. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37. 01
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38. 00
	enter subsequent dates.				V /N		V /	'NI	
					1. 00		Y/ 2. (
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii)), (ii), or (the mileage r	iii)? Ent equiremen	er in column ts in	N		N		39. 00
40. 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	ber 1. Enter	"Y" for y		N		N	I	40. 00
	, and the second	(11111111111111111111111111111111111111			'	V	XVIII	XI X	
	Prospective Payment System (PPS)-Capital					1. 00	2. 00	3.00	
45. 00	Does this facility qualify and receive Capital paymen	nt for dispro	porti onat	e share in acc	cordance	N	N	N	45. 00
46. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46. 00
47. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS (capital? Ent	er "Y for	ves or "N" fo	or no.	N	N	N	47. 00
	Is the facility electing full federal capital paymen					N	N	N	48. 00
56 00	Teaching Hospitals Is this a hospital involved in training residents in	approved GME	nrograms	2 Enter "V" fo	or ves or	V	Υ	1	56. 00
30.00	"N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pu	e to column 1 rograms in th	is "Y", ne prior y	or if this hos ear or penulti	spital mate	'			30.00
57. 00	year, and are you are impacted by CR 11642 (or applice Enter "Y" for yes; otherwise, enter "N" for no in collifine 56 is yes, is this the first cost reporting for the first cost reporting for the first cost reporting for the first cost reports the following section of the first cost reports the fi	lumn 2. period during	, which re	sidents in app	oroved	N			57. 00
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first monfor yes or "N" for no in column 2. If column 2 is "\"N", complete Wkst. D, Parts III & IV and D-2, Pt. II	th of this co Y", complete	st report Worksheet	ing period? [Enter "Y"				
58. 00	If line 56 is yes, did this facility elect cost reiml defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement for	physicia	ns' services a	as	N			58. 00
59. 00	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59. 00

ealth Financial Systems COMMUNITY OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		NETWORK, INC. Provider CO	:N: 15-0074 P	eri od:	u of Form CMS-2 Worksheet S-2	
3311 ME AND HOST THE HEAETH STATE COMM EEX TREATH FOR THE DAY		Trovider of		rom 01/01/2021	Part I Date/Time Prep 5/30/2022 2:48	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	·
			1. 00	2. 00	3.00	
O.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent Cadjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	see If column 1	N			60.00
[20] do temente. Enten i 101 years. 11 101 11 30. 0	Y/N	IME	Direct GME	I ME	Direct GME	
1 00 Did your bookital massive FTF slate under ACA	1. 00 Y	2. 00	3. 00	4. 00	5.00	61. 00
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	Y			32. 85	29.67	61.00
column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. 01
instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61. 0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 0
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 0
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1 10 06 the FTF- in Line (1 05 and 6) and 5		1. 00	2. 00	3.00	4.00	/1 1
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	FAMI LY	MEDI CI NE	1350	0.00		61. 10
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 Ser	rvi ces /	Admi ni strati on	(HRSA)		1.00	
2.00 Enter the number of FTE residents that your hospital		in this cost	reporting peri	od for which	0. 00	62. 00
your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	a Teachi gram. (s	see instruction		your hospital	0.00	62. 0
Teaching Hospitals that Claim Residents in Nonprovider se 3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			Y	63. 0
			Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base year	2.00 is your cost r	3.00 eporting	
period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	y trair n-primar all nor d non-pr	ned residents ry care nprovider rimary care	0. 17	3. 25	0. 049708	64. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0074 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/30/2022 2: 48 pm Ratio (col. 3/ Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 FAMILY MEDICINE 3. 92 25. 07 0. 135219 65. 00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 2, 25 11, 65 0. 161871 66. 00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 2.00 3. 00 1.00 4.00 5.00 67.00 Enter in column 1, the program FAMILY PRACTICE 0. 168746 67. 00 1350 5.95 29.31 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 Ν O N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 Ν subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems COMMUNITY HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider Co	CN: 15-0074	Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part I Date/Time Pr 5/30/2022 2:	-2 repared:
	<u> </u>			1.00	
Long Term Care Hospital PPS				1.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under sectio	ı	N	87. 00
1.000(0)(1.7(0)(1.7)(2.10)			V 1. 00	XI X 2. 00	
Title V and XIX Services			1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospitates yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the appl			N	N	91. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificat			N	92. 00
instructions) Enter "Y" for yes or "N" for no in the application of the property of the proper		d XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94. 00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app			0. 00	0.00	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for n	o in the	N	N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app 98.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" in column 1 for title V, and in column 2 for title XIX.	nterns and res	dents post	0. 00 Y	0. 00 N	97. 00 98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the ro C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti				Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the caped costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of			Y	Y	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a crireimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.				N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i			N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a				Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	-inclusive met	nod of payme			106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column	n 1. (see ins	tructions)	N		107. 00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded II Enter "Y" for yes or "N" for no in column 2. (see instructions)	PF and/or IRF (ions)	uni t(s)?			
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					108. 00
	Physi cal 1.00	Occupationa 2.00	Speech 3.00	Respiratory 4.00	/
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	3.00 N	4. 00 N	109. 00
itor yes or in tor no tor each therapy.					
				1.00	

1.0	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Memonstration) 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.	110. 00

Health Financial Systems COMMUNITY HEALTH NETWORK, INC.		In Li	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO		eriod: com 01/01/2021	Worksheet S- I Part I	-2 repared:
			07 007 2022 2.	J piii
111.00 If this facility qualifies as a CAH, did it participate in the Frontier CC Health Integration Project (FCHIP) demonstration for this cost reporting; "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	1. 00 N	2.00	111.00
	1.00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N N	2.00	3.00	112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or	Y			116. 00
"N" for no. 117.00 s this facility legally-required to carry malpractice insurance? Enter	Υ			117. 00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	1			118. 00
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:	1. 00 4, 290, 830	2.00	3.00	0 118. 01
		1. 00	2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost center other and Administrative and General? If yes, submit supporting schedule listing country and amounts contained therein.		N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov		N	N	119. 00 120. 00
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y' "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions in column 2, "Y" for year "N" for polymonary "N" for polymonary "N" for year "N" for	ne Outpatient			120.00
"N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction in the column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices	ne Outpatient ructions)	Y		121. 00
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"N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction for provided that the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction for provided that the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction for provided that the Hold Harmless provided the Hold Harmless p	ne Outpatient ructions) s charged to (w)(3) of the rin column 2 for no. If fication date cation date cation date in tification ertification	N		121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00
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143.00 Ci ty:	I NDI ANAPOLI S	State: II	V	Zip Code:	4621	9-3095	143. 00
						1. 00	
144.00 Are pr	ovi der based physicians	costs included in Worksheet	A?			Υ	144. 00
					1. 00	2. 00	
145.00 lf cos	ts for renal services a	are claimed on Wkst. A, line 74	, are the costs	s for	Y		145. 00
i npati	ent services only? Ente	er "Y" for yes or "N" for no ir	column 1. If a	column 1 is			
no, do	es the dialysis facilit	y include Medicare utilization	for this cost	reporting			
peri od	? Enter "Y" for yes or	"N" for no in column 2.					
146.00 Has th	e cost allocation metho	odology changed from the previo	ously filed cost	t report?	N		146. 00
Enter	"Y" for yes or "N" for	no in column 1. (See CMS Pub.	15-2, chapter 4	40, §4020) If			
yes, e	nter the approval date	(mm/dd/yyyy) in column 2.					
						1. 00	
		ntistical basis? Enter "Y" for				Y	147. 00
	3	der of allocation? Enter "Y" fo	,			N	148. 00
149.00 Was th	ere a change to the sin	nplified cost finding method? E	nter "Y" for ye	es or "N" for n	0.	N	149. 00
			Part A	Part B	Title V	Title XIX	
			1.00	2.00	3.00	4.00	
		provider that qualifies for an					
		s or "N" for no for each compor	ent for Part A	and Part B. (S	See 42 CFR §413	3. 13)	
155. 00 Hospi t			N	l N	N	N	155. 00
156.00 Subpro			N	l N	N	N	156. 00
157. 00 Subpro			N	N	N	N	157. 00
158. 00 SUBPRO	VI DER						158. 00
159. 00 SNF			N	N	N	N	159. 00
160.00 HOME H	EALTH AGENCY		N	N	N	N	160.00
161.00 CMHC				N	N	N	161. 00
						1. 00	
Multic	ampus						
		ılticampus hospital that has or	ne or more campu	uses in differe	nt CBSAs?	N	165. 00
Enter	"Y" for yes or "N" for	no.					

165.00 is this nospital part of a multicampus nospital that has one or more campuses in different CBSAS?							l N	165.00
	Enter "Y" for yes or "N" for no.							
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1. 00	2. 00	3.00	4. 00	5.00	
	166.00 If line 165 is yes, for each						0.00	166. 00
	campus enter the name in column							
	O, county in column 1, state in							
	column 2, zip code in column 3,							
	CBSA in column 4, FTE/Campus in							
	column 5 (see instructions)							

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment	Act		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00
168.00 If 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 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"	'), enter the	0.00	169. 00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting			170. 00
		,	l

period respectively (mm/dd/yyyy)			
	1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	0	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

	Financial Systems COMMUNITY HEALTH TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0074	Peri od:	worksheet S-2	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/30/2022 2:4	epared:
				Y/N	Date	.5 6111
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ente	er all dates in t	the	
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	a heginning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in o					1.00
			Y/N	Date	V/I	
0.00	Tu	2 0 1 6	1.00	2. 00	3. 00	0.00
2.00	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.	mn 3, "V" for	N			2. 00
3. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Туре	Date	
	Financial Data and Day		1. 00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	tified Public	Y	A	03/31/2022	4.00
7.00	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1 or "R" for Reviewed. Submit complete copy or enter date avaicolumn 3. (see instructions) If no, see instructions.	for Compiled,	,	A	03/31/2022	4.00
5.00	Are the cost report total expenses and total revenues diffe		Y			5. 00
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities					
6.00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	· ·	the provider			6.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.	ed and/or renew	Ü			7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	Y		9. 00
10. 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	Y		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N	V /N	11. 00
					Y/N 1. 00	
	Bad Debts				1.00	
12. 00 13. 00	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 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see inst t A		Y t B	15. 00
		Y/N	Date	Y/N	Date	
	DSQL Data	1. 00	2. 00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 00
17. 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	05/02/2022	Υ	05/02/2022	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

ROSPITAL AND MOSPITAL HEALTH CARE RELINGUISERS (DIAMALRE) Provider CN: 15-0074 Period (01/01/2021) Retrieved (17/01/2021) Retrieved (17/	Heal th	Financial Systems COMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CM	S-2552-10
Description Y/N Y/N	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0074	From 01/01/2021	Part II Date/Time P	repared:
Page 1						Y/N	
Report data for Other? Describe the other adjustments: Y/N Date Y/N Date	20.00	If line 16 or 17 is was were adjustments made to DS&D		0			20.00
21.00 Bas the cost report prepared only using the provider's N 0.00 2.00 3.00 4.00	20.00				IN	IN	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00				+			
COUNTETER BY, DOST RELIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Sopital Related Cost	21 00	Was the seat assessed as to use the seas ideal.		2.00		4. 00	21.00
COMPLETED BY COST RETURBURSED AND TERRA MOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capit tal Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. 25.00 Have the leaves and/or amendments to existing leases entered into during this cost reporting period? If yes, see linstructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see linstructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. 28.00 Were mel loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 Did the provider have a funded depreciation account? If yes, see instructions. 30.00 Has existing the provider have a funded depreciation account? If yes, see instructions. 30.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 If I line 31 is yes, did the provider restriction	21.00		IN		IN .		21.00
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Heal th	Financial Systems COMMUNITY HEALT	H NETWORK, INC.	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0074	Period: From 01/01/2021	Worksheet S-2 Part II	
			To 12/31/2021	Date/Time Pre 5/30/2022 2:4	pared: 8 pm
		3. 00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	NETWORK DIRECTOR OF			41. 00
	held by the cost report preparer in columns 1, 2, and 3,	REIMBURSEMENT			
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Heal th Fi nancialSystemsCOMMUNITYHOSPITALANDHOSPITAL HEALTH CARE COMPLEXSTATISTICAL DATA Provider CCN: 15-0074

				Т	o 12/31/2021	Date/Time Prep 5/30/2022 2:48	
						I/P Days / 0/P	J pili
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	· ·	Line Number		Avai I abl e			
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	280	102, 200	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		280	102, 200	0.00	0	7. 00
	beds) (see instructions)					_	
8. 00	INTENSIVE CARE UNIT	31. 00	68				8. 00
9. 00	CORONARY CARE UNIT	32. 00	0	C	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT					_	11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	18	6, 570	0.00		12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		366	133, 590	0.00		14. 00
15. 00	CAH visits					0	15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE	20.00					24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10 25. 00
25. 00 26. 00	CMHC - CMHC	88. 00				o	25. 00 26. 00
	RURAL HEALTH CLINIC					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	366			U	26. 25 27. 00
27. 00 28. 00	Total (sum of lines 14-26)		300	1		0	28. 00
28.00	Observation Bed Days					ا	28. 00 29. 00
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)						29. 00 30. 00
31.00	Employee discount days (see instruction)						30.00
	. 3		0				
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0	1			32. 00 32. 01
32. UI	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 00
55.01	Eron or to houtrar days and droundinges	ı		I	1		55.01

Provider CCN: 15-0074

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/30/2022 2:48 pm	

						5/30/2022 2:4	8 pm
		I/P Days	o/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	14, 380	7, 172	82, 459			1.00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	20, 449	36, 031				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	۷	0	C			5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation	14, 380	7, 172	82, 459	1		7.00
7.00	beds) (see instructions)	14, 360	7, 172	02, 439			7.00
8.00	INTENSIVE CARE UNIT	3, 237	0	15, 060)		8. 00
9.00	CORONARY CARE UNIT	0	0	C)		9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	0	0	2, 214			12. 00
13. 00	NURSERY		1, 439	1, 689			13. 00
14. 00	Total (see instructions)	17, 617	8, 611	101, 422	49. 16	2, 911. 00	
15. 00	CAH visits	0	0	C)		15. 00
16. 00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19. 00 20. 00	SKILLED NURSING FACILITY						19. 00 20. 00
20.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
22. 00	HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			130	1		24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	o	0	C	0.00	0.00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	C	0.00		
27. 00	Total (sum of lines 14-26)				49. 16	2, 911. 00	27. 00
28. 00	Observation Bed Days		1, 782	6, 358	1		28. 00
29. 00	Ambul ance Trips	o					29. 00
30.00	Employee discount days (see instruction)			647			30. 00
31.00	Employee discount days - IRF			C)		31.00
32.00	Labor & delivery days (see instructions)	o	46	486			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33. 00	1	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0074

				To	12/31/2021	Date/Time Prep 5/30/2022 2:48	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0		1, 211	20, 497	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, 313	,		
2. 00	HMO and other (see instructions)			3, 777	6, 993		2. 00
3. 00	HMO IPF Subprovider			3, 111	0, 773		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				o o		5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNI						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	3, 673	1, 211	20, 497	14. 00
15. 00	CAH visits			, , ,	,		15. 00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days			0			33. 00
33. UI	LTCH site neutral days and discharges			0	1		33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0074

					To	o 12/31/2021	Date/Time Prep 5/30/2022 2:48	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries	Sal ari es	Paid Hours Related to	Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
	PART II - WAGE DATA	1. 00	2.00	3. 00	4.00	5. 00	6. 00	
	SALARI ES							
1.00	Total salaries (see instructions)	200. 00	232, 552, 170	-1, 100, 600	231, 451, 570	6, 055, 396. 00	38. 22	1. 00
2. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		1, 776, 098	0	1, 776, 098	9, 251. 00	191. 99	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		782, 340 8, 508, 640	l .	782, 340 8, 508, 640	6, 247. 00 76, 802. 00		1
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	4, 260, 334	-1, 510	4, 258, 824	137, 156. 00	31. 05	7. 00
7. 01	Contracted interns and residents (in an approved		C	О	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	4, 578, 532	-28, 052	0 4, 550, 480	0. 00 174, 728. 00	1	ł
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		7, 990, 524	0	7, 990, 524	88, 816. 00	89. 97	11. 00
12. 00	Contract labor: Top level management and other management and administrative		2, 809, 728	0	2, 809, 728	15, 270. 00	184. 00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		3, 258, 472	0	3, 258, 472	25, 083. 00	129. 91	13. 00
14. 00	Home office and/or related organization salaries and		C	0	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		76, 637, 941	0	76, 637, 941	1, 611, 814. 00	47. 55	14. 01
14. 02	Related organization salaries		C	0	0	0.00	1	14. 02
15. 00	Home office: Physician Part A - Administrative		C	0	0	0.00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		60, 174, 300	0	60, 174, 300			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 718, 347 C	0	1, 718, 347 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	0	0			21. 00
22. 00	B Physician Part A - Administrative		119, 122	0	119, 122			22. 00
22. 01	Physician Part A - Teaching		80, 441		80, 441			22. 01
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		988, 956 0 1, 016, 624	0	988, 956 0 1, 016, 624			23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		18, 062, 645					25. 50
25. 51	(core) Rel ated organization		C	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		C	0	0			25. 52

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0074

					Т	o 12/31/2021	Date/Time Prep 5/30/2022 2:48	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE			_				
26. 00	Employee Benefits Department	4. 00	225, 065		225, 065	i i		
27. 00	Administrative & General	5. 00	14, 409, 483			i i		
28. 00	Administrative & General under		19, 749, 242	0	19, 749, 242	138, 523. 00	142. 57	28. 00
	contract (see inst.)		_	_	_			
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	1, 872, 601	-25, 100	1, 847, 501	62, 699. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32. 00	Housekeepi ng	9. 00	3, 652, 785			i i		
33. 00	Housekeeping under contract		585, 725	0	585, 725	12, 563. 00	46. 62	33. 00
	(see instructions)	40.00	0 /44 405	4 7/4 400		40 700 00	40.0/	
34. 00	Dietary	10. 00	2, 614, 425	-1, 761, 499		· ·	l .	34. 00
35. 00	Di etary under contract (see		482, 091	0	482, 091	10, 400. 00	46. 35	35. 00
0/ 00	instructions)	44.00	0.45 007	4 750 054	4 000 457	00 740 00	00.04	07.00
36.00	Cafeteria	11. 00	245, 206	1, 752, 951	1, 998, 157			36. 00
37. 00	Maintenance of Personnel	12.00	0 ((0 004	04 074	0 (40 (50	0.00		
38. 00	Nursing Administration	13. 00	2, 663, 924		2, 642, 653			
39. 00	Central Services and Supply	14. 00	473, 403		470, 882			
40. 00	Pharmacy	15. 00	9, 696, 607		7, 844, 006	i i		
41. 00	Medical Records & Medical	16. 00	161, 904	0	161, 904	4, 160. 00	38. 92	41. 00
40.00	Records Library	17.00	1 072 505	4 500	1 0/0 0/0	42 000 00	40.07	40.00
42. 00	Social Service	17. 00	1, 873, 585	-4, 523	1, 869, 062			42.00
43. 00	Other General Service	18. 00	0	1 0	1 0	0.00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part III | Date/Time Prepared: | 5/30/2022 2:48 pm | Pai d Hours | Average Hourly | Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0074

	Worksheet A	Amount	Reclassi fi cati	Adjusted	Paid 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						
Net salaries (see		239, 817, 914	-1, 099, 090	238, 718, 824	5, 996, 677. 00	39. 81	1.00
instructions)							
Excluded area salaries (see		4, 578, 532	-28, 052	4, 550, 480	174, 728. 00	26. 04	2.00
instructions)							
Subtotal salaries (line 1		235, 239, 382	-1, 071, 038	234, 168, 344	5, 821, 949. 00	40. 22	3.00
minus line 2)							
Subtotal other wages & related		90, 696, 665	0	90, 696, 665	1, 740, 983. 00	52. 10	4.00
costs (see inst.)							
Subtotal wage-related costs		78, 356, 067	0	78, 356, 067	0.00	33. 46	5.00
(see inst.)							
Total (sum of lines 3 thru 5)		404, 292, 114	-1, 071, 038	403, 221, 076	7, 562, 932. 00	53. 32	6.00
Total overhead cost (see		58, 706, 046	-1, 985, 035	56, 721, 011	1, 282, 326. 00	44. 23	7.00
instructions)							
	Net salaries (see instructions) Excluded area salaries (see instructions) Subtotal salaries (line 1 minus line 2) Subtotal other wages & related costs (see inst.) Subtotal wage-related costs (see inst.) Total (sum of lines 3 thru 5) Total overhead cost (see	PART III - HOSPITAL WAGE INDEX SUMMARY Net salaries (see instructions) Excluded area salaries (see instructions) Subtotal salaries (line 1 minus line 2) Subtotal other wages & related costs (see inst.) Subtotal wage-related costs (see inst.) Total (sum of lines 3 thru 5) Total overhead cost (see	Line Number Reported	Line Number Reported on of Salaries (from Worksheet A-6) 1.00 2.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY Net salaries (see instructions) Excluded area salaries (see instructions) Subtotal salaries (line 1 235, 239, 382 -1, 071, 038 minus line 2) Subtotal other wages & related costs (see inst.) Subtotal wage-related costs (see inst.) Total (sum of lines 3 thru 5) Total overhead cost (see 58, 706, 046 -1, 985, 035	Line Number Reported on of Salaries (col.2 ± col. 3) 1.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY Net salaries (see instructions) Excluded area salaries (see 4,578,532 -28,052 4,550,480 instructions) Subtotal salaries (line 1 235,239,382 -1,071,038 234,168,344 minus line 2) Subtotal other wages & related costs (see inst.) Subtotal wage-related costs (see inst.) Total (sum of lines 3 thru 5) Total overhead cost (see	Line Number Reported on of Salaries (from Worksheet A-6) 3) Col. 2 ± col. 3) col. 4	Line Number Reported on of Salaries (from Worksheet A-6) 3) col. 4 col. 5) col. 5 co

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0074	Peri od: Worksheet S-3

	From 01/01/. To 12/31/.		Part IV Date/Time Prep 5/30/2022 2:48	
			Amount	
		L	Reported	
			1. 00	
	PART IV - WAGE RELATED COSTS			
	Part A - Core List			
	RETI REMENT COST			
1.00	401K Employer Contributions		9, 385, 632	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)		757, 737	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		6, 111, 055	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)		21, 917, 748	8. 02
8. 03	Heal th Insurance (Purchased)	ŀ	0	8. 03
9.00	Prescription Drug Plan		6, 843, 050	
10.00	Dental, Hearing and Vision Plan		235, 959	
11. 00 12. 00	Life Insurance (If employee is owner or beneficiary)		127, 022	11. 00 12. 00
	Accident Insurance (If employee is owner or beneficiary)		0 1, 794, 471	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			
15. 00	Long-Term Care Insurance (If employee is owner or beneficiary) 'Workers' Compensation Insurance		0 540, 830	14. 00 15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 100	_	540, 830 0	16. 00
16.00	Non cumulative portion)	٥.	U	16.00
	TAXES	_		
17 00	FICA-Employers Portion Only	\neg	16, 187, 315	17. 00
	Medicare Taxes - Employers Portion Only	l	0	18. 00
	Unempl oyment Insurance	l	0	19. 00
	State or Federal Unemployment Taxes	l	0	20. 00
20.00	OTHER		Ü	20.00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above.	(see	0	21. 00
	instructions))			
22. 00	Day Care Cost and Allowances		0	22. 00
23. 00	Tuition Reimbursement		196, 972	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)		64, 097, 791	24.00
	Part B - Other than Core Related Cost			
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)			25. 00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0074	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Prepared: 5/30/2022 2:48 pm
			D CI + O +

		0 12/31/2021	5/30/2022 2: 48	
	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	7, 990, 524	64, 097, 791	1.00
2.00	Hospi tal	7, 990, 524	64, 097, 791	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Di al ysi s	0	0	17.00
18.00	0ther	0	0	18.00

Heal th	Financial Systems COMMUNITY HEALTH NET	WORK, INC.	In Lie	eu of Form CMS-2	2552-10					
		Provider CCN: 15-0074	Peri od:	Worksheet S-1						
			From 01/01/2021 To 12/31/2021	Date/Time Pre	pared·					
			1.0 1.2, 0.1, 2.02.1	5/30/2022 2: 4						
				1. 00						
	Uncompensated and indigent care cost computation									
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div Medicaid (see instructions for each line)	vided by line 202 colum	ın 8)	0. 227681	1.00					
2.00	Net revenue from Medicaid			168, 458, 881	2.00					
3.00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3. 00					
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		ai d?	N	4. 00					
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	rom Medicaid		-20, 327, 491	5. 00					
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)			680, 483, 770 154, 933, 225						
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of li	nes 2 and 5 if	6, 801, 835						
0.00	< zero then enter zero)	•	nes 2 and 0, 11	0,001,000	0.00					
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)								
9.00	Net revenue from stand-alone CHIP			0						
10.00	Stand-alone CHIP charges			0						
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (if / zero then	0	1						
12.00	lenter zero)	Title II millus IIIle 4,	ii < zero then		12.00					
	Other state or local government indigent care program (see inst	ructions for each line)							
13. 00	Net revenue from state or local indigent care program (Not incl			1	13. 00					
14. 00	Charges for patients covered under state or local indigent care	e program (Not included	in lines 6 or	0	14. 00					
15. 00	10) State or local indigent care program cost (line 1 times line 14	1)		0	15. 00					
16. 00	Difference between net revenue and costs for state or local inc		ne 15 minus line	ĺ						
	13; if < zero then enter zero)									
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)									
17. 00	Private grants, donations, or endowment income restricted to fu	ınding charity care		0	17. 00					
18. 00	Government grants, appropriations or transfers for support of h		(0						
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent care program	is (sum of lines	6, 801, 835	19. 00					
		Uni nsured	Insured	Total (col. 1						
		pati ents	pati ents	+ col . 2)						
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00						
20. 00	Charity care charges and uninsured discounts for the entire fac	cility 23,607,9	3, 441, 839	27, 049, 780	20. 00					
	(see instructions)									
21. 00	Cost of patients approved for charity care and uninsured discou	ınts (see 5,375,0	3, 441, 839	8, 816, 919	21. 00					
22. 00	instructions) Payments received from patients for amounts previously written	off as	0 762	762	22. 00					
22.00	charity care	011 43	702	702	22.00					
23. 00	Cost of charity care (line 21 minus line 22)	5, 375, 0	3, 441, 077	8, 816, 157	23. 00					
				1. 00						
24 00	Does the amount on line 20 column 2, include charges for patier	nt days beyond a Length	of stav limit	1.00 N	24. 00					
	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th	program?			25. 00					
20.00	stay limit	io margent care progra	3 rengtii oi		25.00					
26. 00	Total bad debt expense for the entire hospital complex (see ins	,		25, 705, 665						
27. 00	Medicare reimbursable bad debts for the entire hospital complex			650, 797	ı					
27. 01	Medicare allowable bad debts for the entire hospital complex (s	see instructions)		1, 001, 227	1					
28. 00 29. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp	nanca (saa instructions)	24, 704, 438 5, 975, 161						
	Cost of uncompensated care (line 23 column 3 plus line 29)	ochae (ace iliatiuctions		14, 791, 318						
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		21, 593, 153	1					
	•	•		•	•					

		DMMUNITY HEALTH		CN: 15 0074 D		u of Form CMS-1	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	F	eriod: rom 01/01/2021	Worksheet A	
				Т	o 12/31/2021	Date/Time Pre 5/30/2022 2:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	Din Din
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0	0	26, 958, 952	26, 958, 952	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	0	,,		2.00
3.00	00300 OTHER CAP REL COSTS		0	0	0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	225, 065	485, 199				4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	14, 409, 483 1, 872, 601	223, 396, 226 11, 620, 372				5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 457, 265			1, 457, 265	8.00
9. 00	00900 HOUSEKEEPI NG	3, 652, 785	2, 324, 015			5, 938, 998	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 614, 425	3, 556, 855	6, 171, 280 490, 057			10. 00 11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	245, 206 2, 663, 924	244, 851 876, 973				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	473, 403	855, 014				
15.00	01500 PHARMACY	9, 696, 607	187, 643, 016				
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	161, 904 1, 873, 585	643, 594 506, 863			-	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	4, 260, 334	1, 425, 974			5, 686, 308	1
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	9, 321, 660	3, 028, 667	12, 350, 327	-177, 318	12, 173, 009	
23. 00	02300 EMS TRAINING-ALLIED HEALTH 02301 RADIOLOGY SCHOOL-ALLIED HEALTH	0	0	0	0	0	23. 00 23. 01
23. 01 23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0		0	0	23. 01
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	49, 476, 673 11, 413, 628	25, 387, 789 7, 558, 877				1
32. 00	03200 CORONARY CARE UNIT	0	0 0	0, 772, 303		0	32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1, 504, 765	710, 651			2, 152, 074	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	533, 934	533, 934	43. 00
50. 00	05000 OPERATING ROOM	9, 431, 743	34, 295, 980	43, 727, 723	-23, 448, 916	20, 278, 807	50.00
51.00	05100 RECOVERY ROOM	609, 356	501, 513				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	494, 171	1, 134, 109				
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	4, 323, 081 502, 101	3, 177, 413 2, 917, 298			4, 482, 078 2, 055, 067	54. 00 55. 00
57. 00	05700 CT SCAN	1, 154, 426	2, 246, 696			3, 780, 994	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	652, 633	1, 264, 024			1, 155, 498	
59. 00 60. 00	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY	3, 847, 851	40, 626, 440 16, 410, 050				
64. 00	06400 I NTRAVENOUS THERAPY	778, 967	1, 143, 048				
65.00	06500 RESPI RATORY THERAPY	4, 592, 510	2, 110, 030				
66.00	06600 PHYSI CAL THERAPY	7, 261, 946	3, 547, 973				
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0				
	06900 ELECTROCARDI OLOGY	3, 081, 429	1, 548, 477	4, 629, 906			
70.00	07000 ELECTROENCEPHALOGRAPHY	705, 369	463, 413			996, 705	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	,,		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	Ö	145, 521, 583		1
73. 01	07301 SPECIALTY PHARMACY	0	13, 804, 760			63, 665, 271	73. 01
74.00	07400 RENAL DI ALYSI S	0	1, 652, 703			1, 652, 152	
76. 00 76. 01	03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	437, 679 30, 288, 673	784, 890 13, 172, 591	1, 222, 569 43, 461, 264		933, 916 41, 786, 842	76. 00 76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	7, 983, 721	5, 882, 061	13, 865, 782			76. 03
76. 04	03952 WOUND CARE CENTER	897, 283	2, 157, 528			2, 503, 991	76. 04
76. 05 76. 06	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS	17, 734, 399 3, 425, 767	20, 515, 530 5, 430, 480				
76. 07	03954 BREAST DIAGNOSTIC CENTER	0	2, 841, 730			2, 746, 143	
76. 97	07697 CARDI AC REHABILITATION	847, 105	417, 920				
76. 98	O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	340, 878	340, 878	76. 98
88. 00	08800 RURAL HEALTH CLINIC	O	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01 90. 02	04950 DI ABETI C CARE CENTER 04951 HEALTHY HEARTS CENTER	1, 723, 147	0 790, 435	0 2, 513, 582	0 -185, 025	0 2, 328, 557	90. 01 90. 02
90. 03	09001 CLI NI C	0	, , , , , , , , 0	2, 515, 562	0	2, 320, 337	90.03
90. 04	04953 SPI NE CENTER	0	0	0	0	0	90.04
90. 05	04954 I NFUSI ON CENTERS	313, 410	8, 286, 944	8, 600, 354	-8, 120, 896	479, 458	90. 05 90. 06
		\ \n	^	_ ^		/ \	
90. 06 90. 07	09002 MEDCHECK CLINICS 09003 KNEE CENTER	0 2, 011, 556	0 2, 430, 695	0 4, 442, 251	-211, 767	0 4, 230, 484	
90. 06	09002 MEDCHECK CLINICS	0 2, 011, 556 0 0	0 2, 430, 695 0 0	0	0		90. 07 90. 08

		NETWORK INC			C.E. OUC.	2550 40
Health Financial Systems CC RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	MMUNITY HEALTH	Provider CO	N: 15 0074 E	eri od:	u of Form CMS-2 Worksheet A	2552-10
RECEASSITICATION AND ADSOSTMENTS OF TRIAL BALANCE OF	LAFLINGLS	FIOVIDEI CO		From 01/01/2021	WOI KSHEEL A	
			Т	o 12/31/2021	Date/Time Pre 5/30/2022 2:4	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	0.00	0.00		col . 4)	
OR TO DESCRIPTION AND MATERIATIVE CARE	1.00	2. 00	3.00	4. 00	5. 00	00.40
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	(0	0	90. 12
91. 00 09100 EMERGENCY	11, 009, 267	7, 551, 057	18, 560, 324	-1, 246, 559	17, 313, 765	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	00.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS	Ч	U) 0	U	98. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	227, 973, 638	668, 827, 989	896, 801, 627	1, 527, 292	898, 328, 919	110 00
NONREI MBURSABLE COST CENTERS	221, 913, 030	000, 027, 707	090,001,027	1, 321, 272	070, 320, 717	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	0	(0	0	190. 00
191. 00 19100 RESEARCH		0				191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o o	53, 529	53, 529	-193	53, 336	
194. 00 07950 HOME OFFI CE	0	0	(0		194. 00
194. 01 07951 CHNW LEASED SPACE	o	0	d	o o		194. 01
194. 02 07952 ACCOUNTABLE CARE	425, 426	134, 883	560, 309	0	560, 309	194. 02
194. 03 07953 SCHOOL BASED CLINICS	42, 380	87, 362	129, 742	-72	129, 670	194. 03
194.04 07954 SMO-NON PROVIDER BASED	568, 745	185, 346	754, 091	-3, 719	750, 372	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	2, 591, 146	2, 484, 674	5, 075, 820	-1, 388, 116	3, 687, 704	194. 05
194. 07 07957 LI FECHECK	O	0	(0	0	194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	950, 835	839, 986	1, 790, 821	-135, 192	1, 655, 629	194. 08
194.09 07959 SURGERY CENTER EAST	0	0	(0	0	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	232, 552, 170	672, 613, 769	905, 165, 939	0	905, 165, 939	200. 00

Health Financial Systems	COMMUNITY HEALTH	I NETWORK, INC.		In Lie	u of Form CMS	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provider CCN:	15-0074	Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pr	enared:
				10 12/31/2021	5/30/2022 2:	48 pm
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For Allocation				
GENERAL SERVICE COST CENTERS	6. 00	7.00				
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	-8, 675, 305	18, 283, 647				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	5, 194, 401	1 1				2. 00
3.00 00300 OTHER CAP REL COSTS	0	0				3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11, 640, 638					4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-77, 121, 378					5. 00
7.00 00700 OPERATION OF PLANT	5, 082, 413					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	, , , , , , , , , , , , , , , , , , , ,				8. 00
9. 00 00900 HOUSEKEEPI NG	0					9.00
10. 00 01000 DI ETARY	2 200 222	1, 960, 601				10.00
11. 00 01100 CAFETERI A	-2, 209, 333					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	4, 827, 171 6, 990, 846					13. 00 14. 00
15. 00 01400 CENTRAL SERVICES & SUPPLY	-99, 796	1 1				15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	5, 020, 964					16. 00
17. 00 01700 SOCI AL SERVI CE	0,020,701	1				17. 00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRVD						21. 00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD						22. 00
23. 00 02300 EMS TRAINING-ALLIED HEALTH	0	O				23. 00
23. 01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0	0				23. 01
23. 02 02302 PHARMACY RESI DENCY-ALLI ED HEALTH	0	1 1				23. 02
23. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0				23. 03
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	-11, 133, 237	1 1				30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	533, 934				43.00
50. 00 05000 OPERATING ROOM	-1, 505, 690	18, 773, 117				50.00
51. 00 05100 RECOVERY ROOM	-1, 303, 070					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	-1, 117, 442					52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6,004					54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	2, 055, 067				55. 00
57. 00 05700 CT SCAN	0	3, 780, 994				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 155, 498				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	-179, 686	6, 651, 170				59. 00
60. 00 06000 LABORATORY	-2, 983	16, 289, 200				60.00
64.00 06400 INTRAVENOUS THERAPY	-15, 765	1, 850, 438				64. 00
65. 00 06500 RESPIRATORY THERAPY	0					65. 00
66. 00 06600 PHYSI CAL THERAPY	502, 320					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67. 00
68. 00 06800 SPEECH PATHOLOGY	00 074	,				68. 00
69. 00 06900 ELECTROCARDI OLOGY	-32, 971					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	167, 223					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 102, 131					73. 00
73. 01 07301 SPECI ALTY PHARMACY	2, 102, 131					73. 00
74. 00 07400 RENAL DI ALYSI S						74. 00
76. 00 03330 ENDOSCOPY		933, 916				76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	-28, 296, 924	1				76. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P	-9, 380, 080					76. 03
76. 04 03952 WOUND CARE CENTER	0	2, 503, 991				76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	-36, 072					76. 05
76. 06 03953 I MAGI NG CENTERS	13, 024					76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	-133, 901					76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	-18, 830					76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	340, 878				76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 09000 CLI NI C	0	0				90.00
90. 01 04950 DI ABETI C CARE CENTER	1 1/0 05/	1 150 701				90. 01
90. 02 04951 HEALTHY HEARTS CENTER 90. 03 09001 CLI NI C	-1, 169, 856	1, 158, 701				90. 02
90. 03 09001 CLI NI C 90. 04 04953 SPI NE CENTER		U				90. 03 90. 04
90. 04 04953 SPINE CENTER 90. 05 04954 INFUSION CENTERS		479, 458				90.04
90. 06 09002 MEDCHECK CLINICS		4/7,400				90.05
90. 07 09003 KNEE CENTER	-73, 846	4, 156, 638				90.08
90. 08 09004 PALLI ATI VE CARE	75,040	1, 130, 030				90.08
90. 10 09006 WORK SITE CLINICS	n	ا				90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE		l ő				90. 12
91. 00 09100 EMERGENCY	2, 286, 187	19, 599, 952				91.00
711 00 07100 EMERCENO!						

