HUSPITAL AND F	103PLIAL REALIR CARE COMPLEX COST REPORT CERTIFICATION	Provider Con. 13-01		WOLKSHEEL 3
AND SETTLEMENT	「 SUMMARY		From 07/01/2020	Parts I-III
7110 SETTEEMENT			To 06/30/2021	
				11/23/2021 10:28 am
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost report		Date: 11/23/2	2021 Time: 10:28 am
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report enter the number	of times the provide	er resubmitted this c	ost report
	4. [F] Medicare Utilization. Enter "F" for full or "I	L" for low.		·
Contractor	5. [1] Cost Report Status 6. Date Received:		10. NPR Date:	
use only	(1) As Submitted 7. Contractor No.		11. Contractor's Vende	
, , , ,	(2) Settled without Audit 8. [N] Initial Report for	or this Provider CCN	12. [0]If line 5, co	olumn 1 is 4: Enter
	(3) Settled with Audit 9. [N] Final Report for	this Provider CCN	number of tir	mes reopened = 0-9.
	(4) Reopened	1		
	(5) Amended			

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL (15-0125) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 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.

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

(Si gned) DANI EL 0' BRI EN
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 280, 045	-151, 865	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	18, 221	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	1, 298, 266	-151, 865	0	0	200. 00

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

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI C		Provi d	er CCN:	15-0125	Period: From 07/01/ To 06/30/	/2021	Workshe Part I Date/Ti 11/23/2	me Pre	pared:
	1.00	l A -l-	2.00		3. 00		<u> </u>	4. 00			
1. 00	Hospital and Hospital Health Care Co Street: 901 MACARTHUR BOULEVARD	mpi ex Add	PO Box:								1.00
2. 00	Ci ty: MUNSTER		State: IN	Zip Code	e: 46321	Count	ty: LAKE				2.00
	1		ponent Name	CCN	CBSA	Provi der		Payme	nt Syst	em (P,	
				Number	Number	Type	Certi fi ed		0, or	N)	
								V	XVIII	XIX	
	Harrital and Harrital Barad Campana	A 1 -1 4 ! 4	1.00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
3. 00	Hospital and Hospital-Based Componen Hospital		rication: Y HOSPITAL	150125	23844	1	10/03/1973	N	Р	Р	3.00
4.00	Subprovider - IPF	COMMONT	I HOSFITAL	130123	23044	•	10/03/19/3	l IN	-	「	4.00
5. 00	Subprovider - IRF	THE REHAI	B CENTER AT	15T125	23844	5	06/30/1996	N	P	P	5.00
0.00	Caspi evi dei	COMMUNI T		101120	20011		00,00,1,70	''	'		0.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										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	Hospi tal -Based OLTC		,	453403			04 (07 (4007			l	11.00
12. 00	Hospi tal -Based HHA		Y HOME HEALTH	157487	23844		01/07/1997	N	P	N	12. 00
13. 00	Separately Certified ASC	SERVI CES									13. 00
	Hospi tal -Based Hospi ce										14. 00
15. 00	· ·										15. 00
	Hospi tal -Based Health Clinic - FQHC										16. 00
17. 00	·										17. 00
18.00	Renal Dialysis										18. 00
19.00	0ther										19. 00
							From:		То		
20.00	0 1 0 1: 0 : 1 (/11/)						1.00		2. (00.00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						07/01/2	020	06/30	/2021	20.00
21.00	Type of control (see mistructions)										21.00
						1. 00	2. 00		3. (00	
	Inpatient PPS Information										
22. 00	Does this facility qualify and is it					Υ	N				22. 00
	disproporti onate share hospi tal adju				2						
	§412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section §			enament							
22. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un			e for thi	_	Υ	Y				22. 01
22.01	cost reporting period? Enter in colu						'				22.01
	the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N										
	reporting period occurring on or aft										
22. 02						N	N				22. 02
	payments to be determined at cost re	port sett	lement? (see ir	nstructi on	ıs)						
	Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob										
	or "N" for no, for the portion of th	e cost re	eporting period	on or art	er						
22. 03	October 1. Did this hospital receive a geograph	ic reclas	sification from	urban to	,	N	N		N		22. 03
22.03	rural as a result of the OMB standar					IV	1		14		22.03
	adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reporting										
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft										
	Does this hospital contain at least			•							
	counted in accordance with 42 CFR 41	2.105)? E	inter in column	3, "Y" fo	or						
22.04	yes or "N" for no.		-! 6!+! 6			N	N.				22.04
22. 04	Did this hospital receive a geograph rural as a result of the revised OMB					N	N		N		22. 04
	adopted by CMS in FY 2021? Enter in										
	for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for				·						
	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 41	2. 105)?	Enter in column	1 3, "Y" f	or						
00.0-	yes or "N" for no.			., ==	.						00.05
23. 00	Which method is used to determine Me						3 N				23. 00
	below? In column 1, enter 1 if date if date of discharge. Is the method			,							
	reporting period different from the				Jost						
	reporting period? In column 2, enter "Y" for yes or "N" for no.										

57.00 | If line 56 is yes, is this the first cost reporting period during which residents in approved

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

57 00

58 00

59.00

N

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

N

Health Financial Systems	COMM	MUNITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provi der CC		eriod: com 07/01/2020 o 06/30/2021	Worksheet S-2 Part I Date/Time Prep 11/23/2021 10	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	0.00	0. 00		64. 00		
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 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)	., 55	2.00	0.00	0.00		65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting				
beginning on or after July 1, 20			0.00	0.00	0.00000	
66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66.00
(Cost diiii)	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00 Enter in call 4.11	1.00	2. 00	3.00	4.00	5.00	(7.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67. 00

	patient Psychiatric Facility PPS				4
	this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subp	rovi der?	N		70
	ter "Y" for yes or "N" for no. line 70 is yes: Column 1: Did the facility have an approved GME teaching program in t	he most		0	71
rec	cent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for n	no. (see			′ ′
	CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teach				
	ogram in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for n				
	umn 3: If column 2 is Y, indicate which program year began during this cost reporting				
(se	ee instructions)				
	patient Rehabilitation Facility PPS				
	this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		Y		75
	pprovider? Enter "Y" for yes and "N" for no.				
	line 75 is yes: Column 1: Did the facility have an approved GME teaching program in t		N N	0	76
	cent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or				
	Column 2: Did this facility train residents in a new teaching program in accordance				
	R 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y,				
ĮI IIC	dicate which program year began during this cost reporting period. (see instructions)				
			1	. 00	-
Lor	ng Term Care Hospital PPS			. 00	
	this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80
	this a LTCH co-located within another hospital for part or all of the cost reporting	period? Ente	r	N	81
	for yes and "N" for no.				-
	FRA Provi ders		<u> </u>		
5.00 Is	this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes of	r "N" for no		N	85
5.00 Did	d this facility establish a new Other subprovider (excluded unit) under 42 CFR Section				86
§41	<pre>13.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.</pre>				
	this hospital an extended neoplastic disease care hospital classified under section			N	87
188	36(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				
		V		I X	4
T	N. LVIV.C.	1. 00		. 00	-
	tle V and XIX Services	N.		V	4
	es this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Υ	90
	s or "N" for no in the applicable column. this hospital reimbursed for title V and/or XIX through the cost report either in	N		Υ	91
I .	I or in part? Enter "Y" for yes or "N" for no in the applicable column.	IN		i	91
. 00 Are	e title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		ŀ	N	92
	structions) Enter "Y" for yes or "N" for no in the applicable column.			IN	92
	es this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N		N	93
	for yes or "N" for no in the applicable column.			14	/ 3
	es title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	l N	ŀ	N	94
	of i cable column.				' '
	line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0	.00	95
	es title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	l N		N	96
	olicable column.				
7.00 If	line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0	.00	97
3. 00 Doe	es title V or XIX follow Medicare (title XVIII) for the interns and residents post	N		N	98
ste	epdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in				
col	umn 1 for title V, and in column 2 for title XIX.				
	es title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.	N		Υ	98
С,	Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for				
	tle XIX.				
	es title V or XIX follow Medicare (title XVIII) for the calculation of observation	N		Υ	98
	d costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1				
- 1	title V, and in column 2 for title XIX.				
	es title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N		N	98
	mbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1				
	title V, and in column 2 for title XIX.	N.		NI.	0.0
	es title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N		N	98
	tpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and				
	column 2 for title XIX. es title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	N	ŀ	Υ	98
	st. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	IN.		1	70
	umn 2 for title XIX.				
1	es title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	N		N	98
	s. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in				/
	umn 2 for title XIX.				
	ral Providers	•			
	es this hospital qualify as a CAH?	N			105
	this facility qualifies as a CAH, has it elected the all-inclusive method of payment				106
	outpatient services? (see instructions)				
	umn 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R				107
	aining programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)				
	ining programs: Litter in for yes or in for no fire cordining it. (see first detrois)		1		
tra	umn 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an				
tra Col					

COMMUN	NI TY HOSPI TAL			In Lie	u of Form CMS-	-2552-10
EX IDENTIFICATION DATA	Provider CCN	l: 15-0125				
					11/23/2021 10	
			1	. 00	2. 00	
		ti fi cati on				131. 00
slet transplant center	r, enter the certific	cation date				132. 00
	ter the OPO number in	n column 1				133. 00 134. 00
"N" for no in column 1	1. If yes, and home o	office costs	5	Υ	15H054	140. 00
	2. 00			3. 00		
			name and	address	of the	
			or's Num	ber: 0800	1	141. 00
PO Box:						142. 00
State:	IN	Zi p Code):	4632	.1	143. 00
					1.00	+
sts included in Worksh	neet A?				Υ	144. 00
			1	00	2 00	-
				Υ	2.00	145. 00
clude Medicare utiliza						
	reviously filed cost	renort?		N		146. 00
			-			110.00
					1 00	-
ical basis? Enter "Y"	for yes or "N" for r	10.			Y	147. 00
			r no		N N	148. 00 149. 00
rea cost finding metho	Part A	Part B		tle V	Title XIX	147.00
ider that qualifies for	1.00	2.00			4.00	
	NI NI				. 13)	
	N N	N		N	N	
	N N N					156. 00
	N N	N N		N N N	N N N	156. 00 157. 00 158. 00
	N	N N		N N	N N	155. 00 156. 00 157. 00 158. 00 159. 00 160. 00
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	N N N N	N N N N N		N N N N N	N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 00
ampus hospital that ha	N N N N	N N N N N		N N N N N	N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00
. Name	N N N N N N N N N N N N N N N N N N N	N N N N N Sees in diffe	erent CBS	N N N N N SAS?	N N N N N 1.00	156. 00 157. 00 158. 00 159. 00 160. 00 161. 00
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Name 0 T) incentive in the Am	as one or more campus County 1.00	N N N N N N N N N N N N N N N N N N N	p Code 3.00	N N N N N SAS?	N N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 00
Name 0 T) incentive in the Amr under §1886(n)? Ent	as one or more campus County 1.00 merican Recovery and ter "Y" for yes or "N	N N N N N N N N N N N N N N N N N N N	p Code 3.00	N N N N N N SAS? CBSA 4.00	N N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 00
Name O T) incentive in the Amr under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru	County 1.00 merican Recovery and ter "Y" for yes or "Neaningful user (line actions)	N N N N N N N N N N N N N N N N N N N	p Code 3.00	N N N N N N N N N N N N N N N N N N N	N N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 00 165. 00 166. 00
Name O T) incentive in the Amr under \$1886(n)? Ent 05 is "Y") and is a me	Recovery and ter "Y" for yes or "Neaningful user (line uctions) does this provider	Rei nvestmer Rei nvestmer Tor no. 167 is "Y") qualify for	p Code 3.00	N N N N N N N N N N N N N N N N N N N	N N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 00 165. 00
	ntestinal transplant of date, if applicable, islet transplant center if applicable, in column 2. In or home office costs "N" for no in column 1 e home office chain nu in organization, enter fice contractor name at IN, Contractor's Name PO Box: State: Sts included in Worksh alimed on Wkst. A, lir "for yes or "N" for rolude Medicare utilization for no in column 2. The polyment of the polyment o	ntestinal transplant center, enter the cerdate, if applicable, in column 2. slet transplant center, enter the certification if applicable, in column 2. rganization (OPO), enter the OPO number in le, in column 2. n or home office costs as defined in CMS FINT for no in column 1. If yes, and home center to be home office chain number. (see instruction 2.00 in organization, enter on lines 141 through fice contractor name and contractor number in lines 141 through fice contractor name and contractor number in lines 141 through fice contractor in lines 141 through fice contractor name and contractor number in lines 141 through fice contractor in lines 141 through fice con	Intestinal transplant center, enter the certification date, if applicable, in column 2. Slet transplant center, enter the certification date if applicable, in column 2. In column 2. In or home office costs as defined in CMS Pub. 15-1, "N" for no in column 1. If yes, and home office costs entore home office chain number. (see instructions)	Provider CCN: 15-0125 Period: From 07. To 06. Period: From 07. To 06. Period: From 07. To 06. Period:	Provider CCN: 15-0125 Period: From 07/01/2020 To 06/30/2021 1.00 1.00 Intestinal transplant center, enter the certification date, if applicable, in column 2. 1.00 1.00 Intestinal transplant center, enter the certification date if applicable, in column 2. 1.00 1.00 In or home office costs as defined in CMS Pub. 15-1, Y Y Y Y Y Y Y Y Y	Provider CCN: 15-0125 Period: From 07/01/2020 Part I Date/Time Provider CCN: 15-0125 Period: From 07/01/2020 Part I Date/Time Provider CCN: 15-0125 Period: From 07/01/2020 Part I Date/Time Provider CCN: 15-0125 Power Provider CCN: 15-0125 Part I Date/Time Provider CCN: 15-0125 Power Provider CCN: 15-0125 Part I Date/Time Provider CCN: 15-0125 Power Provider CCN: 15-0125 Part I Date/Time Provider CCN: 15-0125 Power Provider CCN

Health Financial Systems	COMMUNITY HOSPITAL			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I				od:	Worksheet S-2	
				07/01/2020	Part Date/Time Pre	nared.
			10	007 007 2021	11/23/2021 10): 28 am
				Begi nni ng	Endi ng	
				1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170. 00
				1. 00	2.00	
171.00 If line 167 is "Y", does this provide				N	(171. 00
section 1876 Medicare cost plans repo						
"Y" for yes and "N" for no in column		nter the number of section	on			
1876 Medicare days in column 2. (see	Instructions)					

information? If yes, see instructions.

Heal th	Financial Systems COMMUNITY	HOSPI TAL		In Lie	u of Form CMS-	2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0125	Peri od: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Pre 11/23/2021 10	pared:				
		Descri	pti on	Y/N	Y/N	20 am				
		(1. 00	3. 00					
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00				
	The port of the strict of the strict day detinents.	Y/N	Date	Y/N	Date					
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21. 00				
	records? If yes, see instructions.	IV.				21.00				
					1. 00					
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)							
	Capital Related Cost									
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00				
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	ais made dur	ing the cost		23. 00				
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	porting period?		24. 00				
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00				
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? I	f yes, see		26. 00				
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit		27. 00				
28. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	ntorod into dur	ing the cost	roporting		28. 00				
28.00	period? If yes, see instructions.	intered Titto dar	ing the cost	reporting		20.00				
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see insti		bt Service R	eserve Fund)		29. 00				
30. 00	Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes	, see		30.00				
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	, see		31. 00				
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvices furnishe	d through co	ntractual		32.00				
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		g to competi	tive bidding? If		33. 00				
	no, see instructions. Provider-Based Physicians					1				
34. 00	Are services furnished at the provider facility under an all f yes, see instructions.	rrangement with	provi der-ba	sed physi ci ans?		34. 00				
35. 00	If line 34 is yes, were there new agreements or amended exilohysicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. 00				
	priysicians during the cost reporting period? IT yes, see it	ristructions.		Y/N	Date					
				1. 00	2. 00					
	Home Office Costs									
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	repared by the	home office?			36. 00 37. 00				
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of			38. 00				
39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other			,		39. 00				
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00				
	i nstructi ons.									
		1.	00	2.	00					
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position bold by the cost report preparer in columns 1, 2, and 2	CATHERI NE		WOERNER		41. 00				
42. 00	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	COMMUNITY HOSP	ΙΤΔΙ			42. 00				
	preparer.		I IAL							
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	12197031267		CATHERI NE. R. WOI G	ERNER@COMHS. OR	43. 00				

Heal th F	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI TAI	L AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der 0		Peri od:	Worksheet S-2	
						Part II Date/Time Pre	narod:
					10 00/30/2021	11/23/2021 10	: 28 am
			3	. 00			
С	Cost Report Preparer Contact Information						
	Enter the first name, last name and the t		REIMBURSEMENT	MANAGER			41. 00
	held by the cost report preparer in colum	ns 1, 2, and 3,					
	respecti vel y.						
42. 00 E	Enter the employer/company name of the co	st report					42. 00
	oreparer.	ļ					
	Enter the telephone number and email addr						43. 00
r	report preparer in columns 1 and 2, respe	cti vel y.					[

Health Financial Systems COMM
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0125

				Ť	06/30/2021	Date/Time Pre 11/23/2021 10	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	35p31.0111	Line Number		Avai I abl e	07.11 11041 0		
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	314			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		314	114, 610	0.00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00	39			0	8. 00
8. 01	NEONATAL INTENSIVE CARE	31. 01	32	11, 680	0. 00	0	8. 01
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00					12.00
13.00	NURSERY	43. 00	205	140 505	0.00	0	13.00
14.00	Total (see instructions)		385	140, 525	0.00	0	14.00
15. 00 16. 00	CAH visits SUBPROVIDER - IPF					U	15. 00 16. 00
17. 00	SUBPROVIDER - IPF	41. 00	14	5, 110		0	17. 00
18. 00	SUBPROVI DER - TRF	41.00	14	3, 110		U	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00					23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		399				27. 00
28.00	Observation Bed Days					0	28. 00
29.00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01