			5/30/2022 2.46 pill
Cost Center Description	Adjustments	Net Expenses	
		For Allocation	
	6. 00	7. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS			
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-102, 791, 861	795, 537, 058	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
191. 00 19100 RESEARCH	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	53, 336	192. 00
194.00 07950 HOME OFFICE	0	0	194. 00
194.01 07951 CHNW LEASED SPACE	0	0	194. 01
194. 02 07952 ACCOUNTABLE CARE	0	560, 309	194. 02
194. 03 07953 SCHOOL BASED CLINICS	0	129, 670	194. 03
194. 04 07954 SMO-NON PROVIDER BASED	0	750, 372	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	3, 687, 704	194. 05
194. 07 07957 LI FECHECK	0	0	194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	1, 655, 629	194. 08
194.09 07959 SURGERY CENTER EAST	0	0	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-102, 791, 861	802, 374, 078	200. 00

Heal th	Financial Systems	C	OMMUNITY HEALTH	H NETWORK, INC.	In Lieu of Form CMS-2552-10		
RECLAS	SIFICATIONS			Provi der CCN:	15-0074	Period: Worksh From 01/01/2021	neet A-6
						To 12/31/2021 Date/1	Γi me Prepared:
		Increases				5/30/2	2022 2:48 pm
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4.00	5. 00			
1 00	A - Chargeable Medical Suppli CENTRAL SERVICES & SUPPLY		٥	4 057			1 00
1. 00 2. 00	MEDICAL SUPPLIES CHARGED TO	14. 00 71. 00	0	4, 957 37, 429, 224			1. 00 2. 00
2.00	PATI ENTS	, 65		077 1277 22 1			2.00
3.00		0.00	0	0			3.00
4. 00 5. 00		0. 00 0. 00	0	0			4. 00 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 10. 00		0. 00 0. 00	0	0			9. 00 10. 00
11. 00		0.00	o	0			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	Ö	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	Ō	0			21. 00
22. 00		0.00	0	0			22. 00
23. 00 24. 00		0. 00 0. 00	0	0			23. 00 24. 00
25. 00		0.00	0	0			25. 00
26.00		0.00	0	0			26. 00
27. 00		0.00	0	0			27. 00
28. 00 29. 00		0. 00 0. 00	0	0			28. 00 29. 00
30. 00		0.00	Ö	0			30.00
31.00		0.00	0	0			31.00
32. 00	TOTALS — — — —	0.00	— — o	<u>0</u> 37, 434, 181			32. 00
	B - Implantable Device Reclas	SS	-	, , , , ,			
1.00	IMPL. DEV. CHARGED TO	72. 00	0	28, 086, 184			1.00
2. 00	PATI ENTS	0.00	o	0			2. 00
3.00		0.00	Ö	0			3. 00
4.00		0.00	0	0			4.00
5. 00		0.00	— — —	<u>28,</u> 086, 184			5. 00
	C - Drugs Charges to Pat		51	20/000/101			
1.00	ELECTROCARDI OLOGY	69. 00	0	10, 572			1. 00
2. 00 3. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	145, 521, 583 0			2. 00 3. 00
4. 00		0.00	o	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		0.00	0	0			10.00
11. 00 12. 00		0. 00 0. 00	0	0			11. 00 12. 00
13. 00		0.00	o	Ö			13. 00
14. 00		0.00	O	0			14. 00
15. 00 16. 00		0. 00 0. 00	0	0			15. 00 16. 00
17. 00		0.00	0	0			17. 00
18.00		0.00	0	0			18. 00
19.00		0.00	0	0			19. 00
20. 00 21. 00		0. 00 0. 00	0	0			20. 00 21. 00
22. 00		0.00	o	Ö			22. 00
23.00		0.00	0	0			23. 00
24. 00 25. 00		0. 00 0. 00	0	0			24. 00 25. 00
26. 00		0.00	0	0			26. 00
27.00		0.00	0	0			27. 00
28. 00 29. 00		0. 00 0. 00	0	0			28. 00 29. 00
29. 00 30. 00		0.00	0	0			30.00
	•	·	'	<u> </u>			· · · · · · · · · · · · · · · · · · ·

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm Provider CCN: 15-0074

					5/30/2022 2:	
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5 00		
31. 00	2. 00	3.00	4. 00	5. 00		31.00
32. 00		0.00	0	o		32. 00
33.00		0.00	0	0		33. 00
34.00		0.00	0	0		34. 00
35. 00	L	0.00	0	0		35. 00
	TOTALS			145, 532, 155		
4 00	D - Depreciation Expense	0.00		00 575 405		4 00
1. 00 2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0			1. 00 2. 00
3.00		0.00	0			3. 00
4. 00		0.00	0			4. 00
5. 00		0.00	0	Ö		5. 00
6.00		0.00	0			6. 00
7.00		0.00	0			7. 00
8.00		0.00	0			8. 00
9. 00		0.00	0			9. 00
10.00		0.00	0			10.00
11.00		0.00	0			11.00
12. 00 13. 00		0. 00 0. 00	0			12. 00 13. 00
14. 00		0.00	0			14. 00
15. 00		0.00	0			15. 00
16. 00		0.00	0			16. 00
17. 00		0.00	0			17. 00
18. 00		0.00	0			18. 00
19. 00		0.00	0			19. 00
20. 00		0.00	0			20.00
21. 00		0.00	0			21. 00
22. 00 23. 00		0. 00 0. 00	0			22. 00
24. 00		0.00	0			23. 00 24. 00
25. 00		0.00	0			25. 00
26. 00		0.00	0			26. 00
27. 00		0.00	0			27. 00
28. 00		0.00	0			28. 00
29. 00		0.00	0			29. 00
30. 00		0.00	0	0		30. 00
31.00		0.00	0			31.00
32. 00 33. 00		0. 00 0. 00	0			32. 00 33. 00
34. 00		0.00	0			34.00
35. 00		0.00	0			35. 00
36. 00		0.00	0			36. 00
37.00		0.00	0			37. 00
38. 00		0.00	0			38. 00
39. 00		0.00	0			39. 00
40.00		0.00	0			40.00
41. 00	TOTALS — — — —		$ \frac{0}{0}$			41. 00
	E - Interest Expense		U	29, 373, 193		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11, 603, 552		1. 00
	TOTALS			11, 603, 552		
	F - Other Capital Rental					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	, ,		1. 00
2.00		0.00	0	0		2. 00
3.00		0. 00 0. 00	0			3. 00
4. 00 5. 00		0.00	0	-		4. 00 5. 00
6.00		0.00	0			6. 00
7. 00		0.00	0	Ö		7. 00
8. 00		0.00	0			8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0			11. 00
12. 00		0.00	0			12. 00
13.00		0.00	0			13. 00
14.00		0.00	0			14. 00
15. 00 16. 00		0. 00 0. 00	0	-		15. 00 16. 00
17. 00		0.00	0			17. 00
17. 00		0.00	0	0		18.00
19. 00		0.00	0			19. 00
20. 00		0.00	0			20. 00
21. 00		0.00	0			21. 00

Heal th	Financial Systems	C	OMMUNITY HEALTH	H NETWORK, INC.		In Lieu	of Form CMS-	2552-10
RECLASS	SIFICATIONS			Provi der CCN:	: 15-0074		Worksheet A-6	5
						From 01/01/2021 To 12/31/2021	Date/Time Pre	epared:
							5/30/2022 2: 4	48 pm
	Cost Center	Increases Line #	Salary	Other				
	2. 00	3.00	4. 00	5. 00				
22. 00	2100	0.00	0	0				22. 00
23.00		0. 00	0	0				23. 00
24.00		0. 00	0	0				24. 00
25. 00		0. 00	0	0				25. 00
26. 00		0.00	0	0				26. 00
27. 00		0.00	0	0				27. 00
28. 00 29. 00		0. 00 0. 00	0	0				28. 00 29. 00
30. 00		0.00	0	0				30.00
31. 00		0.00	0	0				31.00
32. 00		0.00	o	Ö				32. 00
33.00		0.00	0	0				33. 00
34.00		0.00	0	0				34. 00
35.00		0.00	0	0				35. 00
36.00		0. 00	0	0				36. 00
37. 00		0.00	0	0				37. 00
38. 00 39. 00		0.00	0	0				38. 00
39.00		0.00	0	11, 306, 080				39. 00
	G - STD BENEFIT		<u> </u>	11,000,000				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	19, 200				1.00
2.00	OPERATION OF PLANT	7. 00	0	25, 100				2. 00
3.00	HOUSEKEEPI NG	9. 00	0	12, 376				3. 00
4.00	DI ETARY	10. 00	0	8, 404				4. 00
5.00	CAFETERI A	11. 00	0	144				5. 00
6.00	NURSI NG ADMI NI STRATI ON	13.00	0	21, 271				6.00
7. 00 8. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	2, 521 37, 269				7. 00 8. 00
9. 00	SOCIAL SERVICE	17. 00	0	4, 523				9. 00
10. 00	I&R SERVICES-SALARY &	21. 00	0	1, 510				10. 00
	FRINGES APPRVD							
11. 00	I&R SERVICES-OTHER PRGM	22. 00	0	17, 985				11. 00
10.00	COSTS APPRVD	20.00		227 702				10.00
12. 00 13. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	227, 703 86, 910				12. 00 13. 00
14. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0	7, 229				14. 00
15. 00	OPERATING ROOM	50.00	o	38, 519				15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	27, 969				16. 00
17.00	CT SCAN	57.00	0	4, 764				17. 00
18. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	1, 672				18. 00
40.00	(MRI)	50.00		40.054				40.00
19. 00	CARDI AC CATHETERI ZATI ON	59.00	0	13, 251				19.00
20. 00 21. 00	I NTRAVENOUS THERAPY RESPIRATORY THERAPY	64. 00 65. 00	0	2, 303 41, 117				20. 00 21. 00
	PHYSICAL THERAPY	66.00	0	72, 061				22. 00
	ELECTROCARDI OLOGY	69.00	0	19, 551				23. 00
24.00	ELECTROENCEPHALOGRAPHY	70. 00	0	135				24. 00
25. 00	ENDOSCOPY	76. 00	0	914				25. 00
26. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	151, 239				26. 00
27. 00	SERVICES LUTHERWOOD PARTNERSHIP	76. 03	o	37, 545				27. 00
28. 00	WOUND CARE CENTER	76. 03 76. 04	0	482				28. 00
29. 00	ONCOLOGY-CANCER CARE CENTER	76. 04 76. 05	0	106, 947				29. 00
30. 00	I MAGING CENTERS	76. 06	0	21, 053				30.00
31. 00	CARDIAC REHABILITATION	76. 97	O	4, 495				31. 00
32.00	HEALTHY HEARTS CENTER	90. 02	0	3, 922				32. 00
33.00	KNEE CENTER	90. 07	0	14, 234				33. 00
34.00	EMERGENCY	91. 00	0	38, 230				34. 00
35. 00	SMO-NON PROVIDER BASED	194. 04	0	8, 061				35. 00
36.00	FAMILY PRACTICE MEDICINE	194. 05	0	18, 277				36.00
37. 00	GROUP HOMES AND MISC. N_R CTRS	194. 08	0	1, 714				37. 00
	TOTALS — — — — —	+	$-$	1, 100, 600				
	H - Labor and Delivery		<u> </u>					1
1.00	NURSERY	43.00	503, 040	0				1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	2, 148, 729	0				2. 00
3.00	NURSERY	43.00	0	233, 593				3. 00
4. 00	DELIVERY ROOM & LABOR ROOM		0	997, 791				4. 00
	TOTALS I - Cafeteria		2, 651, 769	1, 231, 384				1
1.00	CAFETERI A	11. 00	1, 753, 095	0				1.00
2. 00	CAFETERI A	11. 00	0	2, 239, 378				2. 00
	TOTALS — — — —		1, 753, 095	2, 239, 378				1

| Period: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

Cost Center						То	12/31/2021	Date/Time Prepared: 5/30/2022 2:48 pm
2.00 3.00 4.00 5.00			Increases		,	<u>'</u>		
J - Therrapy RecLass		Cost Center	Li ne #	Sal ary	0ther			
1.00		2. 00	3. 00	4. 00	5.00			
2.00 SPEECH PATHOLOGY		J - Therapy Reclass						
3.00 OCCUPATIONAL THERAPY	1.00	OCCUPATI ONAL THERAPY	67.00	1, 504, 941	0			1.00
A . 00 SPECH PATHOLOGY 68. 00 0 235, 858 70 70 TALS	2.00	SPEECH PATHOLOGY	68.00	539, 008	0			2. 00
TOTALS	3.00	OCCUPATI ONAL THERAPY	67.00	O	658, 527			3.00
1.00	4.00	SPEECH PATHOLOGY	68.00	O	235, 858			4. 00
1.00		TOTALS		2, 043, 949	894, 385			
TOTALS		K - Builiding Depreciation			<u>.</u>			
1.00	1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14, 682, 299			1.00
1.00		TOTALS			14, 682, 299			
TOTALS		L - Capital Insurance Costs	•		<u>.</u>			
M - Radi ology Support	1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	673, 101			1.00
1.00		TOTALS			673, 101			
2. 00 CT SCAN		M - Radiology Support	•	•				
3.00 MAGNETIC RESONANCE I MAGI NG (MRI)	1.00	RADI OLOGY-THERAPEUTI C	55.00	284, 750	0			1.00
MRI MAGI NG CENTERS 76.06 89,351 0 4.00	2.00	CT SCAN	57.00	131, 762	0			2. 00
4. 00 IMAGING CENTERS 76. 06 89, 351 0 4. 00 5. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 119, 980 5. 00 6. 00 CT SCAN 57. 00 0 55, 518 6. 00 7. 00 MAGNETI C RESONANCE I MAGING 58. 00 0 9, 050 7. 00 (MRI) 8. 00 IMAGING CENTERS 76. 06 0 37, 648 TOTALS 527, 342 222, 196 N - Hyperbaric Oxygen Therapy 1. 00 HYPERBARI C OXYGEN THERAPY 76. 98 92, 235 0 1. 00 1. 00 HYPERBARI C OXYGEN THERAPY 76. 98 92, 235 248, 643 0 2. 00 1. 00 CT SCAN 57. 00 774, 261 0 1. 00 2. 00 CT SCAN 57. 00 774, 261 323, 306 774, 261 323, 306 P - Special ty Pharmacy SPECIALTY PHARMACY 73. 01 1, 854, 227 0 0 2. 00 3. 00 SPECIALTY PHARMACY 73. 01 0 48, 006, 284 4. 00 1. 00 TOTALS 1, 854, 227 48, 006, 284	3.00	MAGNETIC RESONANCE I MAGING	58.00	21, 479	0			3.00
5. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 119, 980 5. 00 6. 00 CT SCAN 57. 00 0 55. 518 6. 00 7. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 58. 00 0 9, 050 7. 00 8. 00 I MAGI NG CENTERS 76. 06 0 37, 648 8. 00 TOTALS 527, 342 222, 196 8. 00 N - Hyperbari C Oxygen Therapy 1. 00 1. 00 1. 00 HYPERBARI C OXYGEN THERAPY 76. 98 92, 235 0 1. 00 2. 00 HYPERBARI C OXYGEN THERAPY 76. 98 0 248, 643 2. 00 TOTALS 92, 235 248, 643 2. 00 1. 00 CT SCAN 57. 00 774, 261 0 1. 00 2. 00 CT SCAN 57. 00 774, 261 323, 306 2. 00 TOTALS 774, 261 323, 306 2. 00 9 - Special ty Pharmacy 73. 01 1, 854, 227 0 1. 00 2. 00 0 0 0 0 2. 00 3. 00 SPECI ALTY PHARMACY 73. 01 1, 854, 227 48, 006, 284 3. 00 4. 00 TOTALS 1, 854, 227 48, 006, 284 <td></td> <td>(MRI)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		(MRI)						
6. 00 CT SCAN	4.00	I MAGING CENTERS	76.06	89, 351	0			4. 00
7. 00 MAGNETIC RESONANCE IMAGING 58. 00 0 9, 050 7. 00	5.00	RADI OLOGY-THERAPEUTI C	55.00	0	119, 980			5. 00
MRI MAGING CENTERS 76.06 0 37,648 70TALS 222,196 70.00	6.00	CT SCAN	57.00	O	55, 518			6. 00
8. 00 MAGÍNG CENTERS 76. 06 0 37, 648 70TALS 527, 342 222, 196 70TALS 76. 98	7.00	MAGNETIC RESONANCE I MAGING	58.00	O	9, 050			7. 00
TOTALS		(MRI)						
N - Hyperbari c Oxygen Therapy	8.00	I MAGING CENTERS	76.06	0	37, 648			8.00
1. 00 HYPERBARI C OXYGEN THERAPY 76. 98 92, 235 0 248, 643 2.00 HYPERBARI C OXYGEN THERAPY 76. 98 0 248, 643 2.00 TOTALS 92, 235 248, 643 0 1.00 CT SCAN 57.00 774, 261 0 2.00 CT SCAN 57.00 0 323, 306 TOTALS 774, 261 323, 306 P - Special ty Pharmacy 5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		TOTALS		527, 342	222, 196			
2. 00 HYPERBARI C OXYGEN THERAPY 76. 98 0 248, 643 70TALS 92, 235 248, 643 70 1 1 1 1 00		N - Hyperbari c Oxygen Therapy	,					
TOTALS 0 - I HH Cat Scan 1. 00 CT SCAN 2. 00 CT SCAN 57. 00 774, 261 0 CT SCAN TOTALS 774, 261 323, 306 P - Special ty Pharmacy 1. 00 SPECIALTY PHARMACY 73. 01 1, 854, 227 0 2. 00 3. 00 SPECIALTY PHARMACY 73. 01 0 48, 006, 284 4. 00 TOTALS 1, 854, 227 48, 643 4. 00 TOTALS 1. 00 4. 00 TOTALS 1. 00 4. 00 TOTALS 1. 00 4. 00 TOTALS 1. 854, 227 48, 006, 284	1.00	HYPERBARIC OXYGEN THERAPY	76. 98	92, 235	0			1.00
1. 00 CT SCAN 57. 00 774, 261 0 1. 00 2. 00 CT SCAN 57. 00 0 323, 306 2. 00 TOTALS 774, 261 323, 306 2. 00 P - Special ty Pharmacy SPECIALTY PHARMACY 73. 01 1, 854, 227 0 1. 00 2. 00 3. 00 SPECIALTY PHARMACY 73. 01 0 48, 006, 284 3. 00 4. 00 0.00 0 0 0 48, 006, 284 4. 00 0.00 0 0 0 0 TOTALS 1, 854, 227 48, 006, 284 48, 006, 284	2.00	HYPERBARIC OXYGEN THERAPY	76. 98	0	248, 643			2. 00
1. 00 CT SCAN 57. 00 774, 261 0 2. 00 CT SCAN 57. 00 0 323, 306 TOTALS 774, 261 323, 306 P - Special ty Pharmacy 1. 00 SPECIALTY PHARMACY 73. 01 1, 854, 227 0 1. 00 2. 00 3. 00 SPECIALTY PHARMACY 73. 01 0 48, 006, 284 3. 00 4. 00 0. 00 0 0 0 0 TOTALS 1, 854, 227 48, 006, 284 4. 00		TOTALS		92, 235	248, 643			
2. 00 CT_SCAN		0 - IHH Cat Scan						
TOTALS 774, 261 323, 306 P - Special ty Pharmacy 1. 00 SPECIALTY PHARMACY 73. 01 1, 854, 227 0 1. 00 2. 00 0 0 0 0 2. 00 3. 00 SPECIALTY PHARMACY 73. 01 0 48, 006, 284 4. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00	CT SCAN	57.00	774, 261	0			1.00
P - Special ty Pharmacy 1. 00 2. 00 3. 00 SPECIALTY PHARMACY 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 74. 00 75. 01 75.	2.00	CT SCAN	57.00	O	323, 306			2. 00
1. 00 SPECIALTY PHARMACY 73. 01 1, 854, 227 0 1. 00 2. 00 0. 00 0 0 0 3. 00 SPECIALTY PHARMACY 73. 01 0 48, 006, 284 3. 00 4. 00 0. 00 0 0 0 0 48, 006, 284 TOTALS 1, 854, 227 48, 006, 284		TOTALS		774, 261	323, 306			
2. 00 3. 00 SPECIALTY PHARMACY 73. 01 0 48, 006, 284 4. 00 TOTALS 1, 854, 227 48, 006, 284		P - Specialty Pharmacy			<u>.</u>			
3. 00 SPECIALTY PHARMACY 73. 01 0 48, 006, 284 3. 00 4. 00 TOTALS 1, 854, 227 48, 006, 284	1.00	SPECIALTY PHARMACY	73. 01	1, 854, 227	0			1. 00
4. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00		0.00	o	0			2. 00
TOTALS 1, 854, 227 48, 006, 284	3.00	SPECIALTY PHARMACY	73. 01	o	48, 006, 284			3.00
	4.00		0.00	o	0			4. 00
500, 00 Grand Total: Increases 9, 696, 878 333, 158, 923		TOTALS		1, 854, 227	48, 006, 284			
	500.00	Grand Total: Increases		9, 696, 878	333, 158, 923			500. 00

Provider CCN: 15-0074

In Lieu of Form CMS-2552-10

| Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 2:48 pm

						5/30/2022 2:	
	Cost Contor	Decreases	Calami	Othon	Wko+ A 7 Dof		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - Chargeable Medical Suppli		0.00	7.00	10.00		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	3, 778	0		1.00
2.00	OPERATION OF PLANT	7.00	0	178, 294	0		2. 00
3.00	DI ETARY	10.00	0	979	0		3. 00
4.00	PHARMACY	15. 00	0	227, 756	l t		4. 00
5. 00	I &R SERVICES-OTHER PRGM	22. 00	0	103, 584	0		5. 00
	COSTS APPRVD	20.00		4 404 000			, , , ,
6. 00 7. 00	ADULTS & PEDIATRICS	30.00	0	1, 101, 338	0		6. 00 7. 00
8. 00	INTENSIVE CARE UNIT	31. 00 35. 00	0	1, 085, 461 32, 137	0		8. 00
9. 00	OPERATING ROOM	50.00	0	7, 545, 224			9. 00
10. 00	RECOVERY ROOM	51.00	0	12, 358			10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	182, 007			11.00
12. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	1, 524, 312	o		12. 00
13. 00	CT SCAN	57.00	0	52, 238			13. 00
14. 00	MAGNETIC RESONANCE IMAGING	58.00	0		l t		14. 00
	(MRI)			,			
15.00	CARDIAC CATHETERIZATION	59.00	0	21, 922, 656	0		15. 00
16.00	INTRAVENOUS THERAPY	64.00	0	50, 879	0		16. 00
17.00	RESPIRATORY THERAPY	65.00	0	443, 369			17. 00
18. 00	PHYSI CAL THERAPY	66.00	0	13, 549			18. 00
19. 00	ELECTROCARDI OLOGY	69.00	0	24, 829	1		19. 00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	16, 383	l .		20.00
21. 00	ENDOSCOPY	76.00	0	128, 119	1		21. 00
22. 00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76. 01	0	450	0		22. 00
23. 00	LUTHERWOOD PARTNERSHIP	76. 03	0	14, 870	o		23. 00
24. 00	WOUND CARE CENTER	76. 03 76. 04	0	136, 356	l t		24. 00
25. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	500, 188			25. 00
26. 00	I MAGING CENTERS	76.06	0	1, 268, 905			26.00
27. 00	CARDIAC REHABILITATION	76. 97	0	4, 797	0		27. 00
28. 00	HEALTHY HEARTS CENTER	90. 02	0	5, 818	o		28. 00
29. 00	INFUSION CENTERS	90. 05	0	3, 148	l !		29. 00
30.00	KNEE CENTER	90. 07	0	585	l 1		30.00
31.00	EMERGENCY	91.00	0	832, 132	0		31.00
32.00	FAMILY PRACTICE MEDICINE	194. 05	0	5, 023	0		32. 00
	TOTALS		0	37, 434, 181			
4 00	B - Implantable Device Reclas		٥	40.004.450			1 00
1.00	OPERATING ROOM	50.00	0	, ,	l I		1. 00
2. 00 3. 00	RADI OLOGY-THERAPEUTI C CARDI AC CATHETERI ZATI ON	55. 00 59. 00	0	,	l t		2. 00 3. 00
4. 00	ENDOSCOPY	76.00	0	14, 423, 832 10, 035			4. 00
5. 00	WOUND CARE CENTER	76.00	0	41, 282			5. 00
5.00	TOTALS	— 70. 04	— — <u> </u>				3.00
	C - Drugs Charges to Pat		<u> </u>	20/000/101			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 316	0		1.00
2.00	HOUSEKEEPI NG	9.00	0	146	0		2. 00
3.00	NURSING ADMINISTRATION	13.00	0	7, 018	0		3. 00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	45, 937			4. 00
5.00	PHARMACY	15. 00	0	135, 680, 817	l t		5. 00
6. 00	MEDICAL RECORDS & LIBRARY	16. 00	0	3, 562	l t		6. 00
7. 00	I &R SERVICES-OTHER PRGM	22. 00	0	4, 548	0		7. 00
0 00	COSTS APPRVD	30.00		24 047			0 00
8. 00 9. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	34, 817 24, 997	0 0		8. 00 9. 00
9. 00 10. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0	24, 997 104	1		10.00
11. 00	OPERATING ROOM	50.00	0	48, 624			11. 00
12. 00	RECOVERY ROOM	51.00	0	46, 624 242			12.00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	253, 551	o		13. 00
14. 00	RADI OLOGY-THERAPEUTI C	55. 00	Ö	1, 131	1		14. 00
15. 00	CT SCAN	57.00	0	171, 124	1		15. 00
16.00	MAGNETIC RESONANCE IMAGING	58.00	O	53, 617	l t		16. 00
	(MRI)						
17. 00	CARDIAC CATHETERIZATION	59.00	0	87, 938	l I		17. 00
18. 00	INTRAVENOUS THERAPY	64.00	0	111	0		18. 00
19. 00	RESPI RATORY THERAPY	65.00	0	20	0		19. 00
20.00	PHYSI CAL THERAPY	66.00	0	2, 821	0		20.00
21. 00	ELECTROENCEPHALOGRAPHY	70.00	0	18	1		21. 00
22. 00	RENAL DI ALYSI S	74.00	0	48	l I		22. 00
23. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	28, 948	0		23. 00
24. 00	SERVICES LUTHERWOOD PARTNERSHIP	76. 03	0	13, 172	0		24. 00
25. 00	WOUND CARE CENTER	76. 03	0		l !		25. 00
26. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	·	l 1		26. 00
			- '		·		<u> </u>

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

						o 12/31/2021 Date/Time Pr 5/30/2022 2:	
		Decreases					
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
27. 00	I MAGI NG CENTERS	7.00	0.00	130, 126			27. 00
28. 00	HEALTHY HEARTS CENTER	90.02	0	375			28. 00
29. 00	INFUSION CENTERS	90. 05	0	7, 885, 004	0		29. 00
30.00	KNEE CENTER	90. 07	0	29, 976	0		30.00
31. 00	EMERGENCY	91.00	0	16, 425	0		31. 00
32.00	SCHOOL BASED CLINICS	194. 03	0	72			32. 00
33. 00	SMO-NON PROVIDER BASED	194. 04	0	3, 719			33. 00
34. 00	FAMILY PRACTICE MEDICINE	194. 05	0	308, 428			34. 00
35. 00	GROUP HOMES AND MISC. N_R CTRS	194. 08	0	115	0		35. 00
	TOTALS — — — — —		— — _ō	145, 532, 155			
	D - Depreciation Expense			11070027100			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	737	9		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	13, 408, 743			2. 00
3.00	OPERATION OF PLANT	7. 00	0	507, 557			3. 00
4.00	HOUSEKEEPI NG	9.00	0	7, 995			4. 00
5.00	DIETARY	10.00	0	212, 728			5. 00
6. 00 7. 00	CAFETERI A NURSI NG ADMI NI STRATI ON	11. 00 13. 00	0	12, 184 38, 530			6. 00 7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	117, 987			8.00
9. 00	PHARMACY	15. 00	0	126, 414	-		9. 00
10.00	I&R SERVICES-OTHER PRGM	22. 00	0	69, 186			10.00
	COSTS APPRVD						
11. 00	ADULTS & PEDIATRICS	30. 00	0	1, 279, 756	0		11. 00
12.00	INTENSIVE CARE UNIT	31. 00	0	1, 205, 140			12. 00
13. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	31, 101			13. 00
14. 00	OPERATING ROOM	50.00	0	1, 830, 160			14. 00
15. 00 16. 00	RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	51. 00 54. 00	0	117, 305 734, 705			15. 00 16. 00
17. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	27, 169			17. 00
18. 00	CT SCAN	57. 00	0	677, 402			18.00
19. 00	MAGNETIC RESONANCE I MAGING	58.00	0	725, 243	-		19. 00
	(MRI)			,			
20.00	CARDIAC CATHETERIZATION	59. 00	0	1, 206, 202	0		20. 00
21. 00	LABORATORY	60.00	0	64, 654			21. 00
22. 00	I NTRAVENOUS THERAPY	64.00	0	4, 822			22. 00
23. 00	RESPIRATORY THERAPY	65.00	0	91, 332			23. 00
24. 00 25. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	74, 049 457, 131	-		24. 00 25. 00
26. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	124, 030			26. 00
27. 00	RENAL DI ALYSI S	74.00	0	503			27. 00
28. 00	ENDOSCOPY	76. 00	0	72, 818			28. 00
29.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	184, 690	0		29. 00
	SERVI CES						
30. 00	LUTHERWOOD PARTNERSHIP	76. 03	0	135, 332			30.00
31. 00	WOUND CARE CENTER	76.04	0	6, 984			31.00
32. 00	ONCOLOGY-CANCER CARE CENTER I MAGING CENTERS	76. 05	0	4, 050, 034 1, 080, 138			32. 00 33. 00
	BREAST DIAGNOSTIC CENTER	76. 06 76. 07	0				34.00
35. 00	CARDI AC REHABI LI TATI ON	76. 97 76. 97	0	39, 877			35. 00
36. 00	HEALTHY HEARTS CENTER	90. 02	0	17, 035			36. 00
37.00	INFUSION CENTERS	90. 05	0	52, 762			37. 00
38.00	KNEE CENTER	90. 07	0	178, 494	0		38. 00
39. 00	EMERGENCY	91.00	0	397, 401			39. 00
40.00	FAMILY PRACTICE MEDICINE	194. 05	0	160, 308			40. 00
41. 00	GROUP HOMES AND MISC. N_R	194. 08	0	45, 970	0		41. 00
	TOTALS	+	— — ₀				
	E - Interest Expense		U	27, 373, 173			
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	11, 603, 552	11		1.00
	TOTALS		₀				
	F - Other Capital Rental						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0				1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	878, 802			2. 00
3.00	OPERATION OF PLANT	7.00	0	271, 545			3.00
4.00	HOUSEKEEPI NG	9.00	0	29, 661			4.00
5. 00 6. 00	DI ETARY CAFETERI A	10. 00 11. 00	0	4, 499 12, 281			5. 00 6. 00
7. 00	NURSING ADMINISTRATION	13.00	0	12, 281			7.00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	2, 114, 570			8.00
9. 00	PHARMACY	15. 00	Ö	811, 211			9. 00
10.00	SOCI AL SERVI CE	17. 00	0	133			10.00
11. 00	NURSERY	43. 00	0	202, 699			11. 00
12. 00	ADULTS & PEDIATRICS	30. 00	0	850, 515	0		12. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0074

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/30/2022 2: 48 pm

						5/30/2022 2	: 48 pm
		Decreases					
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
10.00	6. 00	7. 00	8.00	9. 00	10.00		10.00
13.00	INTENSIVE CARE UNIT	31. 00	0	294	0		13.00
14.00	OPERATING ROOM	50.00	0	630, 250	0		14. 00
15.00	RECOVERY ROOM	51.00	0	428	0		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 048	0		16.00
17. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	73	0		17. 00
18.00	CT SCAN	57. 00	0	4, 211	0		18.00
19. 00	MAGNETIC RESONANCE I MAGING	58. 00	U	169	0		19. 00
20. 00	(MRI)	59.00	0	2 907	0		20. 00
	CARDIAC CATHETERIZATION	•	0	2, 807	0		
21. 00	LABORATORY THERAPY	60.00	-	53, 213	0		21. 00
22. 00	RESPIRATORY THERAPY	65. 00	0	644	-		22. 00
23. 00	PHYSI CAL THERAPY	66.00	0	1, 142, 441	0		23. 00
24. 00	ELECTROCARDI OLOGY	69.00	0	176, 466	0		24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00	0	31, 646	0		25. 00
26. 00	ENDOSCOPY	76.00	0	77, 681	0		26. 00
27. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	1, 460, 334	0		27. 00
20.00	SERVICES	7/ 02		25 072	0		20.00
28. 00	LUTHERWOOD PARTNERSHIP	76. 03	0	25, 873	0		28. 00
29. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	444, 056	0		29. 00
30.00	I MAGING CENTERS	76.06	0	472, 872	-		30.00
31. 00	BREAST DIAGNOSTIC CENTER	76. 07	0	95, 000	0		31.00
32.00	CARDI AC REHABI LI TATI ON	76. 97	0	136, 625	0		32.00
33. 00	HEALTHY HEARTS CENTER	90. 02	0	161, 797	0		33. 00
34. 00	INFUSION CENTERS	90. 05	0	179, 982	0		34. 00
35. 00	KNEE CENTER	90. 07	0	2, 712	0		35. 00
36. 00	EMERGENCY	91.00	0	601	0		36. 00
37. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	193	0		37. 00
38. 00	FAMILY PRACTICE MEDICINE	194. 05	0	914, 357	0		38. 00
39. 00	GROUP HOMES AND MISC. N_R	194. 08	0	89, 107	0		39. 00
	CTRS	+					
	TOTALS		0	11, 306, 080			
	G - STD BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5. 00	19, 200	0			1. 00
2.00	OPERATION OF PLANT	7. 00	25, 100	0			2. 00
3.00	HOUSEKEEPI NG	9. 00	12, 376	0			3. 00
4.00	DI ETARY	10.00	8, 404	0	0		4. 00
5.00	CAFETERI A	11. 00	144	0	0		5. 00
6.00	NURSING ADMINISTRATION	13. 00	21, 271	0	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14. 00	2, 521	0	0		7. 00
8.00	PHARMACY	15. 00	37, 269	0	0		8. 00
9.00	SOCI AL SERVI CE	17. 00	4, 523	0	0		9. 00
10. 00	I&R SERVICES-SALARY &	21. 00	1, 510	0	0		10. 00
	FRI NGES APPRVD			_	_		
11. 00	I &R SERVICES-OTHER PRGM	22. 00	17, 985	0	0		11. 00
40.00	COSTS APPRVD						40.00
12.00	ADULTS & PEDIATRICS	30.00	227, 703	0	0		12.00
13.00	INTENSIVE CARE UNIT	31. 00	86, 910	0	0		13.00
14. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	7, 229	0	0		14. 00
15. 00	OPERATING ROOM	50.00	38, 519	0	0		15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54.00	27, 969	0	0		16. 00
17. 00	CT SCAN	57. 00	4, 764	0	0		17. 00
18. 00	MAGNETIC RESONANCE IMAGING	58. 00	1, 672	0	0		18. 00
10.00	(MRI)	F0 00	10 051	_	_		10.00
19.00	CARDI AC CATHETERI ZATI ON	59.00	13, 251	0	0		19. 00
20.00	I NTRAVENOUS THERAPY	64.00	2, 303	0	0		20.00
21. 00	RESPIRATORY THERAPY	65. 00	41, 117	0	0		21. 00
22. 00	PHYSI CAL THERAPY	66.00	72, 061	0	0		22. 00
23. 00	ELECTROCARDI OLOGY	69. 00	19, 551	0	0		23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70. 00	135	0	0		24. 00
25. 00	ENDOSCOPY	76. 00	914	0	0		25. 00
26. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	151, 239	0	0		26. 00
07.00	SERVICES	_, _	07 -:-	-	_		07.00
27. 00	LUTHERWOOD PARTNERSHIP	76. 03	37, 545	0	0		27. 00
28. 00	WOUND CARE CENTER	76. 04	482	0	0		28. 00
29. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	106, 947	0	0		29. 00
30. 00	I MAGING CENTERS	76. 06	21, 053	0	0		30. 00
31.00	CARDIAC REHABILITATION	76. 97	4, 495	0	0		31. 00
32.00	HEALTHY HEARTS CENTER	90. 02	3, 922	0	0		32. 00
33.00	KNEE CENTER	90. 07	14, 234	0	0		33. 00
34.00	EMERGENCY	91.00	38, 230	0	0		34. 00
35.00	SMO-NON PROVIDER BASED	194. 04	8, 061	0	0		35. 00
36.00	FAMILY PRACTICE MEDICINE	194. 05	18, 277	0	0		36. 00
37.00	GROUP HOMES AND MISC. N_R	194. 08	1, 714	0	0		37. 00
	CTRS						

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0074

Provider CR: 15-0074	Heal th	Financial Systems	CC	DMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-255	52-10	
To 12/31/202 Date/Time Prepared:	RECLASSI FI CATI ONS				Provi der CCI	N: 15-0074				
Sya0/2022 2: 48 pm Salary Other Wist. A.7 Ref. Salary Other Othe								5		
Cost Center							10 12/31/2021			
Cost Center										
1.00		Cost Center		Sal arv	Other W	kst. A-7 Ref.	.1			
H - Labor and Del Ivery 1.00							7			
1.00		TOTALS		1, 100, 600	0					
2.00		H - Labor and Delivery		<u> </u>	<u> </u>		<u>'</u>			
3. 00	1.00	ADULTS & PEDIATRICS	30.00	2, 651, 769	0	(O		1.00	
1.00	2.00		0.00	o	0		o		2.00	
TOTALS	3.00	ADULTS & PEDIATRICS	30.00	0	1, 231, 384	(0		3.00	
1.00 DETARY 10.00 1,753,09\$ 0 0 0 0 0 0 0 0 0	4.00		0.00	0_	0	(<u>o</u>		4.00	
1.00		TOTALS		2, 651, 769	1, 231, 384					
DETARY										
TOTALS				1, 753, 095						
1.00	2.00		10. 00	0_		(<u>D</u>		2.00	
1.00				1, 753, 095	2, 239, 378					
2 00										
3. 00		PHYSI CAL THERAPY			-		- 1			
4.00				-1	9		-			
TOTALS		PHYSI CAL THERAPY	1	0	894, 385		-			
1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 14, 682, 299 9 1. 00 14, 682, 299 1. 00 1.	4. 00			0	0_	'	<u> </u>		4. 00	
1.00				2, 043, 949	894, 385					
TOTALS	4 00		2 22		44 (00 000				4 00	
L - Capit tal Insurance Costs ADMINISTRATIVE & GENERAL 5.00 0 673, 101 12 12 170TALS	1.00					`	9		1.00	
1.00				UU	14, 682, 299					
TOTALS	1 00		E 00	ما	(72 101	1:	n		1 00	
M - Radi ol ogy Support	1.00					'	2		1.00	
1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 527, 342 0 0 0 2. 00 2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				<u> </u>	6/3, 101					
2.00 3.00 4.00 5.00 RADI OLOGY-DI AGNOSTI C 54.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	1 00		54 00	527 242	0				1 00	
3.00 4.00 0.00 0.00 0.00 0.00 0.00 0.00		RADI OLOGI - DI AGNOSTI C		l l	-		- 1			
4.00 5.00 RADI OLOGY-DI AGNOSTI C 54.00 0 0 222, 196 0 6.00 7.00 0 0 0 0 0 8.00 8.00 0 0 0 0 0 0 8.00 10TALS					0					
S. 00					0	·				
6.00 7.00 8.00 TOTALS N - Hyperbaric Oxygen Therapy 1.00 WOUND CARE CENTER 76.04 76.04 92, 235 0		RADI OLOGY-DI AGNOSTI C		0	222 196	·				
7. 00 8. 00		TOTAL DESCRIPTION OF THE	•	0			-			
8.00 TOTALS 527, 342 222, 196				0	Ö		-			
TOTALS				0	Ö					
N - Hyperbari c Oxygen Therapy		TOTALS		527, 342	222, 196	`	7			
2.00 WOUND CARE CENTER 76.04 0 248,643 0 2.00		N - Hyperbari c Oxygen Therapy	,	, , , , , , , , , , , , , , , , , , , ,	, ,		'			
2.00 WOUND CARE CENTER 76.04 0 248,643 0 2.00	1.00	WOUND CARE CENTER	76. 04	92, 235	0	()		1.00	
0 - I HH Cat Scan 1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 774, 261 0 0 1. 00 2. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 323, 306 0 2. 00 TOTALS 774, 261 323, 306 P - Special ty Pharmacy 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 38, 895 0 0 1. 00 2. 00 PHARMACY 15. 00 1, 815, 332 0 0 0 2. 00 3. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 2. 00 4. 00 PHARMACY 15. 00 0 242, 476 0 3. 00 PHARMACY 15. 00 0 47, 763, 808 0 4. 00 TOTALS 0 1, 854, 227 48, 006, 284	2.00	WOUND CARE CENTER		0	248, 643		o		2.00	
1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 774, 261 0 0 2. 00 1. 00 2. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 323, 306 0 2. 00 70TALS 774, 261 323, 306 70 2. 00 70TALS 774, 261 323, 306 70 70TALS 774, 261 323, 306 70TALS 774, 261 323, 306 70 70TALS 774, 261 323, 306 70 70TALS 774, 261 323, 306 70 70TALS 774, 261 323, 306 7		TOTALS	- $ +$	92, 235	248, 643		7			
2. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 323, 306 0 2. 00 TOTALS 774, 261 323, 306 0 2. 00		O - IHH Cat Scan								
TOTALS P - Special ty Pharmacy 1. 00 ADMI NI STRATI VE & GENERAL 2. 00 PHARMACY 3. 00 ADMI NI STRATI VE & GENERAL 5. 00 1, 815, 332 0 0 0 2. 00 3. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 242, 476 0 4. 00 PHARMACY 15. 00 0 47, 763, 808 0 4. 00 TOTALS 1, 854, 227 48, 006, 284	1.00	RADI OLOGY-DI AGNOSTI C	54.00	774, 261	0	(O		1.00	
P - Special ty Pharmacy 1. 00	2.00	RADI OLOGY-DI AGNOSTI C	54.00		32 <u>3, 3</u> 06	(<u>D</u>		2.00	
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 38, 895 0 0 2. 00 PHARMACY 15. 00 1, 815, 332 0 0 3. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 242, 476 0 4. 00 PHARMACY 15. 00 0 47, 763, 808 0 TOTALS 1, 854, 227 48, 006, 284				774, 261	323, 306					
2. 00 PHARMACY 15. 00 1, 815, 332 0 0 3. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 242, 476 0 4. 00 PHARMACY 15. 00 0 47, 763, 808 0 TOTALS 1, 854, 227 48, 006, 284										
3. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 242, 476 0 0 47, 763, 808 0 0 0 0 0 0 0 0 0					-		-			
4. 00 PHARMACY					-			l l		
TOTALS 1, 854, 227 48, 006, 284				0						
	4.00		1500	•		(<u> </u>		4. 00	
500.00 Grand Iotal: Decreases 10,797,478 332,058,323 500.00							4			
	500. 00	Grand Total: Decreases		10, 797, 478	332, 058, 323			500	ω. 00	

Un Lieu of Form CMS-2552-10
Worksheet A-7
Part I
B1/2021 Date/Time Prepared:
5/30/2022 2:48 pm Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS COMMUNITY HEALTH NETWORK, INC. Provider CCN: 15-0074 Peri od: From 01/01/2021 To 12/31/2021

			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	2, 743, 049		0	0	0	1.00
2.00	Land Improvements	4, 209, 543	139, 500		139, 500		2.00
3.00	Buildings and Fixtures	517, 411, 041	19, 295, 602		19, 295, 602		3.00
4.00	Building Improvements	11, 643, 583	263, 670	0	263, 670	-1, 068, 649	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	218, 153, 931	3, 692, 874	0	3, 692, 874	-256, 579	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	754, 161, 147	23, 391, 646	0	23, 391, 646	148, 426	8.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	754, 161, 147	23, 391, 646	0	23, 391, 646	148, 426	10.00
		Endi ng Bal ance					
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 743, 049					1. 00
2.00	Land Improvements	4, 349, 043	0				2.00
3.00	Buildings and Fixtures	535, 232, 989	0				3.00
4.00	Building Improvements	12, 975, 902	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	222, 103, 384	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	777, 404, 367	0				8.00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	777, 404, 367	0				10.00

Heal th	Financial Systems C	DMMUNITY HEALTH NETWORK, INC.			In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider CO	CN: 15-0074	Peri od: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part II Date/Time Prep 5/30/2022 2:48	pared:	
			SL	IMMARY OF CAP	PITAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	,		
		9. 00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00	
3.00	Total (sum of lines 1-2)	0	0		0 0	ol	3. 00	
SUMMARY OF CAPITAL								
	Cost Center Description	Other	Total (1) (sum					
	·	Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00	
0 00	T 1 1 (C1' 4 0)						0 00	

0 0 0

0 0 0

1. 00 2. 00 3. 00

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

Heal th	Financial Systems C	OMMUNITY HEALTH	I NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der Co		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Pre 5/30/2022 2:4	pared:	
		COM	COMPUTATION OF RATIOS			OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
			Leases	for Ratio (col. 1 - col	instructions)			
		1.00	2.00	2)	4.00	F 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	1.00	2. 00	3. 00	4. 00	5. 00		
1. 00	CAP REL COSTS-BLDG & FLXT	555, 300, 983	0	555, 300, 98	3 0. 714301	0	1.00	
2. 00	CAP REL COSTS-MVBLE EQUIP	222, 103, 384	l .	222, 103, 38				
3.00	Total (sum of lines 1-2)	777, 404, 367	l .	777, 404, 36			3. 00	
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
			Capi tal -Relate					
			d Costs	through 7)				
	DART III DECONOLILATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00		
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS			0 14, 682, 299	0	1. 00	
2.00	CAP REL COSTS-BLDG & FIXT	0	1		0 14, 682, 299	l e		
3.00	Total (sum of lines 1-2)				0 34, 769, 596		1	
3.00	00 10tal (Suil 01 111les 1-2) 0 0 34, 709, 590 11, 500, 000 SUMMARY OF CAPITAL							
		Community of Children						
	Cost Center Description	Interest	Insurance (see			Total (2) (sum		
			instructions)	instructions)				
					d Costs (see	through 14)		
		11. 00	12.00	13.00	instructions) 14.00	15. 00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	CAP REL COSTS-BLDG & FLXT	2, 928, 247	673, 101		0 0	18, 283, 647	1.00	
2. 00	CAP REL COSTS-MVBLE EQUIP	0	0	1	o o		2. 00	
3.00	Total (sum of lines 1-2)	2, 928, 247	673, 101		0 0		3. 00	

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0074 Peri od: Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of В OADMINISTRATIVE & GENERAL 5.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 -7, 703, 316 10.00 10.00 Provider-based physician A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 37, 065, 200 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -2, 031, 021 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines 20.00 0.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 27.00 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 *** Cost Center Deleted *** 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0.00 Depreciation and Interest
33.00 Space Rental Income -122, 125 ADMI NI STRATI VE & GENERAL В 5.00 0 33.00

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0074 Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared:

Page					To	12/31/2021	Date/Time Prep 5/30/2022 2:48	pared: 8 nm
Cost Center Description					Expense Classification on	Worksheet A	070072022 2. 10	Б
1.00 2.00 3.00 4.00 5.00 3.01 3.01 3.00					To/From Which the Amount is	to be Adjusted		
3. 01 Space Rental Income								
3. 01 Space Rental Income								
3. 01 Space Rental Income								
3. 01 Space Rental Income		Cost Center Description	Basis/Code (2)	Amount	Cost Center	line #	Wkst A-7 Ref	
33.01 Space Rental Income B		oost center besen per on						
1. Coss on Asserts	33. 01	Space Rental Income						33. 01
1.03	34.00	HAF Tax Offset	A	-30, 175, 308	ADMINISTRATIVE & GENERAL	5. 00	0	34.00
SERVICES		1						
1.000 1.00	34. 02	Loss on Assets	A	-9, 001		76. 01	0	34. 02
35.00 Bad Debt	0.4.00			40.000	i i	7/ 0/		04.00
Section		1			i i			
35. 02 Bad Debt		4			i i			
FININGES APPRIVO		4			i i			
35.04 Bad Debt	00.02	Bud Bost		102, 700		21.00	J	00.02
35.04 Bad Debt	35. 03	Bad Debt	A	-243, 883	1	22. 00	0	35. 03
35.06 Bad Debt					COSTS APPRVD			
35.00 Bad Debt	35. 04	Bad Debt	A			30.00	0	35. 04
S5. 07 Bad Debt		4	1		ł I			
SERVICES SAID SAI		1			1			
25.09 Bad Debt	35. 07	Bad Debt	Α	-1, 640, 523		76. 01	0	35. 07
55.00 Bad Debt	25 00	Pad Dobt	_	16 420	ł	76 02		25 NO
15. 10 Bad Debt		1	1		ı ı			
35. 11 Bad Debt A -1,930EMERGENCY 91.00 0 35. 11					i i			
1-179,686 CARDIAC CATH SHARED SERVICES TRUE A -32,971 ELECTROCARDIOLOGY 69,00 0 36,00		4			i i			
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36 O2 Non. Allow Marketing Expense A -576, 945 ADMIN ISTRATIVE & GENERAL 5.00 0.36, 0.20	36. 01	TELEMERTY SHARED SERVICES TRUE	Α	-32, 971	ELECTROCARDI OLOGY	69. 00	0	36. 01
36. 03 PavIII ions		1 7						
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36 06 Debt Issuance Expense A		1			1			
36. 06 LOC Non-Allow Interest Expense A -96.622/CAP REL COSTS-BLDG & FIXT 1.00 11 36. 06 36. 07 12A Non-Allow Interest Expense A -120, 148 CAP REL COSTS-BLDG & FIXT 1.00 11 36. 07 36. 08 12B Non-Allow Interest Expense A -88, 666/CAP REL COSTS-BLDG & FIXT 1.00 11 36. 07 36. 10 36. 11 36. 10 36. 11 36.		1	1		1			
36. 07 12A Non-Allow Interest Expense A -120,148 CAP REL COSTS-BLOG & FIXT 1.00 11 36. 07 36. 08 13B Non-Allow Interest Expense A -4,911,072 CAP REL COSTS-BLOG & FIXT 1.00 11 36. 11 36. 12 00 Non-Allow Interest Expense A -4,911,072 CAP REL COSTS-BLOG & FIXT 1.00 11 36. 11 36. 13 01 elial enum Professional Fee A -26,615,399 SYCHIARTIC / PSYCHOLOGIC AL 76. 01 036. 12 36. 14 Gall ahue Professional Fee A -9,363,660 UJTHERWOOD PARTNERSHIP 76. 03 0 36. 14 36. 15 08 Labori st Loss A -1,117,442 DELI VERY ROOM & LABOR ROOM 52. 00 0 36. 15 36. 16 Hospital ist Loss A -1,117,442 DELI VERY ROOM & LABOR ROOM 52. 00 0 36. 15 36. 17 APP A -1,139,341 ADULTS & PEDI ATRICS 30. 00 0 36. 16 36. 19 APP A -508,114 ADULTS & PEDI ATRICS 30. 00 0 36. 18 36. 20 APP A -508,114 ADULTS & PEDI ATRICS 30. 00 0 36. 18 36. 21 APP A -1,168,790 HEALTHY HEARTS CENTER 90. 02 0 36. 20 36. 22 Misc Revenue B -6,048,125 ADMINISTRATIVE & GENERAL 5. 00 0 36. 22 36. 23 Misc Revenue B -6,048,125 ADMINISTRATIVE & GENERAL 5. 00 0 36. 23 36. 24 Misc Revenue B -99,174 PHARMACY 15. 00 0 36. 25 36. 25 Misc Revenue B -99,174 PHARMACY 15. 00 0 36. 25 36. 26 Misc Revenue B -12,366 ADMINISTRATIVE & GENERAL 5. 00 0 36. 26 36. 27 Misc Revenue B -17,390 NOCOLOGY - DIAGNOSTIC 54. 00 0 36. 28 36. 30 Misc Revenue B -17,796 PNOCOLOGY - CANCER CARE CENTER 76. 05 0 36. 31 36. 31 Misc Revenue B -17,796 PNOCOLOGY - CANCER CARE CENTER 76. 07 0 36. 33 36. 32 Misc Revenue B -133,901 BREAST DIAGNOSTIC CENTER 76. 07 0 36. 33 36. 34 Misc Revenue B -133,901 BREAST DIAGNOSTIC CENTER 76. 07 0 36. 33 36. 34 Misc Revenue B -133,901 BREAST DIAGNOSTIC CENTER 76. 07 0 36. 34 37. 20 Misc Revenue B		1	1		1			
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36. 12 ON Non-Allow Interest Expense A -3, 458, 797 CAP REL COSTS-BLDG & FIXT 1.00 11 36. 12 36. 13 Gallahue Professional Fee A -26, 615, 399 PSYCHI ARTIC C/PSYCHOLOGI CAL SERVI CES 76. 01 O 36. 13 SERVI CES OB Labori st Loss A -1, 117, 442 DELI VERY ROOM & LABOR ROOM 52. 00 O 36. 15 36. 16 Hospitalist Loss A -4, 351, 186 ADULTS & PEDI ARTIC S 30. 00 O 36. 16 36. 17 APP A -1, 139, 341 ADULTS & PEDI ARTIC S 30. 00 O 36. 18 36. 18 APP A -588, 114 ADULTS & PEDI ARTIC S 30. 00 O 36. 18 36. 19 APP A -588, 114 ADULTS & PEDI ARTIC S 30. 00 O 36. 18 36. 19 APP A -588, 114 ADULTS & PEDI ARTIC S 30. 00 O 36. 19 36. 20 APP A -1, 168, 790 HEALTHY HEARTS CENTER 90. 02 O 36. 21 36. 22 Misc Revenue B -6, 048, 125 ADMIN NI STRATIVE & GENERAL 5. 00 O 36. 23 36. 24 Misc Revenue B -32, 555 CAFETER A 11. 00 O 36. 24 36. 25 Misc Revenue B -99, 174 PHARMACY 15. 00 O 36. 25 36. 26 Misc Revenue B -99, 174 PHARMACY 15. 00 O 36. 26 36. 28 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 29 36. 30 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 32 36. 30 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 32 36. 30 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 32 36. 30 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 32 36. 32 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 32 36. 32 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 32 36. 32 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 32 36. 32 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 32 36. 32 Misc Revenue B -12, 366 (RADI LOGY -DI AGNOSTIC 54. 00 O 36. 32 36. 32 Misc Revenue B -17, 390 (NOCLOGY -CANCER CARE CENTER 76. 05 O 36. 34					ı ı			
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36. 14 Gal lahue Professi onal Fee A -9, 363, 660 LUTHERWOOD PARTNERSHIP 76. 03 0 36. 14 36. 15 0B Labori st Loss A -1, 117, 442 DELI VERY ROOM & LABOR ROOM 52. 00 0 36. 15 36. 16 Hospi tal i st Loss A -4, 351, 186 ADULTS & PEDI ATRICS 30. 00 0 36. 16 36. 17 APP A -1, 117, 442 DELI VERY ROOM & LABOR ROOM 52. 00 0 36. 16 36. 18 APP A -1, 139, 341 ADULTS & PEDI ATRICS 30. 00 0 36. 18 APP A -5508, 117 OPERATI NG ROOM 50. 00 0 36. 18 APP A -5538, 117 OPERATI NG ROOM 50. 00 0 36. 19 36. 20 APP A -1, 168, 790 HEALTHY HEARTS CENTER 90. 02 0 36. 20 36. 21 APP A -1, 168, 790 HEALTHY HEARTS CENTER 90. 07 0 36. 21 APP A -6, 048, 125 ADMIN IN STRATI VE & GENERAL 5. 00 0 36. 22 36. 23 Mi sc Revenue B -6, 048, 125 ADMIN IN STRATI VE & GENERAL 5. 00 0 36. 22 36. 24 Mi sc Revenue B -32, 555 CAFETER I A 11. 00 0 36. 23 36. 24 Mi sc Revenue B -32, 555 CAFETER I A 11. 00 0 36. 25 36. 26 Mi sc Revenue B -99, 174 PARAMACY 15. 00 0 36. 25 36. 26 Mi sc Revenue B -99, 174 PARAMACY 15. 00 0 36. 26 36. 27 Mi sc Revenue B -752, 810 ADMIN STRATI VE & GENERAL 5. 00 0 36. 26 36. 29 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 60. 00 0 36. 28 36. 30 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 60. 00 0 36. 28 36. 31 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 60. 00 0 36. 32 36. 33 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 60. 00 36. 32 36. 33 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 60. 00 36. 33 36. 34 Mi sc Revenue B -133, 901 MI SC REVENUE B -133, 901 REAST DI AGNOSTI C CENTER 76. 05 0 36. 31 36. 32 Mi sc Revenue B -133, 901 REAST DI AGNOSTI C CENTER 76. 07 0 36. 33 36. 34 Mi sc Revenue B -133, 901 REAST DI AGNOSTI C CENTER 76. 07 0 36. 33 36. 34 Mi sc Revenue B -133, 901 REAST DI AGNOSTI C CENTER 76. 07 0 36. 34 50. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	36. 13	Gallahue Professional Fee	A	-26, 615, 399	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	36. 13
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36. 22 Mi sc Revenue B		di d	1					
36. 23 Mi sc Revenue B -550, 733 OPERATION OF PLANT 7. 00 0 36. 23 36. 24 Mi sc Revenue B -32, 555 CAFETERI A 11. 00 0 36. 24 36. 25 Mi sc Revenue B -99, 174 PHARMACY 15. 00 0 36. 25 36. 26 Mi sc Revenue B -840, 524 R SERVI CES-OTHER PRGM 22. 00 0 36. 26 36. 27 Mi sc Revenue B -558 ADULTS & PEDI ATRICS 30. 00 0 36. 27 36. 28 Mi sc Revenue B -172, 366 RADI OLOGY-DI AGNOSTI C 54. 00 0 36. 28 36. 29 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 60. 00 0 36. 30 36. 31 Mi sc Revenue B -17, 739 ONCOLOGY-CANCER CARE CENTER 76. 05 0 36. 31 36. 32 Mi sc Revenue B -176 I MAGI NG CENTERS 76. 06 0 36. 32 36. 33 Mi sc Revenue B -133, 901 BREAST DI AGNOSTI C CENTER 76. 07 0 36. 33 36. 34 Mi sc Revenue B -133, 901 BREAST DI AGNOSTI C CENTER 76. 07 0 36. 34 50. 00 TOTAL (sum of I i nes 1 thru 49) (Transfer to Worksheet A, col umn 6, I i ne 200.)		1	1	·	1			
36. 25 Mi sc Revenue B -99, 174 PHARMACY 15. 00 0 36. 25 36. 26 Mi sc Revenue B -840, 524 RR SERVICES-OTHER PRGM 22. 00 0 36. 26 27 Mi sc Revenue B -558 ADULTS & PEDI ATRI CS 30. 00 0 36. 27 36. 28 Mi sc Revenue B -172, 366 RADI OLOGY-DI AGNOSTI C 54. 00 0 36. 28 36. 29 Mi sc Revenue B -2, 983 LABORATORY 60. 00 0 36. 29 36. 30 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 66. 00 0 36. 30 36. 31 Mi sc Revenue B -17, 739 ONCOLOGY-CANCER CARE CENTER 76. 05 0 36. 31 36. 32 Mi sc Revenue B -176 MAGI NG CENTERS 76. 06 0 36. 32 36. 33 Mi sc Revenue B -133, 901 BREAST DI AGNOSTI C CENTER 76. 07 0 36. 33 36. 34 Mi sc Revenue B -878 CARDI AC REHABI LI TATI ON 76. 97 0 36. 34 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1			ł			
36. 26 Mi sc Revenue B -840, 524 L&R SERVICES-OTHER PRGM 22. 00 0 36. 26 COSTS APPRVD 36. 27 Mi sc Revenue B -558 ADULTS & PEDIATRICS 30. 00 0 36. 27 36. 28 Mi sc Revenue B -172, 366 RADI OLOGY-DI AGNOSTIC 54. 00 0 36. 28 36. 29 Mi sc Revenue B -2, 983 LABORATORY 60. 00 0 36. 29 36. 30 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 66. 00 0 36. 30 36. 31 Mi sc Revenue B -172, 776 PHYSI CAL THERAPY 66. 00 0 36. 31 36. 32 Mi sc Revenue B -176 MAGI NG CENTERS 76. 05 0 36. 31 36. 32 Mi sc Revenue B -133, 901 BREAST DI AGNOSTI C CENTER 76. 07 0 36. 33 36. 34 Mi sc Revenue B -878 CARDI AC REHABI LI TATI ON 76. 97 0 36. 34 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	36. 24	Mi sc Revenue	В	-32, 555	CAFETERI A	11. 00	0	36. 24
COSTS APPRVD Section		4	1			15. 00	0	
36. 27 Mi sc Revenue B -558 ADULTS & PEDIATRICS 30. 00 0 36. 27 36. 28 Mi sc Revenue B -172, 366 RADI OLOGY-DI AGNOSTI C 54. 00 0 36. 28 36. 29 Mi sc Revenue B -2, 983 LABORATORY 60. 00 0 36. 29 36. 30 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 66. 00 0 36. 30 36. 31 Mi sc Revenue B -17, 739 ONCOLOGY-CANCER CARE CENTER 76. 05 0 36. 31 36. 32 Mi sc Revenue B -176 I MAGI NG CENTERS 76. 06 0 36. 32 36. 33 Mi sc Revenue B -133, 901 BREAST DI AGNOSTI C CENTER 76. 07 0 36. 33 36. 34 Mi sc Revenue B -878 CARDI AC REHABI LI TATI ON 76. 97 0 36. 34 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	36. 26	Mi sc Revenue	В	-840, 524		22. 00	0	36. 26
36. 28 Mi sc Revenue B -172, 366 RADI OLOGY-DI AGNOSTI C 54. 00 0 36. 28 36. 29 Mi sc Revenue B -2, 983 LABORATORY 60. 00 0 36. 29 36. 30 Mi sc Revenue B -72, 776 PHYSI CAL THERAPY 66. 00 0 36. 30 36. 31 Mi sc Revenue B -1, 739 ONCOLOGY-CANCER CARE CENTER 76. 05 0 36. 31 36. 32 Mi sc Revenue B -176 I MAGI NG CENTERS 76. 06 0 36. 32 36. 33 Mi sc Revenue B -133, 901 BREAST DI AGNOSTI C CENTER 76. 07 0 36. 33 36. 34 Mi sc Revenue B -878 CARDI AC REHABI LI TATI ON 76. 97 0 36. 34 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	24 27	Mi sa Payanya		FF0		20.00		24 27
36. 29 Mi sc Revenue B -2, 983 LABORATORY 60. 00 36. 29 36. 30 Mi sc Revenue B -72, 776 PHYSICAL THERAPY 66. 00 0 36. 30 36. 31 Mi sc Revenue B -1, 739 ONCOLOGY -CANCER CARE CENTER 76. 05 0 36. 31 36. 32 Mi sc Revenue B -176 MAGING CENTERS 76. 06 0 36. 32 36. 33 Mi sc Revenue B -133, 901 BREAST DI AGNOSTIC CENTER 76. 07 0 36. 33 36. 34 Mi sc Revenue B -878 CARDIAC REHABILITATION 76. 97 0 36. 34 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1			1			
36. 30 Mi sc Revenue B -72, 776 PHYSICAL THERAPY 66. 00 0 36. 30 36. 31 Mi sc Revenue B -1, 739 ONCOLOGY-CANCER CARE CENTER 76. 05 0 36. 31 36. 32 Mi sc Revenue B -176 MAGING CENTERS 76. 06 0 36. 32 36. 33 Mi sc Revenue B -133, 901 BREAST DIAGNOSTIC CENTER 76. 07 0 36. 33 36. 34 Mi sc Revenue B -878 CARDIAC REHABILITATION 76. 97 0 36. 34 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		II .	1					
36. 31 Misc Revenue B -1,739 ONCOLOGY-CANCER CARE CENTER 76. 05 0 36. 31 36. 32 Misc Revenue B -176 IMAGING CENTERS 76. 06 0 36. 32 36. 33 Misc Revenue B -133,901 BREAST DIAGNOSTIC CENTER 76. 07 0 36. 33 36. 34 Misc Revenue B -878 CARDIAC REHABILITATION 76. 97 0 36. 34 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1						
36. 32 Misc Revenue B -176 IMAGING CENTERS 76. 06 0 36. 32 36. 33 Misc Revenue B -133, 901 BREAST DIAGNOSTIC CENTER 76. 07 0 36. 33 36. 34 Misc Revenue B -878 CARDIAC REHABILITATION 76. 97 0 36. 34 50. 00 (Transfer to Worksheet A, column 6, line 200.)		1			ł .			
36. 33 Misc Revenue B -133, 901 BREAST DIAGNOSTIC CENTER 76. 07 0 36. 33 36. 34 Misc Revenue B -878 CARDIAC REHABILITATION 76. 97 0 36. 34 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)					1			
36. 34 Misc Revenue B -878 CARDIAC REHABILITATION 76. 97 0 36. 34 50. 00 (Transfer to Worksheet A, column 6, line 200.)		1						1
(Transfer to Worksheet A, column 6, line 200.)		1	•		ł .			
column 6, line 200.)	50.00			-102, 791, 861				50. 00
		7						
	(4) 5	•			CMC Dub. 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: 15-0074 Peri od: Worksheet A-8-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared: OFFICE COSTS

				10 12/31/2021	5/30/2022 2:4	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	•
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
1. 00		I &R SERVICES-SALARY & FRINGE	DESI DENTS	5, 211, 797	6, 998, 588	1. 00
2. 00		I &R SERVICES-SALARI & TRINGE		7, 052, 735		2. 00
3. 00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	5, 194, 401		3. 00
3. 01		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	11, 640, 638		3. 01
3. 02		ADMINISTRATIVE & GENERAL	HOME OFFICE	114, 914, 574		3. 02
3. 03	7. 00	OPERATION OF PLANT	HOME OFFICE	6, 131, 809		3. 03
3.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	4, 827, 171		3. 04
3.05	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	6, 990, 846	0	3. 05
3.06	16. 00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	5, 020, 964	0	3.06
3.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	340, 520	0	3. 07
3.08	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	178, 370	0	3.08
3.09	66.00	PHYSI CAL THERAPY	HOME OFFICE	575, 096	0	3. 09
3. 10	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	167, 223	0	3. 10
3. 11		DRUGS CHARGED TO PATIENTS	HOME OFFICE	2, 102, 131	1	3. 11
3. 12		EMERGENCY	HOME OFFICE	310, 854		3. 12
4.00		ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	61, 903		4. 00
4. 01		EMERGENCY	CPN ED ON CALL	2, 617, 263		4. 01
5.00	TOTALS (sum of lines 1-4).			173, 338, 295	136, 273, 095	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.				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.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of		
			Ownershi p		Ownershi p		
	1. 00	2. 00	3.00	4. 00	5. 00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6. 00	В	CHNW	100.00	0. 00	6. 00
7.00			0.00	0. 00	7. 00
8.00			0.00	0. 00	8. 00
9.00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

							To 12/31/2021	Date/Time Pr 5/30/2022 2:	epared: 48 nm
	Net	Wkst. A-7 Ref.						07 007 2022 2.	TO PIII
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RRED AND ADJUSTM	MENTS REQUIRED AS A RES	SULT OF TRAN	ISACTIONS WITH R	ELATED OR	GANIZATIONS OR (CLAI MED	
	HOME OFFICE CO								
1.00	-1, 786, 791								1. 00
2.00	-2, 417, 930								2. 00
3.00	5, 194, 401								3. 00
3. 01	11, 640, 638								3. 01
3.02	-4, 889, 268	0							3. 02
3.03	6, 131, 809	0							3. 03
3.04	4, 827, 171	0							3. 04
3.05	6, 990, 846	0							3. 05
3.06	5, 020, 964	0							3. 06
3.07	340, 520	0							3. 07
3.08	178, 370	0							3. 08
3.09	575, 096	0							3. 09
3. 10	167, 223	0							3. 10
3. 11	2, 102, 131	0							3. 11
3. 12	310, 854	0							3. 12
4.00	61, 903	s o							4. 00
4.01	2, 617, 263								4. 01
5.00	37, 065, 200								5. 00
* The	amounts on lin	es 1_4 (and sub	scrints as annronriate) are trans	ferred in detail	I to Work	sheet A column	6 lines as	

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

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

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

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

i Ci ilibui	Schicit under title Aviii.		
6.00		6.00	<u> </u>
7. 00 8. 00		7.00	
8. 00		8.00	
9.00		9.00)
10. 00		10.00)
10. 00 100. 00		100.00)

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

| Period: | Worksheet A-8-2 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0074

					j	To 12/31/2021	Date/Time Pre 5/30/2022 2:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	ю рііі
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
1.00	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	1.00
1.00	5. 00	AGGREGATE-ADMINISTRATIVE &	884, 344	884, 344	0	0	0	1. 00
2. 00	22. 00	GENERAL AGGREGATE-I&R SERVICES-OTHER PRGM CO	30, 000	30, 000	0	0	0	2. 00
3.00	30. 00	AGGREGATE-ADULTS & PEDI ATRI CS	5, 192, 238	5, 028, 970	163, 268	211, 500	944	3. 00
4.00	50.00	AGGREGATE-OPERATING ROOM	968. 436	968, 436	0	0	0	4. 00
5. 00		AGGREGATE-PSYCHI ATRI C/PSYCHO	69, 420		69, 420	211, 500	-	5. 00
6. 00	76. 05	AGGREGATE-ONCOLOGY-CANCER CARE CENTE	34, 333	34, 333	0	0	0	6. 00
7. 00	76. 97	AGGREGATE-CARDI AC REHABI LI TATI ON	17, 952	17, 952	0	0	0	7. 00
8.00		AGGREGATE-EMERGENCY	640, 000	640, 000	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0. 00		0 7 007 700	7 (04 025	0	0	0	10.00
200.00	Wkst. A Line #	Cost Center/Physician	7, 836, 723 Unadj usted RCE		232, 688 Cost of	Provi der	Physician Cost	200. 00
	WKST. A LITTE #	I denti fi er	Li mi t	Unadjusted RCE Limit		Component Share of col.	of Malpractice Insurance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1. 00
2. 00	22. 00	AGGREGATE-1&R SERVICES-OTHER PRGM CO	0	0	0	0	0	2. 00
3.00	30. 00	AGGREGATE-ADULTS & PEDI ATRI CS	95, 988	4, 799	0	0	0	3. 00
4.00		AGGREGATE-OPERATING ROOM	0	0	0	0	0	4. 00
5. 00	76. 01	AGGREGATE-PSYCHI ATRI C/PSYCHO LOGI CAL	37, 419	1, 871	0	0	0	5. 00
6.00	76. 05	AGGREGATE-ONCOLOGY-CANCER CARE CENTE	0	0	0	0	0	6. 00
7. 00	76. 97	AGGREGATE - CARDI AC REHABI LI TATI ON	0	0	0	0	0	7. 00
8.00	91. 00	AGGREGATE-EMERGENCY	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	14/1 1 2 1 1 //	0 1 0 1 (D)	133, 407			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	884, 344		1. 00
2. 00	22. 00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	0	0	30, 000		2. 00
3.00	30. 00	AGGREGATE-ADULTS & PEDIATRICS	0	95, 988	67, 280	5, 096, 250		3. 00
4.00	50. 00	AGGREGATE-OPERATING ROOM	О	0	0	968, 436		4.00
5. 00	76. 01	AGGREGATE-PSYCHI ATRI C/PSYCHO LOGI CAL	0	37, 419	32, 001	32, 001		5. 00
6. 00	76. 05	AGGREGATE-ONCOLOGY-CANCER CARE CENTE	0	0	0	34, 333		6. 00
7. 00	76. 97	AGGREGATE-CARDI AC REHABI LI TATI ON	0	0	0	17, 952		7. 00
8.00		AGGREGATE-EMERGENCY	0	0	0	640, 000		8.00
9. 00	0. 00	1	0		0	0		9. 00
10.00	0. 00		0		0	0		10.00
200. 00	l		0	133, 407	99, 281	7, 703, 316		200. 00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	COMMUNITY HEALTH		CN: 15 0074 D		u of Form CMS-2	2552-10
CUST	ALLUCATION - GENERAL SERVICE COSTS		Provi der C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre	nared:
			CAPITAL REI	LATED COSTS	12, 01, 2021	5/30/2022 2: 4	8 pm
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost Allocation			BENEFITS DEPARTMENT		
		(from Wkst A			DELYNTHIEN		
		col . 7)	1.00		4.00		
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	4. 00	4A	
1.00	00100 CAP REL COSTS-BLDG & FIXT	18, 283, 647	18, 283, 647	1			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	31, 393, 377		31, 393, 377			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	12, 325, 493				440 400 500	4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	133, 833, 668 17, 617, 990	653, 924 2, 143, 326	1		140, 193, 599 20, 152, 726	1
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 457, 265	2, 143, 320	1		1, 457, 265	1
9. 00	00900 HOUSEKEEPI NG	5, 938, 998	203, 726	17, 189		6, 603, 391	
10.00	01000 DI ETARY	1, 960, 601	220, 524			2, 300, 958	
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	2, 248, 732 8, 321, 908	448, 848 144, 633	1		3, 025, 490 8, 807, 912	
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 045, 726	303, 640	1		7, 515, 531	
15. 00	01500 PHARMACY	10, 814, 489	108, 337	1		12, 331, 232	
16.00	01600 MEDICAL RECORDS & LIBRARY	5, 822, 900	30, 446	1		5, 873, 069	
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	2, 380, 315 3, 796, 557	53, 569 0			2, 661, 641 4, 316, 361	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	8, 640, 672	82, 315	1		9, 990, 412	
23. 00	02300 EMS TRAINING-ALLIED HEALTH	0	0	0	0	0	
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0	0	0	0	0	
23. 02 23. 03	02302 PHARMACY RESIDENCY-ALLIED HEALTH 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	_	1	0	
23. 03	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	0	25.05
30. 00	03000 ADULTS & PEDIATRICS	56, 581, 646	3, 276, 270	l		66, 287, 256	1
31.00	03100 I NTENSI VE CARE UNI T	16, 656, 613	1, 325, 521	1		19, 884, 192	
32. 00 35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 2, 152, 074	61, 943	0 15, 446	_	0 2, 411, 894	32. 00 35. 00
43. 00	04300 NURSERY	533, 934	106, 088	1		731, 401	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	18, 773, 117	2, 190, 020			23, 149, 311	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	980, 536 3, 657, 358	172, 755 453, 197	l		1, 285, 995 4, 561, 080	1
54. 00	05400 RADI OLOGY - DI AGNOSTI C	4, 488, 082	563, 634	l		5, 763, 704	
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 055, 067	6, 899			2, 171, 855	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 780, 994	26, 172 525			4, 396, 349 1, 598, 255	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 155, 498 6, 651, 170	294, 666			7, 925, 040	
60.00	06000 LABORATORY	16, 289, 200	56, 468	1		16, 400, 100	
64. 00	06400 I NTRAVENOUS THERAPY	1, 850, 438		1		1, 955, 646	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	6, 167, 175 7, 141, 045		1		6, 786, 702 8, 498, 482	
	06700 OCCUPATI ONAL THERAPY	2, 163, 468	39, 445	1		2, 393, 868	
68. 00	06800 SPEECH PATHOLOGY	774, 866	14, 123			857, 381	
69. 00	06900 ELECTROCARDI OLOGY	3, 949, 081	12, 449	1		4, 641, 869	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 163, 928 37, 429, 224	31, 346	66, 576 0	l	1, 347, 762 37, 429, 224	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	28, 086, 184	0	0	-	28, 086, 184	
73. 00	07300 DRUGS CHARGED TO PATIENTS	147, 623, 714	0	0		147, 623, 714	73. 00
73. 01	07301 SPECIALTY PHARMACY	63, 665, 271	0	0	225, 884	63, 891, 155	
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	1, 652, 152 933, 916	5, 549	74, 745	53, 207	1, 657, 701 1, 061, 868	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	13, 489, 918	104, 488	l		18, 082, 251	
76. 03	03951 LUTHERWOOD PARTNERSHIP	4, 296, 455	0	73, 484		5, 337, 950	
76. 04	03952 WOUND CARE CENTER	2, 503, 991	103, 113	l		2, 708, 137	
76. 05 76. 06	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS	32, 551, 611 6, 044, 229	2, 886, 264 2, 175			39, 292, 745 7, 231, 729	
76. 07	03954 BREAST DI AGNOSTI C CENTER	2, 612, 242	115, 687	1	l '	2, 775, 111	
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 064, 896	122, 586			1, 370, 515	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	340, 878	15, 323	448	11, 236	367, 885	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	ő	o	0	
90. 00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	04950 DI ABETI C CARE CENTER	0	0	0 00	0	1 517 026	
90. 02 90. 03	04951 HEALTHY HEARTS CENTER 09001 CLI NI C	1, 158, 701 0	66, 542 0	82, 345 0	209, 438 0	1, 517, 026 0	
90. 04	04953 SPI NE CENTER		Ö	ő	ol	0	1
90. 05	04954 INFUSION CENTERS	479, 458	0	105, 704	38, 180	623, 342	90. 05
90.06	09002 MEDCHECK CLINICS	4 154 (20)	250 100	7 041	0	4 750 004	90.06
90.07	09003 KNEE CENTER	4, 156, 638	350, 109	7, 941	243, 316	4, 758, 004	70.07

Provider CCN: 15-0074	Health Financial Systems (COMMUNITY HEALTH	I NETWORK. INC.		In Lie	u of Form CMS-:	2552-10
Net Expenses			Provider CC	F	eriod: rom 01/01/2021	Worksheet B Part I Date/Time Pre	pared:
FOR COST All Ocation CFrom Wrist A Cool Color			CAPITAL REL	LATED COSTS			
90. 08 09004 PALLIATIVE CARE 0 0 0 0 0 0 0 0 0	Cost Center Description	for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	BENEFITS	Subtotal	
90. 10			1.00	2. 00	4. 00	4A	
91. 00 09100 EMERGENCY 19, 599, 952 1, 158, 765 188, 828 1, 336, 503 22, 284, 048 91. 00 09200 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00 0 0 0 0 0 0 0 98. 00 0 0 0 0 0 0 0 0 0		0	0	C	0	· ·	
92. 00 OTHER REIMBURSABLE COST CENTERS 98. 00 OTHER REIMBURSABLE COST CENTERS 99. 00 OTHER REIMBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 795, 537, 058 18, 265, 874 30, 804, 754 27, 613, 879 794, 376, 318 118. 00	90.12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	C	0	0	90. 12
98. 00 OTHER REIMBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O O	91. 00 09100 EMERGENCY	19, 599, 952	1, 158, 765	188, 828	1, 336, 503	22, 284, 048	91.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0						0	92. 00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 795, 537, 058 18, 265, 874 30, 804, 754 27, 613, 879 794, 376, 318 118. 00							
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 795, 537, 058 18, 265, 874 30, 804, 754 27, 613, 879 794, 376, 318 118. 00		0	0	C	0	0	98. 00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 191. 00 192. 00 192.00 192.00 192.00 192.00 192.00 192.00 HOME OFFI CES 53, 336 0 96 0 53, 432 192. 00 194. 00 07950 HOME OFFI CES 0 0 0 0 0 0 0 194. 00 194. 00 194. 01 07951 CHNW LEASED SPACE 0 0 0 0 0 0 0 194. 00 194. 00 194. 02 07952 ACCOUNTABLE CARE 560, 309 0 0 0 51, 826 612, 135 194. 02 194. 03 07953 SCHOOL BASED CLI NI CS 129, 670 0 0 51, 826 612, 135 194. 03 194. 04 07954 SMO-NON PROVI DER BASED 750, 372 0 0 68, 303 818, 675 194. 04 194. 05 07955 FAMI LY PRACTI CE MEDI CI NE 3, 687, 704 0 533, 733 313, 429 4, 534, 866 194. 05 194. 07 07957 LI FECHECK 0 0 0 0 0 0 194. 07 194. 08 07958 GROUP HOMES AND MI SC. N_R CTRS 1, 655, 629 17, 773 54, 794 115, 623 1, 843, 819 194. 08 194. 09 07959 SURGERY CENTER EAST 0 0 0 0 0 0 0 0 0		_					1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 191. 00 191. 00 191. 00 192. 00		795, 537, 058	18, 265, 874	30, 804, 754	27, 613, 879	794, 376, 318	118. 00
191. 00 19100 RESEARCH							
192. 00 1920		0	0	C	0		
194. 00 07950 HOME OFFICE		0	0	0	0		
194. 01 07951 CHNW LEASED SPACE 0 0 0 0 194. 01 194. 02 194. 02 07952 ACCOUNTABLE CARE 560, 309 0 0 51, 826 612, 135 194. 02 194. 03 194. 04 07953 SCHOOL BASED CLINICS 129, 670 0 0 5, 163 134, 833 194. 03 194. 04 07954 SMO-NON PROVIDER BASED 750, 372 0 0 68, 303 818, 675 194. 04 194. 05 07955 FAMILY PRACTICE MEDICINE 3, 687, 704 0 533, 733 313, 429 4, 534, 866 194. 05 194. 07 07957 LI FECHECK 0 0 0 0 0 0 0 194. 07 194. 08 07958 GROUP HOMES AND MISC. N_R CTRS 1, 655, 629 17, 773 54, 794 115, 623 1, 843, 819 194. 08 194. 09 07959 SURGERY CENTER EAST 0 0 0 0 194. 09	· · · · · · · · · · · · · · · · · · ·	53, 336	0	96	0		
194. 02 07952 ACCOUNTABLE CARE 560, 309 0 0 51, 826 612, 135 194. 02 194. 03 07953 SCHOOL BASED CLINICS 129, 670 0 0 5, 163 134, 833 194. 03 194. 04 07954 SMO-NON PROVIDER BASED 750, 372 0 0 68, 303 818, 675 194. 04 194. 05 079595 FAMI LY PRACTICE MEDICINE 3, 687, 704 0 533, 733 313, 429 4, 534, 866 194. 05 194. 07 07959 LI FECHECK 0 0 0 0 0 194. 05 194. 08 07958 GROUP HOMES AND MISC. N_R CTRS 1, 655, 629 17, 773 54, 794 115, 623 1, 843, 819 194. 08 194. 09 07959 SURGERY CENTER EAST 0 0 0 0 0 0 0 194. 09		0	0	Ü	0		
194. 03 07953 SCHOOL BASED CLINICS 129, 670 0 0 5, 163 134, 833 194. 03 194. 04 07954 SMO-NON PROVI DER BASED 750, 372 0 0 68, 303 818, 675 194. 04 194. 05 07955 FAMI LY PRACTI CE MEDI CI NE 3, 687, 704 0 533, 733 313, 429 4, 534, 866 194. 05 194. 08 07958 GROUP HOMES AND MI SC. N_R CTRS 1, 655, 629 17, 773 54, 794 115, 623 1, 843, 819 194. 08 194. 09 07959 SURGERY CENTER EAST 0 0 0 0 0 194. 09		0	0	Ü	0		
194. 04 07954 SMO-NON PROVI DER BASED 750, 372 0 0 68, 303 818, 675 194. 04 194. 05 194. 05 194. 07 1975 LI FECHECK 0 0 0 194. 07 194. 08 1975 SURGERY CENTER EAST 0 0 0 0 194. 09 194. 09 194. 09 07959 SURGERY CENTER EAST 0 0 0 0 194. 09				U	•		
194. 05 07955 FAMILY PRACTICE MEDICINE 3, 687, 704 0 533, 733 313, 429 4, 534, 866 194. 05 194. 07 07957 LI FECHECK 0 0 0 0 194. 07 194. 08 07958 GROUP HOMES AND MISC. N_R CTRS 1, 655, 629 17, 773 54, 794 115, 623 1, 843, 819 194. 08 194. 09 07959 SURGERY CENTER EAST 0 0 0 0 194. 09				U	•		
194. 07 07957 LI FECHECK 0 0 0 0 0 194. 07 194. 08 07958 GROUP HOMES AND MISC. N_R CTRS 1, 655, 629 17, 773 54, 794 115, 623 1, 843, 819 194. 08 194. 09 07959 SURGERY CENTER EAST 0 0 0 0 194. 09				F22 722			
194. 08 07958 GROUP HOMES AND MISC. N_R CTRS 1,655,629 17,773 54,794 115,623 1,843,819 194. 08 194. 09 07959 SURGERY CENTER EAST 0 0 0 194. 09		3,687,704	0	533, /33	313, 429		
194. 09 07959 SURGERY CENTER EAST 0 0 0 0 194. 09		1 (55 (20	17 770	E4 704	115 (22)		
		1, 655, 629	17,773	54, 794	115, 623		
200 00 Cross Foot Adjustments 1 01200 00	200 00 Cross Foot Adjustments						200 00

802, 374, 078

18, 283, 647

Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)

200.00 201.00

202.00

31, 393, 377

28, 168, 223

0 200. 00 0 201. 00 802, 374, 078 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0074

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: 5/30/2022 2:48 pm

						5/30/2022 2: 4	8 pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
	I	5. 00	7. 00	8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	140, 193, 599					5. 00
7.00	00700 OPERATION OF PLANT	4, 266, 634	24, 419, 360				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	308, 525	0	1, 765, 790			8. 00
9.00	00900 HOUSEKEEPI NG	1, 398, 037	324, 299	882, 893	9, 208, 620		9. 00
10.00	01000 DI ETARY	487, 147	351, 039	0	134, 160	3, 273, 304	10.00
11. 00	01100 CAFETERI A	640, 542	714, 492	1			11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 864, 767	230, 232		87, 990	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 591, 151	483, 345			Ö	14. 00
15. 00	01500 PHARMACY			1		0	•
	01600 MEDICAL RECORDS & LIBRARY	2, 610, 707	172, 455	1	,	_	15.00
16.00		1, 243, 417	48, 466		,	0	16.00
17. 00	01700 SOCIAL SERVICE	563, 509	85, 273	0	32, 589	0	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	913, 838		0	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	2, 115, 120	131, 033	8 0	50, 078	0	22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH	0	0) 0	0	0	23. 00
23. 01	02301 RADIOLOGY SCHOOL-ALLIED HEALTH	0	0	0	0	0	23. 01
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0	0	0	0	23. 02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	ol o	0	0	23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS	•					
30. 00	03000 ADULTS & PEDIATRICS	14, 034, 006	5, 215, 285	299, 719	1, 993, 173	1, 377, 603	30.00
31. 00	03100 I NTENSI VE CARE UNI T	4, 209, 782	2, 110, 013	1	806, 402	259, 049	31.00
32. 00	03200 CORONARY CARE UNIT	1,207,702	2,110,013	0	000, 402	257, 047	32.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	1	98, 603		27 404	0	1
		510, 634			37, 684		35.00
43. 00	04300 NURSERY	154, 849	168, 874	8, 912	64, 540	0	43. 00
	ANCILLARY SERVICE COST CENTERS	1					
50. 00	05000 OPERATI NG ROOM	4, 901, 056	3, 486, 155			0	50.00
51. 00	05100 RECOVERY ROOM	272, 264	274, 998	1			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	965, 649	721, 416	38, 073	275, 710	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 220, 263	897, 214	82, 727	342, 896	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	459, 814	10, 982	2 0	4, 197	0	55. 00
57.00	05700 CT SCAN	930, 773	41, 661	1		0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	338, 375		1		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 677, 850		1		Ö	59.00
60.00	06000 LABORATORY	3, 472, 147	89, 889	1		Ö	60.00
				1		0	•
64. 00	06400 NTRAVENOUS THERAPY	414, 040		1	.,		64.00
65. 00	06500 RESPI RATORY THERAPY	1, 436, 847	31, 037		,	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 799, 256	217, 658		,	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	506, 818		1	,	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	181, 520	22, 482	2 0	8, 592	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	982, 753	19, 816	0	7, 573	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	285, 341	49, 898	0	19, 070	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 924, 328	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 946, 266	0	ol o	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	31, 254, 214	0	ol o	0	0	73. 00
73. 01	07301 SPECIALTY PHARMACY	13, 526, 716	Ö	ol o	0	Ö	73. 01
74. 00	07400 RENAL DIALYSIS	350, 960			3, 376	Ö	74. 00
76. 00	03330 ENDOSCOPY		0,034			0	76.00
	l i	224, 813	1// 220	20, 192			1
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 828, 284	166, 328	3	63, 567	0	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	1, 130, 124	0	0	0	0	76. 03
76. 04	03952 WOUND CARE CENTER	573, 353	164, 139			0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	8, 318, 864	4, 594, 462	1	1, 755, 906	0	76. 05
76. 06	03953 I MAGI NG CENTERS	1, 531, 066	3, 462	2 0	1, 323	0	76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	587, 533	184, 154	1 0	70, 380	0	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	290, 159	195, 137	0	74, 577	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	77, 887	24, 392	2 0	9, 322	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			_	ő	89. 00
90.00	09000 CLINIC				_	Ö	90.00
		0		1	_		•
90. 01	04950 DI ABETI C CARE CENTER	0	405.004	0	_	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	321, 177	105, 924	312	40, 482	0	90. 02
90. 03	09001 CLI NI C	0	0) 0	0	0	90. 03
90. 04	04953 SPI NE CENTER	0	0	0	0	0	90. 04
90. 05	04954 I NFUSI ON CENTERS	131, 971	0	0	0	0	90. 05
90.06	09002 MEDCHECK CLINICS	0	0	0	0	0	90.06
90. 07	09003 KNEE CENTER	1, 007, 341	557, 317	0	212, 995	0	90. 07
90. 08	09004 PALLI ATI VE CARE	n	0	ا ا	_, . , o	Ö	90. 08
90. 10	09006 WORK SITE CLINICS	1 0	n	م ا	١	Ö	90. 10
90. 10	04961 FAMILY PRACTICE AND MATERNITY CARE				_	0	90. 10
		1 717 0/7	1 0// 5/5	220 024	704 OF 4	0	91.00
91.00	09100 EMERGENCY	4, 717, 867	1, 844, 565	228, 926	704, 954	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1		1			92. 00