Provider CCN: 15-0125

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 07/01/2020 Part I
To 06/30/2021 Date/Time Prepared:
11/23/2021 10:28 am

				•		11/23/2021 10	: 28 am
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8.00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	26, 597	1, 436	62, 605			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)	18, 146	12, 611				2. 00
3.00	HMO IPF Subprovider	o	0	1			3. 00
4.00	HMO IRF Subprovider	712	153				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	26, 597	1, 436	62, 605			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	4, 143	55	11, 468			8. 00
8. 01	NEONATAL INTENSIVE CARE	0	619	4, 432			8. 01
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		139				13. 00
14. 00	Total (see instructions)	30, 740	2, 249	81, 257	0.00	2, 447. 75	
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	3, 612	6	4, 924	0.00	26. 54	
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	25, 743	0	46, 335	0.00	44. 99	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			11			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)			45.00/	0.00	2, 519. 28	
28. 00	Observation Bed Days		0	15, 826			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF	_		0			31. 00
32.00	Labor & delivery days (see instructions)	0	231	540			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33.00
33. U I	LTCH site neutral days and discharges	ı O		l		1	33. 01

| Period: | Worksheet S-3 | From 07/01/2020 | Part | To 06/30/2021 | Date/Time Prepared: Provi der CCN: 15-0125

				To	06/30/2021	Date/Time Prep 11/23/2021 10	
		Full Time	_	Di scha	arges		
		Equi val ents			_		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	5, 847	333	15, 249	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, 774	2, 287		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				18		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE						8. 01
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		_				13. 00
14. 00	Total (see instructions)	0. 00	0	5, 847	333	15, 249	14.00
15. 00	CAH visits						15. 00
16. 00	SUBPROVIDER - I PF		_		_		16. 00
17. 00	SUBPROVIDER - IRF	0. 00	0	337	2	459	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	0. 00					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)			0			33. 00
33.00	LTCH non-covered days LTCH site neutral days and discharges			0			33.00
33. UT	LIGHT SI LE HEUTT AT UAYS AND UI SCHAFGES	I		ı o	l		33.01

| Period: | Worksheet S-3 | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0125

Number Number Reput Per						To	06/30/2021		pared:
PART II - 990E DATA 1.00 2.00 3.00 4.00 5.00 6.00								Average Hourly	
Note 11 - MAGE_DATA 1.00 2.00 3.00 4.00 5.00					(from Wkst.	(col.2 ± col.	Salaries in		
SAMANES SAMANES 200.00 185,776,520 0 185,776,520 0 33,44 1.00 10741 541			1. 00	2.00				6. 00	
1.00 Total saturaries (see 1.00 185,726,520 0 185,726,520 0 35,44 1.00 1.00 1.00 0.									-
2.00 Non-physic clain anesthetist Part 0 0 0 0 0.00 0.00 2.00 2.00 3.00	1.00		200. 00	185, 726, 520	0	185, 726, 520	5, 240, 099. 01	35. 44	1.00
4.00 Physician-Part A - Administrative	2. 00	,		C	0	0	0.00	0.00	2. 00
Admin is trative Admin is trative Physicians - Part A - Teaching Physicians - Part B FGr Nospital - Bosed Risc and Non Physicians - Part B FGr Nospital - Bosed Risc and Non Physicians - Part B FGr Nospital - Bosed Risc and Folic Services Interns & residents (In an 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00	A Non-physician anesthetist Part		4, 310, 428	0	4, 310, 428	40, 639. 31	106. 07	3. 00
Physicians - Part A - Touching 9,433,496 0 9,433,496 0 9,433,496 143,115 5,00 Physician and from 9,433,496 0 9,433,496 0 9,433,496 0 0 0 0 0 0 0 0 0	4. 00	3		C	0	0	0. 00	0. 00	4. 00
Physician-Part B		Physicians - Part A - Teaching		C	1				
Nospital - based BMC and FDMC Services		Physician-Part B					·		
Interna's a residents (in an approved program) 0 0 0 0 0 0 0 0 0	6. 00	hospital-based RHC and FQHC		С	0	0	0. 00	0.00	6. 00
Contracted interins and register Contracted interins and personnel perso	7. 00	Interns & residents (in an	21. 00	C	0	0	0.00	0.00	7. 00
8	7. 01	Contracted interns and		C	0	0	0. 00	0. 00	7. 01
9.00 SNF	8. 00	programs) Home office and/or related		C	0	0	0. 00	0.00	8. 00
10.00 Excluded area salaries (see 9, 239, 310 448, 483 9, 687, 793 264, 812, 48 36.58 10.00	9. 00		44. 00	C	0	0	0.00	0.00	9. 00
11.00 Contract labor: Direct Patient		Excluded area salaries (see instructions)		9, 239, 310	448, 483	9, 687, 793			
12.00 Contract labor: Top level management and other management and other management and administrative services	11. 00	Contract Labor: Direct Patient		2, 337, 547	0	2, 337, 547	24, 386. 89	95. 85	11. 00
management and administrative services services	12. 00	Contract Labor: Top Level		C	0	0	0.00	0.00	12. 00
13. 00 Contract Labor: Physici an-Part 602, 916 0 602, 916 3, 538. 14 170. 40 13. 00 A - Administrative 14. 00 14. 00 0 0 0 0 0 0 0 0 0		management and administrative							
14. 00 Home office and/or related or organization salaries and wage-related costs 23,021,399 0 23,021,399 626,576.00 36.74 14.01 14.02 Related organization salaries 0 0 0 0 0 0 0 0 0	13. 00	Contract Labor: Physician-Part		602, 916	0	602, 916	3, 538. 14	170. 40	13. 00
14. 01 Home office salaries	14. 00	Home office and/or related organization salaries and		C	0	О	0. 00	0. 00	14. 00
14. 02 Rel ated organization salaries 0 0 0 0 0.00 14. 02	14. 01			23, 021, 399	0	23, 021, 399	626, 576, 00	36. 74	14. 01
- Admin i strative Home office and Contract Physicians Part A - Teaching Home office Physicians Part A - Teaching Home office Contract Physicians Part A - Teaching Home office Contract Physicians Part A - Teaching Home office Contract Physicians Part A - Teaching WAGE-RELATED COSTS 17. 00 Wage-related costs (core) (see instructions) Recomposition of the part A - Teaching WAGE-RELATED COSTS 18. 00 Vage-related costs (other) (see instructions) Value Vage-related (see instructions Value Vage-related (see instructions) Value Vage-related (see instruct	14. 02	Related organization salaries		C	0	0	0.00	0.00	14. 02
16.00 Home office and Contract 0 0 0 0 0.00 0.00 16.00	15. 00			C	0	0	0. 00	0. 00	15. 00
16. 01 Home office Physicians Part A 0 0 0 0 0 0 0 0 0	16. 00	Home office and Contract		C	0	0	0. 00	0. 00	16. 00
16.02 Home office contract Physician Part A - Teaching Wage-related costs (core) (see instructions) 17.00 Wage-related costs (other) (see instructions) 18.00	16. 01	Home office Physicians Part A		C	0	0	0. 00	0. 00	16. 01
17. 00 Wage-related costs (core) (see instructions) 17. 00 18. 00 1	16. 02	Home office contract		C	0	0	0.00	0.00	16. 02
18.00 Wage-rel ated costs (other) (see instructions) 18.00	17. 00			42, 530, 857	0	42, 530, 857			17. 00
19. 00 Excl uded areas 2, 410, 064 0 2, 410, 064 19. 00 20. 00 Non-physi ci an anestheti st Part A 0 0 0 0 21. 00 Non-physi ci an anestheti st Part B 628, 756 0 628, 756 21. 00 22. 00 Physi ci an Part A - Admini strati ve 0 0 0 0 0 22. 00 23. 00 Physi ci an Part B 0 0 0 0 0 22. 01 24. 00 Physi ci an Part B 1, 116, 148 0 1, 116, 148 0 23. 00 0 24. 00 25. 00 Interns & residents (in an approved program) 0 0 0 0 25. 00 25. 51 Rel ated organization wage-rel ated (core) 0 0 0 0 25. 51 25. 52 Home office: Physician Part A - Administrative - 0 0 0 0 25. 52	18. 00	Wage-related costs (other)							18. 00
A Non-physician anesthetist Part B Physician Part A - Teaching O O O O O O O O O O O O O O O O O O O		Excluded areas		2, 410, 064	0	2, 410, 064			19.00
B		A		628. 756	0	628. 756			
Administrative Physician Part A - Teaching 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		В		, 700 C	0	0			22. 00
23. 00 Physician Part B 1,116,148 0 1,116,148 23. 00 24. 00 Wage-related costs (RHC/FQHC) 0 0 0 24. 00 25. 00 Interns & residents (in an approved program) 0 0 0 0 25. 00 25. 50 Home office wage-related (core) 5,745,347 0 5,745,347 25. 50 25. 51 Related organization wage-related (core) 0 0 0 25. 51 25. 52 Home office: Physician Part A - Administrative - 0 0 0 25. 52	22 ∩1	Admi ni strati ve		r					22 01
25. 00 Interns & residents (in an approved program) 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A - Administrative -				1, 116, 148	1	_			23. 00
approved program) 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A	24. 00	Wage-related costs (RHC/FQHC)		C	0	0			24. 00 25. 00
25. 51 Related organization 0 0 0 0 25. 51 wage-related (core) 0 0 0 0 25. 52 Home office: Physician Part A 0 0 0 0 25. 52 - Administrative -	25. 50	approved program) Home office wage-related		5, 745, 347	0	5, 745, 347			25. 50
25. 52 Home office: Physician Part A 0 0 0 0 25. 52 - Administrative -	25. 51	Related organization		C	0	0			25. 51
	25. 52	Home office: Physician Part A		C	О	0			25. 52

Provi der CCN: 15-0125

					Т	o 06/30/2021	Date/Time Pre 11/23/2021 10	
		Wkst. A Line		Recl assi fi cati		Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries		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)							
27 00	OVERHEAD COSTS - DIRECT SALARIE		1 001 042		1 001 042	22 021 00	20.42	27.00
26. 00	Employee Benefits Department	4. 00	1, 001, 843		1, 001, 843			
27. 00	Administrative & General	5. 00	20, 238, 647	0	20, 238, 647	·		
28. 00	Administrative & General under		2, 809, 351	0	2, 809, 351	23, 175. 34	121. 22	28. 00
29. 00	contract (see inst.)	6. 00	0	_	_	0.00	0.00	29. 00
30.00	Maintenance & Repairs Operation of Plant	7.00	0 0E1 (0E	0	2 051 405			
31.00	, ·	7. 00 8. 00	3, 851, 685 96, 188		3, 851, 685 96, 188	·		
32.00	Laundry & Linen Service Housekeeping	9.00	3, 604, 401	0	3, 604, 401	·		32.00
32.00	, ,	9.00	3, 004, 401	0	3, 604, 401	0.00		
33.00	Housekeeping under contract (see instructions)		U	U		0.00		
34.00	Di etary	10. 00	3, 409, 226	-1, 157, 061	2, 252, 165	117, 168. 00	19. 22	34.00
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36.00	Cafeteri a	11. 00	0	1, 157, 061	1, 157, 061	60, 196. 00	19. 22	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	5, 960, 243	-293, 389	5, 666, 854	154, 037. 00	36. 79	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41. 00
	Records Library							
42.00	Social Service	17. 00	849, 850	0	849, 850	·		42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

Provider CCN: 15-0125

| Peri od: | Worksheet S-3 | From 07/01/2020 | Part III | To 06/30/2021 | Date/Time Prepared: | 11/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 | 12/2020 |

					'	0 00/30/2021	11/23/2021 10:			
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly			
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷			
				(from	(col.2 ± col.	Salaries in	col . 5)			
				Worksheet A-6)	3)	col. 4				
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00			
	PART III - HOSPITAL WAGE INDEX SUMMARY									
1.00	Net salaries (see		174, 791, 947	0	174, 791, 947	5, 156, 737. 00	33. 90	1.00		
	instructions)									
2.00	Excluded area salaries (see		9, 239, 310	448, 483	9, 687, 793	264, 812. 48	36. 58	2. 00		
	instructions)									
3.00	Subtotal salaries (line 1		165, 552, 637	-448, 483	165, 104, 154	4, 891, 924. 52	33. 75	3.00		
	minus line 2)									
4.00	Subtotal other wages & related		25, 961, 862	0	25, 961, 862	654, 501. 03	39. 67	4. 00		
	costs (see inst.)									
5.00	Subtotal wage-related costs		48, 276, 204	0	48, 276, 204	0.00	29. 24	5.00		
	(see inst.)									
6.00	Total (sum of lines 3 thru 5)		239, 790, 703	-448, 483	239, 342, 220	5, 546, 425. 55	43. 15	6. 00		
7.00	Total overhead cost (see		41, 821, 434	-293, 389	41, 528, 045	1, 332, 104. 34	31. 17	7. 00		
	instructions)									

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0125	Period: Worksheet S-3

	To 06/30/2021	Date/Time Prep 11/23/2021 10:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		l
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	5, 976, 300	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		l
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		l
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)	23, 800, 326	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	1, 428, 085	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	120, 172	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	111, 700	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	1, 583, 272	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		l
	TAXES		l
	FICA-Employers Portion Only	10, 576, 793	17. 00
	Medicare Taxes - Employers Portion Only	2, 591, 056	
	Unempl oyment Insurance	498, 121	19. 00
	State or Federal Unemployment Taxes	0	20. 00
	OTHER		l
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		1
	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	46, 685, 825	24. 00
	Part B - Other than Core Related Cost		l
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Heal th	Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Peri od:	Worksheet S-3	
			From 07/01/2020 To 06/30/2021		oorod
			10 00/30/2021	11/23/2021 10:	
	Cost Center Description	· · · · · · · · · · · · · · · · · · ·	Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identific	cation:			
1.00	Total facility's contract labor and benefit co	st	2, 337, 547	46, 685, 825	1. 00
2.00	Hospi tal		2, 337, 547	46, 685, 825	2. 00
3.00	Subprovider - IPF				3. 00
4.00	Subprovider - IRF		0	0	4. 00
5.00	Subprovider - (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 10.00 11.00

12.00

13.00 14. 00 15.00 16.00 0 17. 00 0 18. 00

9. 00 Hospi tal -Based NF 10. 00 Hospi tal -Based NF 11. 00 Hospi tal -Based HHA

12.00 Separately Certified ASC

12.00 | Separately Certified ASC 13.00 | Hospital - Based Hospice 14.00 | Hospital - Based Health Clinic RHC 15.00 | Hospital - Based Health Clinic FQHC 16.00 | Hospital - Based - CMHC 17.00 | Renal Dialysis 18.00 | Other

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOME I	HEALTH AGENCY STATISTICAL DATA			F	eriod: rom 07/01/2020 o 06/30/2021	Worksheet S-4 Date/Time Pre	
			Component	0011. 13 7407 1	Home Health	11/23/2021 10 PPS	
					Agency I	113	
						00	
0. 00	County	Title V	Title XVIII	Title XIX	LAKE Other	Total	0. 00
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours		1, 535	C	864	2, 399	1.00
2.00	Unduplicated Census Count (see instructions)	0.00		0.00		2, 598. 00	
				Number of Empi	oyees (Full Ti	me Equivalent)	
			er of hours in	Staff	Contract	Total	
		your norma	work week				
)	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		10. 00	1. 19	0.00	1. 19	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			17. 22 12. 62			1
7. 00	Nursi ng Supervi sor			0.00			
8.00	Physical Therapy Service			7.50			1
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			1. 40 2. 57			1
11. 00	Occupational Therapy Supervisor			0. 42			1
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 04 0. 69			1
14. 00	Medical Social Service			0. 02	0.00	0. 02	14. 00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. 00 1. 32			1
17. 00	Home Health Aide Supervisor			0.00			
18. 00	Other (specify)	1		0.00	0.00	0.00	18. 00
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where			1			19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			23844			20. 00
	during this cost reporting period (line 20 contains the first code).						
	contains the irrst code).		oi sodes				
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	10, 252	2, 873	304	77	13, 506	21. 00
22. 00	Skilled Nursing Visit Charges	2, 058, 747	576, 935	60, 936	14, 070	2, 710, 688	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	5, 070 1, 188, 350		1			
25.00	Occupational Therapy Visits	1, 681	1, 508	18	11	3, 218	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	393, 550 138		i .		754, 270 311	1
28. 00	Speech Pathology Visit Charges	32, 520		l .			
29. 00 30. 00	Medical Social Service Visits	1, 598	10 2, 620	1	_		
31. 00	Medical Social Service Visit Charges Home Health Aide Visits	1, 056		l .			
32.00	Home Health Aide Visit Charges	159, 723	71, 448	310	930	232, 411	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	18, 203	6, 990	391	159	25, 743	33. 00
34.00	Other Charges	2 924 499		1			34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3, 834, 488	1, 504, 373	81, 221	32, 860	5, 452, 942	35. 00
36. 00	Total Number of Episodes (standard/non outlier)	1, 722		228	20	1, 970	36. 00
37. 00	Total Number of Outlier Episodes		297		3		37. 00
38. 00	Total Non-Routine Medical Supply Charges	452, 091	95, 592	9, 887	657	558, 227	38.00