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COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0074	Peri od:	Worksheet B	
				From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre	pared:
					5/30/2022 2: 4	8 pm
Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8. 00	9. 00	10.00	

					5/30/2022 2:48 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7. 00	8. 00	9. 00	10. 00
OTHER REIMBURSABLE COST CENTERS					
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	138, 500, 354	24, 391, 068	1, 765, 790	9, 197, 808	3, 273, 304 118. 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	11, 312	0	0	0	0 192. 00
194.00 07950 HOME OFFICE	0	0	0	0	0 194. 00
194.01 07951 CHNW LEASED SPACE	0	0	0	0	0 194. 01
194.02 07952 ACCOUNTABLE CARE	129, 598	0	0	0	0 194. 02
194. 03 07953 SCHOOL BASED CLINICS	28, 546	0	0	0	0 194. 03
194.04 07954 SMO-NON PROVIDER BASED	173, 326	0	0	0	0 194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	960, 099	0	0	0	0 194. 05
194. 07 07957 LI FECHECK	0	0	0	0	0 194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	390, 364	28, 292	0	10, 812	0 194. 08
194. 09 07959 SURGERY CENTER EAST	0	0	0	0	0 194. 09
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	140, 193, 599	24, 419, 360	1, 765, 790	9, 208, 620	

Provider CCN: 15-0074

| Period: | Worksheet B | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: | 5/30/2022 2:48 pm

	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/30/2022 2: 4 MEDI CAL	
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	1	11.00	13.00	14.00	15.00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						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 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	6, 290, 240					11. 00
13. 00	01300 NURSING ADMINISTRATION	121, 747	1 ' ' 1				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	30, 437		15, 361, 512	00 005 745		14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	344, 949 6, 764	1	7, 680, 493 0	23, 205, 745 11, 602, 872		15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	71, 019	1	38	11, 002, 072	0	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	223, 202	1	92	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	172, 474	. 0	5, 598	0	0	22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH	C	0	0	0	0	23. 00
23. 01 23. 02	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 02302 PHARMACY RESI DENCY-ALLI ED HEALTH			0	0	0	23. 01 23. 02
23. 02	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH			0	0	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	_	-1	-1			
30. 00	03000 ADULTS & PEDIATRICS	1, 714, 596		77, 739	0		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	439, 640	1	33, 511	0	,	31.00
32. 00 35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	60, 873	-1	0 3, 293	0	0 99, 959	32. 00 35. 00
43. 00	04300 NURSERY	20, 291	1	1, 581	0		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	20/27	00,070	.,		11,7071	10.00
50.00	05000 OPERATING ROOM	382, 149		602, 503	0	.,,	50. 00
51. 00	05100 RECOVERY ROOM	20, 291	1	1, 109	0	80, 762	51.00
52. 00 54. 00	05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	87, 928 77, 783		6, 752 0	0	61, 482 345, 583	52. 00 54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	30, 437	1	17, 030	0	147, 599	55.00
57. 00	05700 CT SCAN	111, 601	1	3, 654	0	572, 112	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	23, 673	1	8	0	92, 089	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	142, 038	1	509, 257	0	1, 768, 234	59.00
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	33, 818	- 1	102, 559 440	0	1, 055, 372 16, 884	60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	148, 801		7, 049	0	213, 201	65. 00
66. 00	06600 PHYSI CAL THERAPY	98, 074	·	4, 926	0	128, 291	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	57, 491		907	0	38, 214	67. 00
68. 00	06800 SPEECH PATHOLOGY	20, 291	1	325	0	13, 693	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	145, 420 30, 437	1	5, 350 2, 923	0	311, 180 40, 883	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 437		1, 240, 854	0	487, 340	71.00
72. 00		C	o	0	0	552, 071	1
73. 00	1	C		4, 824, 332	11, 602, 873		
73. 01	07301 SPECI ALTY PHARMACY	C	-	109, 351	0		
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	16, 909	1	985 1, 786	0	46, 060 31, 221	74. 00 76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	182, 620		5, 274	0	126, 227	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	C	o	9, 182	0	4, 827	76. 03
76. 04	03952 WOUND CARE CENTER	37, 200	1	7, 294	0	72, 130	76. 04
76. 05 76. 06	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS	744, 007 3, 382	1	29, 288 6, 464	0	1, 429, 130 374, 564	76. 05 76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	3, 302	1	0, 404	0	36, 339	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	47, 346	- 1	587	0	21, 314	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	6, 764	. 0	695	0	10, 981	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS	1	.l	al			1 00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	88. 00 89. 00
90.00	09000 CLINIC			0	0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	C	o	0	0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	64, 255	0	2, 635	0	19, 201	90. 02
90. 03	09001 CLI NI C	0		0	0	0	90. 03
90. 04 90. 05	04953 SPI NE CENTER 04954 I NFUSI ON CENTERS			0 1, 405	0	4 102, 998	90. 04 90. 05
90.05	09002 MEDCHECK CLINICS			1, 405	0	102, 998	90.05
90. 07	09003 KNEE CENTER	118, 365	o o	529	0	30, 180	90. 07
90. 08	09004 PALLI ATI VE CARE	C	이	0	0	735	1
90. 10	09006 WORK SITE CLINICS			0	0	0	90. 10
90. 12 91. 00	04961 FAMILY PRACTICE AND MATERNITY CARE 09100 EMERGENCY	453, 168	812, 825	50, 898	0	0 1, 507, 450	90. 12 91. 00
71.00	15 ==================================	133, 100	012,020	33, 070	0	1, 557, 450	, , , , , , ,

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0074 Peri od: Worksheet B From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 11.00 13.00 15.00 14.00 16, 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 92.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 6, 290, 240 11, 112, 648 15, 358, 696 23, 205, 745 18<u>,</u> 793, 111 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH 0 190. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 191, 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 0 0 194.00 07950 HOME OFFICE 0 0 0 194. 00 194. 01 07951 CHNW LEASED SPACE 0 0 194. 01 0 0 0 194. 02 194. 02 07952 ACCOUNTABLE CARE 39 194. 03 07953 SCHOOL BASED CLINICS 0 43 0 194. 03 194. 04 07954 SMO-NON PROVIDER BASED 79 0 194. 04 194.05 07955 FAMILY PRACTICE MEDICINE 0 0 194. 05 107 194. 07 07957 LI FECHECK 0 0 194. 07 C 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 2,548 0 0 194. 08 194. 09 07959 SURGERY CENTER EAST 0 o 0 194. 09 0

6, 290, 240

11, 112, 648

15, 361, 512

23, 205, 745

200.00

0 201.00

18, 793, 111 202. 00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0074

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/30/2022 2:48 pm	

				'	0 12/31/2021	5/30/2022 2: 4	
			INTERNS &	RESI DENTS			
	0 1 0 1 0 1 1	COOL AL . CEDVI OF	CEDWINES CALAR	SCEDIU AEG ATUED	FMC	DADI OLOOV	
	Cost Center Description	SUCTAL SERVICE	Y & FRINGES	SERVICES-OTHER PRGM COSTS	EMS TRAI NI NG-ALLI E	RADI OLOGY	
			I W TRINGES	TROW COSTS	D HEALTH	HEALTH	
		17. 00	21.00	22. 00	23.00	23. 01	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2 414 040					16.00
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	3, 414, 069		,			17. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		5, 455, 475	12, 464, 715			22.00
23. 00	02300 EMS TRAINING-ALLIED HEALTH	0		12, 404, 713	0		23. 00
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0			J	0	23. 01
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0					23. 02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0					23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1				
30. 00	03000 ADULTS & PEDI ATRI CS	2, 775, 736				0	30.00
31. 00	03100 INTENSIVE CARE UNIT	506, 950		132, 996	0	0	31.00
32. 00	03200 CORONARY CARE UNIT	74.530	_	0 (01	0	0	32.00
35. 00 43. 00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	74, 528 56, 855		96, 601	0	0	35. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	30, 633	0	ή υ	U	0	43.00
50. 00	05000 OPERATING ROOM	0	244, 462	558, 751	0	0	50.00
51. 00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0	0	59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY				0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	0			0	Ö	65.00
66. 00	06600 PHYSI CAL THERAPY	0	62, 091	141, 918	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	91, 992	210, 261	0	0	69. 00
70. 00		0	4, 556	1		0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	_	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	124 254	20/ 0/2	0	0	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 SPECIALTY PHARMACY	0	134, 256	306, 862	0	0 0	73. 00 73. 01
74. 00		0			0	0	74.00
76. 00	03330 ENDOSCOPY	0	Ö		0	ő	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	267, 220	610, 767	0	0	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	0	0	0	0	0	76. 03
76. 04		0	22, 758	52, 016	0	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0	0	0	0	0	76. 05
76. 06		0	0	0	0	0	76.06
76. 07	03954 BREAST DIAGNOSTIC CENTER	0	0		0	0	76. 07
76. 97 76. 98	O7697 CARDI AC REHABI LI TATI ON O7698 HYPERBARI C OXYGEN THERAPY		0		0	0	76. 97 76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	1 0	0	ή	U	0	70. 70
88. 00		0	0		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	Ö	0	Ō	89. 00
90.00		0	0	0	0	0	90. 00
90. 01	04950 DIABETIC CARE CENTER	0	0	0	0	0	90. 01
90. 02		0	0	0	0	0	90. 02
90. 03	09001 CLINIC	0	0	0	0	0	90. 03
90. 04	04953 SPINE CENTER	0	0	0	0	0	90.04
90.05	04954 I NFUSION CENTERS				0	0	90.05
90. 06 90. 07	09002 MEDCHECK CLINICS 09003 KNEE CENTER		50, 060	114, 419	0	0	90. 06 90. 07
90.07	09003 RNEE CENTER 09004 PALLI ATI VE CARE		31, 858			0	90.07
90. 10	09006 WORK SITE CLINICS	Ö		1		o o	90. 10
	· · · · · ·						· ·

			T	o 12/31/2021	Date/Time Pre	
		I NTERNS &	DECI DENTE		5/30/2022 2: 4	8 pm
		INTERNS &	RESIDENTS			
Cost Center Description	SOCIAL SERVICES	SEDVI CES SALAD	SEDVI CES_OTHED	EMS	RADI OLOGY	
cost center bescription	SOCIAL SERVICES	Y & FRINGES		TRAI NI NG-ALLI E		
		1 4 11111025	1110111 00010	D HEALTH	HEALTH	
	17. 00	21. 00	22. 00	23. 00	23. 01	
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	0	0	0	90. 12
91. 00 09100 EMERGENCY	o	194, 105	443, 655	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 414, 069	3, 639, 886	8, 319, 465	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
194. 00 07950 HOME OFFICE	0	0	0	0		194. 00
194.01 07951 CHNW LEASED SPACE	0	0	0	0		194. 01
194. 02 07952 ACCOUNTABLE CARE	0	0	0	0		194. 02
194. 03 07953 SCHOOL BASED CLINICS	0	0	0	0		194. 03
194. 04 07954 SMO-NON PROVI DER BASED	0	0	0	0		194. 04
194. 05 07955 FAMILY PRACTICE MEDICINE	0	1, 714, 460	3, 918, 636	0		194. 05
194. 07 07957 LI FECHECK	0	0	0	0		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	99, 147	226, 614	0		194. 08
194.09 07959 SURGERY CENTER EAST	0	0	0	0		194. 09
200.00 Cross Foot Adjustments		0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 414, 069	5, 453, 493	12, 464, 715	0	0	202. 00

	FINANCIAI SYSTEMS	COMMUNITY HEALTH		N 15 0074		Wardington CMS-	2552-10
COST F	NLLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 2:4	
	Cost Center Description	PHARMACY RESI DENCY-ALLI ED HEALTH	PHARMACY RESI DNECY-BTH ALLI ED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23. 02	23. 03	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 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 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD						21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD						22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH						23. 00
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH						23. 01
23. 02 23. 03	02302 PHARMACY RESIDENCY-ALLIED HEALTH 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	C	΄ ο				23. 02
20.00	INPATIENT ROUTINE SERVICE COST CENTERS						20.00
30. 00	1 1	C					
31.00						29, 542, 163	
32. 00 35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT		1	3, 436, 33	0 3 -138, 865	0 3, 297, 468	32. 00 35. 00
43. 00	04300 NURSERY	d		1, 258, 09:			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	C	1	36, 484, 18			
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM			2, 040, 51 ² 6, 875, 80 ²		2, 040, 517 6, 875, 802	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C			8, 730, 170		8, 730, 170	1
55.00	05500 RADI OLOGY-THERAPEUTI C	C	0	2, 841, 91		2, 841, 914	1
57. 00	05700 CT SCAN	C	0	6, 072, 073		6, 072, 072	1
58. 00 59. 00	05800 MAGNETI C RESONANCE MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON			2, 053, 55 12, 670, 74		2, 053, 555 12, 670, 744	1
60. 00	06000 LABORATORY		ol ö	21, 154, 420		21, 154, 420	1
64.00	06400 I NTRAVENOUS THERAPY	C	0	2, 438, 86		2, 438, 868	
65. 00	06500 RESPI RATORY THERAPY	C	0	8, 635, 49		8, 635, 499	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0	11, 033, 880 3, 084, 086		10, 829, 871 3, 084, 086	1
68. 00	1 1		ή				
69. 00	06900 ELECTROCARDI OLOGY	C	0	6, 416, 21		6, 113, 961	
	07000 ELECTROENCEPHALOGRAPHY	C	0	1, 791, 28			1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS			47, 081, 74 34, 584, 52		47, 081, 746 34, 584, 521	
73. 00	07300 DRUGS CHARGED TO PATIENTS			201, 519, 27			
73. 01	07301 SPECIALTY PHARMACY	C	0	78, 042, 32		78, 042, 323	
74.00	07400 RENAL DIALYSIS	C	0	2, 067, 91		2, 067, 916	
76. 00 76. 01	03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			1, 356, 78 ⁹ 23, 332, 53		1, 356, 789 22, 454, 551	
76. 03	03951 LUTHERWOOD PARTNERSHIP			6, 482, 08		6, 482, 083	
76. 04	03952 WOUND CARE CENTER	C	0	3, 718, 83		3, 644, 060	
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	C	0	56, 164, 40		56, 164, 402	
76. 06 76. 07	03953 I MAGI NG CENTERS 03954 BREAST DI AGNOSTI C CENTER			9, 151, 990 3, 653, 51		9, 151, 990 3, 653, 517	
76. 97	07697 CARDI AC REHABI LI TATI ON			1, 999, 63!		1, 999, 635	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	C	0	497, 92			
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	C		(0	
90. 00	09000 CLINIC					0	1
90. 01	04950 DIABETIC CARE CENTER	C	0		0	0	
90. 02	04951 HEALTHY HEARTS CENTER	C	0	2, 071, 01:	2 0	2, 071, 012	
90. 03 90. 04	09001 CLI NI C 04953 SPI NE CENTER				0	0	90. 03
90. 04	04954 I NFUSION CENTERS		o o	859, 71 ₀	6 0	859, 716	
90. 06	09002 MEDCHECK CLINICS		o o		0	0	90.06
90. 07	09003 KNEE CENTER	C	0	6, 849, 210			
90. 08 90. 10	O9004 PALLIATIVE CARE O9006 WORK SITE CLINICS		1	105, 410	0 -104, 675 0 0		
-3. 10	12.225 NO.W. St. 12. SELIN 55	1	·, 0	<u>'</u>	-1 0	<u> </u>	, , , , , , ,

Health Financial Systems C	OMMUNITY HEALTH	I NETWORK INC		Inlia	u of Form CMS-2	2552_10
COST ALLOCATION - GENERAL SERVICE COSTS	OMINIONI II IILALIII	Provider CO	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 2:4	pared:
Cost Center Description	PHARMACY RESI DENCY-ALLI ED HEALTH	PHARMACY RESI DNECY-BTH ALLI ED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23. 02	23. 03	24.00	25. 00	26.00	
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	() 0	0	90. 12
91. 00 09100 EMERGENCY	0	0	33, 242, 461	-637, 760	32, 604, 701	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS	1			-1		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	98. 00
SPECIAL PURPOSE COST CENTERS	•			'		1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	786, 682, 296	-11, 959, 351	774, 722, 945	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
191. 00 19100 RESEARCH	0	0	(o	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	64, 744	0	64, 744	192. 00
194.00 07950 HOME OFFICE	0	0	(0	0	194. 00
194.01 07951 CHNW LEASED SPACE	0	0	(0	0	194. 01
194. 02 07952 ACCOUNTABLE CARE	0	0	741, 772	0	741, 772	194. 02
194.03 07953 SCHOOL BASED CLINICS	0	0	163, 422	0	163, 422	194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	0	992, 080	o	992, 080	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	0	11, 128, 168	-5, 633, 096	5, 495, 072	194. 05
194. 07 07957 LI FECHECK	0	0	(o	0	194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	0	2, 601, 596	-325, 761	2, 275, 835	194. 08
194.09 07959 SURGERY CENTER EAST	0	0	(0	0	194. 09
200.00 Cross Foot Adjustments	0	0	(o o	0	200. 00
201.00 Negative Cost Centers	0	0	(o o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	o	802, 374, 078	-17, 918, 208	784, 455, 870	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | Part | I | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074

					То	12/31/2021	Date/Time Prep 5/30/2022 2:48	
				CAPI TAL REI	ATED COSTS		070072022 2. 10	рш
		Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		cost center bescription	Assigned New	DLDG & FIXI	WVBLE EQUIP	Subtotal	BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	U	1.00	2.00	ZA	4.00	
1.00	00100	CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP		444 000	45 (0) (07	45 040 700	45 040 700	2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0	146, 033 653, 924		15, 842, 730 4, 611, 631	15, 842, 730 983, 300	4. 00 5. 00
7. 00		OPERATION OF PLANT	0	2, 143, 326		2, 309, 672	126, 583	7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	0	0	·	0	0	8. 00
9.00	1	HOUSEKEEPI NG DI ETARY	0	203, 726	17, 189 15, 929	220, 915	249, 426	9. 00 10. 00
10. 00 11. 00	1	CAFETERIA	0	220, 524 448, 848		236, 453 533, 341	58, 439 136, 906	11. 00
13. 00	1	NURSING ADMINISTRATION	0	144, 633		164, 073	181, 064	13. 00
14.00	1	CENTRAL SERVICES & SUPPLY	0	303, 640		1, 412, 442	32, 263	
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	108, 337 30, 446	1	561, 178 30, 446	537, 440 11, 093	
17. 00		SOCIAL SERVICE	0	53, 569		53, 635	128, 061	17. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		990	291, 798	
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRVD	0	82, 315	134, 042	216, 357	637, 451	22. 00
23. 00 23. 01		EMS TRAINING-ALLIED HEALTH RADIOLOGY SCHOOL-ALLIED HEALTH	0	0		0	0	23. 00 23. 01
23. 02	1	PHARMACY RESIDENCY-ALLIED HEALTH	0	Ö	·	Ö	0	23. 02
23. 03		PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23. 03
30. 00		I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	0	3, 276, 270	752, 840	4, 029, 110	3, 192, 667	30.00
31. 00		INTENSIVE CARE UNIT	0	1, 325, 521	522, 226	1, 847, 747	776, 061	31.00
32. 00		CORONARY CARE UNIT	0	0	0	0	0	32. 00
35. 00		NEONATAL INTENSIVE CARE UNIT	0	61, 943		77, 389	102, 605	
43. 00		NURSERY LARY SERVICE COST CENTERS	0	106, 088	30, 098	136, 186	34, 466	43. 00
50. 00		OPERATING ROOM	0	2, 190, 020	1, 041, 882	3, 231, 902	643, 586	50.00
51. 00		RECOVERY ROOM	0	172, 755		231, 227	41, 751	
52.00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0	453, 197		581, 761 910, 950	181, 081	52.00
54. 00 55. 00		RADI OLOGY - DI AGNOSTI C	0	563, 634 6, 899		20, 933	205, 103 53, 912	
57. 00		CT SCAN	0	26, 172		364, 929	140, 847	57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	525		360, 840	46, 073	
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0	294, 666 56, 468		806, 735 110, 900	262, 731 0	59. 00 60. 00
64. 00	1	INTRAVENOUS THERAPY	0	8, 199		10, 594	53, 214	
65. 00	06500	RESPI RATORY THERAPY	0	19, 498	45, 574	65, 072	311, 843	65. 00
66.00		PHYSI CAL THERAPY	0	136, 734		730, 554	352, 579	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	39, 445 14, 123		47, 067 16, 853	103, 113 36, 931	
69. 00	06900	ELECTROCARDI OLOGY	0	12, 449		319, 787	209, 788	
70. 00		ELECTROENCEPHALOGRAPHY	0	31, 346		97, 922	48, 320	
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00		DRUGS CHARGED TO PATTENTS	0	0		o	0	
73. 01	07301	SPECIALTY PHARMACY	0	0	O	o	127, 044	73. 01
74.00		RENAL DIALYSIS	0	5, 549		5, 549	0	
76. 00 76. 01		ENDOSCOPY PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	104, 488	74, 745 816, 473	74, 745 920, 961	29, 925 2, 064, 896	
76. 03	1	LUTHERWOOD PARTNERSHIP	0	0	1	73, 484	544, 440	
76. 04	03952	WOUND CARE CENTER	0	103, 113	3, 020	106, 133	55, 126	76. 04
76. 05 76. 06		ONCOLOGY-CANCER CARE CENTER I MAGING CENTERS	0	2, 886, 264 2, 175		4, 593, 740 761, 850	1, 207, 763 239, 399	
		BREAST DIAGNOSTIC CENTER	0	2, 175 115, 687		162, 869	239, 399	•
76. 97	07697	CARDI AC REHABI LI TATI ON	0	122, 586	80, 385	202, 971	57, 732	76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	0	15, 323	448	15, 771	6, 320	76. 98
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	0		ol	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER		0		ol	0	89. 00
90.00	09000	CLINIC	0	0	0	o	0	90. 00
90. 01	1	DI ABETI C CARE CENTER	0	0	0 245	140 007	117 704	90. 01
90. 02 90. 03	1	HEALTHY HEARTS CENTER CLINIC	0	66, 542 0	82, 345	148, 887 0	117, 794 0	
90. 04	04953	SPINE CENTER	Ö	Ö	0	ő	Ö	90. 04
90.05		INFUSION CENTERS	0	0	105, 704	105, 704	21, 474	
90. 06 90. 07		MEDCHECK CLINICS KNEE CENTER	0	0 350, 109	0 7, 941	0 358, 050	0 136, 849	90. 06 90. 07
		PALLI ATI VE CARE	0	350, 109	1	338, 030		90.07
	•	<u>:</u>		•	. '	<u>'</u>	<u>'</u>	

Health Financial Systems C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co	<u> </u>	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/30/2022 2:4	
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2. 00	2A	4. 00	
90. 10 09006 WORK SITE CLINICS 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	(0	0	90. 10 90. 12
91. 00 09100 EMERGENCY	0	1, 158, 765	188, 828	1, 347, 593	751, 692	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		,		0	,	92.00
OTHER REIMBURSABLE COST CENTERS]
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	98. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	18, 265, 874	30, 804, 75	49, 070, 628	15, 530, 949	118. 00
NONREI MBURSABLE COST CENTERS	1		1	ا		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0				190. 00 191. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	96	5 96		191.00
192.00 19200 PHTSICIANS PRIVATE OFFICES	0	0	90	90		194. 00
194.0107951 CHNW LEASED SPACE	0	0				194. 00
194. 02 07952 ACCOUNTABLE CARE	0	0				194. 02
194. 03 07953 SCHOOL BASED CLINICS	0	0		o o		194. 03
194. 04 07954 SMO-NON PROVIDER BASED	0	0		o	38, 416	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	0	533, 733	533, 733	176, 283	194. 05
194. 07 07957 LI FECHECK	0	0	(0		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	17, 773	54, 79	72, 567		194. 08
194. 09 07959 SURGERY CENTER EAST	0	0	(0	0	194. 09

0 194. 09 200. 00

0 201.00

15, 842, 730 202. 00

31, 393, 377

18, 283, 647

49, 677, 024

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074

				1	0 12/31/2021	Date/lime Pre 5/30/2022 2:4	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	3.00	7.00	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	OO4OO	5, 594, 931					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	170, 270	2, 606, 525				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	12, 312	0	1			8. 00
9.00	00900 HOUSEKEEPI NG	55, 792	34, 616				9. 00
10.00	01000 DI ETARY	19, 441	37, 470		-		10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	25, 562 74, 418	76, 265 24, 575			180, 031 0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	63, 499	51, 592		11, 372	0	14. 00
15. 00	01500 PHARMACY	104, 187	18, 408			0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	49, 622	5, 173	0	1, 140	0	16. 00
17. 00	01700 SOCIAL SERVICE	22, 488	9, 102	1		0	17. 00
21. 00 22. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	36, 469 84, 409	12 004	1	0 3, 083	0	21. 00 22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH	04, 409	13, 986		3,003	0	23. 00
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0	0	o o	0	0	23. 01
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0	0	0	0	23. 02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23. 03
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	560, 061	556, 680	2, 090	122, 706	151, 536	30. 00
31. 00	03100 INTENSIVE CARE UNIT	168, 002	225, 223			28, 495	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	1		0	32. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	20, 378	10, 525	0	2, 320	0	35. 00
43. 00	04300 NURSERY	6, 180	18, 026	62	3, 973	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	195, 589	372, 113	607	82, 022	0	50. 00
51.00	05100 RECOVERY ROOM	10, 865	29, 353			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	38, 537	77, 004			0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	48, 698	95, 769	577	21, 110	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	18, 350	1, 172			0	55. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	37, 145 13, 504	4, 447 89		980 20	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	66, 959	50, 067			0	59.00
60.00	06000 LABORATORY	138, 564	9, 595			0	60.00
64.00	06400 I NTRAVENOUS THERAPY	16, 523	1, 393	0	307	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	57, 341	3, 313			0	65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	71, 804 20, 226	23, 233 6, 702	1		0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	7, 244	2, 400	1	•	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	39, 219	2, 115	1		0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	11, 387	5, 326	0	1, 174	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	316, 240	0	1	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	237, 300 1, 247, 441	0	0	0	0	72. 00 73. 00
	07301 SPECIALTY PHARMACY	539, 816	0	•			1
	07400 RENAL DIALYSIS	14, 006	943	Ö	208	0	74. 00
76. 00	03330 ENDOSCOPY	8, 972	0	1	0	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	152, 777	17, 754			0	76. 01
76. 03 76. 04	03951 LUTHERWOOD PARTNERSHI P 03952 WOUND CARE CENTER	45, 100 22, 881	0 17, 520	1	_	0	76. 03 76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	331, 984	490, 413			0	76. 05
76. 06	03953 I MAGING CENTERS	61, 101	370		81	0	76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	23, 447	19, 657		.,	0	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	11, 579	20, 829			0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	3, 108	2, 604	0	574	0	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01	04950 DI ABETI C CARE CENTER	0	0	0	0	0	90. 01
90. 02 90. 03	04951 HEALTHY HEARTS CENTER 09001 CLI NI C	12, 817	11, 306	0	2, 492	0	90. 02 90. 03
90. 04	04953 SPI NE CENTER	0	Ö	o o	0	0	90.04
90. 05	04954 I NFUSI ON CENTERS	5, 267	0	Ö	Ō	0	90. 05
90. 06	09002 MEDCHECK CLINICS	0	0	0	0	0	90. 06
90. 07	09003 KNEE CENTER	40, 200	59, 488	0	13, 112	0	90. 07
90. 08 90. 10	09004 PALLIATIVE CARE 09006 WORK SITE CLINICS	0	0	0	0	0	90. 08 90. 10
90. 10	04961 FAMILY PRACTICE AND MATERNITY CARE		0	, 0	0	0	90. 10
91.00	09100 EMERGENCY	188, 278	196, 889	1, 596	43, 399	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	<u> </u>		<u> </u>		<u> </u>	92. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 5/30/2022 2:48 pm 12/31/2021 Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 5, 527, 359 2, 603, 505 12, 312 566, 239 360, 062 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 191. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 451 0 0 0 0 0 0 194.00 07950 HOME OFFICE 0 194, 00 0 0 194. 01 07951 CHNW LEASED SPACE 0 194. 01 194. 02 07952 ACCOUNTABLE CARE 5, 172 0 0 194. 02 194. 03 07953 SCHOOL BASED CLINICS 0 0 194. 03 0 1, 139 194. 04 07954 SMO-NON PROVIDER BASED 0 194. 04 6, 917 0 194.05 07955 FAMILY PRACTICE MEDICINE 38, 315 0 0 0 0 194. 05 194. 07 07957 LI FECHECK 0 0 0 194. 07 0 194. 08 07958 GROUP HOMES AND MISC. N_R CTRS 0 0 194. 08 15, 578 3,020 666

5, 594, 931

2, 606, 525

0

0

566, 905

12, 312

0 194. 09

0 201.00

360, 062 202. 00

200.00

194. 09 07959 SURGERY CENTER EAST

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074

			To	12/31/2021	Date/Time Pre 5/30/2022 2:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<u>Б</u>
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
OFNEDAL CEDIU OF COCT CENTEDS	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 OO200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	968, 915					10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	18, 753	1				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	4, 688		1, 810, 007			14. 00
15. 00 01500 PHARMACY	53, 134	0	905, 024	2, 183, 429	l e	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	1, 042 10, 939	0	0	1, 091, 714 0	1, 190, 230 0	16. 00 17. 00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRVD	34, 381	Ö	11	0	Ö	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	26, 567	0	660	0	0	22. 00
23. 00 02300 EMS TRAINING-ALLIED HEALTH 23. 01 02301 RADIOLOGY SCHOOL-ALLIED HEALTH	0	0	0	0	0	23. 00 23. 01
23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0	0	0	0	23. 01
23. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23. 03
INPATIENT ROUTINE SERVICE COST CENTERS	0.4.405				75.405	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	264, 105 67, 720		9, 159 3, 948	0		30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	07,720	0 33, 231	3, 740	0	25, 757	32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	9, 377	o	388	0	-,	35. 00
43. 00 04300 NURSERY	3, 126	1, 534	186	0	912	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	58, 864	28, 885	70, 988	0	66, 857	50.00
51. 00 05100 RECOVERY ROOM	3, 126		131	0	,	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	13, 544	1	796	0	-,	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 981	0	0	0	21, 900	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN	4, 688 17, 190	1	2, 006 430	0	9, 354 36, 256	55. 00 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 646	1	1	Ō	5, 836	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	21, 879	0	60, 001	0	112, 055	59. 00
60. 00 06000 LABORATORY 64. 00 06400 NTRAVENOUS THERAPY	0 5, 209	0	12, 084 52	0	66, 880 1, 070	60. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	22, 921	0	831	0	13, 511	1
66. 00 06600 PHYSI CAL THERAPY	15, 107	0	580	0	8, 130	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	8, 856	1	107	0	2, 422	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	3, 126 22, 400	0	38 630	0	868 19, 720	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 688	1	344	0	2, 591	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	146, 199	0	30, 883	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0 540,407	1 001 715	34, 985	
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 SPECIALTY PHARMACY		0	568, 407 12, 884	1, 091, 715 0	365, 127 32, 643	
74. 00 07400 RENAL DI ALYSI S	0		116	0	2, 919	74. 00
76. 00 03330 ENDOSCOPY	2, 605	1	210	0	1, 978	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 03 03951 LUTHERWOOD PARTNERSHI P	28, 130	0	621 1, 082	0	7, 999 306	76. 01 76. 03
76. 04 03952 WOUND CARE CENTER	5, 730	o o	859	0	4, 571	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	114, 603	o	3, 451	0	90, 566	76. 05
76. 06 03953 I MAGI NG CENTERS	521	0	762	0	23, 737	76.06
76. 07 03954 BREAST DIAGNOSTIC CENTER 76. 97 07697 CARDIAC REHABILITATION	0 7, 293	1	0 69	0	2, 303 1, 351	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 042	1		0		76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	-	88. 00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 90. 00 09000 CLI NI C	0	0	0	0	0	89. 00 90. 00
90. 01 04950 DI ABETI C CARE CENTER	Ö	o	0	Ō	Ö	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	9, 898	0	310	0	1, 217	
90. 03 09001 CLI NI C 90. 04 04953 SPI NE CENTER	0		0	0	0	90. 03 90. 04
90. 04 04953 SPINE CENTER 90. 05 04954 INFUSION CENTERS	0		165	0	6, 527	90.04
90. 06 09002 MEDCHECK CLINICS	Ö	0	0	0	0	90. 06
90. 07 09003 KNEE CENTER	18, 232	0	62	0	1, 913	
90. 08 09004 PALLI ATI VE CARE 90. 10 09006 WORK SI TE CLI NI CS	0	0	0	0	47 0	90. 08 90. 10
90. 10 09000 WORK SITE CLIMICS 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE			o	0	0	90. 10
91. 00 09100 EMERGENCY	69, 804	34, 253	5, 997	0	95, 529	

near th Trhanerar Systems	SIVIIVIOIVI II IIE/CEII	I ILL I WORKE, THO.		111 210	u or rorm omo	2002 10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre	
					5/30/2022 2: 4	8 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14. 00	15. 00	16.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	98. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	968, 915	468, 300	1, 809, 675	2, 183, 429	1, 190, 230	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
191. 00 19100 RESEARCH	0	0	(0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	(0	0	192. 00
194.00 07950 HOME OFFICE	0	0	(0	0	194. 00
194.01 07951 CHNW LEASED SPACE	0	0	(0	0	194. 01
194. 02 07952 ACCOUNTABLE CARE	0	O	Ę	0	0	194. 02
194. 03 07953 SCHOOL BASED CLINICS	0	0	Ę	0	0	194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	0	Ç	0	0	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	0	13	0	0	194. 05
194. 07 07957 LI FECHECK	0	0	(0	0	194. 07
194.08 07958 GROUP HOMES AND MISC. N R CTRS	0	0	300	0	0	194. 08
194.09 07959 SURGERY CENTER EAST	0	0	(0	0	194. 09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	968, 915	468, 300	1, 810, 007	2, 183, 429		
	•				1	

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074

					Т	o 12/31/2021	Date/Time Prep 5/30/2022 2:48	
				INTERNS &	RESI DENTS		37 307 2022 2. 40	э рш
		Cost Center Description	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	E EMS	RADI OLOGY	
		oost content beschiptron	SOOTAL SERVICE	Y & FRI NGES	PRGM COSTS	TRAI NI NG-ALLI E		
			17. 00	21. 00	22.00	D HEALTH 23.00	HEALTH 23. 01	
	GENER	AL SERVICE COST CENTERS	17.00	21.00	22.00	23.00	23.01	
1.00		CAP REL COSTS BLDG & FIXT						1.00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00		ADMINISTRATIVE & GENERAL						5. 00
7.00		OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00	1	CAFETERI A						11. 00
13. 00		NURSING ADMINISTRATION						13.00
14.00		CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY						15. 00 16. 00
17. 00		SOCIAL SERVICE	226, 235					17. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD	0	363, 649				21. 00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		982, 513			22. 00
23. 00	1	EMS TRAINING-ALLIED HEALTH	0			0	0	23. 00
23. 01 23. 02	1	RADIOLOGY SCHOOL-ALLIED HEALTH PHARMACY RESIDENCY-ALLIED HEALTH	0				0	23. 01 23. 02
23. 03	1	PHARMACY RESIDNECY-BTH ALLIED HEALTH	0					23. 03
		IENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	183, 935 33, 593					30. 00 31. 00
32.00	1	CORONARY CARE UNIT	33, 393					32. 00
35. 00	1	NEONATAL INTENSIVE CARE UNIT	4, 939					35. 00
43. 00		NURSERY	3, 768					43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0					50. 00
51.00	1	RECOVERY ROOM	0					51. 00
52.00		DELIVERY ROOM & LABOR ROOM	0					52.00
54.00	1	RADI OLOGY - DI AGNOSTI C	0					54.00
55. 00 57. 00	1	RADI OLOGY-THERAPEUTI C CT SCAN	0					55. 00 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0					58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	0					59. 00
60.00		LABORATORY	0					60.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0					64. 00 65. 00
66. 00		PHYSI CAL THERAPY	0					66. 00
67. 00	1	OCCUPATI ONAL THERAPY	0					67. 00
68.00		SPEECH PATHOLOGY	0					68. 00
69. 00 70. 00	1	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0					69. 00 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	0					72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	0					73.00
73. 01 74. 00		SPECIALTY PHARMACY RENAL DIALYSIS	0					73. 01 74. 00
76. 00		ENDOSCOPY	0					76. 00
76. 01	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0					76. 01
76. 03 76. 04		LUTHERWOOD PARTNERSHIP WOUND CARE CENTER	0					76. 03 76. 04
	1	ONCOLOGY-CANCER CARE CENTER	0					76. 04 76. 05
		I MAGING CENTERS	0					76. 06
	1	BREAST DI AGNOSTI C CENTER	0					76. 07
76. 97 76. 98		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0					76. 97 76. 98
70. 70		TIENT SERVICE COST CENTERS	0					70. 70
88. 00	08800	RURAL HEALTH CLINIC	0					88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0					89. 00
90. 00 90. 01		CLINIC DIABETIC CARE CENTER	0					90. 00 90. 01
90. 02	1	HEALTHY HEARTS CENTER	0					90. 01
90. 03	09001	CLI NI C	0					90. 03
90.04	1	SPI NE CENTER	0					90. 04
90. 05 90. 06	1	INFUSION CENTERS MEDCHECK CLINICS	0					90. 05 90. 06
		KNEE CENTER						90. 07
90. 08	09004	PALLI ATI VE CARE	0					90. 08
90. 10	09006	WORK SITE CLINICS	0		<u> </u>	1		90. 10

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 2:48 pm Provider CCN: 15-0074

					5/30/2022 2:48	5 piii
		INTERNS &	RESI DENTS			
Cost Conton Decement on	SOCIAL SERVICES	CEDVICES SALAD	CEDVI CEC OTHER	EMS	RADI OLOGY	
Cost Center Description	SUCIAL SERVICES					1
		Y & FRINGES	PRGM COSTS	TRAI NI NG-ALLI E		1
	47.00	04.00	00.00	D HEALTH	HEALTH	
OO 40 040/4 FAMILY BRACTIOE AND MATERNITY CARE	17. 00	21. 00	22. 00	23. 00	23. 01	00.40
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0					90. 12
91. 00 09100 EMERGENCY	0					91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					<u> </u>	92.00
OTHER REIMBURSABLE COST CENTERS			r	ı		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0					98. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	226, 235	0	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
191. 00 19100 RESEARCH	0					191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0					192. 00
194.00 07950 HOME OFFICE	0					194. 00
194.01 07951 CHNW LEASED SPACE	0					194. 01
194. 02 07952 ACCOUNTABLE CARE	o					194. 02
194. 03 07953 SCHOOL BASED CLINICS	0					194. 03
194. 04 07954 SMO-NON PROVI DER BASED	0					194. 04
194. 05 07955 FAMILY PRACTICE MEDICINE	0					194. 05
194. 07 07957 LI FECHECK	0					194. 07
194. 08 07958 GROUP HOMES AND MISC. N R CTRS						194. 08
194. 09 07959 SURGERY CENTER EAST						194. 09
	U U	2/2 /40	000 510	0	ا	200.00
200.00 Cross Foot Adjustments		363, 649	982, 513			
201.00 Negative Cost Centers	22/ 225	242 442	000 540	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	226, 235	363, 649	982, 513	0	0	202. 00

	TION OF CADITAL DELATED COSTS	COMMUNITY HEALTS		N. 15 0074 F		Workshoot P	2002 10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provi der CCI	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/30/2022 2:4	
	Cost Center Description	PHARMACY RESI DENCY-ALLI ED HEALTH	PHARMACY RESI DNECY-BTH ALLI ED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23. 02	23. 03	24. 00	25.00	26. 00	
	GENERAL SERVICE COST CENTERS		1		1		
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 17. 00 22. 00 23. 00 23. 01 23. 02	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 EMS TRAINING-ALLIED HEALTH 02301 RADIOLOGY SCHOOL-ALLIED HEALTH						1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 14.00 15.00 16.00 17.00 22.00 23.00 23.01 23.02
23. 02	02303 PHARMACY RESIDENCY-ALLIED HEALTH) ol				23. 02
00	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS			9, 277, 134		9, 277, 134	
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT			3, 260, 084		3, 260, 084 0	31. 00 32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT			234, 256	-	234, 256	
43.00	04300 NURSERY			208, 419	9 0	208, 419	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS			4 751 417		4 751 412	FO 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM			4, 751, 413 328, 041		4, 751, 413 328, 041	
52. 00	05200 DELIVERY ROOM & LABOR ROOM			920, 503		920, 503	
54.00	05400 RADI OLOGY-DI AGNOSTI C			1, 316, 088		1, 316, 088	1
55. 00	05500 RADI OLOGY-THERAPEUTI C			110, 673		110, 673	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)			602, 224 430, 009		602, 224 430, 009	
59. 00	05900 CARDI AC CATHETERI ZATI ON			1, 391, 463		1, 391, 463	1
60.00	06000 LABORATORY			340, 138	0	340, 138	
64. 00	06400 I NTRAVENOUS THERAPY			88, 362		88, 362	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY			475, 562 1, 207, 108		475, 562 1, 207, 108	
67. 00	06700 OCCUPATI ONAL THERAPY			189, 970		189, 970	
68.00	06800 SPEECH PATHOLOGY			67, 989		67, 989	1
	06900 ELECTROCARDI OLOGY			614, 125		614, 125	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			171, 752 493, 322		171, 752 493, 322	70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS			272, 285		272, 285	
73.00	07300 DRUGS CHARGED TO PATIENTS			3, 272, 690		3, 272, 690	
73. 01	07301 SPECI ALTY PHARMACY			712, 387		712, 387	
74. 00 76. 00	07400 RENAL DIALYSIS 03330 ENDOSCOPY			23, 741 118, 57 <i>6</i>		23, 741 118, 576	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			3, 197, 051		3, 197, 051	
76. 03	03951 LUTHERWOOD PARTNERSHIP			664, 412		664, 412	
76. 04	03952 WOUND CARE CENTER			216, 815		216, 815	
76. 05 76. 06	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS			6, 940, 618 1, 087, 821		6, 940, 618 1, 087, 821	
76. 07	03954 BREAST DIAGNOSTIC CENTER			212, 609		212, 609	
76. 97	07697 CARDI AC REHABI LI TATI ON			306, 415	0	306, 415	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY			30, 197	7 0	30, 197	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC			(ol lo	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			(-	0	89. 00
90.00	09000 CLI NI C			(0	0	
90. 01 90. 02	04950 DI ABETI C CARE CENTER 04951 HEALTHY HEARTS CENTER			304, 723		0 304, 723	90. 01
90. 02	09001 CLINIC			304, 723		304, 723	90.02
	04953 SPI NE CENTER			(0	90. 04
90. 04		1	1	139, 137	7I O	139, 137	90.05
90. 04 90. 05	04954 I NFUSI ON CENTERS			,	.		
90. 04 90. 05 90. 06	09002 MEDCHECK CLINICS			(o	0	90. 06
90. 04 90. 05				627, 906 47	0 0		90. 06 90. 07

Heelth Financial Cyatama	COMMUNITY LIFALTI	L NETWORK LNC		العالما	u of Form CMS-:	DEED 10
ALLOCATION OF CAPITAL RELATED COSTS	COMMUNITY HEALTH	Provider CC		Period: From 01/01/2021 Fo 12/31/2021	Worksheet B Part II	pared:
Cost Center Description	PHARMACY RESI DENCY-ALLI ED HEALTH	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23. 02	23. 03	24. 00	25. 00	26. 00	
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			2, 735, 03	0 0	0 2, 735, 030	
					0	98. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS				0	U	98.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)			47, 341, 09	- 0	47 241 005	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	0	47, 341, 09	5 0	47, 341, 095	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0 0	^	190. 00
191.00/19100/RESEARCH						191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES			54	7		191.00
194.00 07950 HOME OFFICE			54	0		194. 00
194. 01 07951 CHNW LEASED SPACE						194. 00
194. 02 07952 ACCOUNTABLE CARE			34, 32	5	34, 325	
194. 03 07953 SCHOOL BASED CLINICS			4, 04			194. 02
194. 04 07954 SMO-NON PROVIDER BASED			45, 34		45, 342	
194. 05 07955 FAMILY PRACTICE MEDICINE			748, 34		748, 344	
194. 07 07957 LI FECHECK	•		740, 34	1 0		194. 03
194. 08 07958 GROUP HOMES AND MISC. N R CTRS	•		157, 16	1 0	157, 161	
194. 09 07959 SURGERY CENTER EAST	•		137, 10) 0		194. 09
200.00 Cross Foot Adjustments	0	0	1, 346, 16		1, 346, 162	
201.00 Negative Cost Centers			1, 540, 10.			201.00
202.00 TOTAL (sum lines 118 through 201)		0	49, 677, 02	4 0	49, 677, 024	
202. 00 TOTAL (Sum TITIES TTO thirough 201)	1	1	47, 077, 02	., 0	47, 077, 024	1202.00

	•	UMMUNITY HEALTH		ON 15 0074		Wassissian D. 1	
COST	LLOCATION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2021	Worksheet B-1	
					Γο 12/31/2021		
		CADITAL DE	LATED COCTO			5/30/2022 2: 4	8 pm
		CAPITAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	oost center bescriptron	(SQUARE FEET)			icconci i i ati on	& GENERAL	
		(040/1112 1221)	(50227 77.202)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(
				SALARI ES)			
		1.00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS		1		1	1	
1.00	00100 CAP REL COSTS-BLDG & FIXT	731, 431	1				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	F 042	63, 210, 107		_		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	5, 842				442 100 470	4. 00 5. 00
5. 00 7. 00	00700 OPERATION OF PLANT	26, 160 85, 743				662, 180, 479 20, 152, 726	1
8. 00	00800 LAUNDRY & LINEN SERVICE	03, 743	1	1, 047, 30			8.00
9. 00	00900 HOUSEKEEPI NG	8, 150	_		-		
10.00	01000 DI ETARY	8, 822	1				
11. 00	01100 CAFETERI A	17, 956					
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 786	39, 142	2, 642, 653	0	8, 807, 912	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 147	2, 232, 557	470, 882	0	7, 515, 531	14. 00
15. 00	01500 PHARMACY	4, 334	911, 790			12, 331, 232	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 218		161, 904		-,,	
17. 00	01700 SOCIAL SERVICE	2, 143	1				
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	1 ., , , ,				
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	3, 293	269, 892	1		9, 990, 412	
23. 00	02300 EMS TRAINING-ALLIED HEALTH 02301 RADIOLOGY SCHOOL-ALLIED HEALTH			•	0	0	
23. 01 23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH			1	0	0	
23. 02	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH		1				
23.03	INPATIENT ROUTINE SERVICE COST CENTERS		, 0		0	0	23.03
30. 00	03000 ADULTS & PEDIATRICS	131, 066	1, 515, 834	46, 597, 20	1 0	66, 287, 256	30.00
	03100 I NTENSI VE CARE UNI T	53, 027	1				1
32.00	03200 CORONARY CARE UNIT	0			0		
35.00	02060 NEONATAL INTENSIVE CARE UNIT	2, 478	31, 101	1, 497, 536	6 0	2, 411, 894	35. 00
43.00	04300 NURSERY	4, 244	60, 602	503, 040	0	731, 401	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	87, 611					
51. 00	05100 RECOVERY ROOM	6, 911	1				1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	18, 130					
54. 00	05400 RADI OLOGY - DI AGNOSTI C	22, 548	1				
55. 00	O5500 RADI OLOGY-THERAPEUTI C	276	1				
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 047	1				
59. 00	05900 CARDI AC CATHETERI ZATI ON	11, 788	1				
60.00	06000 LABORATORY	2, 259				16, 400, 100	
64. 00	06400 I NTRAVENOUS THERAPY	328	1		٠	1, 955, 646	
65. 00	06500 RESPI RATORY THERAPY	780					
66.00	06600 PHYSI CAL THERAPY	5, 470					
67.00	06700 OCCUPATI ONAL THERAPY	1, 578	15, 346	1, 504, 94 ⁻	1 0	2, 393, 868	67. 00
68.00	06800 SPEECH PATHOLOGY	565				857, 381	68. 00
69. 00	06900 ELECTROCARDI OLOGY	498	618, 821	3, 061, 878	0	4, 641, 869	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 254	134, 050	705, 23	1 0	., 0 ., , , 02	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(1		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1 054 22	0	147, 623, 714	
73. 01	07301 SPECIALTY PHARMACY	222		1, 854, 22	0	63, 891, 155	
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	222	150, 499	436, 76!	5 0	1, 657, 701 1, 061, 868	1
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4, 180	1			18, 082, 251	
76. 03	03951 LUTHERWOOD PARTNERSHIP	4, 100	147, 960				
76. 04	03952 WOUND CARE CENTER	4, 125		804, 566			1
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	115, 464	1			39, 292, 745	
76. 06	03953 I MAGING CENTERS	87	1			7, 231, 729	
76. 07	03954 BREAST DIAGNOSTIC CENTER	4, 628			0		
76. 97	07697 CARDI AC REHABI LI TATI ON	4, 904	161, 854	842, 610	0	1, 370, 515	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	613	903	92, 23!	5 0	367, 885	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	_	•	0	· -	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		
90.00	09000 CLINIC	0	0		ر ٥	0	
90. 01	04950 DI ABETI C CARE CENTER	0 440	1/5 001	1 710 00	0	l .	
90. 02 90. 03	04951 HEALTHY HEARTS CENTER 09001 CLI NI C	2, 662	165, 801	1, 719, 22!		1, 517, 026 0	1
90. 03	04953 SPI NE CENTER					0	1
	04954 I NFUSI ON CENTERS		212, 833	313, 410			
90.06	09002 MEDCHECK CLINICS			313,410			1
	09003 KNEE CENTER	14, 006	15, 990	1, 997, 322			
	•						•

Hool th Fi	nancial Systems	OMMUNITY HEALTH	I NETWORK INC		In Lie	eu of Form CMS-:	2552 10
	nancial Systems CO DCATION - STATISTICAL BASIS	JININUNI IY HEALIF	Provider CO	N: 15 0074 E	Period:	Worksheet B-1	
COST ALL	JUANTON - STATISTICAL BASIS		Provider CC		rom 01/01/2021	WOLKSHEEL D-1	
					o 12/31/2021	Date/Time Pre 5/30/2022 2:4	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE FEET)	(DULLAR VALUE)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(ACCOM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
90. 08 09	004 PALLIATIVE CARE	0	0	C	0	0	90. 08
90. 10 09	006 WORK SITE CLINICS	0	0	C	0	0	90. 10
	961 FAMILY PRACTICE AND MATERNITY CARE	0	0	C	0	0	90. 12
	100 EMERGENCY	46, 356	380, 202	10, 971, 037	0	22, 284, 048	
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	HER REIMBURSABLE COST CENTERS	_	-				
	850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	730, 720	62, 024, 922	226, 676, 025	-140, 193, 599	654, 182, 719	110 00
	NREIMBURSABLE COST CENTERS	/30, /20	02, 024, 922	220, 070, 023	-140, 193, 599	054, 182, /19	1118.00
	OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0		(0	190. 00
	100 RESEARCH						191. 00
	200 PHYSI CLANS' PRI VATE OFFI CES	0	193	(192. 00
	950 HOME OFFICE	0	0	C	Ö		194. 00
194. 01 07	951 CHNW LEASED SPACE	0	o	C	0	0	194. 01
194. 02 07	952 ACCOUNTABLE CARE	0	o	425, 426	0	612, 135	194. 02
	953 SCHOOL BASED CLINICS	0	0	42, 380	0	134, 833	
	954 SMO-NON PROVIDER BASED	0	0	560, 684		818, 675	
	955 FAMILY PRACTICE MEDICINE	0	1, 074, 665	2, 572, 869	0	4, 534, 866	
	957 LI FECHECK	0	0	(0		194. 07
	958 GROUP HOMES AND MISC. N_R CTRS	711	110, 327	949, 121	0	1, 843, 819	
	959 SURGERY CENTER EAST	0		C	٥		194. 09 200. 00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	-					200.00
201.00	Cost to be allocated (per Wkst. B,	18, 283, 647	31, 393, 377	28, 168, 223		140, 193, 599	
202.00	Cost to be allocated (per wkst. b,	10, 203, 047	31, 373, 377	20, 100, 223	΄	140, 173, 377	202.00

24. 997091

0. 496651

0. 121821

0.068516

15, 842, 730

0. 211715 203. 00 5, 594, 931 204. 00

0. 008449 205. 00

206. 00 207. 00

203.00

204.00

205.00

206.00

207.00

Part II)

H)

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,

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

Unit cost multiplier (Wkst. B, Part

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0074 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (SQUARE FEET) (PATIENT DAYS) (ONSITE FTES) PLANT LINEN SERVICE (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 10.00 11.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 613, 686 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 367, 558 8.00 00900 HOUSEKEEPI NG 9.00 8.150 183, 779 605, 536 9.00 10.00 01000 DI ETARY 8,822 8.822 190, 296 10.00 01100 CAFETERI A 17, 956 17, 956 95, 148 1,860 11.00 11.00 01300 NURSING ADMINISTRATION 5, 786 5, 786 13.00 36 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 12, 147 12, 147 0 14.00 15.00 01500 PHARMACY 4, 334 4, 334 102 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 218 0 16.00 1.218 16.00 01700 SOCIAL SERVICE 21 17.00 2, 143 2, 143 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD C 66 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 3, 293 3, 293 0 51 22.00 02300 EMS TRAINING-ALLIED HEALTH 23 00 C 0 23 00 C23.01 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 0 C 0 0 23.01 02302 PHARMACY RESIDENCY-ALLIED HEALTH 0 0 0 0 23.02 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23.03 23.03 0 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 131,066 62, 388 131, 066 80,088 507 30.00 31.00 03100 INTENSIVE CARE UNIT 53,027 20, 386 53, 027 15,060 130 31.00 32 00 03200 CORONARY CARE UNIT 32 00 C C 0 0 02060 NEONATAL INTENSIVE CARE UNIT 35.00 2,478 2, 478 0 18 35.00 04300 NURSERY 4, 244 1,855 4, 244 0 43.00 ANCILLARY SERVICE COST CENTERS 87, 611 50 00 05000 OPERATING ROOM 87, 611 0 113 50.00 18, 114 51.00 05100 RECOVERY ROOM 6, 911 6, 911 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 18, 130 7, 925 18, 130 26 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 22, 548 17, 220 22, 548 23 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 276 276 9 C 55.00 57.00 05700 CT SCAN 1,047 C 1,047 33 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 21 21 58.00 59.00 05900 CARDIAC CATHETERIZATION 11.788 0 11. 788 42 59.00 06000 LABORATORY 60.00 2.259 C 2.259 Ω 60.00 64.00 06400 I NTRAVENOUS THERAPY 328 328 10 64.00 65.00 06500 RESPIRATORY THERAPY 780 780 44 65.00 06600 PHYSI CAL THERAPY 66.00 5.470 5.470 29 66,00 1, 578 06700 OCCUPATIONAL THERAPY 17 67.00 1.578 67.00 68.00 06800 SPEECH PATHOLOGY 565 565 68.00 69.00 06900 ELECTROCARDI OLOGY 498 498 43 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 254 70.00 1, 254 9 70.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 C C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 07301 SPECIALTY PHARMACY 73.01 0 C Λ 0 73.01 07400 RENAL DIALYSIS 74.00 222 222 0 74.00 03330 ENDOSCOPY 76.00 4, 203 5 76.00 C 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 4.180 4.180 54 76.01 76. 03 03951 LUTHERWOOD PARTNERSHIP 0 76.03 76.04 03952 WOUND CARE CENTER 4, 125 3, 971 4, 125 0 11 76.04 03480 ONCOLOGY-CANCER CARE CENTER 220 76.05 76.05 115, 464 115, 464 03953 I MAGING CENTERS 76.06 87 C 87 1 76.06 0 76.07 03954 BREAST DIAGNOSTIC CENTER 4,628 0 4,628 0 76.07 07697 CARDIAC REHABILITATION 0 76. 97 4,904 4, 904 14 76.97 07698 HYPERBARIC OXYGEN THERAPY o 76. 98 76.98 613 0 613 2 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 C 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 89.00 90 00 09000 CLI NI C 0 Ω 0 90 00 0 04950 DIABETIC CARE CENTER 90.01 0 0 90.01 04951 HEALTHY HEARTS CENTER 2,662 19 90.02 90.02 2.662 65 90.03 09001 CLI NI C 0 C 0 90.03 04953 SPINE CENTER 0 O 90 04 Ω 0 90 04 90.05 04954 INFUSION CENTERS 0 0 0 0 90.05 09002 MEDCHECK CLINICS 90.06 0 90.06 0 90.07 09003 KNEE CENTER 14.006 0 14.006 35 90.07 09004 PALLIATIVE CARE 90.08 90 08 0 C 0 90. 10 09006 WORK SITE CLINICS 0 0 0 90.10 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 90.12

Health Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2021	Worksheet B-1	
			_	Го 12/31/2021	Date/Time Pre 5/30/2022 2:4	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(ONSITE FTES)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7. 00	8. 00	9. 00	10.00	11. 00	
01 00 00100 EMEDGENCY	47 257	47 (52	44 25	(124	01 00

			T	o 12/31/2021	Date/Time Pre 5/30/2022 2:48	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERI A	О ріп
	7.00	LAUNDRY) 8.00	9. 00	10.00	11. 00	
91. 00 09100 EMERGENCY	46, 356				134	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,000	1.7,002	10,000			92.00
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
SPECIAL PURPOSE COST CENTERS				,		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	612, 975	367, 558	604, 825	190, 296	1, 860	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
194. 00 07950 HOME OFFICE	0	0	0	0		194. 00
194.01 07951 CHNW LEASED SPACE	0	0	0	0		194. 01
194. 02 07952 ACCOUNTABLE CARE	0	0	0	0		194. 02
194. 03 07953 SCHOOL BASED CLINICS	0	0	0	0	0	194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	0	0	0	0	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	0	0	0	0	194. 05
194. 07 07957 LI FECHECK	0	0	0	0	0	194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	711	0	711	0	0	194. 08
194.09 07959 SURGERY CENTER EAST	0	0	0	0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	24, 419, 360	1, 765, 790	9, 208, 620	3, 273, 304	6, 290, 240	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	39. 791294	4. 804113	15. 207387	17. 201118	3, 381. 849462	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)	2, 606, 525	12, 312	566, 905	360, 062	968, 915	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	4. 247327	0. 033497	0. 936204	1. 892115	520. 922043	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

	Financial Systems ALLOCATION - STATISTICAL BASIS	COMMUNITY HEALTH	Provider CC	'N: 15 0074 D		u of Form CMS-2 Worksheet B-1	2552-10
CUST	ALLUCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2021 o 12/31/2021	Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/30/2022 2: 4 SOCIAL SERVICE	8 pm
	·	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	/TOTAL DATIENT	
		(DI RECT NURS.	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	(TOTAL PATIENT DAYS)	
		HRS.)	REQUIS.)		CHARGES)		
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE						8. 00 9. 00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1, 832 916	463, 369, 657				13. 00 14. 00
15. 00	01500 PHARMACY	0	231, 678, 704	200			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	100	3, 402, 673, 016		16. 00
17. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	1, 147 2, 777	0	0	101, 422 0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	168, 869	0	_	0	22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH	0	0	0	_	0	23. 00
23. 01 23. 02	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 02302 PHARMACY RESI DENCY-ALLI ED HEALTH	0	0	0	_	0	23. 01 23. 02
23. 02	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	-	0	
	INPATIENT ROUTINE SERVICE COST CENTERS		0.044.000		045 (70 (5)	22 452	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	507 130	2, 344, 920 1, 010, 837	0		82, 459 15, 060	
32. 00	03200 CORONARY CARE UNIT	0	0	0		0	32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	0	99, 317	0		2, 214	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	6	47, 681	0	2, 606, 127	1, 689	43. 00
50.00	05000 OPERATING ROOM	113	18, 173, 968	0		0	50. 00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0 26	33, 437 203, 667	0		0	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	203, 007	0		0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	O	513, 695	0	,,,	0	55. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	110, 209 229	0		0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	15, 361, 266	0		0	59. 00
60.00	06000 LABORATORY	0	3, 093, 601	0		0	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	13, 270 212, 639	0	3, 057, 019 38, 602, 455	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	148, 578	0		0	66. 00
67.00		0	27, 369	0	-, ,	0	67. 00 68. 00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	9, 802 161, 391	0	_,,	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	88, 174	0	7, 402, 258	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	37, 429, 223	0	88, 238, 225 99, 958, 559	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	145, 521, 588	100		0	73.00
73. 01	07301 SPECIALTY PHARMACY	0	3, 298, 469	0	, ,	0	73. 01
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	0	29, 705 53, 866	0	8, 339, 676 5, 652, 823	0	74. 00 76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	159, 085	0		0	
76. 03	03951 LUTHERWOOD PARTNERSHIP	0	276, 972	0	873, 937	0	76. 03
76. 04 76. 05	03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER	0	220, 023 883, 461	0	13, 059, 868 258, 759, 759	0	76. 04 76. 05
	03953 I MAGI NG CENTERS	0	194, 971	0	67, 818, 999	0	76. 06
76. 07	03954 BREAST DI AGNOSTI C CENTER	0	0	0	-, ,	0	76. 07
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	17, 721 20, 956	0		0	76. 97 76. 98
	OUTPATIENT SERVICE COST CENTERS		==, :==				
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00		0	0	0	0	0	90.00
90. 01	04950 DI ABETI C CARE CENTER	0	0	0	0	0	90. 01
90. 02 90. 03	04951 HEALTHY HEARTS CENTER 09001 CLI NI C	0	79, 489 0	0	3, 476, 566 0	0	90. 02 90. 03
	04953 SPI NE CENTER		o	0	653	0	90.03
90. 05	04954 INFUSION CENTERS	0	42, 369	0	18, 648, 930	0	90. 05
90. 06 90. 07	09002 MEDCHECK CLINICS 09003 KNEE CENTER	0	0 15, 968	0	0 5, 464, 459	0	90. 06 90. 07
90. 08	09004 PALLIATIVE CARE	0	0	0	133, 159	0	90. 08
90. 10	09006 WORK SITE CLINICS	0	0	0	0	0	90. 10

		OMMUNITY HEALTH				eu of Form CMS-	
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON		(COSTED	RECORDS &		
			SUPPLY	REQUI S.)	LI BRARY	(TOTAL PATIENT	
		(DI RECT NURS.	(COSTED		(GROSS	DAYS)	
		HRS.)	REQUIS.)		CHARGES)		
	T	13. 00	14. 00	15. 00	16. 00	17. 00	
	FAMILY PRACTICE AND MATERNITY CARE	0	0		0 0	1	1 /0
91.00 09100		134	1, 535, 303		0 272, 940, 497	0	1 / 00
	OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	REIMBURSABLE COST CENTERS						00.00
	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98. 00
118. 00	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1, 832	463, 284, 716	20	00 3, 402, 673, 016	101, 422	110 00
	IMBURSABLE COST CENTERS	1, 032	403, 204, 710		0 3, 402, 673, 010	101, 422	1110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
191. 00 19100		0	0		o c		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0		o c		192. 00
194. 00 07950	HOME OFFICE	o	0		0 0	0	194.00
194. 01 07951	CHNW LEASED SPACE	0	0		0 0	0	194. 01
194. 02 07952	ACCOUNTABLE CARE	0	1, 168		0 0	0	194. 02
194. 03 07953	SCHOOL BASED CLINICS	0	1, 302		0 0	0	194. 03
194. 04 07954	SMO-NON PROVIDER BASED	0	2, 382		0 0	0	194. 04
194. 05 07955	FAMILY PRACTICE MEDICINE	0	3, 237		0 0	0	194. 05
194. 07 07957	LIFECHECK	0	0		0 0	0	194. 07
194. 08 07958	GROUP HOMES AND MISC. N_R CTRS	O	76, 852		0 0	0	194. 08
194. 09 07959	SURGERY CENTER EAST	0	0		0 0	0	194. 09
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	11, 112, 648	15, 361, 512	23, 205, 74	5 18, 793, 111	3, 414, 069	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)			116, 028. 72500			
204. 00	Cost to be allocated (per Wkst. B,	468, 300	1, 810, 007	2, 183, 42	1, 190, 230	226, 235	204. 00
205 00	Part II)	255 (22271	0.002004	10 017 14500	0 000350	2 220/20	205 00

255. 622271

0. 003906 10, 917. 145000

0.000350

2. 230630 205. 00

206. 00

207. 00

205.00

206.00

207.00

11)

Unit cost multiplier (Wkst. B, Part

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

		JOMMUNITY HEALTH		ON 45 0074 5		eu of Form CMS	
COST	ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2021	Worksheet B-1	
				Т	o 12/31/2021	Date/Time Pre 5/30/2022 2:4	
		INTERNS &	RESI DENTS			37 307 2022 2. 4	o piii
		050,41,050,041,45	050,4,050,07450	5.40	545101001	5,,,5,,,0,,	
	Cost Center Description	SERVICES-SALAR Y & FRINGES			RADI OLOGY SCHOOL-ALLI ED	PHARMACY ALLI	
		(ASSI GNED	(ASSI GNED	D HEALTH	HEALTH	ED HEALTH	
		TIME)	TIME)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
			,	TI ME)	TIME)	TIME)	
	GENERAL SERVICE COST CENTERS	21.00	22. 00	23. 00	23. 01	23. 02	
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 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
	01700 SOCI AL SERVI CE						17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	459, 615					21. 00
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		459, 615	1			22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH 02301 RADIOLOGY SCHOOL-ALLIED HEALTH				0		23. 00
23. 01	02302 PHARMACY RESIDENCY-ALLIED HEALTH				0	0	
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH					Ĭ	23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS			,		,	
30.00	03000 ADULTS & PEDIATRICS	205, 310	205, 310	1			
31.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	4, 904	4, 904 0				
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	3, 562	3, 562	•			
43.00	04300 NURSERY	0	0		0	0	43. 00
	ANCILLARY SERVICE COST CENTERS		00 (00	.1			
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	20, 603	20, 603				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0				
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0	0		0	
57. 00	05700 CT SCAN	0	0			0	
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0			0	
60.00	06000 LABORATORY	o	0			Ö	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0			0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	5, 233	5, 233		0	0	
	06800 SPEECH PATHOLOGY	Ö	Ö		o o	Ö	
69. 00	06900 ELECTROCARDI OLOGY	7, 753	7, 753	s c	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	384	384		0	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	11, 315	11, 315		0	0	1
73. 01	07301 SPECIALTY PHARMACY	0	0		0	0	1
	07400 RENAL DIALYSIS	0	0	0	0	0	
76. 00 76. 01	03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	
76. 01	03951 LUTHERWOOD PARTNERSHIP	22, 521	22, 521 0		0	0	76. 01 76. 03
76. 04	03952 WOUND CARE CENTER	1, 918	1, 918		o o	o o	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0	0) (0	0	1
76. 06	03953 I MAGI NG CENTERS	0	0)	0	0	76. 06
76. 07 76. 97	03954 BREAST DIAGNOSTIC CENTER 07697 CARDIAC REHABILITATION	0	0) (0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0		-	· -	1
70.70	OUTPATIENT SERVICE COST CENTERS	<u> </u>					70.70
88. 00	1 1	0	0	0			
89. 00	1 1	0	0		0		
90. 00 90. 01	O9000 CLINIC O4950 DIABETIC CARE CENTER		0	,	0	0	
	04951 HEALTHY HEARTS CENTER	j ő	Ö		Ö	ő	1
90. 03	09001 CLI NI C	0	0) (0	0	90. 03
	04953 SPINE CENTER	0	0		0	0	
	04954 INFUSION CENTERS 09002 MEDCHECK CLINICS		0	,) O	0	
	09003 KNEE CENTER	4, 219	4, 219		Ö		
		,					

Heal th Finar	ncial Systems C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2021		
					To 12/31/2021		
		INTERNS & I	DECLIDENTS			5/30/2022 2:4	8 pili
		I INTERNS & I	KESI DENIS				
	Cost Center Description	SERVI CES-SALARS	SEDVICES OTHER	EMS	RADI OLOGY	PHARMACY	
	cost center bescription	Y & FRI NGES	PRGM COSTS		E SCHOOL-ALLI ED		
		(ASSI GNED	(ASSI GNED	D HEALTH	HEALTH	ED HEALTH	
		TIME)	TIME)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		I I WL	IIIwc)	TIME)	TIME)	TIME)	
		21.00	22.00	23. 00	23. 01	23. 02	
90 08 09004	PALLI ATI VE CARE	2, 685	2, 685		0 0	0	90. 08
	WORK SITE CLINICS	2,000	2, 000		0	, o	
	FAMILY PRACTICE AND MATERNITY CARE		0			o o	
91. 00 09100		16, 359	16, 359			0	
	OBSERVATION BEDS (NON-DISTINCT PART)	10, 337	10, 337		5	J	92.00
	REIMBURSABLE COST CENTERS						72.00
	OTHER REIMBURSABLE COST CENTERS	O	0	1	0 0	0	98. 00
	AL PURPOSE COST CENTERS	<u> </u>		′1	<u>J</u>	0	70.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	306, 766	306, 766		0 0	0	118. 00
	IMBURSABLE COST CENTERS	300, 700	300, 700	1	<u>J</u>	0	1110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	1	0 0	0	190. 00
191. 00 19100			0		0 0		191.00
	PHYSICIANS' PRIVATE OFFICES	0	0	1	0 0	_	192. 00
	HOME OFFICE	0	0				194. 00
	CHNW LEASED SPACE	0	0				194. 00
	ACCOUNTABLE CARE	0	0		0		194. 02
	SCHOOL BASED CLINICS	0	0				194. 02
	SMO-NON PROVIDER BASED	0	0				194. 04
	FAMILY PRACTICE MEDICINE	144, 493	144, 493				194. 05
194. 07 07957		144, 473	144, 473				194. 07
	GROUP HOMES AND MISC. N_R CTRS	8, 356	8, 356	(194. 07
	SURGERY CENTER EAST	0, 330	0, 330				194. 09
200. 00	Cross Foot Adjustments	0	U	<u>'</u>	3	U	200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	5, 453, 493	12, 464, 715		0	_	202.00
202.00	Part 1)	5, 455, 475	12, 404, 713	'	3	U	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	11. 865350	27. 119905	0.00000	0. 000000	0. 000000	203 00
204. 00	Cost to be allocated (per Wkst. B,	363, 649	982, 513		0.000000		204. 00
204.00	Part II)	303, 047	702, 313		5	0	204.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 791204	2. 137687	0. 00000	0. 000000	0. 000000	205 00
203.00		0. 771204	2. 13/00/	0.00000	0.000000	0.00000	203.00
206. 00	NAHE adjustment amount to be allocated				0	n	206. 00
250.00	(per Wkst. B-2)						250.00
207. 00	NAHE unit cost multiplier (Wkst. D,			0.00000	0. 000000	0. 000000	207. 00
	Parts III and IV)				3. 000000		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0074 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm Cost Center Description PHARMACY RESIDNECY-BTH ALLIED HEALTH (ASSI GNED TIME) 23.03 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16 00 17. 00 | 01700 | SOCIAL SERVICE 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22 00 23.00 02300 EMS TRAINING-ALLIED HEALTH 23.00 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 23.01 23.01 23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23. 03 23 03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 32.00 03200 CORONARY CARE UNIT 32 00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 35.00 04300 NURSERY 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 51.00 05100 RECOVERY ROOM 51.00 00000000000000000000000000000 52. 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 57.00 05700 CT SCAN 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 06000 LABORATORY 60.00 60.00 64.00 06400 INTRAVENOUS THERAPY 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 73 00 07301 SPECIALTY PHARMACY 73.01 73.01 07400 RENAL DIALYSIS 74.00 74.00 76. 00 03330 ENDOSCOPY 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 01 76.01 76.03 03951 LUTHERWOOD PARTNERSHIP 76.03 03952 WOUND CARE CENTER 76.04 76.04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 76 05 03953 I MAGING CENTERS 76.06 76.06 76. 07 03954 BREAST DIAGNOSTIC CENTER 76.07 0 76.97 07697 CARDIAC REHABILITATION 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 76. 98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0000000000 89.00 09000 CLI NI C 90.00 90.00 90.01 04950 DIABETIC CARE CENTER 90.01 04951 HEALTHY HEARTS CENTER 90.02 90.02 90.03 09001 CLI NI C 90.03 90.04 04953 SPINE CENTER 90.04 04954 INFUSION CENTERS 90.05 90.05 90.06 09002 MEDCHECK CLINICS 90.06 09003 KNEE CENTER 90 07 90.07 90. 08 09004 PALLIATIVE CARE 90.08 90. 10 09006 WORK SITE CLINICS 90.10

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0074	Peri od:	Worksheet B-1
SOL MEESSAN ON COMPONE SHOLD			From 01/01/2021	
			To 12/31/2021	Date/Time Prepared 5/30/2022 2:48 pm
Cost Center Description	PHARMACY			
	RESI DNECY-BTH			
l A	ALLI ED HEALTH			
	(ASSI GNED			
_	TI ME)			
AO 40 040/4 FAMILY BRACTICE AND MATERNITY CARE	23. 03			00
20. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0			90.
01. 00 09100 EMERGENCY	0			91.
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.
OTHER REIMBURSABLE COST CENTERS	ام			
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0			98.
SPECIAL PURPOSE COST CENTERS	ما			440
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	0			118.
NONREI MBURSABLE COST CENTERS				400
90. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.
91. 00 19100 RESEARCH	0			191.
92. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			192.
94. 00 07950 HOME OFFI CE	0			194.
94. 01 07951 CHNW LEASED SPACE	0			194.
94. 02 07952 ACCOUNTABLE CARE	0			194.
94. 03 07953 SCH00L BASED CLINICS	0			194.
94. 04 07954 SMO-NON PROVI DER BASED	0			194.
94. 05 07955 FAMILY PRACTICE MEDICINE	0			194.
94. 07 07957 LI FECHECK	0			194.
94.08 07958 GROUP HOMES AND MISC. N_R CTRS	0			194.
94. 09 07959 SURGERY CENTER EAST	0			194.
200.00 Cross Foot Adjustments				200.
201.00 Negative Cost Centers				201.
Cost to be allocated (per Wkst. B,	0			202.
Part I)				
Unit cost multiplier (Wkst. B, Part I)	0. 000000			203.
Cost to be allocated (per Wkst. B,	0			204.
Part II)				
Unit cost multiplier (Wkst. B, Part	0. 000000			205.
	_			
NAHE adjustment amount to be allocated	0			206.
(per Wkst. B-2)	0.00005			
207.00 NAHE unit cost multiplier (Wkst. D,	0. 000000			207.

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider C		Peri od: Worksheet C From 01/01/2021 Part I To 12/31/2021 Date/Time Pre 5/30/2022 2:4		pared:
			Title	XVIII	Hospi tal	PPS	- piii
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	98, 041, 662 29, 542, 163		98, 041, 66 29, 542, 16		98, 108, 942 29, 542, 163	
32. 00	03200 CORONARY CARE UNIT	27, 342, 103			0 0	27, 342, 103	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	3, 297, 468		3, 297, 46	8 0		35. 00
43. 00	04300 NURSERY	1, 258, 092		1, 258, 09	2 0	1, 258, 092	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	35, 680, 972		35, 680, 97	2 0	35, 680, 972	50.00
51. 00	05100 RECOVERY ROOM	2, 040, 517		2, 040, 51			
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 875, 802		6, 875, 80		6, 875, 802	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	8, 730, 170		8, 730, 17		8, 730, 170	1
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	2, 841, 914 6, 072, 072		2, 841, 91 6, 072, 07		2, 841, 914 6, 072, 072	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 053, 555		2, 053, 55			1
59. 00	05900 CARDI AC CATHETERI ZATI ON	12, 670, 744		12, 670, 74		12, 670, 744	1
60.00	06000 LABORATORY	21, 154, 420		21, 154, 42		21, 154, 420	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 438, 868 8, 635, 499	0	2, 438, 86 8, 635, 49		2, 438, 868 8, 635, 499	
66. 00	06600 PHYSI CAL THERAPY	10, 829, 871	0	10, 829, 87		10, 829, 871	
67. 00	06700 OCCUPATI ONAL THERAPY	3, 084, 086	0	3, 084, 08	6 0	3, 084, 086	
68. 00	06800 SPEECH PATHOLOGY	1, 104, 284	0	1, 104, 28			
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	6, 113, 961 1, 776, 314		6, 113, 96 1, 776, 31		6, 113, 961 1, 776, 314	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 081, 746		47, 081, 74		47, 081, 746	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	34, 584, 521		34, 584, 52		34, 584, 521	
73. 00	07300 DRUGS CHARGED TO PATIENTS	201, 078, 153		201, 078, 15		201, 078, 153	
73. 01 74. 00	07301 SPECIALTY PHARMACY 07400 RENAL DIALYSIS	78, 042, 323 2, 067, 916		78, 042, 32 2, 067, 91		78, 042, 323 2, 067, 916	
76. 00	03330 ENDOSCOPY	1, 356, 789		1, 356, 78		1, 356, 789	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	22, 454, 551		22, 454, 55		22, 486, 552	
76. 03	03951 LUTHERWOOD PARTNERSHIP	6, 482, 083		6, 482, 08		6, 482, 083	
76. 04 76. 05	03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER	3, 644, 060		3, 644, 06		3, 644, 060	
76. 05	03953 I MAGI NG CENTERS	56, 164, 402 9, 151, 990		56, 164, 40 9, 151, 99		56, 164, 402 9, 151, 990	
76. 07	03954 BREAST DIAGNOSTIC CENTER	3, 653, 517		3, 653, 51			
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 999, 635		1, 999, 63			
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	497, 926		497, 92	6 0	497, 926	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0		
	09000 CLI NI C	0			0 0		
	04950 DI ABETI C CARE CENTER 04951 HEALTHY HEARTS CENTER	0 2, 071, 012		2, 071, 01	0 0	0 2, 071, 012	
90. 02	09001 CLINIC	2,071,012		2,071,01	0 0	2,0/1,012	
90. 04	04953 SPI NE CENTER	4			4 0	4	90. 04
90. 05	04954 INFUSION CENTERS	859, 716		859, 71	6 0	859, 716	1
90. 06 90. 07	09002 MEDCHECK CLINICS 09003 KNEE CENTER	0 6, 684, 731		4 404 72	0	0	
90.07	09003 KNEE CENTER 09004 PALLI ATI VE CARE	735		6, 684, 73 73		6, 684, 731 735	
90. 10	09006 WORK SITE CLINICS	0		1	0 0	0	1
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0			0 0	0	90. 12
91.00	09100 EMERGENCY	32, 604, 701		32, 604, 70		32, 604, 701	
92. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	7, 023, 174		7, 023, 17	4	7, 023, 174	92.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	
200.00		781, 746, 119	0			781, 845, 400	
201. 00 202. 00		7, 023, 174 774, 722, 945	0	7, 023, 17 774, 722, 94		7, 023, 174 774, 822, 226	
	1 (· ·		, 20.		