	Financial Systems COMMUNITY HOSPI TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN:	15-0125	Peri od:	u of Form CMS-2 Worksheet S-10	
103111	AL UNCOME ENSATED AND TRIDICENT CARE DATA	TOVI del CCIV.		From 07/01/2020		
				To 06/30/2021	Date/Time Prep 11/23/2021 10	
	Uncompensated and indigent care cost computation				1. 00	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line	202 column	8)	0. 217038	1.
00	Medicaid (see instructions for each line)	ded by Title .	202 001 411111		0.217030	١.
00	Net revenue from Medicaid		29, 221, 185	2.		
00	Did you receive DSH or supplemental payments from Medicaid?		, ,	3.		
00	If line 3 is yes, does line 2 include all DSH and/or supplementa	l payments fi	rom Medica	i d?		4.
00	If line 4 is no, then enter DSH and/or supplemental payments fro		0	5.		
00	Medi cai d charges				260, 572, 036	6.
00	Medicaid cost (line 1 times line 6)		6.11		56, 554, 034	7.
00	Difference between net revenue and costs for Medicaid program (I	ine 7 minus s	sum of lin	es 2 and 5; if	27, 332, 849	8.
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	oach Lino)				
00	Net revenue from stand-allone CHIP	each fille)			0	9.
0. 00	Stand-allone CHIP charges		0	10		
. 00	Stand-alone CHIP cost (line 1 times line 10)		0	11.		
2. 00	Difference between net revenue and costs for stand-alone CHIP (I	f < zero then	0	12		
	enter zero)					
	Other state or local government indigent care program (see instru			, ,		
. 00	Net revenue from state or local indigent care program (Not inclu				337	13
. 00	Charges for patients covered under state or local indigent care	program (Not	i nci uaea	in lines 6 or	1, 577	14
. 00	10) State or local indigent care program cost (line 1 times line 14)				342	15
. 00	Difference between net revenue and costs for state or local indi	e 15 minus line	5	16		
	13; if < zero then enter zero)	3 p.	-9 (_	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/lo	ocal indig	ent care program	ıs (see	
	instructions for each line)					
7. 00					0	17.
3. 00 9. 00	Government grants, appropriations or transfers for support of ho			(our of lines	0	18. 19.
7. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	rndrgent care	e programs	(Sull of Titles	27, 332, 854	19.
	0, 12 and 10)	l	Jni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col. 2)	
			1. 00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)					
0. 00	Charity care charges and uninsured discounts for the entire faci	lity	11, 362, 49	2 732, 795	12, 095, 287	20.
. 00	(see instructions) Cost of patients approved for charity care and uninsured discoun	ts (soo	2, 466, 09	3 732, 795	3, 198, 888	21.
1.00	instructions)	113 (366	2, 400, 09	132, 143	3, 170, 000	21.
2. 00	Payments received from patients for amounts previously written o	ff as		ol ol	0	22.
	charity care					
	Cost of charity care (line 21 minus line 22)		2, 466, 09	3 732, 795	3, 198, 888	23.
3. 00						
3. 00					1. 00	
				6 1 11 11		0.4
	Does the amount on line 20 column 2, include charges for patient		a length	of stay limit	N	24.
ł. 00	imposed on patients covered by Medicaid or other indigent care p	rogram?	_		N	
1. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the	rogram?	_			24. 25.
I. 00 5. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit	rogram? indigent ca	_		N O	25.
5. 00 5. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the	orogram? e indigent ca ructions)	re program		N	25. 26.
5. 00 5. 00 7. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst	rogram? indigent cal ructions) (see instruc	re program tions)		N 0 14, 432, 257	25 26 27
4. 00 5. 00 6. 00 7. 00 7. 01 3. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	rogram? indigent cal ructions) (see instruction	re program tions) ns)		N 0 14, 432, 257 986, 306 1, 517, 393 12, 914, 864	25 26 27 27 28
3. 00 4. 00 5. 00 7. 00 7. 01 3. 00 9. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expe	rogram? indigent cal ructions) (see instruction	re program tions) ns)		N 0 14, 432, 257 986, 306 1, 517, 393 12, 914, 864 3, 334, 103	25 26 27 27 28 29
4. 00 5. 00 7. 00 7. 01 3. 00 9. 00 0. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	rogram? indigent cal ructions) (see instruction e instruction ense (see ins	re program tions) ns)		N 0 14, 432, 257 986, 306 1, 517, 393 12, 914, 864	25 26 27 27 28 29 30

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	COMMUNITY H	OSPI TAL Provi der CO	`N: 15_0125	In Lie Period:	u of Form CMS- Worksheet A	2552-10
KLOLAS	STITICATION AND ADDUSTMENTS OF THE DALANCE OF	EXI ENGLG	Trovider co	F	From 07/01/2020 To 06/30/2021	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	11/23/2021 10 Reclassi fi ed	:28 am
	·			+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
		1.00	2.00	3. 00	4.00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		14, 001, 112	14, 001, 112		13, 945, 889	1. 00 2. 00
3. 00	00300 OTHER CAP REL COSTS		13, 943, 393 0	13, 943, 393 (36, 105	13, 979, 498 0	3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 001, 843	24, 481, 447	25, 483, 290	-4, 768	25, 478, 522	4. 00
5. 01	00505 PURCHASING & RECEIVING STORES	640, 606	-129, 913	510, 693		510, 120	
5. 02 5. 03	00506 ADMITTING 00507 CASHIERING/ACCOUNTS RECEIVABLE	4, 093, 539	529, 379 -189	4, 622, 918 -189		4, 622, 918 -189	
5. 04	00508 OTHER ADMIN & GENERAL	15, 504, 502	92, 223, 296	107, 727, 798		106, 263, 692	
6.00	00600 MAINTENANCE & REPAIRS	0	0		o	0	6. 00
7.00	00700 OPERATION OF PLANT	3, 851, 685	10, 971, 507	14, 823, 192		14, 823, 192	
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	96, 188 3, 604, 401	1, 503, 545 1, 634, 056	1, 599, 733 5, 238, 457		1, 599, 733 5, 237, 586	1
10. 00	01000 DI ETARY	3, 409, 226	2, 420, 322				
11. 00	01100 CAFETERI A	0	0			1, 978, 497	
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	7 000 000	0	0	12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	5, 960, 243	1, 263, 746	7, 223, 989	-318, 604	6, 905, 385 0	13. 00 14. 00
15. 00	01500 PHARMACY	Ö	0	(o o	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	2, 780	2, 780		2, 780	1
17. 00	01700 SOCIAL SERVICE	849, 850	95, 781	945, 63	0	945, 631	
19. 00 21. 00	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	(0	
22. 00	02200 I &R SERVI CES-SALARI & TRINGES AITRV	0	0	(0	00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	134, 167	16, 207	150, 374	155, 094	305, 468	23. 00
00.00	INPATIENT ROUTINE SERVICE COST CENTERS	24 247 224	7 540 004	40 405 000	000 077	44 5/7 045	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	34, 947, 236 12, 184, 605	7, 548, 086 2, 883, 341	42, 495, 322 15, 067, 946		41, 567, 045 15, 136, 441	
31. 01	02060 NEONATAL INTENSIVE CARE	3, 328, 457	852, 763	4, 181, 220		4, 180, 517	
41. 00	04100 SUBPROVI DER - I RF	1, 838, 669	834, 587	2, 673, 256		2, 673, 256	
43. 00	04300 NURSERY	0	0	(1, 554, 737	1, 554, 737	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	15, 710, 179	16, 538, 653	32, 248, 832	293, 042	32, 541, 874	50.00
51. 00	05100 RECOVERY ROOM	6, 022, 993	1, 111, 273	7, 134, 266			
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 223, 590	558, 430	2, 782, 020		2, 780, 504	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	13, 412, 312 4, 310, 385	2, 619, 267 2, 406, 236	16, 031, 579 6, 716, 62		16, 031, 579 6, 702, 099	
55. 00	05500 RADI OLOGY - THERAPEUTI C	1, 425, 401	1, 587, 986	3, 013, 387		3, 013, 031	1
56.00	05600 RADI OI SOTOPE	861, 412	1, 537, 539			2, 398, 951	
57. 00	05700 CT SCAN	1, 482, 885	1, 629, 168			3, 112, 053	
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	964, 845 2, 993, 570	1, 039, 680 3, 374, 941			2, 004, 525 6, 759, 260	
	06000 LABORATORY	6, 503, 801	13, 022, 435				
	06300 BLOOD STORING, PROCESSING, & TRANS.	380, 528	2, 352, 727	2, 733, 255		2, 733, 255	
64.00	06400 I NTRAVENOUS THERAPY	375, 756 3, 725, 270	124, 190	499, 946		499, 946	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	5, 516, 275	1, 058, 710 1, 947, 130	4, 783, 980 7, 463, 405		4, 824, 341 7, 594, 946	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 441, 502	727, 776	2, 169, 278		2, 168, 844	1
68. 00	06800 SPEECH PATHOLOGY	1, 215, 845	348, 686	1, 564, 531		1, 564, 212	
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	2, 927, 120 820, 699	1, 082, 648 361, 648	4, 009, 768		4, 009, 768	
70. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	820, 699	29, 289, 454	1, 182, 347 29, 289, 454		1, 392, 498 28, 980, 545	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	37, 850, 472	37, 850, 472		37, 466, 985	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 427, 835	18, 131, 763	22, 559, 598		22, 405, 712	
74. 00 76. 97	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON	120, 560 761, 042	1, 707, 109 116, 737	1, 827, 669 877, 779		1, 827, 669 897, 582	
70. 77	OUTPATIENT SERVICE COST CENTERS	701,042	110, 737	077, 773	7 17, 603	077, 302	70. 97
90. 00	09000 CLI NI C	2, 205, 595	798, 765			2, 999, 801	90.00
91.00	09100 EMERGENCY	7, 185, 429	2, 655, 171	9, 840, 600	2, 376	9, 842, 976	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	4, 207, 543	1, 030, 652	5, 238, 195	-1, 194	5, 237, 001	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	182, 667, 589	320, 084, 492	502, 752, 08	-439, 734	502, 312, 347	118. 00
100 5	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0 816, 605	0 208, 807	1, 025, 412		0 1, 380, 587	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	65, 207	289, 512	354, 719		354, 719	
194.00	07950 OTHER NONREIMBURSEABLE	0	672, 301	672, 301	0	672, 301	194. 00
	07951 ADVERTI SI NG	471 500	215, 939	215, 939		300, 498	
	207952 RETAIL PHARMACY 307953 FITNESS POINTE	671, 509 938, 290	11, 822, 639 607, 432			12, 494, 148 1, 545, 722	
	1	,55,275	337, 132	., 515, 722	<u>ı</u>	., 5 , 5, , 722	1

Health Financial Systems	COMMUNI TY I	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
					11/23/2021 10	28 am
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
194.04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	249, 150	83, 213	332, 363	0	332, 363	194. 04
194.05 07955 EINSTEIN BAGELS	17, 954	16, 412	34, 366	0	34, 366	194. 05
194.06 07956 NONRTHWESTERN IMAGING	300, 216	440, 524	740, 740	0	740, 740	194. 06
200.00 TOTAL (SUM OF LINES 118 through 199)	185, 726, 520	334, 441, 271	520, 167, 79	0	520, 167, 791	200. 00

 Health Financial
 Systems
 COMMUN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0125 Period:

				11/23/2021 10	<u>: 28 am</u>
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-90, 668	13, 855, 221		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2, 208, 173	16, 187, 671		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 828, 991	28, 307, 513		4. 00
5. 01	00505 PURCHASING & RECEIVING STORES	O	510, 120		5. 01
5. 02	00506 ADMITTING	9, 560	4, 632, 478	•	5. 02
5. 03	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE	5, 941, 364	5, 941, 175		5. 03
5. 04	00508 OTHER ADMIN & GENERAL	-48, 853, 140	57, 410, 552	•	5. 04
6. 00	00600 MAINTENANCE & REPAIRS	0	07, 110, 002	1	6. 00
7. 00	00700 OPERATION OF PLANT	124	14, 823, 316	l control of the cont	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0			8.00
		7	1, 599, 733	1	
9.00	00900 HOUSEKEEPI NG	1	5, 237, 593	•	9.00
10.00	01000 DI ETARY	-1, 176	3, 843, 599	l .	10.00
11. 00	01100 CAFETERI A	-1, 548, 225	430, 272	1	11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	l .	12. 00
13. 00	01300 NURSING ADMINISTRATION	305, 038	7, 210, 423		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0		14. 00
15. 00	01500 PHARMACY	0	0		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	5, 041, 845	5, 044, 625		16. 00
17.00	01700 SOCIAL SERVICE	0	945, 631		17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		19.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	O	0		21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	o	0		22. 00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	O	305, 468		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1		1	
30. 00	03000 ADULTS & PEDIATRICS	-103, 801	41, 463, 244		30.00
31. 00	03100 NTENSI VE CARE UNI T	-1, 044, 659	14, 091, 782	•	31.00
31. 00	02060 NEONATAL INTENSIVE CARE	-356, 161	3, 824, 356	•	31. 01
		1		•	41. 00
41. 00	04100 SUBPROVI DER - I RF	0	2, 673, 256		
43. 00	04300 NURSERY	0	1, 554, 737		43. 00
	ANCI LLARY SERVI CE COST CENTERS	1			
50. 00	05000 OPERATI NG ROOM	-7, 415	32, 534, 459	•	50. 00
51. 00	05100 RECOVERY ROOM	0	7, 131, 947	•	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-4, 832	2, 775, 672		52. 00
53.00	05300 ANESTHESI OLOGY	-14, 373, 741	1, 657, 838		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-49, 227	6, 652, 872		54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	-6, 216	3, 006, 815		55.00
56.00	05600 RADI OI SOTOPE	O	2, 398, 951		56. 00
57. 00	05700 CT SCAN	-4, 540	3, 107, 513	l .	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	-5, 465	1, 999, 060		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-8, 944	6, 750, 316		59.00
60. 00	06000 LABORATORY	-25, 379	19, 809, 571		60.00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	23, 37 9	2, 733, 255		63.00
64. 00	06400 I NTRAVENOUS THERAPY			•	64.00
	1 1	1	499, 946	•	
65. 00	06500 RESPI RATORY THERAPY	-1, 896	4, 822, 445	•	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	7, 594, 946	l .	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	2, 168, 844		67. 00
	06800 SPEECH PATHOLOGY	0	1, 564, 212		68. 00
69. 00	06900 ELECTROCARDI OLOGY	12	4, 009, 780	•	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	-2, 292	1, 390, 206		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	28, 980, 545		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	37, 466, 985		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-1, 092, 570	21, 313, 142		73. 00
74.00	07400 RENAL DIALYSIS	ol	1, 827, 669	•	74. 00
	07697 CARDI AC REHABI LI TATI ON	-29	897, 553	•	76. 97
	OUTPATIENT SERVICE COST CENTERS		211, 222	1	
90. 00	09000 CLINIC	-215, 141	2, 784, 660		90.00
91. 00	09100 EMERGENCY	-6, 440	9, 836, 536	•	91.00
		-0, 440	7, 030, 330		
7∠. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
404.00	OTHER REIMBURSABLE COST CENTERS	0.4.005	· · ·	T	
101.00	10100 HOME HEALTH AGENCY	266, 225	5, 503, 226		101. 00
	SPECIAL PURPOSE COST CENTERS				1
118.00	9 ,	-51, 200, 618	451, 111, 729		118. 00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191.00	19100 RESEARCH	0	1, 380, 587		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	102	354, 821	•	192.00
	07950 OTHER NONREI MBURSEABLE	0	672, 301		194. 00
	07951 ADVERTI SI NG		300, 498		194. 01
	07952 RETAIL PHARMACY		12, 494, 148	•	194. 02
	07953 FITNESS POINTE	0	1, 545, 722	•	194. 02
		1		•	194. 03
	07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	332, 363		
194.05	07955 EINSTEIN BAGELS	0	34, 366		194. 05

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	CN: 15-0125	Peri od: From 07/01/2020	Worksheet A	
					Date/Time Pro 11/23/2021 10	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For Allocation				
	6. 00	7.00				
194.06 07956 NONRTHWESTERN I MAGING	0	740, 740				194. 06
200.00 TOTAL (SUM OF LINES 118 through 199)	-51, 200, 516	468, 967, 275				200. 00

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

| Peri od: | Worksheet A-6 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared: Provider CCN: 15-0125

					10 06/	11/23/2021 10: 28 am
		Increases			<u> </u>	117, 207, 2021 131 20 4111
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4.00	5. 00		
	A - BUILDING INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	327, 584		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	<u> 27, 5</u> 00		2. 00
	TOTALS		0	355, 084		
	B - CAFETERIA EXPENSE					
1.00	CAFETERI A	11. 00	<u>1, 157, 0</u> 61	<u>821, 4</u> 36		1. 00
	TOTALS		1, 157, 061	821, 436		
	C - RECLASS NURSERY	40.00	4 040 050	0.44 (0.4		
1. 00	NURSERY	43.00	1, 213, 053	<u>341, 684</u>		1.00
	TOTALS		1, 213, 053	341, 684		
1 00	D - RECLASS PRECEPTOR TIME	22.00	155 004	0		1.00
1. 00	PARAMED ED PRGM-(PHARMACY)	23.00	155, 094	0		1.00
	TOTALS E - COVI D COSTS		155, 094	U		
1.00	NURSING ADMINISTRATION	13.00	0	23, 836		1.00
2.00	ADULTS & PEDIATRICS	30.00	o	642, 941		2. 00
3.00	INTENSIVE CARE UNIT	31.00	o	68, 495		3.00
4. 00	LABORATORY	60.00	Ö	309, 106		4.00
5. 00	RESPIRATORY THERAPY	65. 00	0	40, 361		5. 00
6. 00	PHYSI CAL THERAPY	66.00	o	2, 126		6. 00
7. 00	DRUGS CHARGED TO PATIENTS	73. 00	ol	1, 208		7.00
8.00	EMERGENCY	91.00	O	2, 376		8.00
	TOTALS			1, 090, 449		
	F - INTEREST EXPENSE		<u> </u>	<u> </u>		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8, 605		1. 00
	TOTALS		0	8, 605		
	G - NEUROSCI ENCE RESEARCH					
1.00	RESEARCH	1 <u>91.</u> 00	29 <u>3, 3</u> 89	4 <u>2, 6</u> 73		1.00
	TOTALS		293, 389	42, 673		
	H - INVENTORY ADJ EXPENSE					
1.00	OPERATING ROOM	50. 00	0	301, 647		1. 00
2.00	CARDI AC CATHETERI ZATI ON	<u> </u>	0	39 <u>0, 7</u> 49		2. 00
	TOTALS	IECC LEACE	U	692, 396		
1 00	- SLEEP CLINIC & LAKE BUSIN PHYSICAL THERAPY		0	122 740		1 00
1. 00 2. 00	ELECTROENCEPHALOGRAPHY	66. 00 70. 00	0	133, 740 210, 151		1. 00 2. 00
3.00	CARDI AC REHABI LI TATI ON	76. 97	0	19, 803		3.00
4.00	RESEARCH	191. 00	•	19, 113		4.00
4.00	TOTALS			382, 807		4.00
	J - ADVERTISING NON-REIMBURSA	ABI F	<u> </u>	002,007		
1.00	ADVERTI SI NG	194. 01	0	84, 559		1.00
2.00		0.00	O	0		2. 00
3.00		0.00	o	0		3.00
4.00		0.00	O	0		4. 00
5.00		0.00	O	0		5. 00
6.00		0.00	O	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10. 00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17. 00
18. 00		0.00	0	<u>0</u> 84, 559		18. 00
500 00	Grand Total: Increases		2, 818, 597	3, 819, 693		500. 00
555.00	p. aa rotar. Thereases	ı	2,010,077	5, 517, 675		1 300: 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0125