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provi der CCN: 15-0074 Peri od: From 01/01/2 To 12/31/2		Worksheet C Part I		
							Date/Time Prepared: 5/30/2022 2:48 pm	
				Title XVIII		Hospi tal	PPS	
		Cost Center Description	I npati ent	Charges Outpatient	Total (col. (Cost or Other Ratio	TEFRA I npati ent Rati o	
			6.00	7. 00	8. 00	9. 00	10.00	
		ENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	204, 966, 322 73, 533, 600		204, 966, 32 73, 533, 60			30. 00 31. 00
32. 00		CORONARY CARE UNIT	73, 553, 600			0		32.00
35. 00		NEONATAL INTENSIVE CARE UNIT	18, 098, 639		18, 098, 63	-		35. 00
43. 00	1	NURSERY	2, 606, 127		2, 606, 12			43. 00
		LARY SERVICE COST CENTERS			_,,,	• 1		
50.00	05000	OPERATING ROOM	123, 909, 786	67, 109, 587	191, 019, 37	3 0. 186792	0. 000000	50.00
51. 00		RECOVERY ROOM	7, 151, 668	7, 471, 172				
52. 00		DELIVERY ROOM & LABOR ROOM	11, 132, 033	0			0. 000000	
54.00		RADI OLOGY-DI AGNOSTI C	13, 313, 469	49, 258, 182			0.000000	
55. 00		RADI OLOGY-THERAPEUTI C	13, 255, 970	13, 468, 380			0.000000	
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	28, 408, 550 4, 886, 242	75, 178, 654 11, 787, 515			0. 000000 0. 000000	
59. 00		CARDI AC CATHETERI ZATI ON	114, 433, 563	205, 724, 669			0.00000	
60. 00		LABORATORY	96, 725, 004	94, 361, 769			0. 000000	
64. 00		INTRAVENOUS THERAPY	1, 112, 869	1, 944, 150			0. 000000	
65.00	1	RESPI RATORY THERAPY	36, 209, 836	2, 392, 619			0.000000	
66. 00	06600	PHYSI CAL THERAPY	3, 971, 612	19, 256, 963			0. 000000	66. 00
67. 00	06700	OCCUPATIONAL THERAPY	3, 195, 742	3, 723, 299	6, 919, 04	1 0. 445739	0. 000000	67. 00
68. 00		SPEECH PATHOLOGY	1, 009, 763	1, 469, 468			0. 000000	
69. 00		ELECTROCARDI OLOGY	14, 394, 370	41, 948, 273			0. 000000	
70.00		ELECTROENCEPHALOGRAPHY	914, 617	6, 487, 641				
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 685, 057	47, 553, 168			0.000000	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	60, 181, 563 88, 383, 835	39, 776, 996	99, 958, 55 1, 045, 242, 08		0. 000000 0. 000000	
73. 00		SPECIALTY PHARMACY	00, 303, 033	93, 264, 718			0. 000000	
74. 00		RENAL DIALYSIS	8, 339, 676	0, 201, 710			0. 000000	
76. 00		ENDOSCOPY	2, 365, 548	3, 287, 275			0. 000000	
76. 01		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	22, 854, 715			0.000000	
76. 03	03951	LUTHERWOOD PARTNERSHIP	o	873, 937	873, 93	7. 417106	0. 000000	76. 03
76. 04		WOUND CARE CENTER	722, 001	12, 337, 867			0. 000000	
76. 05		ONCOLOGY-CANCER CARE CENTER	1, 609, 526	257, 150, 233			0. 000000	
76. 06		I MAGI NG CENTERS	155, 931	67, 663, 068			0.000000	
76. 07		BREAST DIAGNOSTIC CENTER	54, 869	6, 524, 648			0. 000000 0. 000000	
76. 97 76. 98		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	26, 736 0	3, 832, 454 1, 988, 224	3, 859, 19 1, 988, 22		0.000000	
70. 70		TIENT SERVICE COST CENTERS	ı o	1, 700, 224	1, 700, 22	4 0. 230430	0.00000	70.70
88. 00		RURAL HEALTH CLINIC	0	0		0		88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	o	0		0		89. 00
90.00	09000	CLI NI C	0	0		0. 000000	0. 000000	90.00
90. 01		DIABETIC CARE CENTER	0	0		0. 000000		
		HEALTHY HEARTS CENTER	19, 605	3, 456, 961			0. 000000	
90. 03		CLINIC	0	0		0.000000	0.000000	
90. 04		SPINE CENTER	653	10 (20 202	65 18, 648, 93		0.000000	1
90. 05 90. 06		INFUSION CENTERS MEDCHECK CLINICS	10, 627	18, 638, 303	10, 040, 93	0.000000	0. 000000 0. 000000	1
90. 07	1	KNEE CENTER	4, 187	5, 460, 272	5, 464, 45		0. 000000	1
90. 08		PALLI ATI VE CARE	0	133, 159			0. 000000	1
90. 10		WORK SITE CLINICS	0	0		0. 000000	0.000000	
90. 12	04961	FAMILY PRACTICE AND MATERNITY CARE	0	0		0. 000000	0. 000000	90. 12
91. 00		EMERGENCY	61, 936, 134	211, 004, 363			0. 000000	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	2, 743, 997	7, 962, 337	10, 706, 33	4 0. 655983	0. 000000	92. 00
0		REI MBURSABLE COST CENTERS	1			al		
98. 00		OTHER REIMBURSABLE COST CENTERS	0	0	•	0.000000	0. 000000	
200. 00 201. 00	1	Subtotal (see instructions) Less Observation Beds	1, 040, 469, 727	2, 362, 203, 289	3, 402, 6/3, 01	0		200. 00 201. 00
201.00		Total (see instructions)	1, 040, 469, 727	2 362 203 280	3 402 673 01	6		201.00
202.00	-1	Total (See Histractions)	1,040,407,121	2, 302, 203, 207	1 5, 402, 075, 01	□	Į.	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 2:48 pm | PPS | Title XVIII

		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31. 00
32. 00 03200 CORONARY CARE UNIT				32.00
· · · · · · · · · · · · · · · · · · ·				
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				35. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 186792			50.00
51.00 05100 RECOVERY ROOM	0. 139543			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 617659			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 139523			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 106342			55. 00
57. 00 05700 CT SCAN	0. 058618			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 123161			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 039577			59. 00
60. 00 06000 LABORATORY	0. 110706			60.00
I I				
64. 00 06400 I NTRAVENOUS THERAPY	0. 797793			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 223703			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 466231			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 445739			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 445414			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 108514			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 239969			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 345989			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 192375			73. 00
73. 01 07301 SPECI ALTY PHARMACY	0. 836783			73. 00
l l				
	0. 247961			74.00
76. 00 03330 ENDOSCOPY	0. 240020			76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	7. 417106			76. 03
76.04 03952 WOUND CARE CENTER	0. 279027			76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0. 217052			76. 05
76.06 03953 I MAGING CENTERS	0. 134947			76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	0. 555287			76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 518149			76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0. 250438			76. 98
OUTPATIENT SERVICE COST CENTERS	0. 230430			70. 70
				99 00
				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 04950 DI ABETI C CARE CENTER	0. 000000			90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0. 595706			90. 02
90. 03 09001 CLI NI C	0. 000000			90. 03
90. 04 04953 SPI NE CENTER	0. 006126			90. 04
90. 05 04954 I NFUSI ON CENTERS	0. 046100			90. 05
90. 06 09002 MEDCHECK CLINICS	0. 000000			90.06
90. 07 09003 KNEE CENTER	1. 223311			90. 07
90. 08 09004 PALLI ATI VE CARE	0. 005520			90. 08
90. 10 09004 PALLIATIVE CARE 90. 10 09006 WORK SITE CLINICS	1			90. 08
1	0.000000			
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE				90. 12
91. 00 09100 EMERGENCY	0. 119457			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	RT) 0. 655983			92. 00
OTHER REIMBURSABLE COST CENTERS				
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	,			

COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2021	Worksheet C Part I	
					To 12/31/2021	Date/Time Pre 5/30/2022 2:4	pared: 8 pm
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
					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	1.00	2.00	3.00	4.00	5.00	
30. 00	03000 ADULTS & PEDIATRICS	106, 045, 726		106, 045, 72	6 67, 280	106, 113, 006	30.00
31. 00	03100 INTENSIVE CARE UNIT	29, 733, 347		29, 733, 34		29, 733, 347	
32.00	03200 CORONARY CARE UNIT	0			0 0	0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	3, 436, 333		3, 436, 33		3, 436, 333	
43. 00	04300 NURSERY	1, 258, 092		1, 258, 09	2 0	1, 258, 092	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	2/ 404 105		2/ 404 10	FI 0	27 404 105	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	36, 484, 185 2, 040, 517		36, 484, 18 2, 040, 51			
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 875, 802		6, 875, 80			
54. 00	05400 RADI OLOGY - DI AGNOSTI C	8, 730, 170		8, 730, 17		8, 730, 170	
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 841, 914		2, 841, 91		2, 841, 914	1
57. 00	05700 CT SCAN	6, 072, 072		6, 072, 07		6, 072, 072	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 053, 555		2, 053, 55	5 0	2, 053, 555	
59. 00	05900 CARDI AC CATHETERI ZATI ON	12, 670, 744		12, 670, 74		12, 670, 744	
60.00	06000 LABORATORY	21, 154, 420		21, 154, 42		21, 154, 420	1
64. 00	06400 NTRAVENOUS THERAPY	2, 438, 868	0	2, 438, 86		2, 438, 868	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	8, 635, 499 11, 033, 880	0			8, 635, 499 11, 033, 880	1
67. 00	06700 OCCUPATI ONAL THERAPY	3, 084, 086	0	3, 084, 08		3, 084, 086	
68. 00	06800 SPEECH PATHOLOGY	1, 104, 284	0	1, 104, 28		1, 104, 284	1
69. 00	06900 ELECTROCARDI OLOGY	6, 416, 214	O	6, 416, 21		6, 416, 214	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 791, 284		1, 791, 28		1, 791, 284	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 081, 746		47, 081, 74	6 0	47, 081, 746	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	34, 584, 521		34, 584, 52	1 0	34, 584, 521	
73. 00	07300 DRUGS CHARGED TO PATIENTS	201, 519, 271		201, 519, 27			
73. 01	07301 SPECIALTY PHARMACY	78, 042, 323		78, 042, 32		78, 042, 323	
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	2, 067, 916 1, 356, 789		2, 067, 91 1, 356, 78		2, 067, 916	
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	23, 332, 538		23, 332, 53		1, 356, 789 23, 364, 539	
76. 03	03951 LUTHERWOOD PARTNERSHIP	6, 482, 083		6, 482, 08		6, 482, 083	
76. 04	03952 WOUND CARE CENTER	3, 718, 834		3, 718, 83		3, 718, 834	
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	56, 164, 402		56, 164, 40	2 0	56, 164, 402	76. 05
76. 06	03953 I MAGI NG CENTERS	9, 151, 990		9, 151, 99	0	9, 151, 990	76. 06
76. 07	03954 BREAST DI AGNOSTI C CENTER	3, 653, 517		3, 653, 51			
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 999, 635		1, 999, 63		1, 999, 635	
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	497, 926		497, 92	6 0	497, 926	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö			o o		
90. 00	09000 CLI NI C	0		•	o o		
90. 01	04950 DI ABETI C CARE CENTER	0			0 0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	2, 071, 012		2, 071, 01	2 0	2, 071, 012	90. 02
90. 03	09001 CLI NI C	0			0	0	
90. 04	04953 SPI NE CENTER	4		050.74	4 0	4	90. 04
90.05	04954 I NFUSION CENTERS	859, 716		859, 71	6 0	859, 716	1
90. 06 90. 07	09002 MEDCHECK CLINICS 09003 KNEE CENTER	6, 849, 210		6, 849, 21	0	6, 849, 210	90. 06 90. 07
90.07	09004 PALLI ATI VE CARE	105, 410		105, 41		105, 410	1
90. 10	09006 WORK SITE CLINICS	0			o o	0	1
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0			0	0	
91.00	09100 EMERGENCY	33, 242, 461		33, 242, 46	1 0	33, 242, 461	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 023, 174		7, 023, 17	4	7, 023, 174	92. 00
	OTHER REIMBURSABLE COST CENTERS	1		1			
	09850 OTHER REIMBURSABLE COST CENTERS	702 705 470	_	702 705 47	0 00 001	0	98. 00
200. 00 201. 00		793, 705, 470 7, 023, 174	0	793, 705, 47 7, 023, 17		793, 804, 751 7, 023, 174	
201.00	1 1	786, 682, 296	0				
	, , , , , , , , , , , , , , , , , , , ,		O		77,201		,

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/30/2022 2:4	pared:
				e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	204, 966, 322		204, 966, 32			30.00
31.00	03100 NTENSI VE CARE UNI T	73, 533, 600		73, 533, 60			31.00
32. 00 35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 18, 098, 639		18, 098, 63	0		32. 00 35. 00
43. 00	04300 NURSERY	2, 606, 127		2, 606, 12			43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	2,000,127		2,000,12	,		1 43.00
50.00	05000 OPERATING ROOM	123, 909, 786	67, 109, 587	191, 019, 37	3 0. 190997	0.000000	50.00
51.00	05100 RECOVERY ROOM	7, 151, 668	7, 471, 172	14, 622, 84	0. 139543	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11, 132, 033	0	11, 132, 03	0. 617659		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	13, 313, 469	49, 258, 182				
55. 00	05500 RADI OLOGY-THERAPEUTI C	13, 255, 970	13, 468, 380			0.000000	
57. 00	05700 CT SCAN	28, 408, 550	75, 178, 654				
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	4, 886, 242	11, 787, 515			0.000000	
59. 00 60. 00	06000 LABORATORY	114, 433, 563 96, 725, 004	205, 724, 669 94, 361, 769			0. 000000 0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	1, 112, 869	1, 944, 150				
65. 00	06500 RESPIRATORY THERAPY	36, 209, 836	2, 392, 619			l e	
66. 00	06600 PHYSI CAL THERAPY	3, 971, 612	19, 256, 963				
67.00	06700 OCCUPATI ONAL THERAPY	3, 195, 742	3, 723, 299				
68.00	06800 SPEECH PATHOLOGY	1, 009, 763	1, 469, 468			0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	14, 394, 370	41, 948, 273				
70.00	07000 ELECTROENCEPHALOGRAPHY	914, 617	6, 487, 641			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 685, 057	47, 553, 168			l .	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	60, 181, 563	39, 776, 996				
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS	88, 383, 835 0		1, 045, 242, 08		0.000000	
74. 00	07301 SPECI ALTY PHARMACY 07400 RENAL DI ALYSI S	8, 339, 676	93, 264, 718 0			0. 000000 0. 000000	
76.00	03330 ENDOSCOPY	2, 365, 548	3, 287, 275			l	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 303, 340	22, 854, 715			0. 000000	
76. 03	03951 LUTHERWOOD PARTNERSHIP	0	873, 937				
76. 04	03952 WOUND CARE CENTER	722, 001	12, 337, 867				
76.05	03480 ONCOLOGY-CANCER CARE CENTER	1, 609, 526	257, 150, 233	258, 759, 75			76. 05
76. 06	03953 I MAGI NG CENTERS	155, 931	67, 663, 068				
76. 07	03954 BREAST DI AGNOSTI C CENTER	54, 869	6, 524, 648			0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	26, 736	3, 832, 454				
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	1, 988, 224	1, 988, 22	0. 250438	0.000000	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0	0		0. 000000	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	1	0. 000000		
90.00	09000 CLINIC	o o	0		0. 000000	0. 000000	
90. 01	04950 DIABETIC CARE CENTER	0	0		0. 000000	l e	
90. 02	04951 HEALTHY HEARTS CENTER	19, 605	3, 456, 961	3, 476, 56	6 0. 595706	0.000000	90. 02
90. 03	09001 CLI NI C	0	0		0. 000000	0. 000000	90. 03
90. 04	04953 SPI NE CENTER	653	0	65			
90. 05	04954 NFUSION CENTERS	10, 627	18, 638, 303			0. 000000	1
90.06	09002 MEDCHECK CLINICS	0	0		0.000000	l	1
90. 07	09003 KNEE CENTER	4, 187	5, 460, 272			0.000000	
90. 08 90. 10	09004 PALLIATIVE CARE 09006 WORK SITE CLINICS		133, 159 0		9 0. 791610 0. 000000	0. 000000 0. 000000	
90. 10	04961 FAMILY PRACTICE AND MATERNITY CARE		0		0. 000000	l .	
91. 00	09100 EMERGENCY	61, 936, 134	211, 004, 363			l .	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 743, 997	7, 962, 337			l	
	OTHER REIMBURSABLE COST CENTERS						
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0. 000000	98. 00
200.00		1, 040, 469, 727	2, 362, 203, 289	3, 402, 673, 01	6		200. 00
201.00		1 040 440 707	2 2/2 222 222	2 402 (72 25	,		201. 00
202. 00	Total (see instructions)	1, 040, 469, 727	2, 302, 203, 289	3,402,6/3,01	υ	I .	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 2:48 pm | PPS | Title XIX

		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
· ·	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 INTENSI VE CARE UNI T				31. 00
32. 00 03200 CORONARY CARE UNIT				32.00
· · · · · · · · · · · · · · · · · · ·				
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				35.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 190997			50.00
51. 00 05100 RECOVERY ROOM	0. 139543			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 617659			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 139523			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 106342			55. 00
57. 00 05700 CT SCAN	0. 058618			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 123161			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 039577			59. 00
60. 00 06000 LABORATORY	0. 110706			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 797793			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 223703			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 475013			
1 1	1 1			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 445739			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 445414			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 113878			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 241992			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	S 0. 533575			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 345989			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 192797			73.00
73. 01 07301 SPECIALTY PHARMACY	0. 836783			73. 01
74.00 07400 RENAL DIALYSIS	0. 247961			74. 00
76. 00 03330 ENDOSCOPY	0. 240020			76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 022307			76. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P	7. 417106			76. 03
76. 04 03952 WOUND CARE CENTER	0. 284753			76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0. 217052			76. 05
76. 06 03953 I MAGI NG CENTERS	0. 134947			76.06
76. 07 03954 BREAST DI AGNOSTI C CENTER	0. 555287			76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 518149			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 250438			76. 98
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 04950 DIABETIC CARE CENTER	0. 000000			90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0. 595706			90. 02
90. 03 09001 CLI NI C	0. 000000			90. 03
90. 04 04953 SPI NE CENTER	0. 006126			90. 04
90. 05 04954 INFUSION CENTERS	0. 046100			90. 05
90. 06 09002 MEDCHECK CLINICS	0. 000000			90.06
	1 1			
90. 07 09003 KNEE CENTER	1. 253410			90. 07
90. 08 09004 PALLI ATI VE CARE	0. 791610			90. 08
90. 10 09006 WORK SITE CLINICS	0. 000000			90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000			90. 12
91. 00 09100 EMERGENCY	0. 121794			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 655983			92. 00
OTHER REIMBURSABLE COST CENTERS				
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
1	1			1

Heal th Financial Systems COMMUNITY HEAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 2:48 pm Provider CCN: 15-0074

						5/30/2022 2:4	8 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
			(Wkst. B, Part		Reducti on	Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
		1, 3011 20)		col . 2)		7	
		1.00	2.00	3.00	4. 00	5. 00	
1	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
	D5000 OPERATING ROOM	36, 484, 185	4, 751, 413	31, 732, 772	0	0	50.00
	D5100 RECOVERY ROOM	2, 040, 517			0		51.00
						l e	
	D5200 DELIVERY ROOM & LABOR ROOM	6, 875, 802			0	l e	52.00
	D5400 RADI OLOGY-DI AGNOSTI C	8, 730, 170			0	l e	54. 00
	D5500 RADI OLOGY-THERAPEUTI C	2, 841, 914			0		55. 00
	D5700 CT SCAN	6, 072, 072			0		57. 00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	2, 053, 555	430, 009	1, 623, 546	0	0	58. 00
59.00	D5900 CARDIAC CATHETERIZATION	12, 670, 744	1, 391, 463	11, 279, 281	0	0	59. 00
60.00	06000 LABORATORY	21, 154, 420	340, 138	20, 814, 282	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	2, 438, 868	88, 362	2, 350, 506	0	0	64.00
	06500 RESPIRATORY THERAPY	8, 635, 499			0	0	65. 00
	06600 PHYSI CAL THERAPY	11, 033, 880			0	o o	66. 00
	06700 OCCUPATI ONAL THERAPY	3, 084, 086			0		67. 00
	06800 SPEECH PATHOLOGY				0		68.00
		1, 104, 284			0		
	06900 ELECTROCARDI OLOGY	6, 416, 214					69. 00
	D7000 ELECTROENCEPHALOGRAPHY	1, 791, 284			0		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 081, 746			0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	34, 584, 521			0		72. 00
	D7300 DRUGS CHARGED TO PATIENTS	201, 519, 271			0	l .	73. 00
73. 01	D7301 SPECIALTY PHARMACY	78, 042, 323	712, 387	77, 329, 936	0	0	73. 01
74.00	07400 RENAL DIALYSIS	2, 067, 916	23, 741	2, 044, 175	0	0	74. 00
76.00	D3330 ENDOSCOPY	1, 356, 789	118, 576	1, 238, 213	0	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	23, 332, 538	3, 197, 051	20, 135, 487	0	0	76. 01
	D3951 LUTHERWOOD PARTNERSHIP	6, 482, 083			0	0	76. 03
	D3952 WOUND CARE CENTER	3, 718, 834			0	0	76. 04
	03480 ONCOLOGY-CANCER CARE CENTER	56, 164, 402	1		0	o o	76. 05
	03953 I MAGI NG CENTERS	9, 151, 990			0	o o	76.06
	D3954 BREAST DIAGNOSTIC CENTER	3, 653, 517			0	0	76.07
	07697 CARDI AC REHABI LI TATI ON	1, 999, 635			0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	497, 926			0	0	76. 98
		497, 920	30, 197	407,729	U	U	70. 90
	DUTPATIENT SERVICE COST CENTERS	1 0	1 0			0	00.00
	D8800 RURAL HEALTH CLINIC	0	_		0		88. 00
	D8900 FEDERALLY QUALIFIED HEALTH CENTER	0	_		0	0	89. 00
	09000 CLI NI C	0	0		0	0	90.00
	D4950 DIABETIC CARE CENTER	0	0		0	0	90. 01
	D4951 HEALTHY HEARTS CENTER	2, 071, 012	304, 723	1, 766, 289	0	0	90. 02
	09001 CLI NI C	0	0	0	0	0	90. 03
90. 04	04953 SPI NE CENTER	4	0	4	0	0	90. 04
90.05	D4954 INFUSION CENTERS	859, 716	139, 137	720, 579	0	0	90. 05
90.06	09002 MEDCHECK CLINICS	0	0	0	0	0	90. 06
90. 07	09003 KNEE CENTER	6, 849, 210	627, 906	6, 221, 304	0	0	90. 07
90.08	09004 PALLIATIVE CARE	105, 410			0	0	90. 08
1	09006 WORK SITE CLINICS	0	0		0	0	90. 10
1	04961 FAMILY PRACTICE AND MATERNITY CARE	1 0	0		0	0	90. 12
	09100 EMERGENCY	33, 242, 461	_		0	Ö	91.00
- 1	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 023, 174			0		
	OTHER REIMBURSABLE COST CENTERS	1,023,174	1 004, 111	0, 337, 003	0	<u> </u>	7∠.00
		_			^	_	00 00
	09850 OTHER REIMBURSABLE COST CENTERS	0			0		
200.00	Subtotal (sum of lines 50 thru 199)	653, 231, 972			0		200.00
201.00	Less Observation Beds	7, 023, 174			0		201. 00
202. 00	Total (line 200 minus line 201)	646, 208, 798	34, 361, 202	611, 847, 596	0	1 0	202. 00

Health Financial Systems COMMUNITY HEACLCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Period: Worksheet C From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm Provider CCN: 15-0074 REDUCTIONS FOR MEDICALD ONLY

					5/30/2022 2: 4	8 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
' '	Capital and		Cost to Charge			
	Operating Cost					
	Reduction	8)	/ col . 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00			
50. 00 05000 OPERATI NG ROOM	36, 484, 185	191, 019, 373	0. 190997			50.00
51. 00 05100 RECOVERY ROOM	2, 040, 517	14, 622, 840				51.00
						1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	6, 875, 802					52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	8, 730, 170		0. 139523			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 841, 914					55. 00
57. 00 05700 CT SCAN	6, 072, 072	103, 587, 204	0. 058618			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 053, 555		0. 123161			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	12, 670, 744	320, 158, 232	0. 039577			59. 00
60. 00 06000 LABORATORY	21, 154, 420	191, 086, 773	0. 110706			60.00
64.00 06400 INTRAVENOUS THERAPY	2, 438, 868	3, 057, 019	0. 797793			64.00
65. 00 06500 RESPIRATORY THERAPY	8, 635, 499	38, 602, 455	0. 223703			65. 00
66. 00 06600 PHYSI CAL THERAPY	11, 033, 880		0. 475013			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 084, 086	6, 919, 041	0. 445739			67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 104, 284	2, 479, 231	0. 445414			68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 416, 214					69. 00
70. 00 07000 ELECTROCARD OLOGT						70.00
	1, 791, 284	7, 402, 258				1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 081, 746	88, 238, 225	0. 533575			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	34, 584, 521	99, 958, 559	0. 345989			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	201, 519, 271		0. 192797			73. 00
73. 01 07301 SPECIALTY PHARMACY	78, 042, 323					73. 01
74. 00 07400 RENAL DI ALYSI S	2, 067, 916	8, 339, 676				74. 00
76. 00 03330 ENDOSCOPY	1, 356, 789	5, 652, 823	0. 240020			76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	23, 332, 538	22, 854, 715	1. 020907			76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	6, 482, 083	873, 937	7. 417106			76. 03
76. 04 03952 WOUND CARE CENTER	3, 718, 834	13, 059, 868	0. 284753			76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	56, 164, 402					76. 05
76. 06 03953 I MAGI NG CENTERS	9, 151, 990					76.06
76. 07 03954 BREAST DIAGNOSTIC CENTER	3, 653, 517	6, 579, 517	0. 555287			76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 999, 635					76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	497, 926		0. 250438			76. 98
OUTPATIENT SERVICE COST CENTERS	477,720	1, 700, 224	0. 230430			70.70
88. 00 08800 RURAL HEALTH CLINIC	0	0	0. 000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		-				89. 00
	1	0				1
90. 00 09000 CLI NI C	0	0	0.000000			90.00
90. 01 04950 DI ABETI C CARE CENTER	0	0	0. 000000			90. 01
90. 02 04951 HEALTHY HEARTS CENTER	2, 071, 012	3, 476, 566	0. 595706			90. 02
90. 03 09001 CLI NI C	0	0	0. 000000			90. 03
90. 04 04953 SPI NE CENTER	4	653	0. 006126			90. 04
90. 05 04954 I NFUSI ON CENTERS	859, 716	18, 648, 930	0. 046100			90. 05
90. 06 09002 MEDCHECK CLINICS	0	0	0.000000			90.06
90. 07 09003 KNEE CENTER	6, 849, 210	5, 464, 459	1. 253410			90. 07
90. 08 09004 PALLI ATI VE CARE	105, 410	133, 159	0. 791610			90. 08
90. 10 09006 WORK SITE CLINICS	0	0	0. 000000			90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	l n	0. 000000			90. 12
91. 00 09100 EMERGENCY	33, 242, 461	272, 940, 497	0. 121794			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 023, 174					92. 00
	1,023,174	10, 700, 334	0.000983			72.00
OTHER REIMBURSABLE COST CENTERS		_	0.000000			00.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0					98. 00
200.00 Subtotal (sum of lines 50 thru 199)	653, 231, 972					200. 00
201.00 Less Observation Beds	7, 023, 174					201. 00
202.00 Total (line 200 minus line 201)	646, 208, 798	3, 103, 468, 328				202. 00

Heal th	Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
APPORT	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/30/2022 2:48	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost (col. 1 - col		Per Diem (col. 3 / col. 4)	
		Part II, col.		l *	•		
		26)	2.00	2) 3, 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00	ADULTS & PEDIATRICS	9, 277, 134	0	9, 277, 13	4 88, 817	104. 45	30.00
31. 00	INTENSIVE CARE UNIT	3, 260, 084		3, 260, 08	•	216. 47	
	CORONARY CARE UNIT	0		1	0 0	0.00	
35. 00	NEONATAL INTENSIVE CARE UNIT	234, 256		234, 25	6 2, 214		35. 00
43.00	NURSERY	208, 419		208, 41			43.00
200.00	Total (lines 30 through 199)	12, 979, 893		12, 979, 89	107, 780		200. 00
	Cost Center Description	I npati ent	I npati ent				
		Program days	Program Capital Cost (col. 5 x col.				
		6. 00	6) 7. 00	+			
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00	ADULTS & PEDIATRICS	14, 380	1, 501, 991				30.00
31. 00	INTENSIVE CARE UNIT	3, 237	700, 713				31. 00
32. 00	CORONARY CARE UNIT	0	0	,			32. 00
35. 00	NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
43.00	NURSERY	0	0				43. 00
200. 00	Total (lines 30 through 199)	17, 617	2, 202, 704	.[200. 00

Heal th	Financial Systems C	OMMUNITY HEALTH	I NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
APPOR	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0074	Peri od:	Worksheet D	
					From 01/01/2021	Part II	
					To 12/31/2021	Date/Time Pre	pared:
						5/30/2022 2: 4	8 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges		t Inpatient	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	
	ANCILLARY SERVICE COST CENTERS	_	,				
50. 00	05000 OPERATING ROOM	4, 751, 413				758, 829	
51.00	05100 RECOVERY ROOM	328, 041				43, 139	
52.00	05200 DELIVERY ROOM & LABOR ROOM	920, 503	11, 132, 033	0. 08269	90 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 316, 088	62, 571, 651	0. 02103	3, 258, 329	68, 532	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	110, 673	26, 724, 350	0. 00414	3, 718, 172	15, 397	55. 00
57.00	05700 CT SCAN	602, 224	103, 587, 204	0.00581	7, 074, 629	41, 132	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	430, 009	16, 673, 757	0. 02579	1, 098, 838	28, 339	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 391, 463					59. 00
60.00	06000 LABORATORY	340, 138				38, 736	1
64.00	06400 I NTRAVENOUS THERAPY	88, 362		1		l	1
65. 00	06500 RESPI RATORY THERAPY	475, 562				l	
66. 00	06600 PHYSI CAL THERAPY	1, 207, 108				l	1
67. 00	06700 OCCUPATI ONAL THERAPY	189, 970				l	
68. 00	06800 SPEECH PATHOLOGY	67, 989		1			1
69. 00	06900 ELECTROCARDI OLOGY	614, 125					
70. 00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	171, 752					1
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1		1			1
		493, 322					1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	272, 285					
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 272, 690		1		l	
73. 01	07301 SPECIALTY PHARMACY	712, 387				0	73. 01
74. 00	07400 RENAL DI ALYSI S	23, 741		1			74. 00
76. 00	03330 ENDOSCOPY	118, 576		1		1, 478	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 197, 051				1	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	664, 412				0	76. 03
76. 04	03952 WOUND CARE CENTER	216, 815				l	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	6, 940, 618		1		l	
76. 06	03953 I MAGI NG CENTERS	1, 087, 821				i e	76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	212, 609				65	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	306, 415	3, 859, 190	0. 07939	700	56	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	30, 197	1, 988, 224	0. 01518	38 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	00	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	00	0	89. 00
90.00	09000 CLI NI C	0	0	0.00000	00	0	90.00
90. 01	04950 DI ABETI C CARE CENTER	0	0	0. 00000	00	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	304, 723	3, 476, 566	0. 08765	51 0	0	90. 02
90. 03	09001 CLI NI C	0	0	0. 00000	00	0	90. 03
90.04	04953 SPI NE CENTER	0	653			0	90. 04
90. 05		139, 137		1			1
	09002 MEDCHECK CLINICS	0		1		0	
90. 07		627, 906				Ö	
90. 08	09004 PALLI ATI VE CARE	47				Ö	90. 08
90. 10	09006 WORK SITE CLINICS	0		0.00000			90. 10
90. 10	04961 FAMILY PRACTICE AND MATERNITY CARE	0		0.00000		0	90. 10
90. 12		_	272 040 407				
	1	2, 735, 030				l	
92. 00	,	664, 111	10, 706, 334	0.06203	1, 006, 322	62, 422	92.00
00.00	OTHER REIMBURSABLE COST CENTERS			0.0000	20		00 00
98.00	1	25 025 212	3, 103, 468, 328	0.00000		1	
200.00	p Total (Titles 50 through 199)	J 30, U25, 313	J 3, 103, 408, 328	1	186, 723, 785	1, 803, 404	₁ 200.00

Health Financial Systems	COMMUNITY HEALTH	I NETWORK, INC.		In Li∈	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/30/2022 2:4	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	0 0	0	•	0 0 0	0 0	31. 00 32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0	0		0 0		
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)		Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6.00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						1
30. 00 03000 ADULTS & PEDI ATRI CS	0	C			14, 380	
31. 00 03100 NTENSI VE CARE UNI T			15, 06			
32. 00 03200 CORONARY CARE UNIT			1	0.00		
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			2, 21		0	35. 00
43. 00 04300 NURSERY		C				
200.00 Total (lines 30 through 199)	I npati ent	C	107, 78	0	17,617	200. 00
Cost Center Description	Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						_
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	0 0 0 0					30. 00 31. 00 32. 00 35. 00 43. 00
200.00 Total (lines 30 through 199)	0	1				200. 00

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2021 Part IV
To 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm
 Heal th Financial
 Systems
 COMMUNITY
 HEALTH N

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

				12/01/2021	5/30/2022 2: 4	8 pm
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C	1	0	0	50. 00
51.00 05100 RECOVERY ROOM	0	C	1	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	[C)	0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	[C)	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	[C)	0	0	55. 00
57. 00 05700 CT SCAN	0	[C)	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0	0	59. 00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	C		0 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	C		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	l c		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	l c		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	l c		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l c		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	l c		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l		0 0	0	73.00
73. 01 07301 SPECIALTY PHARMACY	0			0 0	0	73. 01
74.00 07400 RENAL DIALYSIS	0	l c		0 0	0	74.00
76. 00 03330 ENDOSCOPY	0	l c		0 0	0	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	l c		0 0	0	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P	0	l c		0 0	0	76. 03
76. 04 03952 WOUND CARE CENTER	0	l c		0 0	0	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0	l c		0 0	0	76. 05
76. 06 03953 I MAGI NG CENTERS	0	l c		0 0	0	76.06
76. 07 03954 BREAST DIAGNOSTIC CENTER	0			0	0	76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	0	l d		0 0	o o	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	l d		0 0	1	76. 98
OUTPATIENT SERVICE COST CENTERS	-	<u>-</u>	·I	-		
88. 00 08800 RURAL HEALTH CLINIC	0	C		0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l c		0 0	0	89. 00
90. 00 09000 CLI NI C	0	l c		0 0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	l c		0 0	0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0	l c		0 0	0	90. 02
90. 03 09001 CLI NI C	0	l c		0 0	0	90. 03
90. 04 04953 SPI NE CENTER	0	l		0 0	0	90. 04
90. 05 04954 I NFUSI ON CENTERS	0	l c		0 0	0	90. 05
90. 06 09002 MEDCHECK CLINICS	0	l c		0 0	0	90.06
90. 07 09003 KNEE CENTER	0	l c		0 0	0	90. 07
90. 08 09004 PALLI ATI VE CARE	0	l c		0 0	Ō	90. 08
90. 10 09006 WORK SITE CLINICS	0	ا م		o o	l ő	90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	ا ا		o o	Ö	90. 12
91. 00 09100 EMERGENCY	0			0 0	Ō	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	l .		0	0	92.00
OTHER REIMBURSABLE COST CENTERS		l		<u>-</u>		12.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	C		0 0	0	98. 00
200.00 Total (lines 50 through 199)	0			o o		200. 00
255. 55 ₁ 10tal (11165 55 till 64gil 177)	1	1	1	٥		1200.00

APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/2021	Part IV	narad.
					Го 12/31/2021	Date/Time Prep 5/30/2022 2:48	pareu: 8 nm
			Title	xVIII	Hospi tal	PPS	<u> </u>
	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	
	ANCI LLARY SERVI CE COST CENTERS		1	1			
50. 00	05000 OPERATI NG ROOM	0	0		191, 019, 373		
51. 00	05100 RECOVERY ROOM	0	0		14, 622, 840		•
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		11, 132, 033		1
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		62, 571, 651		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		26, 724, 350		1
57. 00	05700 CT SCAN	0	0		103, 587, 204		1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		16, 673, 757	1	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	•	320, 158, 232	1	59. 00
60.00	06000 LABORATORY	0	0	•	191, 086, 773	1	•
64.00	06400 I NTRAVENOUS THERAPY	0	0		3, 057, 019		64.00
65. 00	06500 RESPI RATORY THERAPY	0	0	•	38, 602, 455		1
66.00	06600 PHYSI CAL THERAPY	0	0	•	23, 228, 575		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	6, 919, 041		1
68. 00	06800 SPEECH PATHOLOGY	0	0		2, 479, 231		1
69. 00	06900 ELECTROCARDI OLOGY	0	0	•	56, 342, 643		1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		7, 402, 258		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	88, 238, 225		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	99, 958, 559	1	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	1, 045, 242, 085	1	1
73. 01	07301 SPECIALTY PHARMACY	0	0		93, 264, 718	1	1
74.00	07400 RENAL DI ALYSI S	0	0	i	8, 339, 676	1	1
76. 00	03330 ENDOSCOPY	0	0	•	5, 652, 823		1
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	•	22, 854, 715		1
76. 03	03951 LUTHERWOOD PARTNERSHIP	0	0		873, 937		76. 03
76. 04	03952 WOUND CARE CENTER	0	0		13, 059, 868 258, 759, 759		76. 04
76. 05 76. 06	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS	0	0	1			76. 05 76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	0	0		67, 818, 999 6, 579, 517		76.00
76. 07 76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		3, 859, 190		•
76. 97 76. 98	07698 HYPERBARI C OXYGEN THERAPY				1, 988, 224		76. 97
70. 70	OUTPATIENT SERVICE COST CENTERS				1, 700, 224	0.000000	70. 70
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		Ö			0. 000000	89. 00
90.00	09000 CLINIC					0. 000000	90.00
90. 01	04950 DIABETIC CARE CENTER			•		0. 000000	90. 01
90. 02	04951 HEALTHY HEARTS CENTER				3, 476, 566		1
90. 03	09001 CLI NI C				0 3, 470, 300	0. 000000	90. 03
90. 04	04953 SPI NE CENTER				653	0. 000000	1
	04954 I NFUSI ON CENTERS	1 0	Ö		18, 648, 930		
	09002 MEDCHECK CLINICS	0	0	•	0 10, 040, 730	0. 000000	1
90. 07	1	1	1		5, 464, 459		
90. 08	09004 PALLI ATI VE CARE	0	l n		133, 159		
90. 10	09006 WORK SITE CLINICS	0	l n		0 .33, 107	0. 000000	
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0	l n			0. 000000	1
	09100 EMERGENCY	1 0	Ö	•	272, 940, 497		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	Ö	•	10, 706, 334	1	
	OTHER REIMBURSABLE COST CENTERS						1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0		98. 00
200.00	Total (lines 50 through 199)	0			3, 103, 468, 328		200. 00
		•	•	•	•		

APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVI CE OTHER PASS		CN: 15-0074	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/30/2022 2:4	pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	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	
	ANCILLARY SERVICE COST CENTERS	•		•			
50.00	05000 OPERATI NG ROOM	0.000000	30, 506, 917		0 11, 575, 703	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	1, 923, 020		0 1, 147, 291	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000		1	0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 258, 329		0 9, 997, 185	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	3, 718, 172		0 4, 105, 925		55. 00
57. 00	05700 CT SCAN	0. 000000	7, 074, 629		0 10, 717, 369		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	1, 098, 838		0 1, 966, 121	Ö	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	33, 496, 329	l .	0 61, 841, 658		59.00
60. 00	06000 LABORATORY	0. 000000	21, 761, 551	l .	0 19, 614, 782	ĺ	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	241, 048		0 19, 014, 782		64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 000000			0 308, 708		65. 00
	1 1		8, 016, 452	l .		l .	•
66.00	06600 PHYSI CAL THERAPY	0.000000	1, 120, 612		0 37, 333		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	915, 788		0 8, 763	1	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	275, 708	1	0 1, 094	l	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	4, 177, 282		0 10, 029, 107	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	233, 313	1	0 827, 227	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	10, 522, 572	1	0 12, 473, 819	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	20, 124, 692	1	0 11, 326, 926		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	18, 849, 452		0 312, 220, 704	l e	73. 00
73. 01	07301 SPECIALTY PHARMACY	0. 000000	0	•	0	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 000000	1, 913, 280		0	0	74. 00
76.00	03330 ENDOSCOPY	0. 000000	70, 467		0 580, 049	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 389, 941	0	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	0. 000000	0		0 271	0	76. 03
76. 04	03952 WOUND CARE CENTER	0. 000000	244, 035		0 3, 546, 732	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 000000	465, 654		0 72, 753, 988	0	76. 05
76.06	03953 I MAGI NG CENTERS	0. 000000	7, 746		0 15, 218, 444	0	76. 06
76.07	03954 BREAST DIAGNOSTIC CENTER	0. 000000	2, 001		0 423, 083	0	76. 07
76. 97	07697 CARDIAC REHABILITATION	0. 000000	700		0 1, 281, 032	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89. 00
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	04950 DI ABETI C CARE CENTER	0. 000000	0		0 0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	0. 000000	0		0 786, 351	0	90. 02
90. 03	09001 CLI NI C	0. 000000	0		0 0	0	90. 03
90. 04	04953 SPI NE CENTER	0. 000000	0		0 0	0	90. 04
90. 05	04954 INFUSION CENTERS	0. 000000	1, 496		0 490, 673	0	90. 05
90. 06	1 1	0. 000000	0	1	0 0	l	90.06
	09003 KNEE CENTER	0. 000000	0		0 608, 580		90. 07
	09004 PALLI ATI VE CARE	0. 000000	0		0 30	l	
90. 10	1 1	0. 000000	0		0 0	0	1
90. 10	1 1	0. 000000	0			0	90. 10
	09100 EMERGENCY	0. 000000	15, 697, 380		0 19, 650, 067	0	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 006, 322	•	0 4, 435, 115	l e	•
72. UU	OTHER REIMBURSABLE COST CENTERS	0.000000	1, 000, 322		υ 4, 430, 115	<u> </u>	72.00
08 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	_	98. 00
200.00	1 1	0.000000	186, 723, 785	1	0 588, 365, 395		200.00
200.00	Trotal (Trilos so till bugli 177)	1	100, 723, 703	I	o ₁ 500, 505, 575	1	1200.00

	Financial Systems C					eu or Form CMS	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
					From 01/01/2021	Part V	
					To 12/31/2021		pared:
						5/30/2022 2: 4	8 pm
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	oost conten bescription	Ratio From	Services (see		Rei mbursed	(see inst.)	
						(See Hist.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 186792	11, 575, 703		0 291	2, 162, 249	50.00
							1
51.00	05100 RECOVERY ROOM	0. 139543			0		•
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 617659		1	0	1	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 139523	9, 997, 185		0	1, 394, 837	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 106342	4, 105, 925		0 0	436, 632	55. 00
57.00	05700 CT SCAN	0. 058618		1	0 0	628, 231	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1			0 0		1
	1 1	0. 123161	1, 966, 121				1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 039577			0	-, ,	
60.00	06000 LABORATORY	0. 110706	19, 614, 782		0	2, 171, 474	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 797793	1, 324		0 0	1, 056	64.00
65.00	06500 RESPIRATORY THERAPY	0. 223703		1	0 0	69, 059	1
66. 00	06600 PHYSI CAL THERAPY	0. 466231	37, 333	1	0 0	17, 406	1
		1		1			1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 445739		1	0		1
68. 00	06800 SPEECH PATHOLOGY	0. 445414	1, 094		0	487	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 108514	10, 029, 107	1	0	1, 088, 299	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 239969	827, 227	1	0	198, 509	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 533575	12, 473, 819		0 0	6, 655, 718	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 345989		1	0 0		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 192375		1	0 163, 296		
				1			1
73. 01	07301 SPECI ALTY PHARMACY	0. 836783	0	1	0	-	
74.00	07400 RENAL DI ALYSI S	0. 247961	0	1	0	0	74.00
76. 00	03330 ENDOSCOPY	0. 240020	580, 049	1	0	139, 223	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 982491	389, 941		0	383, 114	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	7. 417106		1	0 0		•
76. 04	03952 WOUND CARE CENTER	0. 279027		1	0 0		•
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 217052			0 105		•
		l e					•
76. 06	03953 I MAGI NG CENTERS	0. 134947			0		•
76. 07	03954 BREAST DI AGNOSTI C CENTER	0. 555287			0	,	
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 518149	1, 281, 032		0	663, 765	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 250438	0)	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS		•	•	•		1
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
	09000 CLINIC	0.000000					
90. 00		0. 000000		'	0	0	
90. 01	04950 DI ABETI C CARE CENTER	0. 000000		1	0	0	
90. 02	04951 HEALTHY HEARTS CENTER	0. 595706	786, 351		0	468, 434	90. 02
90. 03	09001 CLI NI C	0. 000000	0)	0	0	90. 03
90. 04	04953 SPI NE CENTER	0. 006126	1 0)	0 0	0	90. 04
90. 05	04954 I NFUSI ON CENTERS	0. 046100			0 0		
					0 0		1
	09002 MEDCHECK CLINICS	0.000000		1			
90. 07	09003 KNEE CENTER	1. 223311	608, 580	1	0	744, 483	1
90. 08	09004 PALLI ATI VE CARE	0. 005520		1	0	0	90. 08
90. 10	09006 WORK SITE CLINICS	0. 000000	0		0	0	90. 10
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000	0)	0	0	90. 12
91.00	09100 EMERGENCY	0. 119457	19, 650, 067		0 59	2, 347, 338	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 655983		1	0 0		
72.00		0.000700	1 4,430,110	1	<u>J</u>	2, 707, 300	72.00
00.00	OTHER REIMBURSABLE COST CENTERS	0.000000	1 -				00 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000		1	0 0		
200.00		1	588, 365, 395		0 163, 751	108, 410, 060	•
201.00				1	0	1	201. 00
	Only Charges			1		1	
202.00	Net Charges (line 200 - line 201)		588, 365, 395	i	0 163, 751	108, 410, 060	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0074 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/30/2022 2:48 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 54 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 55.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 60.00 0 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 07301 SPECIALTY PHARMACY 73.01 0 73.01 07400 RENAL DIALYSIS 74.00 0 74.00 03330 ENDOSCOPY 76.00 0 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.01 03951 LUTHERWOOD PARTNERSHIP 76. 03 76.03 03952 WOUND CARE CENTER 76.04 0 76.04 03480 ONCOLOGY-CANCER CARE CENTER 76.05 23 76.05 03953 I MAGING CENTERS 76.06 76.06 03954 BREAST DIAGNOSTIC CENTER 76. 07 0 76.07 07697 CARDIAC REHABILITATION 76.97 76. 97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0 90.00 000000000000 90. 01 04950 DIABETIC CARE CENTER 0 90.01 04951 HEALTHY HEARTS CENTER 90.02 0 90 02 90.03 09001 CLI NI C 0 90.03 90.04 04953 SPINE CENTER 90.04 0 90. 05 04954 INFUSION CENTERS 90.05 09002 MEDCHECK CLINICS 0 90.06 90.06 90.07 09003 KNEE CENTER 0 90.07 90.08 09004 PALLIATIVE CARE 0 90.08 90 10 09006 WORK SITE CLINICS 0 90 10 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 90.12 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 31, 498 200.00 Subtotal (see instructions) 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges

31, 498

202.00

202.00

Net Charges (line 200 - line 201)

Heal th	Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/30/2022 2:4	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
		Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col. 1 - col.			
		26)		2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		T				
30.00	ADULTS & PEDI ATRI CS	9, 277, 134	l e	9, 277, 13	· ·	104. 45	
31. 00	INTENSIVE CARE UNIT	3, 260, 084		3, 260, 084		216. 47	
32. 00	CORONARY CARE UNIT	0			0	0.00	
35. 00	NEONATAL INTENSIVE CARE UNIT	234, 256	l e	234, 256	· ·	105. 81	
43.00	NURSERY	208, 419	l e	208, 419	· ·	123. 40	
200.00	Total (lines 30 through 199)	12, 979, 893		12, 979, 893	3 107, 780		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				
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	ADULTS & PEDI ATRI CS	7, 172	749, 115				30.00
31. 00	INTENSIVE CARE UNIT	0	0)			31.00
32. 00	CORONARY CARE UNIT	0	0)			32. 00
35. 00	NEONATAL INTENSIVE CARE UNIT	0	0)			35. 00
43.00	NURSERY	1, 439		•			43.00
200. 00	Total (lines 30 through 199)	8, 611	926, 688	3			200. 00

Heal th	Financial Systems C	OMMUNITY HEALTH	I NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0074	Peri od:	Worksheet D	
					From 01/01/2021	Part II	
					To 12/31/2021	Date/Time Pre	pared:
						5/30/2022 2: 4	8 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	T	T	,			
50. 00	05000 OPERATING ROOM	4, 751, 413					
51. 00	05100 RECOVERY ROOM	328, 041					
52. 00	05200 DELIVERY ROOM & LABOR ROOM	920, 503				1	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 316, 088	62, 571, 651	0. 02103			
55.00	05500 RADI OLOGY-THERAPEUTI C	110, 673	26, 724, 350	0. 00414	553, 109	2, 290	
57.00	05700 CT SCAN	602, 224	103, 587, 204	0.00581	1, 510, 919	8, 784	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	430, 009	16, 673, 757	0. 02579	241, 390	6, 225	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 391, 463	320, 158, 232	0. 00434	2, 294, 889	9, 974	59. 00
60.00	06000 LABORATORY	340, 138	191, 086, 773	0. 00178	5, 182, 426	9, 225	60.00
64.00	06400 I NTRAVENOUS THERAPY	88, 362		1			1
65.00	06500 RESPI RATORY THERAPY	475, 562					
66. 00	06600 PHYSI CAL THERAPY	1, 207, 108					
67. 00	06700 OCCUPATI ONAL THERAPY	189, 970					
68. 00	06800 SPEECH PATHOLOGY	67, 989		1			1
69. 00	06900 ELECTROCARDI OLOGY	614, 125		1		1	
				1			1
70.00	07000 ELECTROENCEPHALOGRAPHY	171, 752					1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	493, 322					
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	272, 285					
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 272, 690		1		l	
73. 01	07301 SPECI ALTY PHARMACY	712, 387					
74. 00	07400 RENAL DI ALYSI S	23, 741		1	•		
76. 00	03330 ENDOSCOPY	118, 576		1		2, 553	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 197, 051				0	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	664, 412			52 0	0	
76. 04	03952 WOUND CARE CENTER	216, 815	13, 059, 868	0. 01660)2 57, 478	954	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	6, 940, 618	258, 759, 759	0. 02682	71, 521	1, 918	76. 05
76.06	03953 I MAGI NG CENTERS	1, 087, 821	67, 818, 999	0. 01604	1, 050	17	76. 06
76.07	03954 BREAST DIAGNOSTIC CENTER	212, 609	6, 579, 517	0. 03231	10, 277	332	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	306, 415	3, 859, 190	0. 07939	383	30	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	30, 197	1, 988, 224	0. 01518	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l o	1		0	
90.00	09000 CLI NI C	0	0	1		l	1
90. 01	04950 DI ABETI C CARE CENTER	0	0	0.00000		1	1
	04951 HEALTHY HEARTS CENTER	304, 723	3, 476, 566				
90. 03	09001 CLINI C	001,720	0, 170, 000	0. 00000		l	
	04953 SPI NE CENTER	0	653			0	
	04954 I NFUSION CENTERS	139, 137				-	1
		139, 137	10, 040, 930			l	
	09002 MEDCHECK CLINICS	107.001	,	0.0000			70.00
	09003 KNEE CENTER	627, 906				l	90. 07
90. 08	09004 PALLI ATI VE CARE	47	133, 159			0	70.00
90. 10		0	0			0	
90. 12		0	0	0.00000		0	
	09100 EMERGENCY	2, 735, 030					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	664, 111	10, 706, 334	0.06203	99, 392	6, 165	92.00
	OTHER REIMBURSABLE COST CENTERS			1			
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0					98. 00
200.00	Total (lines 50 through 199)	35, 025, 313	3, 103, 468, 328	il .	28, 536, 415	281, 367	200. 00

Health Financial Systems CO	OMMUNITY HEALTH ASS THROUGH COS			In Lie Period: From 01/01/2021 To 12/31/2021	worksheet D Part III Date/Time Pre 5/30/2022 2:4	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdown Adjustments		All Other Medical Education Cost	
ANDATI ENT. DOUTLING OFFICE OF COST, OFFITEDO	1A	1.00	2A	2. 00	3. 00	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0 0 0 0 0	0 0 0 0		0 0 0 0 0 0 0		31. 00 32. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
LUDATI ENT. DOUTLINE OFFICE COOT OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	000000000000000000000000000000000000000	15, 060 (2, 21 1, 689	0. 00 0. 00 4 0. 00 9 0. 00	0 0 1, 439	31. 00 32. 00 35. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
NPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					30. 00 31. 00 32. 00 35. 00 43. 00 200. 00

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2021 Part IV
To 12/31/2021 Date/Time Prepared: 5/30/2022 2:48 pm
 Heal th Financial
 Systems
 COMMUNITY
 HEALTH N

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

Non-Physician Non-Physicia					12/01/2021	5/30/2022 2: 4	8 pm
Ansestherist Cost			Ti tl	e XIX	Hospi tal		
ANCILLARY SERVICE COST CENTERS	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
ANCILLARY SERVICE COST CENTERS		Anestheti st	Program	Program	Post-Stepdown		
ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00		Cost	Post-Stepdown		Adjustments		
ANCILLARY SERVICE COST CENTERS 50.00 GOSCOD OPERATING ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			Adjustments				
50.00 GOODO GEEDRATING ROOM 0 0 0 0 0 51.00 51.00 52.00 GECOVERY ROOM & LABOR ROOM 0 0 0 0 0 51.00 52.00 52.00 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 52.00 52		1.00	2A	2.00	3A	3. 00	
51.00 05100 RECOVERY ROOM	ANCILLARY SERVICE COST CENTERS						
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 55.00	50.00 05000 OPERATING ROOM	0	0)	0	0	50.00
54 00 05400 RADIOLOGY-DIACMOSTIC 0 0 0 0 0 0 0 55.00	51.00 05100 RECOVERY ROOM	0	0		0 0	0	51. 00
55.00 05500 ADIO LOGY-THERAPEUTIC 0 0 0 0 55.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
57.00 05700 CT SCAN 0 0 0 0 0 0 0 55.00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN 0 0 0 0 0 0 0 55.00	55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
59.00 05900 CARDI AC CATHETERIZATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 05700 CT SCAN	0			0 0	0	57.00
59.00 05900 CARDINAC CATHETERIZATION	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	l o		0 0	0	58. 00
60.00 06.000 LABBRATORY		0	l o		0 0	0	59.00
64.00 06-400 INTRAVENOUS THERAPY		0			0 0		1
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 65. 00 66. 00 06.00 0PHYSICAL THERAPY 0 0 0 0 0 0 0 0 0 66. 00 06. 00 06.00 0PHYSICAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			0 0	0	1
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			0 0		
67:00 06700 06700 0600 0600 07:00 0 0 0 0 0 0 0 0 0		0			0 0		
68.00 06800 SPECCH PATHOLOGY 0 0 0 0 0 0 0 0 0		0			0 0		1
69-00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			-		
70.00 07000 07000 07000 0 0 0		_			9		
171.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0					0		
172.00 07200 IMPL DEV CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00					0		
73.00 07300 DRUGS CHARGED TO PATIENTS		1	1		9		1
73. 01 07301 SPECIALTY PHARMACY 0 0 0 0 0 0 0 73. 01 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 76. 01 03550 PSYCHIATRI C/PSYCHOLOGICAL SERVICES 0 0 0 0 0 0 0 76. 01 76. 01 03550 PSYCHIATRI C/PSYCHOLOGICAL SERVICES 0 0 0 0 0 0 0 0 76. 01 76. 03 03391 LUTHERWOOD PARTNERSHI P 0 0 0 0 0 0 0 76. 03 76. 04 03952 WOUND CARE CENTER 0 0 0 0 0 0 0 76. 03 76. 05 03480 (NCOLOGY-CANCER CARE CENTER 0 0 0 0 0 0 0 76. 04 76. 05 03480 (NCOLOGY-CANCER CARE CENTER 0 0 0 0 0 0 0 76. 05 76. 06 03953 I IMAGING CENTERS 0 0 0 0 0 0 0 76. 06 76. 07 03954 BREAST DIAGNOSTIC CENTER 0 0 0 0 0 0 0 76. 06 76. 07 03954 BREAST DIAGNOSTIC CENTER 0 0 0 0 0 0 0 76. 07 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 76. 97 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 89. 00 90. 01 04950 DIABETIC CARE CENTER 0 0 0 0 0 0 0 0 0 90. 01 90. 02 04951 HEALTH CLINIC 0 0 0 0 0 0 0 0 0 90. 01 90. 03 09001 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					-		
74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 74. 00 76. 00 03330 RENDSCOPY 0 0 0 0 0 0 0 74. 00 76. 00 03350 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 76. 00 76. 01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 0 76. 01 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 0 0 0 0 0 76. 01 76. 04 03952 WOUND CARE CENTER 0 0 0 0 0 0 0 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 0 0 0 0 76. 05 76. 06 03953 I MAGI NG CENTERS 0 0 0 0 0 0 0 0 76. 06 76. 07 03954 BRAST DI AGNOSTI C CENTER 0 0 0 0 0 0 0 76. 07 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 0 76. 07 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 98 90 00 08900 RURAL HEALTH CLINI C 0 0 0 0 0 0 0 0 89. 00 99. 00 09000 CLINI C 0 0 0 0 0 0 0 0 0 0 90. 00 99. 01 04950 DI ABETLI C CARE CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1			9		1
76. 00 03330 INDOSCOPY						_	1
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 76. 01 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 0 0 0 76. 03 76. 04 03952 WOUND CARE CENTER 0 0 0 0 0 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 0 0 0 76. 06 03953 IMAGI NG CENTERS 0 0 0 0 0 0 0 76. 07 076. 07 076. 07 76. 07 076. 07 076. 07 76. 07 076. 07		_			-		1
76. 03 03951 LUTHERWOOD PARTNERSHIP		_	۷		9		1
76. 04 03952 WOUND CARE CENTER 0 0 0 0 0 0 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 0 0 0 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 0 0 0 0 0 76. 06 76. 07 03954 BREAST DI AGNOSTIC CENTER 0 0 0 0 0 0 0 0 0 76. 07 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 76. 98 0017PATI ENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 88. 00 89. 00 09900 CLINIC 0 0 0 0 0 0 0 0 88. 00 90. 00 10 04950 DI ABETIC CARE CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1			9		
76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 0 0 76. 05 76. 06 03953 IMAGING CENTERS 0 0 0 0 0 0 76. 06 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 88. 00 08900 RURAL HEALTH CLINI C 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90. 01 04950 DIABETI C CARE CENTER 0 0 0 0 0 90. 02 04951 HEALTHY HEARTS CENTER 0 0 0 0 0 90. 03 09001 CLINI C 0 0 0 0 90. 04 04953 SPINE CENTER 0 0 0 0 0 90. 05 04954 INFUSION CENTERS 0 0 0 0 90. 06 04954 INFUSION CENTERS 0 0 0 0 90. 07 09003 MEDICHECK CLINI CS 0 0 0 0 90. 08 09004 PALLI ATI VE CARE 0 0 0 0 90. 09 09000 ONDO CENTERS 0 0 0 0 90. 07 09003 MEDICHECK CLINI CS 0 0 0 90. 08 09004 PALLI ATI VE CARE 0 0 0 0 90. 09 0900 ONDO CENTERS 0 0 0 0 90. 01 04961 FAILY PARCTI CE AND MATERNI TY CARE 0 0 0 0 90. 02 04961 FAILY PARCTI CE AND MATERNI TY CARE 0 0 0 0 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 09 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 99. 09 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 99. 09 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0					9		
76. 06 03953 I MAGI NG CENTERS 0 0 0 0 0 0 76. 06 76. 07 03954 BREAST DI AGNOSTIC CENTER 0 0 0 0 0 0 76. 07 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76. 07 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 90. 00 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 90. 00 90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 0 0 0 0 90. 01 90. 02 04951 HEALTHY HEARTS CENTER 0 0 0 0 0 0 0 90. 02 90. 03 09001 CLI NI C 0 0 0 0 0 0 0 0 90. 02 90. 04 04953 SPI NE CENTER 0 0 0 0 0 0 0 0 0 90. 03 90. 05 04954 I INFUSION CENTERS 0 0 0 0 0 0 0 0 90. 04 90. 06 09002 MEDCHECK CLI NI CS 0 0 0 0 0 0 0 0 90. 05 90. 07 09003 KNEE CENTER 0 0 0 0 0 0 0 0 0 90. 05 90. 07 09003 KNEE CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1			0		
76. 07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 76. 07 76. 97 76.97 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 76. 97 76. 98 76.98 HYPERBARI C DXYGEN THERAPY 0 0 0 0 0 0 0 76. 98		_			0		1
76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 90. 01 04950 DIABETIC CARE CENTER 0 0 0 0 0 0 0 90. 02 04951 HEALTHY HEARTS CENTER 0 0 0 0 0 0 0 90. 03 09001 CLINIC 0 0 0 0 0 0 0 90. 04 04953 SPINE CENTER 0 0 0 0 0 0 0 90. 05 04954 INFUSION CENTERS 0 0 0 0 0 90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 90. 07 09003 RNEE CENTER 0 0 0 0 0 0 90. 08 09004 PALLIATIVE CARE 0 0 0 0 0 90. 09 09006 WORK SITE CLINICS 0 0 0 0 0 90. 10 09006 WORK SITE CLINICS 0 0 0 0 90. 10 09006 WORK SITE CLINICS 0 0 0 0 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 91. 00 076. 98 91. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 91. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 92. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 93. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 94. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 94. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 95. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 96. 00 00 00 00 00 0 0 0 0					0		
76. 98		1			٥		
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88. 00] 0) <u> </u>	0 0	0	76. 98
89. 00			1 0	<u>, </u>	0 0	1 0	00 00
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 01 90. 02 90. 02 90. 02 90. 03 90. 01 CLINIC 0 0 0 0 0 90. 02 90. 03 90. 01 CLINIC 0 0 0 0 0 0 90. 03 90. 04 04953 SPINE CENTER 0 0 0 0 0 0 90. 03 90. 04 90. 05 04954 INFUSION CENTERS 0 0 0 0 0 90. 05 90. 04 90. 05 04954 INFUSION CENTERS 0 0 0 0 0 90. 05 90. 06 90. 07 90. 08 90. 04 90. 05 04954 INFUSION CENTERS 0 0 0 0 0 90. 06 90. 07 90. 08 90. 08		1		1		_	
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90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 90. 06 90. 07 09003 KNEE CENTER 0 0 0 0 0 0 90. 07 90. 08 09004 PALLI ATI VE CARE 0 0 0 0 0 90. 08 90. 10 09006 WORK SITE CLINICS 0 0 0 0 0 0 90. 10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 0 0 90. 12 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 0 0 0 0 98. 00							
90. 07 09003 KNEE CENTER 0 0 0 0 0 0 0 0 90. 07 90. 08 09004 PALLI ATI VE CARE 0 0 0 0 0 0 0 90. 08 90. 10 09006 WORK SITE CLINICS 0 0 0 0 0 0 0 90. 10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 0 0 0 90. 12 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 98. 00		_			9		1
90. 08 09004 PALLIATIVE CARE 0 0 0 0 0 0 90. 08 90. 10 09006 WORK SITE CLINICS 0 0 0 0 0 90. 10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 0 90. 12 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 000 000 000 000 000 000 000 000 000 98. 00 000 000 000 000 000 000 000 000 98. 00 000 000 000 000 000 000 000 000 99. 00 000 000 000 000 000 000 000 99. 00 000 000 000 000 000 000 90. 000 000 000 000 000 90. 000 000 000 000 90. 000 000 000 000 90. 000 000 000 000 90. 000 000 000 000 90. 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 000 000 90. 000 00		0			0		
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91. 00		_]	9		
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 92. 00		_	0	2			
OTHER REI MBURSABLE COST CENTERS O O O O 98.00 98.00 O9850 OTHER REI MBURSABLE COST CENTERS O O O O O 98.00				ή	-		1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98. 00		0			0	0	92.00
				,			
200.00 10tai (11nes 50 through 199) 0 0 0 0 0 200.00							
	200.00 lotal (lines 50 through 199)	1 0	1	ין	UJ 0	1 0	J200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0074 Peri od: Worksheet D From 01/01/2021 Part IV THROUGH COSTS Date/Time Prepared: 12/31/2021 5/30/2022 2:48 pm Title XIX Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost Cost (sum of 1, 2, 3, and Part I, col. (col. 5 ÷ col 8) 4) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 191, 019, 373 0.000000 50.00 05100 RECOVERY ROOM 0 0 0 14, 622, 840 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000000000000000000000000000000 0 11, 132, 033 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0.000000 54 00 54 00 62, 571, 651 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 26, 724, 350 0.000000 55.00 57.00 05700 CT SCAN 103, 587, 204 0.000000 57.00 16, 673, 757 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0.000000 58 00 58 00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0 320, 158, 232 0.000000 59.00 60.00 06000 LABORATORY 191, 086, 773 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 3, 057, 019 0.000000 64.00 06500 RESPIRATORY THERAPY 38, 602, 455 65 00 0.000000 65 00 66.00 06600 PHYSI CAL THERAPY 23, 228, 575 0.000000 66.00 06700 OCCUPATIONAL THERAPY 6, 919, 041 0.000000 67.00 06800 SPEECH PATHOLOGY 2, 479, 231 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0.000000 69 00 0 56, 342, 643 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 7, 402, 258 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 88, 238, 225 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 99, 958, 559 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 045, 242, 085 73.00 0 0.000000 73.00 73. 01 07301 SPECIALTY PHARMACY 93, 264, 718 0.000000 73.01 07400 RENAL DIALYSIS 74.00 8, 339, 676 0.000000 74.00 03330 ENDOSCOPY 76.00 5, 652, 823 0.000000 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 76.01 22, 854, 715 76 01 03951 LUTHERWOOD PARTNERSHIP 873, 937 0.000000 76.03 76.03 03952 WOUND CARE CENTER 13, 059, 868 0.000000 76.04 76.04 03480 ONCOLOGY-CANCER CARE CENTER 0 258, 759, 759 0.000000 76.05 0 76.05 0 76.06 03953 I MAGING CENTERS 0 67, 818, 999 0.000000 76.06 03954 BREAST DIAGNOSTIC CENTER 6, 579, 517 0.000000 76.07 76.07 0 76. 97 07697 CARDIAC REHABILITATION 0 3, 859, 190 0.000000 76. 97 ٥ 07698 HYPERBARI C OXYGEN THERAPY 0 0 1, 988, 224 76.98 0.000000 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 88.00 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0000000000000 89.00 0.000000 89.00 0 0 90.00 09000 CLI NI C 0 0.000000 90.00 90.01 04950 DIABETIC CARE CENTER 0 0.000000 90.01 04951 HEALTHY HEARTS CENTER 3, 476, 566 0.000000 90.02 90.02 09001 CLINIC 0 90.03 90 03 0.000000 90. 04 04953 SPINE CENTER 0 0 653 0.000000 90.04 90.05 04954 INFUSION CENTERS 18, 648, 930 0.000000 90.05 09002 MEDCHECK CLINICS 0 0 0.000000 90.06 90.06 09003 KNEE CENTER 0 90.07 0 5, 464, 459 0.000000 90.07 90.08 09004 PALLIATIVE CARE 133, 159 0.000000 90.08 90.10 09006 WORK SITE CLINICS 0 0 0.000000 90.10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0.000000 90 12 Ω 0 91.00 09100 EMERGENCY 0 272, 940, 497 0.000000 91.00

0

0

10, 706, 334

0 3, 103, 468, 328

0.000000

0.000000

92.00

98 00

200.00

200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2021	Part IV
To 12/31/2021	Date/Time Prepared:
5/30/2022 2:48 pm	Health Financial Systems COMMUNITY HEALTH NA
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0074 THROUGH COSTS

					10 12/31/2021	5/30/2022 2: 4	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	•	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	J	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	1 11 22					
50.00	05000 OPERATING ROOM	0. 000000	2, 608, 832		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	338, 640		0 0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	452, 563		0 0	l .	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	670, 427		0 0		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	553, 109		0 0		55.00
57. 00	05700 CT SCAN	0. 000000	1, 510, 919		0 0		57.00
58. 00		0. 000000	241, 390		0 0	_	58.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	1					
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 294, 889		0		59. 00
60.00	06000 LABORATORY	0. 000000	5, 182, 426		0	_	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	28, 190		0 0	_	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	1, 858, 579		0 0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	170, 884		0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	132, 666		0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	63, 314		0		68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	501, 853		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	62, 405		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 844, 147		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	925, 505		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 857, 850		0 0	0	73. 00
73. 01	07301 SPECIALTY PHARMACY	0. 000000			0 0	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 000000	409, 215		0 0	0	74. 00
76. 00	03330 ENDOSCOPY	0. 000000	121, 710		0 0	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	i	0 0		76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	0. 000000	0		0 0		76. 03
76. 04	03952 WOUND CARE CENTER	0. 000000	57, 478		0 0		76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 000000	71, 521		0 0	_	76. 05
76. 06	03953 I MAGI NG CENTERS	0. 000000	1, 050		0 0		76.06
76. 07	03954 BREAST DIAGNOSTIC CENTER	0. 000000	10, 277		0 0		76. 07
76. 97	07697 CARDIAC REHABILITATION	0. 000000	383		0 0	_	76. 97
76. 97 76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	363		0 0	_	76. 97
70. 90	OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	70.90
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	l .	89. 00
90.00	09000 CLINIC	0. 000000	0		0 0		90.00
90. 00	04950 DI ABETI C CARE CENTER	0. 000000	0		0 0		90.00
		1			0 0		
90. 02	04951 HEALTHY HEARTS CENTER	0. 000000	690		-	_	90. 02
90. 03	09001 CLI NI C	0. 000000	0		0		90. 03
90. 04	04953 SPI NE CENTER	0. 000000	0		0		90. 04
90. 05	04954 NFUSION CENTERS	0. 000000	0		0 0	_	90. 05
90. 06	09002 MEDCHECK CLINICS	0. 000000	0		0		90. 06
90. 07	09003 KNEE CENTER	0. 000000	0		0		90. 07
90. 08	09004 PALLI ATI VE CARE	0. 000000	0		0		90. 08
90. 10	09006 WORK SITE CLINICS	0. 000000	0		0		90. 10
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000	0		0 0	0	90. 12
91.00	09100 EMERGENCY	0. 000000	3, 466, 111		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	99, 392		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0		98. 00
200.00	Total (lines 50 through 199)		28, 536, 415		0	0	200. 00

APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0074	Peri od:	Worksheet D	
					From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	nared:
					10 12/01/2021	5/30/2022 2: 4	8 pm
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not		
		Part I, col. 9		Subject To	Subject To Ded. & Coins.		
				Ded. & Coins (see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATING ROOM	0. 190997	C		0 1, 658, 796	0	50.00
51.00	05100 RECOVERY ROOM	0. 139543	0)	0 285, 501	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 617659	0		0 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 139523	0	1	0 1, 646, 783	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 106342	0	1	0 650, 525	0	55. 00
57.00	05700 CT SCAN	0. 058618	0	1	0 4, 289, 248	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 123161	0)	0 457, 871	0	00.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 039577	0)	0 2, 550, 768	0	
60.00	06000 LABORATORY	0. 110706	0)	0 3, 516, 886	l e	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 797793	0		0 112, 504	l .	
65. 00	06500 RESPI RATORY THERAPY	0. 223703	0		0 114, 890	l e	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 475013	0	1	0 266, 924	l e	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 445739	0	1	0 125, 826	l e	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 445414	0	1	0 46, 860	l e	
69. 00	06900 ELECTROCARDI OLOGY	0. 113878	0		0 438, 425	l e	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 241992	Ü	1	0 163, 770	l e	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 533575	0		0 590, 884	l e	71.00
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 345989	0		0 665, 394 0 19, 556, 904	0	72. 00 73. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS 07301 SPECIALTY PHARMACY	0. 192797 0. 836783	0		0 19, 556, 904	0	73.00
74. 00	07400 RENAL DIALYSIS	0. 247961	0			0	74.00
76. 00	03330 ENDOSCOPY	0. 247901	0		0 102, 418	0	76.00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 020907	0		0 102, 410	0	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	7. 417106	Ö		0 0	0	76. 03
76. 04	03952 WOUND CARE CENTER	0. 284753	0	,	0 723, 246	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 217052	0)	0 5, 444, 585	l	76. 05
76.06	03953 I MAGI NG CENTERS	0. 134947	0)	0 742, 031	0	76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	0. 555287	0	1	0 90, 502	0	76. 07
76. 97	07697 CARDIAC REHABILITATION	0. 518149	0)	0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 250438	0		0 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00							88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLINIC	0. 000000	0	1	0	0	
90. 01	04950 DI ABETI C CARE CENTER	0.000000	0	1	0 0	0	
90. 02	04951 HEALTHY HEARTS CENTER	0. 595706	Ü		0 49, 364	0	
90. 03	09001 CLINIC	0.000000	Ü		0	0	
	04953 SPI NE CENTER	0.006126	0		0 12 520	0	
	04954 I NFUSION CENTERS	0. 046100	0		0 13, 529		70.03
	09002 MEDCHECK CLINICS 09003 KNEE CENTER	0. 000000 1. 253410	0		0 0	0	90. 06 90. 07
90.07		0. 791610	0		0 3, 695 0 6, 756	l e	1
90.08	· ·	0. 791810	0		0, 730	0	1
90. 10		0. 000000	0			0	1
91.00	09100 EMERGENCY	0. 121794	0		0 15, 367, 047		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 655983	Ö		0 439, 600		1
72.00	OTHER REIMBURSABLE COST CENTERS	0. 033703		1	0 437,000	· · · · · ·	72.00
98. 00		0. 000000	C		0 0	0	98. 00
200.00			0		0 60, 121, 532	l	200.00
201.00					0 0]	201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	1	0 60, 121, 532	0	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0074 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/30/2022 2:48 pm Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 316, 825 50.00 51.00 05100 RECOVERY ROOM 0 0 0 39, 840 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 229, 764 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 69, 178 55.00 57.00 05700 CT SCAN 00000000000000000000000000 251, 427 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 56, 392 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 100, 952 59.00 60.00 06000 LABORATORY 389, 340 60.00 06400 I NTRAVENOUS THERAPY 89, 755 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 25, 701 65.00 06600 PHYSI CAL THERAPY 126, 792 66.00 66.00 06700 OCCUPATIONAL THERAPY 56, 086 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 20.872 68 00 69.00 06900 ELECTROCARDI OLOGY 49, 927 69.00 07000 ELECTROENCEPHALOGRAPHY 39, 631 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 315, 281 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 230, 219 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 770, 512 73.00 07301 SPECIALTY PHARMACY 73.01 0 73.01 07400 RENAL DIALYSIS 74.00 74.00 03330 ENDOSCOPY 76.00 24, 582 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 0 03951 LUTHERWOOD PARTNERSHIP 76. 03 76.03 03952 WOUND CARE CENTER 205, 946 76.04 76.04 03480 ONCOLOGY-CANCER CARE CENTER 76.05 1, 181, 758 76.05 03953 I MAGING CENTERS 100, 135 76.06 76.06 76. 07 03954 BREAST DIAGNOSTIC CENTER 50, 255 76.07 07697 CARDIAC REHABILITATION 76.97 76. 97 Ω 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 |08900|FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0 90.00 90. 01 04950 DIABETIC CARE CENTER 00000000000 90.01 04951 HEALTHY HEARTS CENTER 90 02 90 02 29.406 0 90.03 09001 CLI NI C 90.03 90.04 04953 SPINE CENTER 90.04 90. 05 04954 INFUSION CENTERS 90.05 624 09002 MEDCHECK CLINICS 90.06 90.06 90.07 09003 KNEE CENTER 4,631 90.07 90.08 09004 PALLIATIVE CARE 5, 348 90.08 90 10 09006 WORK SITE CLINICS 90 10 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 90.12 09100 EMERGENCY 1, 871, 614 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 288, 370 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 200.00 Subtotal (see instructions) 0 9, 941, 163 200. 00 Less PBP Clinic Lab. Services-Program

0

9, 941, 163

201.00

202.00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0074	Peri od: From 01/01/2021	Worksheet D-1	
		To 12/31/2021	Date/Time Pre 5/30/2022 2:4	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
DADT I ALL DROWLDED COMPONENTS				

		Title XVIII	Hospi tal	PPS	о рііі
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			88, 817 88, 817	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days.	00, 017	1
	do not complete this line.	, , , , , , , , , , , , , , , , , , , ,			
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		21 of the cost	82, 459 0	4. 00 5. 00
5.00	reporting period	on days) through becember	31 of the cost	O	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost				
8.00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost				8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	swi ng-bed and	14, 380	9. 00
40.00	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XII through December 31 of the cost reporting period	X only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar vi			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra		,	0	14. 00
15. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
16.00	SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	s)		98, 108, 942	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		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	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	- · · · · · · · · · · · · · · · · · · ·		0	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		98, 108, 942	26. 00 27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had ab-	argos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	u and observation bed ch	ii ges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	
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	1
34. 00	Average per diem private room charge differential (line 32 mi)		tions)	0. 00	1
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	ł
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 27 minus line 36)	and private room cost di	fferential (line	98, 108, 942	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		<u>'</u>		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		1		
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 104. 62	1
39. 00	Program general inpatient routine service cost (line 9 x line	•		15, 884, 436	1
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 15, 884, 436	
	5 - 5 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	/	ı		

COMPLIT	Financial Systems C ATION OF INPATIENT OPERATING COST	OMMUNITY HEALTH	Provider Co	CN: 15-0074	Peri od:	wof Form CMS-2 Worksheet D-1	
COMPUT	ATION OF INFATIENT OFERATING COST		Frovider Co	JIN. 13-00/4	From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/30/2022 2:4	
	Cook Control Doorsi ati on	T-+-1		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		•		col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
12.00	Intensive Care Type Inpatient Hospital Units		-				
43. 00 44. 00	INTENSIVE CARE UNIT	29, 542, 163	15, 060		·	6, 349, 796 0	
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0.0	0	0	44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	3, 297, 468	2, 214	1, 489. 3	37 0	0	47. 00
	cost denter bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			`		34, 052, 058	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		56, 286, 290	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	n of Parts I and	2, 202, 704	50.00
51. 00	<pre> Pass through costs applicable to Program ing</pre>	ationt ancillar	v sarvicas (fr	om Wkst D s	cum of Darte II	1, 803, 404	51.00
31.00	and IV)	atrent ancirrar	y services (ii	OIII WKSt. D, S	sum of rarts if	1, 003, 404	31.00
52.00	Total Program excludable cost (sum of lines		loted '	ololes - ''	antint	4, 006, 108	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anestr	netist, and	52, 280, 182	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	/					
	Program discharges Target amount per discharge					0	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					l e	56.00
57. 00	Difference between adjusted inpatient operat	line 53)	0				
58. 00 59. 00							
37.00	market basket	sporting perrou	enaring 1770, a	paarea ana co	impounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year				the emount by	l e	60.00
61. 00	1.00 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						61.00
	amount (line 56), otherwise enter zero (see instructions)						
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	
PROGRAM INPATIENT ROUTINE SWING BED COST							00.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (line	44 plus lips 4	E) (+; + o V)/	Loply) For	0	66. 00
00.00	CAH (see instructions)	THE COSTS (TITHE	64 prus rine 6	5)(title XVII	i only). For		00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 o	f the cost re	eporting period	0	67. 00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routir</pre>	ne costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
	(line 13 x line 20)				.		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service c	ost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	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						74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (from W	orksheet B, F	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	,					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der record	s)			79.00
80.00	Total Program routine service costs for comp	parison to the c			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (•				83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85.00	Utilization review - physician compensation Total Program inpatient operating costs (sun						85. 00 86. 00
יווו ממ			. 54gii 55)				1 55. 55
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS						
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	5)	lino 2)			6, 358 1, 104. 62	

Health Financial Systems	OMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 Fo 12/31/2021	Date/Time Prep 5/30/2022 2:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	9, 277, 134	98, 108, 942	0. 094560	7, 023, 174	664, 111	90.00
91.00 Nursing Program cost	0	98, 108, 942	0. 00000	7, 023, 174	0	91.00
92.00 Allied health cost	0	98, 108, 942	0.00000	7, 023, 174	0	92.00
93.00 All other Medical Education	0	98, 108, 942	0.00000	7, 023, 174	0	93.00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0074	Peri od: From 01/01/2021	Worksheet D-1	
		To 12/31/2021	Date/Time Pre 5/30/2022 2:4	pared: 8 pm
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1 00 Innetient days (including private room	days and awing had days avaluding nawbarn)		00 017	1 00

	Title XIX Hospita	<u>al</u>	PPS	
	Cost Center Description		1. 00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		88, 817	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		88, 817	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room of	days,	0	3. 00
4 00	do not complete this line.	1	00.450	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the	cost	82, 459 0	4. 00 5. 00
3.00	reporting period	COST	U	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the co	ost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		_	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the	cost	0	7. 00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the companies of t	st	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed	and	7, 172	9. 00
9.00	newborn days) (see instructions)	anu	7, 172	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)		0	10.00
	through December 31 of the cost reporting period (see instructions)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) as	fter	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	,	0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	,	0	13. 00
.0.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	´	Ü	10.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14. 00
15. 00	Total nursery days (title V or XIX only)		1, 689	
16. 00	Nursery days (title V or XIX only)	$\overline{}$	1, 439	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		0.00	17. 00
17.00	reporting period		0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		0.00	18. 00
	reporting period			
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost		0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	ŀ	0. 00	20. 00
20.00	reporting period		0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)		106, 113, 006	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period	(line	0	22. 00
22.00	5 x line 17)		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (li x line 18)	The 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)			
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (li	ne 8	0	25. 00
27.00	x line 20)		0	27 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	-	0 106, 113, 006	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		100, 113, 000	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	-	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		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 minus line 33)(see instructions)		0. 00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)		0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	.	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential	(I I ne	106, 113, 006	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	$\neg \neg$	1, 194. 74	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		8, 568, 675	39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)		8, 568, 675	41.00

	Financial Systems C ATION OF INPATIENT OPERATING COST	OMMUNITY HEALTH	NETWORK, INC. Provider CCN	I: 15_0074		worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST		Provider CCN		Period: From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/30/2022 2:4	
	Cost Center Description	Total	Ti tl e Total		Hospi tal	PPS Program Cost	
	cost center bescription	Total Inpatient Costl	npatient Days D	Average Per i em (col. 1	Program Days	(col. 3 x col.	
		·		col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1. 00 1, 258, 092	2. 00	3. 00 744. 8	4. 00 7 1, 439	5. 00 1, 071, 868	42.00
42.00	Intensive Care Type Inpatient Hospital Units		1,007	744.0	7 1, 437	1, 071, 000	42.00
43. 00	INTENSIVE CARE UNIT	29, 733, 347	15, 060	1, 974. 3			
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0.0	0	0	44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT	3, 436, 333	2, 214	1, 552. 0	9 0	0	47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	, line 200)			5, 336, 457	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructions	s)		14, 977, 000	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routine	services (from)	Wket D sum	of Parts I and	926, 688	50.00
30.00		atrent routine .	SCI VICES (II OIII I	inkst. D, suiii	or rarts r and	720, 000	30.00
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (from	m Wkst. D, s	um of Parts II	281, 367	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				1, 208, 055	52.00
53.00	Total Program inpatient operating cost exclu	ding capital re	lated, non-physi	cian anesth	etist, and	13, 768, 945	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54.00
	Target amount per discharge					l e	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	rgot omount (Liu	ao E4 minus	lino E2)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and tal	rget amount (iii	le 56 illi flus	111le 53)	0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period (ending 1996, upo	dated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the man	rket hasket		0.00	60.00
61.00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less tha		s (lines 54 x 60	D), or 1% of	the target		
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
(1 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Dogo	mbor 21 of the	anat manamti	na naminal (Can	0	64.00
64. 00	instructions)(title XVIII only)	ts through becer	liber 31 of the c	Lost reporti	ng perrou (see		04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the co	st reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line o	64 nlus line 65`)(title XVII	I only) For	0	66.00
00.00	CAH (see instructions)	ne costs (i i i e	or prus rine ou,	, (11 11 0 7, 111	1 0111 37. 101		00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 of	the cost re	porting period	0	67. 00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after De	ecember 31 of th	ne cost repo	rting period	0	68. 00
	(line 13 x line 20)				3 1		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c		ine 70 ÷ line 2))			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v line	a 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv			3 33)			74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from Wo	rksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78.00	, ,	,					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				us line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi			70	· · · · · · · · · · · · · · · · · ·		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		>)				83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00			rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instructions					6, 358	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 194. 74	88. 00
	Observation bed cost (line 87 x line 88) (se					7, 596, 157	

Health Financial Systems Co	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 Fo 12/31/2021	Date/Time Prep 5/30/2022 2:48	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	9, 277, 134	106, 113, 006	0. 08742	7, 596, 157	664, 109	90.00
91.00 Nursing Program cost	0	106, 113, 006	0.00000	7, 596, 157	0	91. 00
92.00 Allied health cost	0	106, 113, 006	0.000000	7, 596, 157	0	92. 00
93.00 All other Medical Education	0	106, 113, 006	0.000000	7, 596, 157	0	93. 00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0074	Peri od:	Worksheet D-3