					1	To 06/30/2021 Date/Time P 11/23/2021	repared: 10:28 am
		Decreases				1172072021	10. 20 am
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - BUILDING INSURANCE						
1.00	OTHER ADMIN & GENERAL	5. 04	0	355, 084			1.00
2.00	TOTALS — — — —		아	0			2. 00
	B - CAFETERIA EXPENSE		0	355, 084			
1. 00	DI ETARY	10.00	1, 157, 061	821, 436	0		1.00
1.00	TOTALS — — — —		1, 157, 061	821, 436			1.00
	C - RECLASS NURSERY	L	17 1077 001	02.17.100			
1.00	ADULTS & PEDIATRICS	30.00	1, 213, 053	341, 684	0		1. 00
	TOTALS		1, 213, 053	341, 684			
	D - RECLASS PRECEPTOR TIME						
1.00	DRUGS CHARGED TO PATIENTS	73. 00	15 <u>5, 0</u> 94	0			1. 00
	TOTALS		155, 094	0			
	E - COVI D COSTS	= -,1					
1.00	OTHER ADMIN & GENERAL	5. 04	0	1, 090, 449 0			1.00
2. 00 3. 00		0. 00 0. 00	0	0	0		2. 00 3. 00
4. 00		0.00	0	0	0		4. 00
5. 00		0.00	0	0	0		5. 00
6. 00		0.00	o	0	0		6. 00
7.00		0.00	O	0	0		7. 00
8.00		0.00	0	0	0		8. 00
	TOTALS			1, 090, 449			
	F - INTEREST EXPENSE						
1.00	OPERATING ROOM	5000	•	<u>8, 6</u> 05			1. 00
	TOTALS		0	8, 605			
1 00	G - NEUROSCI ENCE RESEARCH	12.00	202 200	42 (72			1 00
1. 00	NURSING ADMINISTRATION TOTALS	1300	29 <u>3, 3</u> 89 293, 389	4 <u>2, 6</u> 73 42, 673			1. 00
	H - INVENTORY ADJ EXPENSE		293, 309	42,073			
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	ol	308, 909	0		1.00
	PATI ENT		1				
2.00	IMPL. DEV. CHARGED TO	72. 00	0	383, 487	0		2. 00
	PATI ENTS						
	TOTALS		0	692, 396			
	I - SLEEP CLINIC & LAKE BUSIN			0.70/			
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	3, 786			1.00
2. 00 3. 00	CAP REL COSTS-BLDG & FIXT	1. 00 0. 00	0	379, 021 0	10		2. 00 3. 00
4. 00		0.00	0	0	0		4. 00
4.00	TOTALS — — — —		— —	382, 807	<u> </u>		4.00
	J - ADVERTISING NON-REIMBURSA	BLE	-,				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 768	0		1. 00
2.00	PURCHASING & RECEIVING	5. 01	0	573	0		2. 00
	STORES						
3.00	OTHER ADMIN & GENERAL	5. 04	0	18, 573			3. 00
4. 00	HOUSEKEEPI NG	9.00	0	871			4. 00
5.00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	6, 276 6, 279			5. 00 6. 00
6. 00 7. 00	ADULTS & PEDIATRICS	30.00	ol Ol	6, 378 16, 481	0		7. 00
8. 00	NEONATAL INTENSIVE CARE	31. 01	0	703			8.00
9. 00	RECOVERY ROOM	51.00	o	2, 319			9. 00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	O	1, 516			10. 00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	14, 522			11. 00
12.00	RADI OLOGY - THERAPEUTI C	55.00	О	356			12. 00
13.00	LABORATORY	60.00	0	392			13. 00
14. 00	PHYSI CAL THERAPY	66.00	0	4, 325			14. 00
15. 00	OCCUPATIONAL THERAPY	67.00	0	434			15. 00
16.00	SPEECH PATHOLOGY	68.00	O O	319			16.00
17.00	CLINIC	90.00	0	4, 559 1, 104			17.00
18. 00	HOME HEALTH AGENCY	101.00	;				18. 00
500 00	Grand Total: Decreases		2, 818, 597	3, 819, 693			500. 00
300.00	orana rotar. Decreases	.	2,010,097	5, 517, 073			1 300. 00

Provider CCN: 15-0125

					To 06/30/2021	Date/Time Pre	pared:
				Acqui si ti ons		11/23/2021 10	: 28 am
		Begi nni ng	Purchases	Donation	Total	Di sposal s and	
		Bal ances	i ui chases	Donation	Total	Retirements	
		1.00	2.00	3. 00	4, 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET					0.00	
1.00	Land	13, 592, 644	25, 235		0 25, 235	0	1.00
2.00	Land Improvements	1, 242, 188	323, 530		0 323, 530	0	2. 00
3.00	Buildings and Fixtures	395, 121, 780	2, 170, 212		0 2, 170, 212	18, 036	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fixed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	152, 801, 806	12, 361, 188		0 12, 361, 188	3, 841, 755	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	562, 758, 418	14, 880, 165		0 14, 880, 165	3, 859, 791	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	10.00 Total (line 8 minus line 9)		14, 880, 165		0 14, 880, 165	3, 859, 791	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
		4.00	Assets				
	DART I ANALYGIC OF GUANGES IN CARLTAL ACCE	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						4 00
1.00	Land	13, 617, 879	0				1.00
2.00	Land Improvements	1, 565, 718	0				2.00
3.00	Buildings and Fixtures	397, 273, 956	0				3. 00
4.00	Building Improvements	0	U				4. 00 5. 00
5.00	Fixed Equipment	1/1 221 220	0				
6. 00 7. 00	Movable Equipment HIT designated Assets	161, 321, 239	0				6. 00 7. 00
8. 00	Subtotal (sum of lines 1-7)	573, 778, 792	0				8.00
9. 00	Reconciling Items	3/3, //0, /92	0				9.00
10.00	Total (line 8 minus line 9)	573, 778, 792	0				10.00
10.00	Tiotal (Time o militas Time 7)	313,110,192	υĮ			l	10.00

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lieu of Form CMS-2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 07/01/2020 To 06/30/2021	Worksheet A-7 Part II Date/Time Pre 11/23/2021 10	pared:
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	12, 756, 561	1, 244, 551		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11, 451, 121	2, 492, 272		0	0	2.00
3.00	Total (sum of lines 1-2)	24, 207, 682	3, 736, 823		0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	14, 001, 112				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	o	13, 943, 393				2. 00
3.00	Total (sum of lines 1-2)	0	27, 944, 505	1			3. 00

Provider CCN: 15-0125	Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description	RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		From 07/01/2020	Part III Date/Time Prep	pared:
Leases For Ratio			COMI	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPI				
Col. 1 - col. 2) Col. 1 - col. 2) Col. 1 - col. 2) Col. 2 - col. 2		Cost Center Description	Gross Assets				Insurance	
PART - RECONCILIATION OF CAPITAL COSTS CENTERS				Leases	(col. 1 - col			
1.00 CAP REL COSTS-BLDG & FIXT 412, 457, 552 0 412, 457, 552 0 718844 0 1.00				2.00	3.00	4. 00	5. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP 161, 321, 239 0 161, 321, 239 0 573, 778, 791 1. 000000 0 3. 00								
Total (sum of lines 1-2) 573,778,791 0 573,778,791 1.000000 0 3.00								
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL								
Taxes	3.00	Total (sum of lines 1-2)						3.00
Capital -Relate d Costs through 7) Cost Center Description			ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL			F CAPITAL		
A Costs through 7)		Cost Center Description				Depreciation	Lease	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
PART - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 13,094,678 432,959 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 13,667,899 2,492,272 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 26,762,577 2,925,231 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Capital -Related Costs (see instructions) Capit		DART LLL DESCRIPTION OF CARLEY COOTS OF		7.00	8.00	9. 00	10.00	
2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 13, 667, 899 2, 492, 272 2. 00 0 0 0 26, 762, 577 2, 925, 231 3. 00	1 00			1	ı	0 12 004 (70	422.050	1 00
3.00 Total (sum of lines 1-2)			Ĭ	Ĭ				
SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Instructions Instr			0					
Cost Center Description	3.00	Total (Suil of Titles 1-2)	0	SI SI	IMMADV OF CADI		2, 920, 231	3.00
instructions instructions Capital -Relate d Costs (see instructions linstructions				30	DIVINIANT OF CAPT	IAL		
Costs (see instructions) 11.00 12.00 13.00 14.00 15.00		Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
Instructions		·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
11.00 12.00 13.00 14.00 15.00							through 14)	
PART - RECONCILIATION OF CAPITAL COSTS CENTERS								
1. 00 CAP REL COSTS-BLDG & FIXT 0 327, 584 0 0 13,855, 221 1.00 2. 00 CAP REL COSTS-MVBLE EQUIP 0 27,500 0 0 16, 187, 671 2.00				12. 00	13.00	14. 00	15. 00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 27,500 0 0 16,187,671 2.00					I	al -	10.055	4 00
			1					
			1					
3.00 10 tal (Suil 0) 11 lies 1-2) 0 355,084 0 0 30,042,892 3.00	3. 00	Total (sum of lines 1-2)	0	355, 084	1	0 0	30, 042, 892	3. 00

| Period: | Worksheet A-8 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0125

				T	06/30/2021	Date/Time Prep 11/23/2021 10:	
				Expense Classification on		1172372021 10.	20 aiii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
0.00	COSTS-BLDG & FIXT (chapter 2)				0.00		0.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3.00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	О	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-405, 596			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	О	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-30, 457, 464			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests	1	Ö		0.00	ō	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and		0		0.00	0	18. 00
19. 00	Abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty charges (chapter 21)		O		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FLXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	o	27. 00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
55.00	therapy costs in excess of		O	TIENN I	37.30		55.50
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)	1 400					
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
-2.00	Depreciation and Interest		Ü		3.30	l	

Health Financial Systems ADJUSTMENTS TO EXPENSES Peri od: Provi der CCN: 15-0125 Worksheet A-8 From 07/01/2020 | To 06/30/2021 | Date/Time Prepared:

				11	0 06/30/2021	11/23/2021 10	
	,			Expense Classification on	Worksheet A	11172072021 10	20 4111
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
33. 00	ANESTHESIA - NON-SALARIES,	A		ANESTHESI OLOGY	53. 00	0	33. 00
	NON-BENEF		2.2,222			_	
33. 01	COVID DRUG DONATIONS	В	-1.088.800	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 01
33. 02	NON-PATIENT CARE COST	A		OTHER ADMIN & GENERAL	5. 04	0	ı
33. 03	PART B CONTRACTED SERVICES	A		INTENSIVE CARE UNIT	31. 00	0	33. 03
33. 04	PART B CONTRACTED SERVICES	A		RADI OLOGY-DI AGNOSTI C	54.00	0	•
33. 05	PART B CONTRACTED SERVICES	A		CT SCAN	57. 00	0	ı
33. 06	PART B CONTRACTED SERVICES	A	·	MAGNETIC RESONANCE I MAGING	58. 00	0	33. 06
33.00	TAKT B CONTRACTED SERVICES		-5, 405	(MRI)	30.00	0	33.00
33. 07	PART B CONTRACTED SERVICES	A	-5 763	CLINIC	90.00	0	33. 07
33. 08	PART B SALARIES	A		OTHER ADMIN & GENERAL	5. 04	ĺ	1
33. 09	PART B SALARIES	Ä		INTENSIVE CARE UNIT	31. 00	0	33. 09
33. 10	PART B SALARIES	A		1	31.00	0	33. 10
33. 10	PART B SALARIES	1		NEONATAL INTENSIVE CARE	53.00	0	33. 10
	1	A		ANESTHESI OLOGY		l ~	•
33. 12	PART B SALARIES	A	-178, 761		90.00	0	
33. 13	PATI ENT TELEPHONES	A		OTHER ADMIN & GENERAL	5. 04	0	33. 13
33. 14	TELEPHONE DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 14
33. 15	TV DEPRECIATION	A	·	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 15
33. 16	COVID VACCINE CLINIC	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 16
33. 17	COVID VACCINE CLINIC	В		OTHER ADMIN & GENERAL	5. 04	0	33. 17
33. 18	OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 19	OTHER REVENUE	В		OTHER ADMIN & GENERAL	5. 04	0	33. 19
33. 20	OTHER REVENUE	В	·	DI ETARY	10. 00	0	
33. 21	OTHER REVENUE	В	-224	ADULTS & PEDIATRICS	30. 00	0	33. 21
33. 22	OTHER REVENUE	В	-72	INTENSIVE CARE UNIT	31.00	0	33. 22
33. 23	OTHER REVENUE	В	-24	OPERATING ROOM	50.00	0	33. 23
33. 24	OTHER REVENUE	В		ANESTHESI OLOGY	53.00	0	33. 24
33. 25	OTHER REVENUE	В	-28, 615	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 25
33. 26	OTHER REVENUE	В	-4, 091	CARDIAC CATHETERIZATION	59. 00	0	33. 26
33. 27	OTHER REVENUE	В	-807	RESPI RATORY THERAPY	65.00	0	33. 27
33. 28	OTHER REVENUE	В	-3, 000	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 28
33. 29	OTHER REVENUE	В	-29	CARDIAC REHABILITATION	76. 97	0	33. 29
33. 30	OTHER REVENUE	В	-6, 440	EMERGENCY	91.00	0	33. 30
33. 31	OTHER REVENUE	В	-10, 500	HOME HEALTH AGENCY	101.00	0	33. 31
33. 32	OTHER REVENUE	В	-1, 548, 225	CAFETERI A	11. 00	0	33. 32
33. 33	OTHER REVENUE	В	-8, 605	CAP REL COSTS-MVBLE EQUIP	2. 00	11	33. 33
33. 34	PART B BENEFITS	A	-536	OTHER ADMIN & GENERAL	5. 04	0	33. 34
33. 35	PART B BENEFITS	A		INTENSIVE CARE UNIT	31.00	0	33. 35
33. 36	PART B BENEFITS	A		NEONATAL INTENSIVE CARE	31. 01	0	1
33. 37	PART B BENEFITS	A		ANESTHESI OLOGY	53. 00	Ö	33. 37
33. 38	PART B BENEFITS	A	-12, 786		90.00	Ö	33. 38
33. 39	PART B BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	ı
33. 40	PARENT ASSET DEPRECIATION	A	·	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 40
55. 40	ADJUSTMENT		2,012	S.E. SEE SOUTH DEDG & TIME	1.00	·	55. 45
33. 41	OTHER ADJUSTMENTS (SPECIFY)		Λ		0.00	0	33. 41
55. 11	(3)		O		0.00		
50. 00	TOTAL (sum of lines 1 thru 49)		-51, 200, 516				50. 00
	(Transfer to Worksheet A,		2., 200, 010				
	column 6, line 200.)						

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

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0125

Worksheet A-8-1

OFFI CE	COSTS			From 07/01/2020 To 06/30/2021	Date/Time Pre	epared:
					11/23/2021 10): 28 am
	Li ne No.	Cost Center	Expense Items	Amount of	Amount Included in	
				Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED - NEW BLDG	263, 485	0	
2.00	1	CAP REL COSTS-MVBLE EQUIP	NEW MOVABLE EQUIPMENT	2, 226, 260	0	00
3.00	1	OTHER ADMIN & GENERAL	SALARI ES/GROSS COSTS	16, 955, 574	0	3. 00
3. 01	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS/GROSS COSTS	3, 496, 426	0	3. 01
3.02	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	5, 041, 845	0	3. 02
3.03	5. 03	CASHI ERI NG/ACCOUNTS RECEI VAB	PATIENT ACCOUNTING	5, 941, 364	0	3. 03
3.04	13. 00	NURSING ADMINISTRATION	CANCER REGISTRY	305, 031	0	3. 04
3.05	5. 04	OTHER ADMIN & GENERAL	OTHER NON-CAPITAL	16, 551, 256	0	3. 05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	901 RIDGE RD LEASE	o	96, 711	3. 06
3.07	101.00	HOME HEALTH AGENCY	901 RIDGE RD LEASE	276, 725	0	3. 07
3.08	1.00	CAP REL COSTS-BLDG & FIXT	CDC LEASE EXPENSE	62, 030	0	3. 08
3.09	5. 04	OTHER ADMIN & GENERAL	CDC A&G	354	0	3. 09
3. 10	7. 00	OPERATION OF PLANT	CDC A&G	124	0	3. 10
3. 11	9. 00	HOUSEKEEPI NG	CDC A&G	7	0	3. 11
3. 12	13.00	NURSING ADMINISTRATION	CDC A&G	7	0	3. 12
3. 13	54.00	RADI OLOGY-DI AGNOSTI C	CDC A&G	502	0	3. 13
3.14	60.00	LABORATORY	CDC A&G	47	0	3. 14
3. 15	69.00	ELECTROCARDI OLOGY	CDC A&G	12	0	3. 15
3. 16	192.00	PHYSICIANS' PRIVATE OFFICES	CDC A&G	102	0	3. 16
3. 17	1.00	CAP REL COSTS-BLDG & FIXT	800 MAC LEASE EXPENSE	o	74, 140	3. 17
3. 18	1.00	CAP REL COSTS-BLDG & FIXT	800 MAC DEPRECIATION	19, 060	0	3. 18
3. 19	5. 02	ADMITTING	800 MAC A&G	9, 560	0	3. 19
3. 20	5. 04	OTHER ADMIN & GENERAL	800 MAC A&G	80, 462	0	3. 20
3. 21	5. 04	OTHER ADMIN & GENERAL	CORPORATE ALLOCATION	o	58, 935, 946	3. 21
3. 22	5. 04	OTHER ADMIN & GENERAL	PHYSICIAN ALLOCATION	o	22, 319, 180	3. 22
3. 23	1.00	CAP REL COSTS-BLDG & FIXT	CDC LEASE EXPENSE	o	261, 720	
3. 24	0.00	l		o	0	
3. 25	0.00			o	0	3. 25
4.00	0.00			o	o	4. 00
5.00	TOTALS (sum of lines 1-4).			51, 230, 233	81, 687, 697	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

 The been poeted to not honore in our amount of the amount of the beat of the b						
			Related Organization(s) and/	or Home Office		
					l	
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 RELA	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:				

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

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

6.00	В	0. 00 CFNI 1	00. 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:			i

- (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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

			11/23/2021 10	:pareu:):28 am
	Net	Wkst. A-7 Ref.	17726,2521.10	20 0
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			ENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1. 00	263, 485			1. 00
2.00	2, 226, 260			2. 00
3.00	16, 955, 574			3. 00
3. 01	3, 496, 426			3. 01
3. 02	5, 041, 845			3. 02
3. 03	5, 941, 364			3. 03
3.04	305, 031	1		3. 04
3.05	16, 551, 256	1		3. 05
3.06	-96, 711	1		3. 06
3. 07	276, 725			3. 07
3. 08	62, 030			3. 08
3.09	354			3. 09
3. 10	124	0		3. 10
3. 11	7	0		3. 11
3. 12	7	0		3. 12
3. 13	502	0		3. 13
3. 14	47	0		3. 14
3. 15	12			3. 15
3. 16	102			3. 16
3. 17	-74, 140			3. 17
3. 18	19, 060			3. 18
3. 19	9, 560			3. 19
3. 20	80, 462			3. 20
3. 21	-58, 935, 946			3. 21
3. 22	-22, 319, 180			3. 22
3. 23	-261, 720			3. 23
3. 24	0	1		3. 24
3. 25	0	0		3. 25
4.00	0	1		4. 00
5.00	-30, 457, 464			5. 00

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

Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

Provider CCN: 15-0125

Peri od: Worksheet A-8-2 From 07/01/2020 To 06/30/2021 Date/Ti me Prepared:

							11/23/2021 10	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00		AGGREGATE-OTHER ADMIN &	227, 201	150, 000		211, 500		1. 00
2. 00	30.00	GENERAL AGGREGATE-ADULTS &	183, 500			211, 500	786	2. 00
3. 00	31.00	PEDIATRICS AGGREGATE-INTENSIVE CARE UNIT	50, 882	С	50, 882	211, 500	361	3. 00
4.00	31. 01	AGGREGATE-NEONATAL INTENSIVE	50, 051	30, 000	20, 051	211, 500	135	4. 00
5. 00 6. 00		AGGREGATE-OPERATING ROOM AGGREGATE-DELIVERY ROOM & LABOR ROOM	34, 756 15, 000					5. 00 6. 00
7. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	25, 000	C	25, 000	271, 900	105	7. 00
8. 00		AGGREGATE-RADI OLOGY - THERAPEUTI C	17, 850	C	17, 850	271, 900	89	8. 00
9. 00		AGGREGATE-CARDI AC CATHETERI ZATI ON	15, 225		12,		102	
10. 00 11. 00	1	AGGREGATE-LABORATORY AGGREGATE-RESPI RATORY THERAPY	67, 850 19, 494	1	0.,000			10. 00 11. 00
12. 00		AGGREGATE-ELECTROENCEPHALOGR APHY	24, 764				221	12. 00
13. 00		AGGREGATE-DRUGS CHARGED TO PATIENTS	4, 125		1, 123			
14. 00 200. 00		AGGREGATE-CLINIC	47, 217 782, 915	180, 000	602, 915		3, 539	14. 00 200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1. 00	2.00	8.00	9. 00	12. 00	13.00	14. 00	
1.00		AGGREGATE-OTHER ADMIN &	57, 654					1. 00
2. 00	30. 00	GENERAL AGGREGATE-ADULTS & PEDIATRICS	79, 923	3, 996	0	0	0	2. 00
3. 00	31.00	AGGREGATE-INTENSIVE CARE UNIT	36, 708	1, 835	0	0	0	3. 00
4. 00	31. 01	AGGREGATE-NEONATAL INTENSIVE CARE	13, 727	686	0	0	0	4. 00
5. 00 6. 00		AGGREGATE-OPERATING ROOM AGGREGATE-DELIVERY ROOM & LABOR ROOM	27, 365 10, 168			1		
7. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	13, 726	686	0	0	0	7. 00
8. 00	55. 00	AGGREGATE-RADI OLOGY - THERAPEUTI C	11, 634	582	0	0	0	8. 00
9. 00		AGGREGATE-CARDI AC CATHETERI ZATI ON	10, 372	519	0	0	0	9. 00
10. 00 11. 00		AGGREGATE-LABORATORY AGGREGATE-RESPI RATORY THERAPY	42, 424 18, 405			l e		
12. 00	70. 00	AGGREGATE-ELECTROENCEPHALOGR	22, 472	1, 124	0	0	0	12. 00
13. 00		AGGREGATE-DRUGS CHARGED TO PATIENTS	3, 355	168	0	0	0	
14. 00 200. 00		AGGREGATE-CLINIC	29, 386 377, 319	18, 865	0	0	0	14. 00 200. 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-OTHER ADMIN &	0			169, 547		1. 00
2. 00	30.00	GENERAL AGGREGATE-ADULTS &	0	79, 923	103, 577	103, 577		2. 00
3. 00	31.00	PEDIATRICS AGGREGATE-INTENSIVE CARE UNIT	0	36, 708	14, 174	14, 174		3. 00
4.00	31. 01	AGGREGATE-NEONATAL INTENSIVE	0	13, 727	6, 324	36, 324		4. 00
5. 00 6. 00		AGGREGATE-OPERATING ROOM AGGREGATE-DELIVERY ROOM &	0	27, 365 10, 168		7, 391 4, 832		5. 00 6. 00
7. 00	54. 00	LABOR ROOM AGGREGATE-RADI OLOGY-DI AGNOST I C	0	13, 726	11, 274	11, 274		7. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
PROVI DER BASED PHYSI CI AN ADJUSTMENT	Provider CCN: 15-0125	Peri od: Worksheet A-8-2 From 07/01/2020
		To 06/30/2021 Date/Time Prepared:

							11/23/2021 10	0: 28 am
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
8.00	55. 00	AGGREGATE-RADI OLOGY -	0	11, 634	6, 216	6, 216		8. 00
		THERAPEUTI C						
9.00	59. 00	AGGREGATE-CARDI AC	0	10, 372	4, 853	4, 853		9. 00
		CATHETERI ZATI ON						
10.00	60.00	AGGREGATE-LABORATORY	0	42, 424	25, 426	25, 426		10. 00
11. 00	65. 00	AGGREGATE-RESPI RATORY	0	18, 405	1, 089	1, 089		11. 00
		THERAPY						
12.00	70.00	AGGREGATE-ELECTROENCEPHALOGR	0	22, 472	2, 292	2, 292		12. 00
		APHY						
13.00	73. 00	AGGREGATE-DRUGS CHARGED TO	0	3, 355	770	770		13. 00
		PATI ENTS						
14.00	90.00	AGGREGATE-CLI NI C	0	29, 386	17, 831	17, 831		14. 00
200.00			0	377, 319	225, 596	405, 596		200.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0125 Peri od: Worksheet B From 07/01/2020 Part I 06/30/2021 Date/Time Prepared: 11/23/2021 10:28 am CAPITAL RELATED COSTS PURCHASING & Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** RECEI VI NG for Cost **BENEFITS STORES** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 13, 855, 221 1 00 00100 CAP REL COSTS-BLDG & FLXT 13, 855, 221 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 16, 187, 671 16, 187, 671 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 28, 307, 513 45, 667 19,085 28, 372, 265 4.00 00505 PURCHASING & RECEIVING STORES 122, 546 5 01 98 392 731, 625 5 01 510, 120 567 5.02 00506 ADMITTING 4, 632, 478 101, 621 14, 413 628, 735 774 5.02 5.03 00507 CASHI ERI NG/ACCOUNTS RECEI VABLE 5, 941, 175 159, 755 0 5.03 5.04 00508 OTHER ADMIN & GENERAL 57, 410, 552 893, 176 734, 994 2, 381, 367 34, 827 5.04 00600 MAINTENANCE & REPAIRS 6.00 6.00 C 0 7.00 00700 OPERATION OF PLANT 14, 823, 316 2, 092, 997 462, 556 591, 588 129 7.00 00800 LAUNDRY & LINEN SERVICE 1, 599, 733 23, 077 14, 774 8.00 8.00 00900 HOUSEKEEPI NG 5, 237, 593 58, 547 553, 607 2, 967 9.00 46.064 9.00 01000 DI ETARY 3, 843, 599 7, 997 10.00 168, 243 145, 407 345, 915 10.00 11.00 01100 CAFETERI A 430, 272 173, 976 177, 715 0 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 01300 NURSING ADMINISTRATION 870, 383 7, 210, 423 48, 909 170, 272 10, 190 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY C C 0 0 14.00 15.00 01500 PHARMACY 0 0 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 044, 625 26, 437 402 0 0 16.00 01700 SOCIAL SERVICE 17.00 945, 631 130, 530 17.00 16, 740 0 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 r 0 0 19.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 22.00 0 23.00 02300 PARAMED ED PRGM-(PHARMACY) 305, 468 0 44. 428 0 23.00 3, 360 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 599, 404 41, 463, 244 614, 886 5, 181, 334 85, 649 30.00 31.00 03100 INTENSIVE CARE UNIT 14, 091, 782 539, 669 752, 909 1, 871, 458 29, 151 31.00 31.01 02060 NEONATAL INTENSIVE CARE 3, 824, 356 163, 734 95, 944 511, 224 9, 932 31.01 04100 SUBPROVIDER - IRF 282, 405 3, 225 41.00 41.00 2, 673, 256 183, 141 18,630 04300 NURSERY 26, 127 43.00 1, 554, 737 186, 315 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 32, 534, 459 1,096,786 3, 280, 617 2, 412, 958 157, 108 50.00 05100 RECOVERY ROOM 7, 131, 947 550, 633 168, 552 925, 084 51.00 9, 158 51.00 05200 DELIVERY ROOM & LABOR ROOM 2, 775, 672 228, 102 79, 022 341, 526 52.00 6.578 52.00 05300 ANESTHESI OLOGY 1, 657, 838 15, 092 53.00 14, 604 174, 872 2, 060, 024 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 652, 872 295, 711 1, 345, 720 662, 041 10,706 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 3,006,815 211, 067 1, 949, 712 218, 930 903 55.00 05600 RADI OI SOTOPE 2, 398, 951 59, 298 250, 574 56 00 132, 306 645 56 00 57.00 05700 CT SCAN 3, 107, 513 86, 649 1, 015, 746 227, 759 8, 771 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 999, 060 59, 284 665, 266 148, 192 2,838 58.00 05900 CARDIAC CATHETERIZATION 59.00 6, 750, 316 230, 076 1, 312, 984 459, 788 60, 754 59.00 06000 LABORATORY 998. 932 19, 809, 571 277 468 782 031 60 00 169, 234 60 00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 2, 733, 255 23, 946 23, 197 58, 446 6,836 63.00 06400 INTRAVENOUS THERAPY 499, 946 82, 066 421 57, 713 1,806 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 4, 822, 445 61, 347 108, 521 572, 172 10, 964 65.00 06600 PHYSI CAL THERAPY 7, 594, 946 66.00 847, 256 5, 676 507, 662 125,066 66.00 67.00 06700 OCCUPATIONAL THERAPY 2, 168, 844 38, 520 14, 358 221, 403 1,032 67.00 06800 SPEECH PATHOLOGY 186, 744 68.00 1, 564, 212 21, 957 42, 150 387 68.00 06900 ELECTROCARDI OLOGY 4,009,780 449, 582 69.00 208, 650 591, 224 8.126 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 390, 206 70.00 39, 626 75, 205 126, 053 5.547 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 980, 545 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 37, 466, 985 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 21, 313, 142 77,070 298, 317 656, 259 6, 578 73 00 74.00 07400 RENAL DIALYSIS 1, 827, 669 17, 153 18, 517 387 74.00 07697 CARDIAC REHABILITATION 897, 553 66, 549 76. 97 76.97 40, 259 116, 890 258 OUTPATIENT SERVICE COST CENTERS 90.00 47, 244 7, 254 2, 784, 660 90.00 09000 CLI NI C 338.762 7.739 1, 103, 624 91.00 09100 EMERGENCY 9, 836, 536 367, 992 191, 886 46, 694 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 5, 503, 226 0 0 129 101. 00 101.00 10100 HOME HEALTH AGENCY 646, 245 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 728, 787 118. 00 118.00 451, 111, 729 12, 116, 586 15, 619, 083 27, 857, 376 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 17,801 0 190, 00 1, 380, 587 191. 00 19100 RESEARCH 8, 385 5, 408 170, 486 129 191. 00

354, 821

672, 301

300, 498

830, 812

104, 082

10, 015

0

0

86, 819

0 192.00

0 194.00

0 194. 01

194. 01 07951 ADVERTI SI NG

192.00 19200 PHYSICIANS' PRIVATE OFFICES

194.00 07950 OTHER NONREIMBURSEABLE

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0125	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/23/2021 10	
		CAPI TAL REL	ATED COSTS		1172072021 10	20 4111
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	PURCHASI NG & RECEI VI NG STORES	
	0	1. 00	2.00	4. 00	5. 01	
194. 02 07952 RETAIL PHARMACY	12, 494, 148	26, 157	2, 28	103, 138	774	194. 02
194. 03 07953 FITNESS POINTE	1, 545, 722	681, 623	106, 92	144, 114	258	194. 03
194. 04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	332, 363	21, 839	7, 80	38, 267	1, 419	194. 04
194.05 07955 EINSTEIN BAGELS	34, 366	8, 915	7, 39	2, 758	0	194. 05
194.06 07956 NONRTHWESTERN IMAGING	740, 740	39, 021	351, 95	46, 111	258	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	468, 967, 275	13, 855, 221	16, 187, 67	28, 372, 265	731, 625	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0125

				1	0 00/30/2021	Date/lime Pre 11/23/2021 10	
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER ADMIN &	MAINTENANCE &	20 0
			OUNTS		GENERAL	REPAI RS	
		5. 02	RECEI VABLE 5. 03	5A. 03	5. 04	6. 00	
	GENERAL SERVICE COST CENTERS	0.02	0.00		0.01	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	OO5O5 PURCHASING & RECEIVING STORES OO5O6 ADMITTING	E 270 021					5. 01 5. 02
5. 02	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE	5, 378, 021 0	6, 100, 930				5. 02
5. 04	00508 OTHER ADMIN & GENERAL	o	0, 100, 730	61, 454, 916	61, 454, 916		5. 04
6.00	00600 MAINTENANCE & REPAIRS	Ō	O	0	0	0	1
7.00	00700 OPERATION OF PLANT	0	0	17, 970, 586	2, 710, 054	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	1, 637, 584	246, 956	0	
9.00	00900 HOUSEKEEPI NG	0	0	5, 898, 778	· ·	0	
10.00	01000 DI ETARY	0	0	4, 511, 161	680, 306	i e	
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	0	781, 963 0	117, 924 0	0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	ol	o	8, 310, 177	1, 253, 216	1	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	o	o	0	0	Ö	14. 00
15. 00	01500 PHARMACY	o	О	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	5, 071, 464	764, 802	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	1, 092, 901	164, 815	i e	17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
21. 00 22. 00	02100 L&R SERVICES-SALARY & FRINGES APPRV 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	0	0	353, 256	53, 273	1	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	000, 200	00, 270		20.00
30.00	03000 ADULTS & PEDIATRICS	403, 326	457, 509	50, 805, 352	7, 661, 717	0	30.00
31.00	03100 INTENSIVE CARE UNIT	88, 027	99, 853	17, 472, 849	2, 634, 993	0	31. 00
31. 01	02060 NEONATAL INTENSIVE CARE	83, 601	94, 832	4, 783, 623	721, 394	l	
41. 00	04100 SUBPROVI DER – I RF	18, 344	20, 808	3, 199, 809	· ·	l e	
43. 00	04300 NURSERY	14, 656	16, 625	1, 798, 460	271, 217	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	801, 893	910, 043	41, 193, 864	6, 212, 241	0	50.00
51. 00	05100 RECOVERY ROOM	84, 859	96, 259	8, 966, 492	1, 352, 192		
52.00	05200 DELIVERY ROOM & LABOR ROOM	24, 174	27, 421	3, 482, 495	525, 178	l	52. 00
53.00	05300 ANESTHESI OLOGY	124, 992	141, 784	4, 189, 206	631, 753	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	214, 689	243, 531	9, 425, 270		l e	54. 00
55. 00	O5500 RADI OLOGY - THERAPEUTI C	120, 798	137, 027	5, 645, 252	851, 332	0	55. 00
56. 00 57. 00	05600	88, 417 316, 006	100, 294 358, 459	3, 030, 485 5, 120, 903	457, 012 772, 258		56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	163, 915	185, 935	3, 224, 490	486, 269	l e	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	398, 030	451, 501	9, 663, 449		i e	1
60.00	06000 LABORATORY	635, 117	720, 438	23, 392, 791	3, 527, 750	i e	60.00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	32, 010	36, 311	2, 914, 001	439, 446	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	9, 530	10, 811	662, 293	99, 877	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	57, 393	65, 103	5, 697, 945	859, 279	l e	65. 00
66. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	92, 980	105, 471	9, 279, 057	1, 399, 328	l	
	06800 SPEECH PATHOLOGY	30, 373 13, 454	34, 453 15, 262	2, 508, 983 1, 844, 166			
	06900 ELECTROCARDI OLOGY	201, 251	228, 287	5, 696, 900	859, 121	0	1
	07000 ELECTROENCEPHALOGRAPHY	48, 175	54, 647	1, 739, 459	262, 319	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	187, 238	212, 391	29, 380, 174	4, 430, 677	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	240, 705	273, 041	37, 980, 731	5, 727, 684	l	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	395, 659	448, 811	23, 195, 836		l	
74. 00	07400 RENAL DIALYSIS	21, 017	23, 841	1, 908, 584	287, 824	l e	
76. 97	O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	8, 380	9, 506	1, 139, 395	171, 826	0	76. 97
90. 00	09000 CLINIC	34, 859	39, 542	3, 260, 060	491, 633	0	90.00
91. 00	09100 EMERGENCY	400, 748	454, 585	12, 402, 065		l	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0			92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	23, 405	26, 549	6, 199, 554	934, 924	0	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS	5, 378, 021	4 100 020	449 294 770	E0 224 102	0	118. 00
110.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	3, 376, 021	6, 100, 930	448, 286, 779	58, 336, 193	0	1116.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17, 801	2, 684	0	190. 00
	19100 RESEARCH	Ö	Ö	1, 564, 995	236, 009		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	o	0	1, 195, 648	180, 310	l	192. 00
	07950 OTHER NONREI MBURSEABLE	0	O	863, 202	130, 175	l	194. 00
	07951 ADVERTI SI NG	0	0	300, 498	45, 317	l e	194. 01
	07952 RETAIL PHARMACY	0	0	12, 626, 497	1, 904, 139	•	194. 02
	07953 FITNESS POINTE 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	2, 478, 640 401, 696			194. 03 194. 04
	07955 EINSTEIN BAGELS	0	0	53, 437			194. 04
	1	<u> </u>	<u> </u>	23, 101	0,307	<u> </u>	