	Timaneral Systems Community in Incaeting in				tu or rorm cws-2	
I NPATI E	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Pre	
				10 12/31/2021	5/30/2022 2: 4	
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cost		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDIATRICS			32, 251, 351		30.00
	03100 INTENSIVE CARE UNIT			15, 706, 264		31. 00
	03200 CORONARY CARE UNIT			0		32. 00
	02060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0. 18679	2 30, 506, 917	5, 698, 448	50.00
	05100 RECOVERY ROOM		0. 13954			51.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 61765		0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C		0. 13952		-	54.00
	05500 RADI OLOGY-THERAPEUTI C		0. 10634		395, 398	1
57. 00	05700 CT SCAN		0. 05861	8 7, 074, 629	414, 701	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 12316			58. 00
	05900 CARDI AC CATHETERI ZATI ON		0. 03957			1
	06000 LABORATORY		0. 11070		2, 409, 134	60.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		0. 79779			1
	06600 PHYSI CAL THERAPY		0. 22370 0. 46623			65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY		0. 44573			67. 00
	06800 SPEECH PATHOLOGY		0. 44541			68. 00
	06900 ELECTROCARDI OLOGY		0. 10851			69. 00
	07000 ELECTROENCEPHALOGRAPHY		0. 23996			1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 53357	5 10, 522, 572	5, 614, 581	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 34598			72. 00
	07300 DRUGS CHARGED TO PATIENTS		0. 19237			1
	07301 SPECIALTY PHARMACY		0.83678		0	73. 01
	07400 RENAL DIALYSIS 03330 ENDOSCOPY		0. 24796 0. 24002		474, 419 16, 913	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 98389			76. 01
	03951 LUTHERWOOD PARTNERSHIP		7. 41710		l o	76. 03
76. 04	03952 WOUND CARE CENTER		0. 27902	7 244, 035	68, 092	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER		0. 21705	2 465, 654	101, 071	76. 05
	03953 I MAGI NG CENTERS		0. 13494			1
	03954 BREAST DI AGNOSTI C CENTER		0. 55528			1
	07697 CARDI AC REHABI LI TATI ON		0. 51814			1
- t	07698 HYPERBARI C OXYGEN THERAPY DUTPATI ENT SERVI CE COST CENTERS		0. 25043	8 0	0	76. 98
-	08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
90.00	09000 CLI NI C		0.00000	0 0	0	90.00
90. 01	04950 DIABETIC CARE CENTER		0.00000	0 0	0	90. 01
	04951 HEALTHY HEARTS CENTER		0. 59570		0	•
	09001 CLINIC		0.00000		1	
	04953 SPINE CENTER		0.00612		0	90. 04
	04954 INFUSION CENTERS		0. 04610 0. 00000			90.05
	09002 MEDCHECK CLINICS 09003 KNEE CENTER		1. 22331		0	90. 06 90. 07
	09004 PALLI ATI VE CARE		0. 00552		0	90. 07
	09006 WORK SITE CLINICS		0. 00000		Ö	90. 10
	04961 FAMILY PRACTICE AND MATERNITY CARE		0. 00000		0	90. 12
91. 00	09100 EMERGENCY		0. 11945	7 15, 697, 380		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 65598	3 1, 006, 322	660, 130	92. 00
-	OTHER REIMBURSABLE COST CENTERS				1	
	09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	
200. 00 201. 00	Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		186, 723, 785	34, 052, 058	200.00
201.00	Net charges (line 200 minus line 201)	5 (11110 01)		186, 723, 785		201.00
202.00	1.00 Sharges (11110 200 millias 11110 201)		1	100, 120, 100	I	1202.00

Health Financial Systems	COMMUNITY HEALTH NETWOR	RK, INC.	In Lieu	ı of Form CMS-2552-10
LNDATIENT ANGLE ARV CERVI OF COCT APPORTS ONMENT	5	' I OON 45 0074		W I I I D O

Health Financial Systems COMM	UNITY HEALTH NETWORK, INC.		<u> </u>	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0074	Peri od:	Worksheet D-3	}
			From 01/01/2021	D-+- /T: D	
			To 12/31/2021	Date/Time Pre 5/30/2022 2:4	
	Ti +I	e XIX	Hospi tal	PPS	ю рііі
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
odst denter beschiptren		To Charges	Program	Program Costs	
		10 onar ges	Charges	(col. 1 x col.	
			onal ges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			13, 844, 621		30.00
31.00 03100 INTENSIVE CARE UNIT			3, 496, 705		31.00
32. 00 03200 CORONARY CARE UNIT			0		32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			2, 666, 687		35.00
43. 00 04300 NURSERY			742, 534		43.00
ANCILLARY SERVICE COST CENTERS		I		I.	1
50. 00 05000 OPERATI NG ROOM		0. 19099	2, 608, 832	498, 279	50.00
51. 00 05100 RECOVERY ROOM		0. 13954			1
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 61765			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13952			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 10634			
57. 00 05700 CT SCAN		0. 05861			1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 12316			1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 03957			
60. 00 06000 LABORATORY		0. 11070			
64. 00 06400 I NTRAVENOUS THERAPY		0. 79779			
65. 00 06500 RESPI RATORY THERAPY		0. 22370			
66. 00 06600 PHYSI CAL THERAPY		0. 47501		81, 172	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 44573			1
68. 00 06800 SPEECH PATHOLOGY		0. 44541			1
69. 00 06900 ELECTROCARDI OLOGY		0. 11387			1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 24199	· ·		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 53357			1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 34598			1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 19279			1
73. 01 07301 SPECIALTY PHARMACY		0. 83678		730, 377	1
74. 00 07400 RENAL DI ALYSI S		0. 24796			1
76. 00 03330 ENDOSCOPY		0. 24002			1
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 02230		0	1
76. 03 03951 LUTHERWOOD PARTNERSHI P		7. 41710		0	1
76. 04 03952 WOUND CARE CENTER		0. 28475			
76. 05 03480 ONCOLOGY-CANCER CARE CENTER		0. 21705		15, 524	1
76. 06 03953 MAGING CENTERS		0. 13494			1
76. 07 03954 BREAST DIAGNOSTIC CENTER		0. 55528		5, 707	1
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 51814			
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 25043			1
OUTPATIENT SERVICE COST CENTERS		0. 200 10	,0 0		70.70
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000			
90. 00 09000 CLI NI C		0. 00000			1
90. 01 04950 DI ABETI C CARE CENTER		0.00000			
90. 02 04951 HEALTHY HEARTS CENTER		0. 59570		-	
90. 03 09001 CLI NI C		0.00000		0	1
90. 04 04953 SPI NE CENTER		0. 00612		0	1
90. 05 04954 INFUSION CENTERS		0. 04610		l o	
90. 06 09002 MEDCHECK CLINICS		0.00000		0	1
90. 07 09003 KNEE CENTER		1. 25341		0	1
90. 08 09004 PALLI ATI VE CARE		0. 79161		l o	1
90. 10 09006 WORK SITE CLINICS		0. 00000		Ö	1
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE		0.00000		l o	1
91. 00 09100 EMERGENCY		0. 12179		422, 152	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 65598		65, 199	1
OTHER REIMBURSABLE COST CENTERS		3. 33376	,,,3,2		1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000	00 0	0	98. 00
200.00 Total (sum of lines 50 through 94 and 96	through 98)		28, 536, 415	5, 336, 457	
201.00 Less PBP Clinic Laboratory Services-Progra	9 ,		0		201.00
202.00 Net charges (line 200 minus line 201)			28, 536, 415		202. 00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0074	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 2:48 pm

PARE A				10 12/31/2021	5/30/2022 2: 4	
No.			Title XVIII	Hospi tal	PPS	
No.					1.00	
1.00 RSS Amounts other than outli ler payments for discharges occurring prior to October 1 (see 5,955,173 1.00		DART A _ INDATIENT HOSPITAL SERVICES LINDER LDDS			1.00	
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 35,955,73 1.01 Instructions) Instructions 1.02 DRG amounts other than outlier payments for discharges occurring on a rather October 1 (see 1.148,70 1.02 1.03 1.06 1.08 1.06 1.08	1 00				0	1 00
DRG amounts other than outlier payments for discharges occurring on or after October 1 (see		DRG amounts other than outlier payments for discharges occurring				
1.03 16 (see instructions) 1.04 18 16 16 16 16 16 16 16	1. 02	DRG amounts other than outlier payments for discharges occurring	11, 148, 701	1. 02		
1.04 0Rc for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04	1. 03	,	lischarges occurring p	orior to October	0	1. 03
October (see Instructions) 0	1. 04		lischarges occurring o	on or after	0	1. 04
2.01 Outlier reconciliation amount 0 2.01	2 00	October 1 (see instructions)				2 00
2.02 Outlier payment for discharges for Model 4 BPCI (see instructions)		, , ,			0	
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 268, 788 2.04			5)		0	•
Managed Car's Simulated Payments	2.03	Outlier payments for discharges occurring prior to October 1 (see	instructions)		627, 609	2. 03
Bed days available divided by number of days in the cost reporting period (see instructions) 348.22 4.00 Indirect Medical Education Adjustment 5.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96 (see instructions) 5.00 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs and accordance with 42 CFR 413.79(c) 7.00 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(c) 7.01 FTE SSO3 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(1) 7.01 FTE SSO3 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(2) if the 0.00 7.01 FTE SSO3 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(2) if the 0.00 7.01 FTE SSO3 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(2) if the 0.00 7.01 FTE SSO3 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(2) if the 0.00 7.01 FTE SSO3 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(1)(8)(2) if the 0.00 7.01 FTE SSO3 reductions in accordance with 42 CFR 413.75(b), 413.79(c)(2)(2)(iv), 64 FR 26340 (May 12, 1988), and 67 FR 5090 (August 1, 2002). FTE SSO3 reductions in accordance with 42 CFR 413.75(b), 413.79(c)(2)(2)(iv), 64 FR 26340 (May 12, 1988), and 67 FR 5090 (August 1, 2002). FTE SSO3 reductions in accordance with 42 CFR 413.75(b), 413.79(c)(2)(2)(iv), 64 FR 26340 (May 12, 1988), and 67 FR 5090 (August 1, 2002). FTE SSO3 reductions in accordance with 42 CFR 413.75(c), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1988), and 67 FR 5090 (August 1, 2002). FTE SSO3 of ACA. (see instructions) 10.00	2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		268, 788	2. 04
Indirect Medical Education Adjustment 3.00 3.00 3.00 3.00 5.00 FIE count for all lopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 3.00 6.00 6.00 FIE count for all lopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MM Section 422 cFR 413.79(e) 7.00 7.01	3.00					3. 00
FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see instructions) FIE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413, 79(e) NAMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(B)(1) 1.00 7.01 ACA §5.503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(B)(2) If the cost report straddle sJuly 1, 2011 then see instructions. Adjustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(1)(1), 64 FR 26340 (May 12, 1998), and 67 FR 80060 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddle sJuly 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5500 of ACA. (see instructions.) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8, 02) (see instructions)	4.00		ng period (see instrud	ctions)	348. 22	4. 00
TEC count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 2.69 7.00 7.01 ACA \$5.503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddies July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50060 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddle sJuly 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddle sJuly 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions). The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions).	5. 00		ecent cost reporting p	period ending on	32. 51	5. 00
new programs in accordance with 42 CFR 413.79(e) 2.69 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 2.69 x 67.00 2.		·		_		
2.01 ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	6. 00		riteria for an add-or	n to the cap for	0. 00	6. 00
cost report straddles July 1, 2011 then see instructions. 8. 00 Ajusthent (increase or decrease) to the FIE count for all opathic and osteopathic programs for affil lated programs in accordance with 42 CRR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1999), and 67 FR 50099 (Muypust 1, 2002). 8. 01 The amount of increase if the hospital was awarded FIE cap slots under 5 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital ounder 5 5506 of ACA. (see instructions) 9. 00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 28.84 9.00 instructions) 10. 00 FIE count for allopathic and osteopathic programs in the current year from your records 46.18 10.00 Current year allowable FIE (see instructions) 11. 00 FIE count for or sidents in dental and podiatric programs. 12. 07 (aurent year allowable FIE count for the prior year. 13. 00 Total allowable FIE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15. 00 Sum of lines 12 through 14 divided by 3. 16. 00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents of the year of the year of the	7.00	MMA Section 422 reduction amount to the IME cap as specified unde	er 42 CFR §412.105(f)	(1) (i v) (B) (1)	2. 69	7. 00
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	7. 01		CFR §412. 105(f)(1)(i	/)(B)(2) If the	0. 00	7. 01
1998), and 67 FR 50069 (August 1, 2002).	8.00	Adjustment (increase or decrease) to the FTE count for allopathic			-12. 99	8. 00
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) The count for residents in dental and podiatric programs in the current year from your records 46,18 lo.00			(2)(IV), 64 FR 26340	(May 12,		
B.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots	under § 5503 of the A	ACA. If the cost	12. 01	8. 01
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 28.84 9.00 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 46.18 10.00 10.00 FTE count for residents in dental and podiatric programs. 2.97 11.00 12.00 Current year allowable FTE (see instructions) 31.84 13.00 13.84 13.00	8. 02		from a closed teaching	ng hospi tal	0.00	8. 02
instructions) 1.0 00 FTE count for allopathic and osteopathic programs in the current year from your records 1.0 00 FTE count for residents in dental and podiatric programs. 2. 97 11.00 11.00 12.00	9. 00		8. 8.01 and 8.02) (s	see	28. 84	9. 00
11.00 TEE count for residents in dental and podiatric programs. 2.97 11.00 12.00 12.00 12.00 13.81 12.00 13.81 12.00 13.80 13.00 15.00 1		instructions)	,			
12.00 Current year allowable FTE (see instructions) 31.81 12.00 13.00 Total allowable FTE count for the prior year. 31.84 13.00 13.0			year rrom your record	.5		
13.00 Total allowable FTE count for the prior year. 31.84 13.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 33.31 14.00 14.00 15.00						
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 33.31 14.00 otherwise enter zero. 32.32 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for resident to bed ratio (line 18 divided by line 4). 0.092815 19.00						
15.00 Sum of lines 12 through 14 divided by 3. 32.32 15.00 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 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for resident to bed ratio (line 18 divided by line 4). 0.094537 19.00 0.094537 19.00 0.094537 19.00 0.094537 19.00 0.094537 19.00 19.	14. 00		ended on or after Sept	ember 30, 1997,	33. 31	14. 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 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.0						
17. 00						
18.00 Adjusted rolling average FTE count 32.32 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.092815 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.094815 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.094815 21.00 22.01 IME payment adjustment (see instructions) 2,327,402 22.00 22.01 IME payment adjustment - Managed Care (see instructions) 2,542,677 1ndirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 25.00 Iff the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 29.01 Total IME payment - Managed Care (sum of lines 22 and 28) 2, 327, 402						
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.092815 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.094537 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.092815 21.00 22.01 IME payment adjustment (see instructions) 2,327,402 22.00 22.01 IME payment adjustment - Managed Care (see instructions) 2,542,677 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f)(1)(iv)(C). 0.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 17.34 24.00 25.00 IME for amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 25.00 27.00 IME payments adjustment amount (see instructions) 0.00000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			3			
20.00 Prior year resident to bed ratio (see instructions) 0.094537 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.092815 21.00 22.00 IME payment adjustment (see instructions) 2,327,402 22.00 IME payment adjustment - Managed Care (see instructions) 2,542,677 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 IME FTE Resident Count Over Cap (see instructions) 17.34 24.00 IME FTE Resident Count Over Cap (see instructions) 17.34 24.00 IME FTE Resident Count Over Cap (see instructions) 17.34 24.00 IME FTE Resident to bed ratio (divide line 25 by line 4) 0.000000 25.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 28.00 29.00 2						
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.092815 21.00 22.00 IME payment adjustment (see instructions) 2,327,402 22.00 2.00 IME payment adjustment - Managed Care (see instructions) 2,542,677 22.01 2.00		, ,				
22. 01 IME payment adjustment - Managed Care (see instructions) 2. 542, 677 22. 01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 0.00 (f) (1) (i v) (C) (f) (1) (I v) (C) (C) (C) (C) (C) (C) (C) (C) (C) (C		, , , , , , , , , , , , , , , , , , , ,			0. 092815	
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 17.34 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 25.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 2, 327, 402 29.00 Total IME payment (sum of lines 22 and 28) 2, 327, 402 29.00 Insproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10.36 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 33.71 33.00	22.00	IME payment adjustment (see instructions)				
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C). (f)(22. 01	IME payment adjustment - Managed Care (see instructions)			2, 542, 677	22. 01
(f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 17.34 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 27.00 IME payment - Managed Care (see instructions) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 33.71 33.00	23. 00			R 412. 105	0.00	23. 00
25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Sum of lines 30 and 31 32. 00 Allowable disproportionate share percentage (see instructions) 33. 11 33. 00		(f)(1)(iv)(C).				
instructions			or of line 23 or line	24 (SAA		
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 2, 327, 402 29. 00 29. 01 Disproportionate Share Adjustment 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10. 36 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 43. 57 31. 00 32. 00 Sum of lines 30 and 31 53. 93 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 33. 71 33. 71	23.00	g and a second s	. 01 TIME 23 01 TIME	24 (300	0.00	25.00
27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30. 00 Sum of lines 30 and 31 30. 00 Allowable disproportionate share percentage (see instructions) 31. 00 Allowable disproportionate share percentage (see instructions) 33. 71 33. 00	26. 00				0.000000	26. 00
28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment 29. 01 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 31. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 33. 71 33. 00		,				
29. 00 Total IME payment (sum of lines 22 and 28) 29. 00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 2,542,677 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10. 36 30. 00 31. 00 Sum of lines 30 and 31 53.90 33. 00 Allowable disproportionate share percentage (see instructions) 33. 71 33. 00	28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
29. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10. 36 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 33. 10 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 34. 57 31. 00 35. 93 32. 00 36. 94 Instructions	28. 01					28. 01
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.71 33.00						•
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.71 33.00	29. 01				2, 542, 677	29. 01
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.71 33.00	30.00		ent days (see instruct	i ons)	10. 36	30.00
33.00 Allowable disproportionate share percentage (see instructions) 33.71 33.00			,	•		•
	32.00	Sum of lines 30 and 31			53. 93	32. 00
34.00 Disproportionate share adjustment (see instructions) 3,969,679 34.00						
	34. 00	Disproportionate share adjustment (see instructions)			3, 969, 679	34.00

ALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0074	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prep 5/30/2022 2:48	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncomponented Caro Adjustment		1. 00	2. 00	
5. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		8, 290, 014, 521	7, 192, 008, 710	35. C
5. 01	Factor 3 (see instructions)		0. 000319716	0. 000434222	35.0
5. 02	Hospital uncompensated care payment (If line 34 is zero, enter	r zero on this line) (se		3, 122, 927	35.0
	instructions)	, (1	, ,		
5. 03	Pro rata share of the hospital uncompensated care payment amount	,	1, 982, 389	787, 149	35. C
5. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0)		2, 769, 538		36. C
	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throu			
0.00	Total Medicare discharges (see instructions)		0		40. (
1. 00 1. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instruct	one)	0		41. (41. (
2. 00	Divide line 41 by line 40 (if less than 10%, you do not quali-		0.00		42.
3. 00	Total Medicare ESRD inpatient days (see instructions)	ry ron adjustment)	0.00		43.
4. 00	Ratio of average length of stay to one week (line 43 divided)	ov line 41 divided by 7	0. 000000		44.
00	days)	., a a	0.00000		
5. 00	Average weekly cost for dialysis treatments (see instructions))	0.00		45.
5. 00	Total additional payment (line 45 times line 44 times line 41	01)	0		46. (
7. 00	Subtotal (see instructions)		57, 066, 890		47.
3. 00	Hospital specific payments (to be completed by SCH and MDH, si	mall rural hospitals	0		48.
	only. (see instructions)			Amount	
				1. 00	
9. 00	Total payment for inpatient operating costs (see instructions)		59, 609, 567	49.
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and			3, 845, 182	
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.	III, see instructions)		0	51.
2. 00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		300, 087	52.
3. 00	Nursing and Allied Health Managed Care payment			0	53.
4. 00	Special add-on payments for new technologies			341, 148	
4. 01	Islet isolation add-on payment			0	54.
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6			0	55.
5.00	Cost of physicians' services in a teaching hospital (see intro	•	h	0	56.
7.00	Routine service other pass through costs (from Wkst. D, Pt. I		nrougn 35).	0	57.
3. 00 9. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	rv, cor. If fine 200)		64, 095, 984	58. 59.
0. 00	Primary payer payments			2, 986	60.
1. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		64, 092, 998	
2. 00	Deductibles billed to program beneficiaries	1111c 00)		3, 625, 036	
3. 00	Coinsurance billed to program beneficiaries			109, 769	
4. 00	Allowable bad debts (see instructions)			325, 971	64.
5. 00	Adjusted reimbursable bad debts (see instructions)			211, 881	65.
5. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		200, 193	66.
7. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			60, 570, 074	67.
3. 00	Credits received from manufacturers for replaced devices for			2, 000	68.
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.
0. 50	Rural Community Hospital Demonstration Project (§410A Demonstration	ration) adjustment (see	ınstructions)	0	70.
0. 87	Demonstration payment adjustment amount before sequestration			0	70.
). 88	SCH or MDH volume decrease adjustment (contractor use only)	suctions)		0	70.
0.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	uctions)		_	70.
). 90). 91	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 70.
). 91). 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 70.
). 92). 93	HVBP payment adjustment amount (see instructions)			48, 113	
). 93). 94	HRR adjustment amount (see instructions)			-480, 775	
					70.

Health Financial Systems	COMMUNITY HEALTH NETWO	ORK, INC.		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovi der CC	N: 15-0074	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre 5/30/2022 2:4	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal y	year (yyyy) (Enter in co	column 0	•	0	0	70. 96

			Т	o 12/31/2021	Date/Time Prep 5/30/2022 2: 48	
-		Title	xVIII	Hospi tal	PPS	о рііі
				уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	(0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
70.00	the corresponding federal year for the period ending on or aft	ter 10/1)			0	70.00
70. 98 70. 99	Low Volume Payment-3				0	70. 98 70. 99
70. 99	HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines 6	SO 8. 70)			60, 135, 412	
71. 00	Sequestration adjustment (see instructions)	07 & 70)			00, 133, 412	71.00
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				59, 444, 150	72. 00
72.01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			691, 262	74. 00
74 01	73)					74 01
74. 01 75. 00	Balance due provider/program-PARHM (see instructions)	oo wi th			2 070 540	74. 01
75.00	Protested amounts (nonallowable cost report items) in accordar CMS Pub. 15-2, chapter 1, §115.2	ice with			2, 079, 569	75. 00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)		l			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90. 00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instru				0	
93.00	Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
94. 00	The rate used to calculate the time value of money (see instru	uctions)			0. 00	
95. 00 96. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions)	tions)			0	95. 00 96. 00
70.00	Trine value of money for capital related expenses (see first del	11 0113)		Prior to 10/1		70.00
				1.00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			,		
	HVBP adjustment factor (see instructions)			0.0000000000	0. 0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0	102. 00
102.00	HRR Adjustment for HSP Bonus Payment			0.0000	0. 0000	102 00
	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)			0.0000		103.00
104.00	Rural Community Hospital Demonstration Project (§410A Demonstr		stment	٩	0	104.00
200.00	Is this the first year of the current 5-year demonstration per					200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 49)				201. 00
	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year	of the current	5 year demonst		203. 00
	period)	iiist year	or the current	5-year demonst	i ati on	
204.00	Medicare target amount					204. 00
205.00	Case-mix adjusted target amount (line 203 times line 204)					205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement			ı		
	Program reimbursement under the §410A Demonstration (see instr	,				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	iine 59)				208. 00
	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use					209. 00 210. 00
	Total adjustment to Medicare IPPS payments (see instructions)					211.00
211.00	Comparision of PPS versus Cost Reimbursement					
212. 00	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
	Low-volume adjustment (see instructions)	•				213. 00
218. 00	Net Medicare Part A IPPS adjustment (difference between PPS ar	nd cost reim	nbursement)			218. 00
	(line 212 minus line 213) (see instructions)					

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0074	Peri od: Worksheet E From 01/01/2021 Part B To 12/31/2021 Date/Time Prepared:

			10 12/31/2021	5/30/2022 2: 48	
		Title XVIII	Hospi tal	PPS	о ріп
			поортта		
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			31, 498	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		108, 410, 060	2. 00
3.00	OPPS payments			89, 847, 289	3. 00
4.00	Outlier payment (see instructions)			606, 536	4. 00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			31, 498	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges			1/0 751	
	Ancillary service charges	(0)		163, 751	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			163, 751	14. 00
15 00	Customary charges	normant for complete on	a abarras basis		15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for participates that would have been realized from patients liable for			0	15. 00 16. 00
10.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e		i a ciiai yebasi s	ا	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	=)		0. 000000	17. 00
	Total customary charges (see instructions)			163, 751	ł
19. 00	Excess of customary charges over reasonable cost (complete onl	v if line 18 exceeds lin	ne 11) (see	132, 253	1
17.00	instructions)	y II Time to exceeds III	10 11) (300	102, 200	17.00
20. 00	Excess of reasonable cost over customary charges (complete onl	vifline 11 exceeds li	ne 18) (see	o	20.00
	instructions)	,	, (
21. 00	Lesser of cost or charges (see instructions)			31, 498	21. 00
22.00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			90, 453, 825	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	5)		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instru	uctions)	14, 613, 102	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	75, 872, 221	27. 00
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		578, 079	1
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			76, 450, 300	1
31. 00	Primary payer payments			19, 025	
32. 00	Subtotal (line 30 minus line 31)	YEC)		76, 431, 275	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)		0	22.00
	Composite rate ESRD (from Wkst. I-5, line 11)				33. 00 34. 00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			675, 256 438, 916	
	Allowable bad debts for dual eligible beneficiaries (see instr	suctions)		480, 383	
	Subtotal (see instructions)	uctions)		76, 870, 191	ı
	MSP-LCC reconciliation amount from PS&R			-88	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-88	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		١	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	-,		o	1
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	36, 771	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	201. 300 (300) 11011 40	,	0	39. 99
40. 00	Subtotal (see instructions)			76, 870, 279	•
	Sequestration adjustment (see instructions)			0	1
40. 02	Demonstration payment adjustment amount after sequestration			Ö	
	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			77, 497, 996	
41. 01	Interim payments-PARHM				41. 01
42.00	Tentative settlement (for contractors use only)			0	1
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			-627, 717	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, o	chapter 1,	90, 858	44. 00
	§115. 2				ļ
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			1	92.00
93. 00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			ا 0	94. 00

| Period: | Worksheet E-1 | Part | I | Date/Time | Prepared: | 5/30/2022 2:48 pm Health Financial Systems COMMUNANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0074

					5/30/2022 2: 48	3 pm
			XVIII	Hospi tal	PPS	
		I npati er	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		59, 444, 150		77, 497, 996	1. 00
2.00	Interim payments payable on individual bills, either		()	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			1	0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER					3. 02
3. 02						3. 02
3. 04						3. 03
3. 05						3. 05
3.03	Provider to Program			1	0	3. 03
3. 50	ADJUSTMENTS TO PROGRAM			1	0	3. 50
3. 51	7.BOSCIMENTO TO TROCKS III				l ol	3. 51
3. 52			1		l ol	3. 52
3. 53		•	1		l ol	3. 53
3.54			ĺ)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		1 0)	o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		59, 444, 150)	77, 497, 996	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		ı			
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)					
5. 01	Program to Provider TENTATIVE TO PROVIDER				0	5. 01
5. 01	TENTATIVE TO PROVIDER					5. 01
5. 02						5. 02
5.05	Provider to Program				U	5.03
5. 50	TENTATI VE TO PROGRAM			1	0	5. 50
5. 51	TELLINITE TO TROOK WIII					5. 51
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		691, 262		0	6. 01
6.02	SETTLEMENT TO PROGRAM				627, 717	6. 02
7.00	Total Medicare program liability (see instructions)		60, 135, 412		76, 870, 279	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	In the second second)	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems COMMUNITY HEALTH N	FTWORK INC	Inlie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0074 Period: From 01/01/2021 To 12/31/2021					
		Title XVIII	Hospi tal	PPS	
	TO DE COMPLETED DV CONTRACTOR FOR MONOTANDARD COST REPORTS			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.		14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and				2.00
2.00	reporting periods beginning on or after 10/01/2013, Line 32)				
3.00					
4.00	4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost				
	reporting periods beginning on or after 10/01/2013, line 32)				
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				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00		(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00

	Financial Systems COMMUNITY HEALTH NE		N 45 0074		u of Form CMS-2	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provider CC	F	Period: From 01/01/2021	Worksheet E-4	
				To 12/31/2021	Date/Time Prep 5/30/2022 2:48	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
1. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic p	programs for	cost reportir	na periods	26. 92	l 1. 00
2 00	ending on or before December 31, 1996.	· ·	·	0 1	0. 00	2. 00
2. 00 3. 00	Unweighted FTE resident cap add-on for new programs per 42 CFF Amount of reduction to Direct GME cap under section 422 of MM		i) (see ilistit	ictrons)	2. 82	
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	§413.79 (m).	(see	0. 00	3. 01
1. 00	Adjustment (plus or minus) to the FTE cap for allopathic and (GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		programs due t	o a Medicare	-12. 99	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instrandling 7/1/2011)		cost reportir	ng periods	10. 93	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	s (see inst	ructions for o	cost reporting	0. 00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus 4.02 plus applicable subscripts	us or minus	line 4 plus li	nes 4.01 and	22. 04	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic precords (see instructions)	orograms for	the current y	ear from your	46. 18	6. 00
7. 00	Enter the lesser of line 5 or line 6		Dri maru Cara	O+box	22. 04	7. 00
			Primary Care 1.00	0ther 2.00	<u>Total</u> 3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteopa program for the current year.	athi c	34. 34	11. 38	45. 72	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherwi multiply line 8 times the result of line 5 divided by the amou		16. 39	5. 43	21. 82	9. 00
10. 00	6. Weighted dental and podiatric resident FTE count for the curre	ent vear		2. 97		10.00
10. 01	Unweighted dental and podiatric resident FTE count for the cur			2. 97		10. 01
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	g year (see	16. 39 16. 35			11. 00 12. 00
13. 00	<pre>instructions) Total weighted resident FTE count for the penultimate cost req year (see instructions)</pre>	porting	18. 07	8. 44		13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	16. 94			14.00
15. 00 15. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pr	rograms	0. 00 0. 00			15. 00 15. 01
16. 00	Adjustment for residents displaced by program or hospital clos		0.00			16. 00
16. 01	Unweighted adjustment for residents displaced by program or ho		0.00			16. 01
17. 00	closure Adjusted rolling average FTE count		16. 94	8. 51		17. 00
	Per resident amount Approved amount for resident costs		92, 582. 93 1, 568, 359	· ·	2, 363, 688	18.00
. ,	The state of the s		., 000, 000	7,07,000		171.00
20.00	Additional unweighted allopathic and osteopathic direct GME F7	TE resident	can slots rece	eived under 42	1. 00	20. 00
20. 00	Sec. 413.79(c)(4)		cap siots rece	rved dilder 42	0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instruc				24. 14	
22. 00 23. 00	Allowable additional direct GME FTE Resident Count (see instru		netrueti enel		0. 00 0. 00	
	Enter the locality adjustment national average per resident an Multiply line 22 time line 23	ilouit (see ii	iisti ucti olis)		0.00	1
	Total direct GME amount (sum of lines 19 and 24)				2, 363, 688	
			Inpatient Part A	Managed Care	Total	
			1. 00	2. 00	3. 00	
26. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	ζ, line	17, 617	20, 449		26. 00
27. 00	3.02, column 2) Total Inpatient Days (see instructions)		100, 219	100, 219		27. 00
20 00	Ratio of inpatient days to total inpatient days		0. 175785			28. 00
	Program direct GME amount		415, 501	482, 294	897, 795	29.00
29. 00		ŀ	,		0,,,,,,	
28. 00 29. 00 29. 01 30. 00	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage		110,00	4. 07 19, 629	19, 629	29. 01

Heal th	Financial Systems COMMUNITY HEALTH N	ETWORK, INC.	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0074	Peri od:	Worksheet E-4	
MEDI CA			From 01/01/2021 To 12/31/2021	Date/Time Prep 5/30/2022 2:48	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	`		OI CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 ar	nd 23, lines 74	0	32. 00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	8, 339, 676	33. 00
34.00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	b.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			56, 286, 290	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Primary payer payments (see instructions)				40. 00
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		56, 283, 304	41. 00
40.00	Part B Reasonable Cost			400 444 550	40.00
	Reasonable cost (see instructions)			108, 441, 558	
	Primary payer payments (see instructions)			19, 025	
	Total Part B reasonable cost (line 42 minus line 43)			108, 422, 533	
	Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (lin	o 41 . lino 45)		164, 705, 837 0. 341720	
	Ratio of Part B reasonable cost to total reasonable cost (IIII	,		0. 658280	
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 030260	47.00
48 00	Total program GME payment (line 31)	KI D		878, 166	48 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		300, 087	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			578, 079	
50. 50	1. a. c. b. moa. oa. b. ome paymone (11110 17 x 10) (cittle xviii oilly)	(333 111311 4011 0113)	ı	5,5,017	50.00

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

Provider CCN: 15-0074 Period From

Peri od: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared:

onl y)				0 12/31/2021	5/30/2022 2:4	
		General Fund	Speci fi c	Endowment Fund		J piii
		1 00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	10, 630		0	0	1.00
2.00	Temporary investments	0		o	0	
3.00	Notes receivable	142, 333	3	0	0	
4.00	Accounts receivable	557, 714, 839	1	0	0	
5.00	Other recei vable	53, 094, 121	1	0	0	1
6.00	Allowances for uncollectible notes and accounts receivable Inventory	11, 982, 297	1		0	
7. 00 8. 00	Prepai d expenses	21, 309, 992 9, 528, 442	1		0	
9. 00	Other current assets	7, 320, 442			0	
10.00	Due from other funds	Ö		ol ol	0	
11.00	Total current assets (sum of lines 1-10)	653, 782, 654		o	0	11.00
	FIXED ASSETS					
12.00	Land	2, 743, 049		1	0	
13.00	Land improvements	4, 349, 043		1	0	1
14.00	Accumulated depreciation	E2E 222 000		1	0	
15. 00 16. 00	Buildings Accumulated depreciation	535, 232, 989			0	
17. 00	Leasehold improvements	12, 975, 903			0	
18. 00	Accumulated depreciation	0		ol ol	0	
19.00	Fi xed equipment	221, 707, 221		o	0	1
20.00	Accumulated depreciation	0) (o	0	20. 00
21. 00	Automobiles and trucks	337, 264	1	0	0	
22. 00	Accumulated depreciation	0		1	0	1
23. 00	Maj or movable equipment	402 042 003		0	0	
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-402, 043, 083			0	
26. 00	Accumulated depreciation	0			0	
27. 00	HIT designated Assets	Ö		ol ol	0	
28. 00	Accumul ated depreciation	O		o	0	
29. 00	Mi nor equi pment-nondepreci abl e	58, 900) (0	0	
30.00	Total fixed assets (sum of lines 12-29)	375, 361, 286		0	0	30.00
31. 00	OTHER ASSETS Investments) Ol	0	31.00
32. 00	Deposits on Leases	0		1	0	
33. 00	Due from owners/officers	Ö		1	Ö	
34.00	Other assets	464, 979, 362		o	0	1
35.00	Total other assets (sum of lines 31-34)	464, 979, 362	2 (0	0	
36.00	Total assets (sum of lines 11, 30, and 35)	1, 494, 123, 302	2 (0	0	36. 00
	CURRENT LI ABI LI TI ES	0.40.005		ا		
37. 00	Accounts payable Salaries, wages, and fees payable	-269, 935	1		0	
38. 00 39. 00	Payrol I taxes payable				0	
40. 00	Notes and Loans payable (short term)			o o	Ö	
41. 00	Deferred income	O		o	0	
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0) (0	0	
44. 00		64, 265, 794		0	0	
45. 00		63, 995, 859) (0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	0			0	46. 00
47. 00	Notes payable	0			0	
48. 00	Unsecured Loans	Ö		1	Ö	1
49.00	Other long term liabilities	5, 834, 072	2	o	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5, 834, 072	2 (0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	69, 829, 931		0	0	51. 00
F2 00	CAPITAL ACCOUNTS	1 404 000 071				F2 00
52. 00 53. 00	General fund balance Specific purpose fund	1, 424, 293, 371 				52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			<u></u>		54.00
55. 00	Donor created - endowment fund balance - unrestricted			l ől		55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
50.00	replacement, and expansion	1 424 202 274			0	59.00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	1, 424, 293, 371 1, 494, 123, 302	1		0	
55. 55	59)	., ., ., 120, 002		<u> </u>		55. 55
		•	•	. '		•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0074

General Fund Special Purpose Fund Endowment f		<i>p</i>
1.00 2.00 3.00 4.00 5.00		
1.00 Fund balances at beginning of period 1,171,194,090 0		1. 00
2.00 Net income (loss) (from Wkst. G-3, line 29) 253,099,281 3.00 Total (sum of line 1 and line 2) 1,424,293,371		2. 00 3. 00
4.00 Additions (credit adjustments) (specify)	0	4. 00
5.00	0	5.00
6. 00 7. 00	0	6. 00
8.00	0	7. 00 8. 00
9.00	0	9. 00
10.00 Total additions (sum of line 4-9)		10.00
11.00 Subtotal (line 3 plus line 10) 1,424,293,371 0 12.00 Deductions (debit adjustments) (specify) 0 0	0	11. 00 12. 00
13. 00 0 0 0	0	13. 00
14. 00	0	14.00
15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	15. 00 16. 00
17. 00	0	17. 00
18.00 Total deductions (sum of lines 12-17) 0 0		18. 00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		19. 00
Endowment Fund Plant Fund		
1.00 Fund balances at beginning of period 0 8.00 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 0		4. 00 5. 00
6.00		6. 00
7. 00		7. 00
8.00		8. 00
9.00 0 0 10.00 Total additions (sum of line 4-9) 0 0		9. 00 10. 00
11.00 Subtotal (line 3 plus line 10) 0		11. 00
12.00 Deductions (debit adjustments) (specify)		12.00
13. 00 14. 00		13. 00 14. 00
15. 00		15. 00
16. 00		16. 00
17.00 0 0 18.00 Total deductions (sum of lines 12-17) 0 0		17. 00 18. 00
19.00 Fund balance at end of period per balance 0		19. 00
sheet (line 11 minus line 18)		

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

To 12/31/2021 Date/Time Prepare 5/30/2022 2:48 pm						
	Cost Center Description		Inpatient	Outpati ent	Total	<u>Б</u>
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		77, 228, 030)	77, 228, 030	1.00
2.00	SUBPROVI DER - I PF					2. 00
3.00	SUBPROVI DER - I RF					3. 00
4.00	SUBPROVI DER					4. 00
5.00	Swing bed - SNF		C		o	
6.00	Swing bed - NF		(0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	İ	77, 228, 030)	77, 228, 030	
	Intensive Care Type Inpatient Hospital Services	<u> </u>	, ===,		, ===, ===	
11. 00	INTENSIVE CARE UNIT		20, 805, 802	2	20, 805, 802	11. 00
12.00	CORONARY CARE UNIT				0	12.00
13.00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT					14.00
15. 00	NEONATAL INTENSIVE CARE UNIT		18, 139, 096		18, 139, 096	
16. 00	Total intensive care type inpatient hospital services (sum of li	ines	38, 944, 898		38, 944, 898	
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		116, 172, 928	3	116, 172, 928	17. 00
18.00	Ancillary services		906, 555, 335	2, 492, 390, 774	3, 398, 946, 109	18. 00
19.00	Outpati ent services			0	0	19. 00
20.00	RURAL HEALTH CLINIC		C	0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		C	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)		C	20, 537, 511	20, 537, 511	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst. 1	, 022, 728, 263		3, 535, 656, 548	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			905, 165, 939		29. 00
30.00	ADD (SPECIFY)		C)		30. 00
31.00			C)		31. 00
32.00			C)		32. 00
33.00			C)		33. 00
34.00			C)		34.00
35.00			C)		35. 00
36.00	Total additions (sum of lines 30-35)			0		36. 00
37.00	DEDUCT (SPECIFY)		C)		37. 00
38. 00			C)		38. 00
39. 00			C)		39. 00
40.00			C)		40. 00
41.00			C)		41. 00
42.00	Total deductions (sum of lines 37-41)			0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		905, 165, 939		43. 00
	to Wkst. G-3, line 4)	ļ				

	5	NETHORY		6.5. 040.6	
	Financial Systems COMMUNITY HEALTH ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0074	Period:	u of Form CMS-2 Worksheet G-3	2552-10
SIAIL	LENT OF REVENUES AND EXITENSES	11001de1 edit. 13 0074	From 01/01/2021		
			•	5/30/2022 2: 48	5 p
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii			3, 535, 656, 548	1. 00
2.00	Less contractual allowances and discounts on patients' accou	unts		2, 410, 585, 010	2. 00
3.00	Net patient revenues (line 1 minus line 2)			1, 125, 071, 538	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		905, 165, 939	
5.00	Net income from service to patients (line 3 minus line 4)			219, 905, 599	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			3, 021, 728	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	on services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase discounts				10.00
11.00	Rebates and refunds of expenses			0	
12. 00	Parking lot receipts			0	
13. 00	Revenue from laundry and linen service			0	13. 00
14. 00	Revenue from meals sold to employees and guests			2, 031, 021	
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		0	
17. 00	Revenue from sale of drugs to other than patients				17. 00
18. 00	Revenue from sale of medical records and abstracts				18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)				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			620, 788	
23. 00	Governmental appropriations			0	23.00
24.00	MI SC REV			24, 261, 699	
24. 50	COVI D-19 PHE Fundi ng			3, 258, 446	
25. 00	Total other income (sum of lines 6-24)			33, 193, 682	
	Total (line 5 plus line 25)			253, 099, 281	
27. 00	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			253, 099, 281	29. 00

Heal th	Financial Systems COMMUNITY HEALTH	NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0074	Peri od: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/30/2022 2:4	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				1
	CAPITAL FEDERAL AMOUNT				1
1. 00	Capital DRG other than outlier			3, 626, 037	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			97, 310	
2.01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	tructions)	276. 35	
4.00	Number of interns & residents (see instructions)			32. 32	
5. 00	Indirect medical education percentage (see instructions)			3. 36	
6. 00	Indirect medical education adjustment (multiply line 5 by t	he sum of lines 1 and 1.0 $^{\circ}$	1, columns 1 and	121, 835	6. 00
7.00	1.01) (see instructions)			0.00	7.00
7. 00					7. 00
8. 00	30) (see instructions) 0 Percentage of Medicaid patient days to total days (see instructions)				8. 00
9. 00	Sum of lines 7 and 8	r de trons)		0. 00 0. 00	
10. 00	Allowable disproportionate share percentage (see instruction	ns)		0.00	
11. 00	Disproportionate share adjustment (see instructions)	113)		0.00	
12. 00				3, 845, 182	
12.00	process process to supreme payments (see thete detroile)			0,010,102	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumsta	nces (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			0.00	
7. 00	Adjustment to capital minimum payment level for extraordina	ry circumstances (line 2)	k line 6)	0	
8. 00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as app			0	
10.00	Current year comparison of capital minimum payment level to			0	
11. 00	Carryover of accumulated capital minimum payment level over	capital payment (from pri	or year	0	11. 00
12 00	Worksheet L, Part III, line 14)	novments (line 10 plus lis	20 11)	0	12 00
12. 00 13. 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent			0	
14. 00	Carryover of accumulated capital minimum payment level over			0	
14.00	(if line 12 is negative, enter the amount on this line)	capital payment for the i	orrowing period		14.00

15.00 0 16.00 0 17.00

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

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