Heal th Finar	ncial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021		
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC OUNTS	Subtotal	OTHER ADMIN & GENERAL	MAINTENANCE & REPAIRS	
			RECEI VABLE		GENERAL	KEPALKS	
		5. 02	5. 03	5A. 03	5. 04	6. 00	
194. 06 07956	NONRTHWESTERN I MAGING	C	0	1, 178, 08	2 177, 661	O	194. 06
200. 00	Cross Foot Adjustments			(0		200. 00
201.00	Negative Cost Centers		o	(0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	5, 378, 021	6, 100, 930	468, 967, 27	61, 454, 916	О	202. 00

Provider CCN: 15-0125

Cost Center Description					10	06/30/2021	Date/lime Pre 11/23/2021 10	
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		ZO GIII
PRIFIGAL SERVICE GRAT CRITTES		·						
1.00		CENEDAL CEDIUSE COCT CENTEDO	7. 00	8. 00	9. 00	10.00	11. 00	
2.00 DOUGGO FAMEL DOUS S-MINES ECOLO P 4.00 DOUGGO FAMEL DOUS S-MINES DEFAMENTON 5.01 DOUGGO FAMEL DOUS S-MINES RECEIVABLE 5.02 DOUGGO FAMEL DOUS BEEFER S-MINES 5.03 DOUGGO FAMEL BEEN RAY, RECORD SECRETARY 5.04 DOUGGO FAMEL BEEN RAY, RECORD SECRETARY 5.05 DOUGGO FAMEL BEEN RAY, RECORD SECRETARY 5.06 DOUGGO FAMEL BEEN RAY, RECORD SECRETARY 6.00 DOUGGO FAMEL BEEN RAY, RECORD SECRET	1 00							1 00
4.00 00000 PARICUYER EMPETTS DEPARTMENT 5.01 00000 PARICUNES MARCHEST PARICUMS STORES 5.01 00000 PARICUMS MARCHEST PARICUMS STORES 5.02 00000 PARICUMS MARCHEST PARICUMS STORES 6.00 000000 PARICUMS MARCHEST PARICUMS STORES 6.00 00000 PARICUMS MARCHEST PARICUMS STORES 6.00 00000 PARICUMS MARCHEST PARICUM								
5.01 00000 PURCHOSING & RECEIVING STORMS 2.02 00000 CARRITH TIME ACCOUNTS SEED WALE 5.03 00000 CARRITH TIME ACCOUNTS SEED WALE 6.00 00000 CARRITH TIME ACCOUNTS SEED WALE 7.00 00000 CARRITH TIME ACCOUNTS SEED WALE 7.00 00000 CARRITH TIME ACCOUNTS SEED WALE 7.00 00000 CARRITH TIME SEED WALE 7.00 00000 CARRITH TI								
5.02 000066 JAMB STING 000066								
5.03 000007 CASSI E PIN RAYACCURUS S RECEIVABLE 5.50 000000 000000 000000 000000 000000								
5.00 000000 MINERAMEN & CENERAL								
0.000 0.0000 I.M. MTEANNEC & REPAIR IS 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000								
7. 00 000000 HUNSEREPH NO								6.00
9.00 00900 NUUSEKEEPINS			20, 680, 640					7. 00
10.00 01000 DETARY 333.291 0 112.147 5.636.905 1.300, 503 11.00 1100 CAFTERIA 344.647 0 115.79 0 0 0 0 0 0 1.200 11.00 11.00 11.00 CAFTERIA 344.647 0 11.00 11	8.00			1, 930, 255				8.00
11 DO 0 1100 CAFETERIA	9.00	00900 HOUSEKEEPI NG	115, 982	0	6, 904, 325			9.00
12.00 01200 MAINTENANCE OF PRESONNEL 0	10.00	01000 DI ETARY	333, 291	0	112, 147	5, 636, 905		10.00
13.00 01300 NURSING ADMINISTRATION 96,890 0 32,602 0 52,221 13.00 14.00 10100 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 14.00 10100 10500 PHARMACY 32,371 0 17,022 0 0 16.00 15.	11. 00	01100 CAFETERI A	344, 647	0	115, 969	o	1, 360, 503	11. 00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 14.00 0 0 0 15.00 0 15.00 0 15.00 01.00 NEDICAL RECORDS & LIBRARY 52.371 0 0 7.622 0 0 0 16.00 15.00 17.00 01700 NEDICAL RECORDS & LIBRARY 52.371 0 0 7.622 0 0 0 16.00 17.00 17.00 17.00 01700 NEDICAL RECORDS & LIBRARY 52.371 0 0 7.622 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
15.00 01500 PHARMACY	13.00	01300 NURSING ADMINISTRATION	96, 890	0	32, 602	0	52, 821	13.00
16.00 01-000 MEDICAL RECORDS & LIBRARY 52,371 0 17,622 0 0 16.00	14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
17.00 01700 SOCIAL SERVICE 33, 103 0 11, 199 0 9,99 77.00 17.00 01900 01900 17.00 01900 021.00 020 021.00 020 021.00 020 021.00 020 021.00 020 020 021.00 020 021.00 020 022.00 020 020 020 020 020 022.00 020	15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
19.00 1900 MOMPHYSICI AN AMESTHETI STS	16. 00		52, 371	0	17, 622	0	0	16. 00
21.00	17. 00	01700 SOCIAL SERVICE	33, 163	0	11, 159	0	9, 993	17. 00
22.00	19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
23.00				0	0	0	0	
INPATILENT ROUTI NE SERVICE COST CENTERS 1,402,207 1,732,712 4,369,796 355,474 31.00 30.00 3000 AURITS & PEDIDI ATRICS 5,149,438 1,402,207 1,732,712 4,369,796 355,474 31.00 31.00 3000 AURITS & PEDIDI ATRICS 2,424,388 99,267 109,142 0 27,124 31.01 31.01 2066 (NOMATAL INTRISVIE CARE 324,388 99,267 109,142 0 27,124 31.01 31.01 2066 (NOMATAL INTRISVIE CARE 324,388 99,267 109,142 0 72,124 31.01 31.01 2066 (NOMATAL INTRISVIE CARE 324,388 99,267 109,142 0 72,124 31.01			-	0	0	0		
30.00 3000 ADULTS & PEDIATRICS 5, 149, 438 1, 402, 207 1, 732, 712 4, 369, 796 355, 474 30.00 310.00 310.00 310.00 MTRINSI VE CARE 31, 408 299, 267 109, 142 102, 787 31.00 31.01 31.01 31.01 32.00 MENDAL I INTENSI VE CARE 324, 388 99, 267 109, 142 0 27, 124 31.01 31.01 31.01 32.00 32.00 MENDAL I INTENSI VE CARE 362, 804 110, 886 122, 078 269, 312 19, 273 41.00 41	23. 00		6, 656	0	2, 240	0	2, 855	23. 00
31.00 03100 INTERIS VIE CARE UNIT	0 -				T T	, 1		
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14.00 04100 SUBPROVI DER - I RF 302, 804 110, 286 122, 078 269, 312 19, 273 41.00 04300 NURSERY 51,788 61,638 17.16 0 11.421 43.00 43500 NURSERY 51,788 61,638 17.16 0 11.421 43.00 43500 NURSERY 50.00 50.0						416, 424		1
43.00 0.4500 NURSERY						0		1
ANCILLARY SERVICE COST CENTERS 50.00 61.00 50.00 61.00 50.00 61.00 50.00 61.00 50.00 61.00 50.00 61.00 50.00 61.00 50.00 61.00 50.00 61.00 50.00 61.00 50.00 61.00 50.00 61.					,			1
50.00	43. 00		51, 758	61, 638	17, 416	0	11, 421	43. 00
51.00 05100 RECOVERY ROOM & LABOR ROOM 1,090,807 0 367,041 243,149 57,818 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 451,871 0 152,048 110,661 21,414 52.00 53.00 05300 DELI VERY ROOM & LABOR ROOM 481,871 0 152,048 110,661 21,414 52.00 30,500 30,000 30,000 30,000 30,000 30,000 30,000 30,000 30,000 30,000 30,000 30,000 30,000 30,000 30,000 30,000 30,500					704 005	al	455 (00	
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OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00			720, 775	0	243, 290	227, 303	17, 232	1
101. 00	, 2, 00							1 ,2.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 17, 236, 391 1, 930, 255 5, 745, 385 5, 636, 905 1, 343, 372 118. 00 NONREI MBURSABLE COST CENTERS	101 00		n	0	n	Λl	0	101 00
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NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 35, 265 0 11, 866 0 0 190. 00 191. 00 191. 00 191. 00 191. 00 191. 00 191. 00 191. 00 192. 00 19	118 00		17 236 301	1 930 255	5 745 385	5 636 905	1 343 372	118 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 35, 265 0 11, 866 0 9, 279 191. 00 191. 00 19100 RESEARCH 16, 611 0 5, 589 0 9, 279 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 645, 844 0 553, 803 0 714 192. 00 194. 00 197950 OTHER NONREI MBURSEABLE 206, 187 0 69, 379 0 0 194. 00 194. 01 194. 01 197951 ADVERTI SI NG 0 0 0 0 0 194. 01 194. 02 197952 RETAIL L PHARMACY 51, 817 0 17, 436 0 7, 138 194. 02 194. 03 197953 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY 43, 263 0 14, 557 0 0 194. 04 194. 05 107955 FI NSTEI N BAGELS 17, 661 0 5, 943 0 0 194. 05	. 10. 00	9 7	17,230,371	1, 730, 233	3, 173, 303	3, 030, 703	1, 575, 572	1
191. 00 19100 RESEARCH	190 00		35 265	0	11 866	n	0	190 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 645, 844 0 553, 803 0 714 192.00 194.00 07950 OTHER NONREI MBURSEABLE 206, 187 0 69, 379 0 0 194.00 194.01 107951 ADVERTI SI NG 0 0 0 0 0 0 194.01 194.02 194.02 194.03 19752 RETAIL PHARMACY 51, 817 0 17, 436 0 7, 138 194.02 194.03 19753 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY 43, 263 0 14, 557 0 0 194.03 194.05 197955 EI NSTEI N BAGELS 17, 661 0 5, 943 0 0 194.05				0		٥		
194. 00 07950 OTHER NONREIMBURSEABLE 206, 187 0 69, 379 0 0 194. 00 194. 00 194. 01 07951 ADVERTI SI NG 0 0 0 0 0 0 194. 01 194. 02 07952 RETAIL PHARMACY 51, 817 0 17, 436 0 7, 138 194. 02 194. 03 07953 FI TNESS POI NTE 1, 350, 299 0 454, 356 0 0 194. 03 194. 04 07954 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY 43, 263 0 14, 557 0 0 194. 04 194. 05 07955 EI NSTEI N BAGELS 17, 661 0 5, 943 0 0 194. 05				0		٥		
194. 01 07951 ADVERTI SI NG 194. 02 07952 RETAI L PHARMACY 194. 03 07953 FI TNESS POI NTE 194. 04 07954 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY 194. 05 07955 EI NSTEI N BAGELS 0 0 0 0 0 194. 01 17, 436 0 7, 138 194. 02 1, 350, 299 0 454, 356 0 0 194. 03 194. 04 194. 05 07955 EI NSTEI N BAGELS 17, 661 0 5, 943 0 0 194. 05				0		٥		
194. 02 07952 RETAIL PHARMACY 194. 03 07953 FI TNESS POI NTE 194. 04 07954 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY 194. 05 07955 EI NSTEI N BAGELS 151, 817 0 17, 436 0 7, 138 194. 02 1, 350, 299 0 454, 356 0 0 194. 03 194. 05 07955 EI NSTEI N BAGELS 17, 661 0 5, 943 0 0 194. 05			200, 107	0	07, 3/9	٥		
194. 03 07953 FI TNESS POI NTE 1, 350, 299 0 454, 356 0 0 194. 03 194. 04 07954 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY 43, 263 0 14, 557 0 0 194. 04 194. 05 07955 EI NSTEI N BAGELS 17, 661 0 5, 943 0 0 194. 05			51 817	0	17 436	٥		
194. 04 07954 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY 43, 263 0 14, 557 0 0 194. 04 194. 05 07955 EI NSTEI N BAGELS 17, 661 0 5, 943 0 0 194. 05				0		٥		
194. 05 07955 EINSTEIN BAGELS 17, 661 0 5, 943 0 0 194. 05				0		٥		
194. 06 07956 NONRTHWESTERN I MAGING 77, 302 0 26, 011 0 0 194. 06				0		٥		
				0		٥	0	194 06
					20,011	<u> </u>		1

Heal th Financial	Systems		COMMUNI TY	HOSI	PI TAL			In Lie	u of Form CMS	-2552-10
COST ALLOCATION	- GENERAL SERVICE	COSTS			Provi der	CCN:	Peri From To	07/01/2020	Worksheet B Part I Date/Time Pr 11/23/2021 1	
							 -			

						11/23/2021 10	28 am
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7.00	8. 00	9. 00	10.00	11. 00	
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)	20, 680, 640	1, 930, 255	6, 904, 325	5, 636, 905	1, 360, 503	202. 00

Provider CCN: 15-0125

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2020 | Part |
| To 06/30/2021 | Date/Time Prepared: | 11/23/2021 | 10:28 am

					06/30/2021	11/23/2021 10	
	Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		12.00	13. 00	14. 00	15. 00	16. 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. 01	00505 PURCHASING & RECEIVING STORES						5. 01
5. 02	00506 ADMI TTI NG						5. 02
5.03	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5. 04 6. 00	00508 OTHER ADMIN & GENERAL						5. 04
7. 00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0					12. 00
13.00	01300 NURSING ADMINISTRATION	O	9, 745, 706				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0			14. 00
15.00	01500 PHARMACY	0	0	0	o		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	5, 906, 259	16. 00
	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			al		
	03000 ADULTS & PEDI ATRI CS	0	4, 067, 276	0	0	442, 898	
	03100 I NTENSI VE CARE UNI T	0	1, 177, 060	0	0	96, 664	1
	02060 NEONATAL INTENSIVE CARE	0	313, 178	0	0	91, 804	1
41. 00	04100 SUBPROVI DER - I RF	0	216, 967	0	0	20, 143	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	J O	133, 771	0	0	16, 094	43. 00
50. 00	05000 OPERATING ROOM	O	1, 781, 476	0	ol	881, 153	50. 00
51. 00	05100 RECOVERY ROOM		659, 168	0	0	93, 184	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	243, 642	0	Ö	26, 546	1
53. 00	05300 ANESTHESI OLOGY	l o	0	0	ol	137, 256	1
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	ol	235, 753	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	0	0	o	132, 650	
56.00	05600 RADI 0I S0T0PE	0	0	0	o	97, 091	
57.00	05700 CT SCAN	0	0	0	o	347, 011	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	o	179, 997	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	437, 081	59. 00
60.00	06000 LABORATORY	0	0	0	0	697, 430	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	35, 151	ı
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	10, 465	
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	63, 024	
	06600 PHYSI CAL THERAPY	0	0	0	0	102, 103	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0		67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	U	14, 775	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	U	220, 996	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	U O	52, 902 205, 608	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	264, 321	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	434, 478	
	07400 RENAL DIALYSIS	0	0	0	o	23, 079	
	07697 CARDI AC REHABI LI TATI ON	0	0	0	ol	9, 202	1
	OUTPATIENT SERVICE COST CENTERS	-		-1	-,	.,	
90.00	09000 CLI NI C	0	242, 341	0	0	38, 279	90. 00
	09100 EMERGENCY	0	910, 827	0	o	440, 067	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	25, 701	101. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	` ;	0	9, 745, 706	0	0	5, 906, 259	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	07950 OTHER NONREI MBURSEABLE	0	0	0	0		194. 00
	07951 ADVERTI SI NG		0	0	O		194. 01
	07952 RETAIL PHARMACY 07953 FITNESS POINTE		0	0	O ₁		194. 02 194. 03
	07954 FITNESS POINTE SPA/PRO SHOP/DIETARY		0	0	o o		194. 03
	07955 EINSTEIN BAGELS		0	0	٥		194. 04
	1	<u> </u>	J.	١	<u> </u>		1

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B	
				From 07/01/2020	Part I	
				To 06/30/2021	Date/Time Pre	
					11/23/2021 10	: 28 am
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	PERSONNEL	ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	12.00	13. 00	14. 00	15. 00	16. 00	
194.06 07956 NONRTHWESTERN I MAGING	0	0		0 0	0	194. 06
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)	0	9, 745, 706		0 0	5, 906, 259	202. 00

Provider CCN: 15-0125

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2020 | Part |
| To 06/30/2021 | Date/Time Prepared: | 11/23/2021 | 10:28 am

						11/23/2021 10	
				I NTERNS &	RESI DENTS		
	Cost Center Description	SOCIAL SERVICE	NONPHYSICI AN	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
			ANESTHETI STS	Y & FRINGES		PRGM-(PHARMACY	
		17. 00	19. 00	APPRV 21.00	APPRV 22. 00	23. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00505 PURCHASING & RECEIVING STORES			•			5. 01
5. 02	00506 ADMITTING						5. 02
5.03	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5.04	00508 OTHER ADMIN & GENERAL						5. 04
6.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCI AL SERVI CE	1, 312, 031					17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	_			19. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0		C	0		21.00
22. 00 23. 00	02200 L&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(PHARMACY)	0			0	418, 280	22. 00 23. 00
23.00	I NPATIENT ROUTINE SERVICE COST CENTERS					410, 200	23.00
30.00	03000 ADULTS & PEDIATRICS	953, 107	O	C	0	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	174, 590	ł	C	0	0	31. 00
31. 01	02060 NEONATAL INTENSIVE CARE	67, 473	l	1		0	31. 01
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	74, 964 41, 897		1	0	0 0	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	41,077			U	0	43.00
50.00	05000 OPERATING ROOM	0	O	C	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0	-		_	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0			0	0	53. 00 54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0			0	0	55.00
56. 00	05600 RADI OI SOTOPE	0	Ö	o c	0	0	56. 00
57. 00	05700 CT SCAN	0	0	C	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	C	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	60. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0			0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	Ö	d	0	_	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0			0	0 0	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGY	0			0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	i c	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	o c	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	O.	0	418, 280	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0 0	74.00
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0			0	0	76. 97
90. 00	09000 CLINIC	Ιο			0	0	90.00
91.00	09100 EMERGENCY	0	O	C	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
404 0	OTHER REIMBURSABLE COST CENTERS						1404 00
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	C C	0	0	101. 00
118. 00		1, 312, 031	0	C	0	418, 280	118 00
110.00	NONREI MBURSABLE COST CENTERS	1,012,001		1	<u> </u>	110, 200	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	C	0		190. 00
	19100 RESEARCH	0	0	C	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
	0/07950 OTHER NONREI MBURSEABLE	0			0		194. 00 194. 01
	207952 RETAIL PHARMACY	0	l o	i c	0		194. 01
	3 07953 FI TNESS POI NTE	0	0	ď	o o		194. 03
	•						

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0125

					11/23/2021 10	:28 am
			INTERNS &	RESI DENTS		
Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
		ANESTHETI STS	Y & FRINGES	PRGM COSTS	PRGM-(PHARMACY	
			APPRV	APPRV)	
	17. 00	19. 00	21.00	22. 00	23. 00	
194. 04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	0	0	0	194. 04
194. 05 07955 EINSTEIN BAGELS	0	0	0	0	0	194. 05
194.06 07956 NONRTHWESTERN IMAGING	o	0	0	0	0	194. 06
200.00 Cross Foot Adjustments		0	0	0	0	200. 00
201.00 Negative Cost Centers	o	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 312, 031	0	0	0	418, 280	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0125

Cost Center Description					'		ne Prepared: 021 10:28 am
## POINT ALL STRUKE COST CENTERS ## DOTOGO CAP NELL DOST-BLUE, & FILT PARTY P		Cost Center Description			Total	,	
Company							
DESCRIPTION							
1.00 001000 COP REL COSTS-BUELD & FIXT 2.00			24. 00		26.00		
2.00 DODDO CAP REL COSIS-MUNIL EQUIL P				1		1	1 00
0.000 DOUGNE DEPLOYEE BEREFITS DEPARTMENT	1	l l					
5.01 0.0000 PURCHASINO & RECEIVING STORES 5.01 5.02 0.0000 AMITTING 5.02 5.01	1	l l					
5.03 000000 MAINTENANCE & REPOLIES 5.03	1						
5.04	1						
0.000 0.00	1	l l					
0.00700 DOPRONTION OF PLANT							
8.00	1	l l					
9.00 00900 FULSEREFEINS 9.00 11	1						
11.00 01100 CAF ETERIA	1						
12.00 1320 MAINTENNINCE OF PERSONNEL							•
13.00 13.00 13.00 13.00 13.00 13.00 13.00 15.0							
14.00 01400 CENTRAL SERVICES & SUPPLY							•
15.00 1000 PHARMACY 16.00 10	1						l l
16.00 1000 MEDICAL RECORDS & LIBRARY	1						•
19.00 01900 NONIMPISICIAN AIRESTHETISTS 21.00 220 18x SERVICES-SALARY & FINIMES APPRY 22.00 220 18x SERVICES-SOTHER PREMI COSTS APPRY 22.00 220 18x SERVICES-SOTHER PREMI COSTS APPRY 22.00 22.0	1						
21.00	17. 00	01700 SOCIAL SERVICE					17. 00
22.00	1	l l					•
23.00							l l
INPATI ENT ROUTINE SERVICE COST CENTERS	1						
30.00	+						23.00
31.00 03100 INTENSIVE CARE UNIT 23, 761, 044 0 23, 761, 044 1.00 41.00 41.00 41.00 51.00 61.00			76, 939, 977	O	76, 939, 977		30.00
11.00 04100 SUBPROVIDER - LIFE 4,878, 183 0 4,878, 183 41.00	1			1			
ABOOD ABOO	31. 01	02060 NEONATAL INTENSIVE CARE	6, 537, 363	0	6, 537, 363		31. 01
ANCIL LARY SERVICE COST CENTERS 50.00				1			l l
50.00			2, 403, 672	0	2, 403, 672		43. 00
1.0 0.5100 0.5100 RECOVERY ROOM 1.2, 829, 851 0 12, 829, 851 5.1 0.0 52.00 0.520			F2 120 177		F2 120 177		50.00
52 00 05200 05200 05200 05200 05200 05200 05200 0530	1			1			l l
53.00 05300 ANESTHESI OLOCY 5,030,428 5,030,428 53.00	1	l		1			•
55.00 05500 RADI OLOGY - THERAPEUTI C	1	l l		l I			l l
56.00 05000 CADRIO I SOTOPE 3, 748, 010 0 3, 748, 010 56.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 4, 056, 993 0 4, 056, 993 58.00 59.00 05900 CARDIA C CATHETERI ZATI ON 12, 191, 956 0 12, 191, 956 59.00 69.00 69.00 69.00 69.00 68.00 LABORATORY 28, 431, 109 60.00 63.00 05.000 LABORATORY 68, 431, 109 60.00 63.00 05.000 CARDIA C LIBERAPY 68, 431, 431, 432, 433 65.00 64.00 64.00 INTRAVINOUS THERAPY 68, 18, 931 0 6, 816, 931 65.00 66.00 66.00 66.00 66.00 66.00 67.00 06600 PHYSI CAL THERAPY 68, 18, 931 0 6, 816, 931 65.00 66.00 66.00 66.00 67.00 06700 OCCUPATI TONAL THERAPY 3, 034, 824 0 3, 034, 824 67.00 68.00 06800 SPECH PATHOLOGY 7, 360, 129 0 7, 360, 129 69.00	1		11, 911, 005	0	11, 911, 005		l l
57. 00 05700 CT SCAN 6, 485, 286 0 6, 485, 286 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 4, 056, 993 0 4, 056, 993 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 12, 191, 956 0 12, 191, 956 59. 00 05900 CARDI AC CATHETERI ZATI ON 12, 191, 956 0 12, 191, 956 60. 00 63. 00 06300 8L00D STORI NG, PROCESSI NG, & TRANS. 3, 455, 567 63. 30. 06 0600 CABDI AC CATHETERI ZATI ON 28, 431, 109 0 28, 431, 109 0 064. 00 064. 00 064. 00 064. 00 064. 00 064. 00 06500 RESPIR ATORY THERAPY 993, 480 0 993, 480 0 64. 00 06500 RESPIR ATORY THERAPY 12, 177, 388 0 12, 177, 388 0 66. 00 06600 PHYSI CAL THERAPY 3, 034, 824 0 3, 034, 824 0 67. 00 06600 SPECH PATHOLOGY 2, 205, 890 2, 205, 890 69. 00 06900 ELECTROCARDI OLOGY 7, 360, 129 0 7, 360, 129 0 69. 00 06900 ELECTROCARDI OLOGY 7, 360, 129 0 7, 360, 129 0 7, 360, 129 0 7, 360, 129 0 7, 360, 129 0 7, 360, 129 0 70. 00 07000 ELECTROCREPHAL OGRAPHY 2, 168, 872 0 2, 168, 872 70. 00 07000 ELECTROCREPHAL OGRAPHY 34, 972, 736 0 34, 016, 459 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 43, 972, 736 0 43, 972, 736 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 27, 786, 883 0 27, 786, 383 73. 00 73. 00 7300 DRUGS CHARGED TO PATI ENTS 2, 266, 329 0 2, 266, 329 74. 00				l			•
58.00 05900 CARDIA C CATHETERI ZATI ON 1.2 191, 956 0.0 05900 CARDIA C CATHETERI ZATI ON 1.2 191, 956 0.0 0.							
59.00 05900 CARDI AC CATHETERI ZATI ON 12, 191, 956 0 12, 191, 956 0 60.00 660.00				1			
60. 00 66000 LABORATORY 28, 431, 109 0 28, 431, 109 0 63. 00 06300 06300 06300 DRUOR STORING, PROCESSING, & TRANS. 3, 455, 567 0 3, 455, 567 0 3, 455, 567 0 64. 00 64. 00 64. 00 1NTRAVENOUS THERAPY 993, 480 0 993, 480 64. 00 65. 00 06500 RESPIRATORY THERAPY 6, 816, 931 0 6, 816, 931 0 6, 816, 931 65. 00 66. 00 06600 PHYSI CAL THERAPY 12, 177, 388 0 12, 177, 388 66. 00 66. 00 06600 PHYSI CAL THERAPY 3, 034, 824 0 3, 034, 824 67. 00 68. 00 06800 SPEECH PATHOLOGY 2, 205, 890 0 2, 205, 890 0 68. 00 69. 00 6900 ELECTROCARDI OLOGY 7, 360, 129 0 7, 360, 129 69. 00 69. 00 6900 ELECTROCARDI OLOGY 7, 360, 129 0 7, 360, 129 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 34, 016, 459 0 34, 016, 459 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 27, 786, 383 0 27, 786, 383 73. 00 73. 00 07300 RUGS CHARGED TO PATI ENTS 27, 786, 383 0 27, 786, 383 73. 00 74. 00 7400 RANAL DIALYSIS 2, 266, 329 0 2, 266, 329 74. 00 7400 RANAL DIALYSIS 70. 00 07000 CLINIC 1, 503, 754 0 1, 503, 754 0 1, 503, 754 0 0. 1000 07000							I
63.00 66300 BLOOD STORING, PROCESSING, & TRANS. 3, 455, 567 0 3, 455, 567 0 63.00 64.00 06400 INTRAVENOUS THERAPY 993, 480 0 993, 480 64.00 65.00 06500 RESPIRATORY THERAPY 12, 177, 388 0 12, 177, 388 66.00 66.00 06600 PHYSI CAL THERAPY 12, 177, 388 0 12, 177, 388 66.00 67.00 06700 OCCUPATI ONAL THERAPY 3, 034, 824 0 3, 034, 824 67.00 68.00 06800 SPEECH PATHOLOGY 2, 205, 890 0 2, 205, 890 68.00 69.00 06900 ELECTROCARDI OLOGY 7, 360, 129 0 7, 360, 129 69.00 71.00 07000 CHECTROCREPHALOGRAPHY 2, 168, 872 0 2, 168, 872 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 34, 016, 459 0 34, 016, 459 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 43, 972, 736 0 43, 972, 736 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 27, 786, 383 0 27, 786, 383 73.00 74.00 07400 RENAL DI ALYSI S 2, 266, 329 0 2, 266, 329 74.00 76.97 07697 CARDI AC REHABI LI TATI ON 1, 503, 754 0 1, 503, 754 0 79.00 09000 CLI NI C 4, 178, 810 0 4, 178, 810 99.00 79.00 09000 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09000 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 EMERGENCY 7, 160, 179 0 7, 160, 179 79.00 09100 EMERGENCY 7, 160, 179 0 7, 160, 179 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART 0 70.00 79.00 09100 OBSERVATI ON BEDS (NON-DISTINCT PART	1						l l
65. 00 06500 RESPIRATORY THERAPY 6, 816, 931 0 6, 816, 931 66. 00 6600 PhYSI CAL THERAPY 12, 177, 388 0 12, 177, 388 66. 00 6600 6700 OCCUPATI ONAL THERAPY 3, 034, 824 0 3, 034, 824 67. 00 6700 OCCUPATI ONAL THERAPY 3, 034, 824 0 3, 034, 824 67. 00 6700 OCCUPATI ONAL THERAPY 2, 205, 890 0 2, 205, 890 68. 00 680 OECUPATI ONAL THERAPY 2, 205, 890 0 2, 205, 890 68. 00 69. 00 OCCUPATI ONAL THERAPY 2, 168, 872 0 7, 360, 129 0 7, 360, 129 0 70. 00 07000 ELECTROCARDI OLOGY 7, 360, 129 0 7	1			0			•
66. 00 06600 PHYSI CAL THERAPY 12, 177, 388 0 12, 177, 388 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 3, 034, 824 0 3, 034, 824 67. 00 68. 00 06800 SPEECH PATHOLOGY 2, 205, 890 0 2, 205, 890 68. 00 69. 00 06900 ELECTROCARDI OLOGY 7, 360, 129 0 7, 360, 129 69. 00 70. 00			993, 480	0	993, 480		64. 00
67. 00 06700 OCCUPATI ONAL THERAPY 3,034,824 0 3,034,824 67.00 68. 00 06800 SPEECH PATHOLOGY 2,205,890 0 2,205,890 68.00 69. 00 06900 ELECTROCARDI OLOGY 7,360,129 0 7,360,129 0 70. 00 07000 ELECTROENCEPHALGRAPHY 2,168,872 0 2,168,872 70.00 71. 00 07100 MEDI CALL SUPPLIES CHARGED TO PATIENT 34,016,459 0 34,016,459 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 43,972,736 0 43,972,736 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 27,786,383 0 27,786,383 73.00 74. 00 07400 RENAL DI ALYSI S 2,266,329 0 2,266,329 74.00 76. 97 07697 CARDI AC REHABI LITATI ON 1,503,754 0 1,503,754 0 79. 00 09000 CLINIC C 4,178,810 0 4,178,810 90.00 79. 00 09000 CLINIC C 4,178,810 0 4,178,810 90.00 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92.00 70. 00 09100 EMERGENCY 7,160,179 0 7,160,179 0 70. 00 09100 EMERGENCY 7,160,179 0 7,160,179 718. 00 SUBTOTALS (SUM OF LINES 1 through 117) 440,547,736 0 440,547,736 118.00 719. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 67,616 0 67,616 190.00 719. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,832,483 0 1,832,483 191.00 719. 00 19000 OTHER REIMBURSABLE COST CENTERS 1,268,943 0 1,268,943 194.00 719. 00 19751 ADVERTI SI NG 345,815 0 345,815 194.01 719. 00 07952 RETAIL PHARMACY 14,607,027 0 14,607,027 194.00							
68. 00 06900 SPEECH PATHOLOGY 2, 205, 890 0 2, 205, 890 68. 00 69. 00 06900 CLECTROCARDI OLOGY 7, 360, 129 0 7, 360, 129 0 7, 360, 129 70. 00 70. 00 CLECTROENCEPHALOGRAPHY 2, 168, 872 0 2, 168, 872 70. 00 70. 00 CLECTROENCEPHALOGRAPHY 2, 168, 872 0 2, 168, 872 70. 00 70. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 34, 016, 459 0 34, 016, 459 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 43, 972, 736 0 43, 972, 736 72. 00 73. 00 7300 DRUGS CHARGED TO PATI ENTS 27, 786, 383 0 27, 786, 383 73. 00 73. 00 7300 DRUGS CHARGED TO PATI ENTS 2, 266, 329 0 2, 266, 329 0 74. 00 76. 97				1			
69. 00 06900 ELECTROCARDI OLOGY 7, 360, 129 0 7, 360, 129 70. 00 7000 ELECTROENCEPHALOGRAPHY 2, 168, 872 0 2, 168, 872 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 2, 168, 872 0 2, 168, 872 70. 00 70. 00 70. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 34, 016, 459 0 34, 016, 459 71. 00 72. 00 73. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 27, 786, 383 0 27, 786, 383 73. 00 74. 00	4						
70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 168, 872 0 2, 168, 872 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 34, 016, 459 0 34, 016, 459 71. 00 7200 MPL. DEV. CHARGED TO PATI ENTS 43, 972, 736 0 43, 972, 736 72. 00 7200 MPL. DEV. CHARGED TO PATI ENTS 27, 786, 383 0 27, 786, 383 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 27, 786, 383 0 27, 786, 383 73. 00 74. 00 07400 RENAL DI ALYSI S 2, 266, 329 0 2, 266, 329 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 1, 503, 754 0 1, 503, 754 76. 97 0000 0000 CLI NI C 4, 178, 810 0 4, 178, 810 90. 00 91. 00 91. 00 91. 00 90.00 CLI NI C 4, 178, 810 0 4, 178, 810 91. 00 91. 00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 09							•
71. 00				1			•
73. 00				1			
74. 00			43, 972, 736	0	43, 972, 736		72. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON 1,503,754 0 1,503,754 0 1,503,754 76. 97 OUTPATI ENT SERVI CE COST CENTERS 90. 00 9000 CLI NI C 4, 178, 810 0 4, 178, 810 90. 00 9100 EMERGENCY 16, 904, 338 0 16, 904, 338 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0		l l		1			
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 4, 178, 810 0 4, 178, 810 90. 00 91. 00 09100 EMERGENCY 16, 904, 338 0 16, 904, 338 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 07. 160, 179 92. 00 01000 HOME HEALTH AGENCY 7, 160, 179 0 7, 160, 179 101. 00 SPECI AL PURPOSE COST CENTERS 18. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 440, 547, 736 0 440, 547, 736 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 67, 616 0 67, 616 190. 00 19100 RESEARCH 1, 832, 483 0 1, 832, 483 191. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3, 576, 319 0 3, 576, 319 192. 00 194. 00 07950 0THER NONREI MBURSEABLE 1, 268, 943 0 1, 268, 943 194. 00 194. 01 07951 ADVERTI SI NG 345, 815 0 345, 815 194. 01 194. 02 07952 RETAI L PHARMACY 14, 607, 027 0 14, 607, 027 194. 02 194. 0				1			
90. 00			1, 503, 754	l O	1, 503, 754		/6. 9/
91. 00			4 178 810	n l	4 178 810		90.00
92. 00 070 09200 085ERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0				1			•
101. 00			., ,	1			
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 440, 547, 736 O 440, 547, 736 118. 00 NONREI MBURSABLE COST CENTERS							
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 440, 547, 736 0			7, 160, 179	0	7, 160, 179		101. 00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 67, 616 0 67, 616 190. 00 191. 00 19100 RESEARCH 1,832, 483 0 1,832, 483 191. 00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3,576, 319 0 3,576, 319 192. 00 194. 00 07950 OTHER NONRE I MBURSEABLE 1,268, 943 0 1, 268, 943 194. 00 194. 01 07951 ADVERTI SI NG 345, 815 0 345, 815 194. 01 194. 02 07952 RETAIL PHARMACY 14,607,027 0 14,607,027 194. 02			440 547 727		440 547 727	I	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 67, 616 0 67, 616 191. 00 19100 RESEARCH 1, 832, 483 0 1, 832, 483 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3, 576, 319 0 3, 576, 319 192. 00 194. 00 07950 OTHER NONREI MBURSEABLE 1, 268, 943 0 1, 268, 943 194. 00 194. 01 07951 ADVERTI SI NG 345, 815 0 345, 815 194. 01 194. 02 07952 RETAI L PHARMACY 14, 607, 027 0 14, 607, 027 194. 02			440, 547, 736	l O	440, 547, 736		118.00
191. 00 19100 RESEARCH 1,832,483 0 1,832,483 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3,576,319 0 3,576,319 192. 00 194. 00 07950 OTHER NONREI MBURSEABLE 1,268,943 0 1,268,943 194. 00 194. 01 07951 ADVERTI SI NG 345,815 0 345,815 194. 01 194. 02 07952 RETAI L PHARMACY 14,607,027 0 14,607,027 194. 02			67 616	nl	67 616		190 00
192. 00 19200 PHYSI CI ANS¹ PRI VATE OFFI CES 3, 576, 319 0 3, 576, 319 192. 00 194. 00 07950 OTHER NONREI MBURSEABLE 1, 268, 943 0 1, 268, 943 194. 00 194. 01 07951 ADVERTI SI NG 345, 815 0 345, 815 194. 01 194. 02 07952 RETAI L PHARMACY 14, 607, 027 0 14, 607, 027 194. 02				1			
194. 01 07951 ADVERTI SI NG 345, 815 0 345, 815 194. 01 194. 02 07952 RETAI L PHARMACY 14, 607, 027 0 14, 607, 027 194. 02				1			192. 00
194. 02 07952 RETAIL PHARMACY 14, 607, 027 0 14, 607, 027 194. 02				1			
	4						
194. US U1935 TITNESS PUTNIE 4, 057, 080 U 4, 057, 080 194. 03	4			1			•
	194. 03	01409 LI INE92 ANIMIE	4, 657, 086	ı O	4, 657, 086		[194. U3

Health Financial Systems	COMMUNITY F	IOSPI TAL		In Lieu of Form CMS-25		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0125	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Prepared: 11/23/2021 10:28 am	
Cost Center Description	Subtotal F	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24.00	25.00	26.00			
194.04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	520, 094	0	520, 09	94	194. 04	
194.05 07955 EINSTEIN BAGELS	85, 100	o	85, 10	00	194. 05	
194.06 07956 NONRTHWESTERN I MAGING	1, 459, 056	0	1, 459, 05	56	194. 06	
200.00 Cross Foot Adjustments	0	0		0	200. 00	
201.00 Negative Cost Centers	0	0		0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	468, 967, 275	0	468, 967, 27	75	202. 00	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0125

				Io	06/30/2021	Date/lime Pre 11/23/2021 10	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA _	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	45, 667		64, 752	64, 752	4. 00
5. 01	00505 PURCHASING & RECEIVING STORES	0	122, 546		123, 113	225	5. 01
5. 02	00506 ADMITTING	0	101, 621		116, 034	1, 437	5. 02
5. 03 5. 04	O0507 CASHI ERI NG/ACCOUNTS RECEI VABLE O0508 OTHER ADMI N & GENERAL	0	159, 755 893, 176		159, 755 1, 628, 170	0 5, 442	5. 03 5. 04
6. 00	00600 MAI NTENANCE & REPAI RS	0	0,0,1,0		0	0, 112	6.00
7. 00	00700 OPERATION OF PLANT	0	2, 092, 997	462, 556	2, 555, 553	1, 352	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	23, 077	0	23, 077	34	8. 00
9. 00	00900 HOUSEKEEPI NG	0	58, 547		104, 611	1, 265	9. 00
10.00	01000 DI ETARY	0	168, 243		313, 650	791	10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	0	173, 976		173, 976 0	406 0	11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION	0	48, 909		219, 181	1, 989	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0	0	14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	26, 437		26, 839	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	16, 740		16, 740	298	17. 00
19. 00 21. 00	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	19. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	l o	3, 360		3, 360	102	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	2, 599, 404		3, 214, 290	11, 755	30. 00
31.00	03100 NTENSIVE CARE UNIT	0	539, 669		1, 292, 578	4, 277	31.00
31. 01 41. 00	02060 NEONATAL INTENSIVE CARE 04100 SUBPROVIDER - IRF	0	163, 734 183, 141		259, 678 201, 771	1, 168 645	31. 01 41. 00
43. 00	04300 NURSERY	0	26, 127		26, 127	426	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	1, 096, 786		4, 377, 403	5, 514	50. 00
51.00	05100 RECOVERY ROOM	0	550, 633		719, 185	2, 114	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	228, 102 14, 604		307, 124 189, 476	780 4, 708	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	295, 711		1, 641, 431	1, 513	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	211, 067		2, 160, 779	500	55. 00
56. 00	05600 RADI OI SOTOPE	0	59, 298		309, 872	302	56. 00
57. 00	05700 CT SCAN	0	86, 649		1, 102, 395	520	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	59, 284		724, 550	339	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	230, 076 277, 468		1, 543, 060 1, 059, 499	1, 051 2, 283	59. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	o o	23, 946		47, 143	134	•
	06400 I NTRAVENOUS THERAPY	O	82, 066		82, 487	132	1
65. 00	06500 RESPI RATORY THERAPY	0	61, 347		169, 868	1, 308	
66. 00	06600 PHYSI CAL THERAPY	0	507, 662		632, 728	1, 936	1
67.00	06700 OCCUPATI ONAL THERAPY	0	38, 520 21, 957		52, 878 64, 107	506	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	208, 650		799, 874	427 1, 027	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	l o	39, 626		114, 831	288	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		o	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	-	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	77, 070		375, 387	1, 500	l .
74. 00 76. 97	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	0	17, 153 66, 549		17, 153 106, 808	42 267	74. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	00, 347	40, 237	100, 000	207	70. 77
90.00		0	47, 244	7, 254	54, 498	774	90. 00
91. 00		0	367, 992	191, 886	559, 878	2, 522	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	O	0	0	0	1 /177	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	0		<u> </u>		1, 477	1101.00
118.00		0	12, 116, 586	15, 619, 083	27, 735, 669	63, 576	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 801		17, 801		190.00
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES		8, 385 830, 812		13, 793 830, 812		191. 00 192. 00
	07950 OTHER NONREIMBURSEABLE		104, 082		190, 901		194. 00
	07951 ADVERTI SI NG	l ol	0		0		194. 01
	07952 RETAIL PHARMACY	0	26, 157	2, 280	28, 437		194. 02

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021		pared:
		CAPITAL REL	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	
194. 03 07953 FI TNESS POINTE	0	681, 623	106, 92	788, 546	329	194. 03
194.04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	21, 839	7, 80	29, 647	87	194. 04
194.05 07955 EINSTEIN BAGELS	0	8, 915	7, 39	16, 313	6	194. 05
194.06 07956 NONRTHWESTERN IMAGING	0	39, 021	351, 95	2 390, 973	105	194. 06
200 00 Cross Foot Adjustments				1	d.	200 00

13, 855, 221

16, 187, 671

30, 042, 892

64, 752 202. 00

200. 00

Cross Foot Adjustments Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00 201.00

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0125

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: | 10 06/30/2021 |

			T	0 06/30/2021	Date/Time Pre 11/23/2021 10	
Cost Center Description	PURCHASING &	ADMI TTI NG	CASHI ERI NG/ACC		MAINTENANCE &	20 4111
	RECEI VI NG		OUNTS	GENERAL	REPAI RS	
	STORES 5. 01	5. 02	RECEI VABLE 5. 03	5. 04	6. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 OO200 CAP REL COSTS-MVBLE EQUIP 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01 00505 PURCHASING & RECEIVING STORES	123, 338					5. 01
5. 02 00506 ADMI TTI NG	130	117, 601				5. 02
5. 03 00507 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	159, 755			5. 03
5.04 OO508 OTHER ADMIN & GENERAL	5, 871	0	0	1, 639, 483		5. 04
6. 00 00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
7. 00 00700 0PERATI ON OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	22	0	0	72, 296 6, 588	0	7. 00 8. 00
9. 00 00900 LAUNDRY & LITNEN SERVICE	500	0	0		0	9.00
10. 00 01000 DI ETARY	1, 348	Ö	0		0	10.00
11. 00 01100 CAFETERI A	0	0	0	3, 146	0	11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 718	0	0	33, 432	0	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	0	0	0	0	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	20, 402	0	16.00
17. 00 01700 SOCI AL SERVI CE	O	0	0		0	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00 02300 PARAMED ED PRGM-(PHARMACY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	1, 421	0	23. 00
30. 00 03000 ADULTS & PEDI ATRI CS	14, 439	8, 828	12, 024	204, 450	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	4, 914	1, 927	2, 624		0	31. 00
31.01 02060 NEONATAL INTENSIVE CARE	1, 674	1, 830	2, 492		0	31. 01
41. 00 04100 SUBPROVI DER - I RF	544	401	547		0	41. 00
43. 00 04300 NURSERY	0	321	437	7, 235	0	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	26, 485	17, 443	23, 332	165, 723	0	50.00
51. 00 05100 RECOVERY ROOM	1, 544	17, 443	23, 332 2, 530		0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 109	529	721	14, 010	0	52. 00
53. 00 05300 ANESTHESI OLOGY	2, 544	2, 736	3, 726		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 805	4, 699	6, 400		0	54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	152	2, 644	3, 601		0	55. 00
56. 00 05600 RADI 0 I SOTOPE 57. 00 05700 CT SCAN	109 1, 479	1, 935 6, 916	2, 636 9, 421		0	56. 00 57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	478	3, 588	4, 887		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	10, 242	8, 712	11, 866		ő	59.00
60. 00 06000 LABORATORY	28, 533	13, 901	18, 934		0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	1, 152	701	954		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	304	209	284		0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 848 957	1, 256 2, 035	1, 711 2, 772	22, 923 37, 330	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	174	2, 035 665	905		0	67.00
68. 00 06800 SPEECH PATHOLOGY	65	294	401	7, 419		68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 370	4, 405	6, 000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	935	1, 054	1, 436			70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	4, 098	5, 582			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	1 100	5, 268	7, 176		0	72.00
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	1, 109 65	8, 660 460	11, 795 627			73. 00 74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	43	183	250		o o	76. 97
OUTPATIENT SERVICE COST CENTERS				.,		
90. 00 09000 CLI NI C	1, 305	763	1, 039			90.00
91. 00 09100 EMERGENCY	7, 872	8, 771	11, 947	49, 894	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	22	512	698	24, 941	0	101. 00
SPECIAL PURPOSE COST CENTERS	22	512	070	24, 741		1101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	122, 861	117, 601	159, 755	1, 556, 285	0	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	72	0	190. 00
191. 00 19100 RESEARCH	22	0	0	6, 296		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	4, 810		192. 00
194. 00 07950 OTHER NONREI MBURSEABLE	0	0	0	-,		194. 00
194. 01 07951 ADVERTISING 194. 02 07952 RETAIL PHARMACY	0 130	0	0	1, 209 50, 796		194. 01 194. 02
194. 03 07953 FLINESS POINTE	43	0	0	9, 972		194. 02
194. 04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	239	Ö	0		0	194. 04
194.05 07955 EINSTEIN BAGELS	0	0	0			194. 05

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Prepared:	

						11/23/2021 10):28 am_
	Cost Center Description	PURCHASING &	ADMI TTI NG	CASHI ERI NG/ACC	OTHER ADMIN &	MAINTENANCE &	
		RECEI VI NG		OUNTS	GENERAL	REPAI RS	
		STORES		RECEI VABLE			
		5. 01	5.02	5. 03	5. 04	6. 00	
194. 06 07956	NONRTHWESTERN IMAGING	43	0	0	4, 739	C	194. 06
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	O	0	0	0	C	201. 00
202. 00	TOTAL (sum lines 118 through 201)	123, 338	117, 601	159, 755	1, 639, 483	C	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0125

| Peri od: | Worksheet B | From 07/01/2020 | Part II | Date/Time Prepared: | 11/23/2021 10:28 am

Cost Center Description
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1-00
2 0 00200 CAP REL COSTS-MUSIC BUILD 2 0 00200 CAP REL COSTS-MUSIC BUILD 3 0 00200 CHROMASTING & RECEIVING STORES 5 0 00200 CHROMASTING & RECEIVING STORES 6 0 00200 CHROMASTING & REPAIR 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
0.0000 DAMPOLEME BERKETT IS DEPARTMENT
5.01 00505 PURCHASTING & RECELLY IND. STORES
5. 02 OBSOR_ADMITTING
0.0500 CASHIER MIKA/ACCIDITS RECEIVABLE
5.0 00000 00000 00100 00100 00100 00100 00100 00000 00100
0.000 0.00
1.00 00700 OPERATION 0 PILANT 2, 629, 223 8.0 00800 LANDRY & LINN SERVICE 5, 812 8.0 00800 LANDRY & LINN SERVICE 5, 812 8.0 00800 LANDRY & LINN SERVICE 14, 745 0.0 144, 852 9.00 00900 LANDRY & LINN SERVICE 14, 745 0.0 144, 852 9.00 0.
8.00 OBSOL LANDRY & LINEN SERVICE 5.8 BTZ 35.511
9.00 0.0000 HOLSEKFEPING
10.00 01000 DIETARY 42, 373 0 2, 353 378, 663 20 10 11 10 01100 CAFETERIA 43, 816 0 2, 433 0 0 0 0 0 0 0 0 0
11.00 01100 CAFETERIA
12.00 01200 MAN INFLANCE OF PERSONNEL 0 0 0 0 0 0 12
13. 00 01300 NURSIN & ADMINI STRATI ON 12, 318 0 684 0 0, 688 14
14. 00 01400 CHITRAL SERVICES & SUPPLY 0 0 0 0 0 0 0 1
15.00 01500 PARAMACY 0 0 0 0 0 0 0 17.00 17.00 17.00 17.00 01700 SOCIAL SERVICE 4,216 0 2344 0 1,644 17.00 17.00 01700 SOCIAL SERVICE 4,216 0 2344 0 1,644 17.00 17.00 01700 SOCIAL SERVICE 4,216 0 2344 0 1,644 17.00 17.00 01700 01700 0 0 0 0 0 0 0 0 0
16. 00 01600 MEDICAL RECORDS & LIBRARY 6, 658 0 370 0 164 17 17. 00 1700 01700 SOICAL SERVICE 4, 216 0 234 0 1, 644 17 19. 00 01900 ROUPHYSICIAN ANESTHETISTS 0 0 0 0 0 0 0 0 0
17.00 O1700 SOCIAL SERVICE
19.00 01900 NOMPIYSI CHAN ANESTHETISTS 0 0 0 0 0 0 0 0 0
22.00 02700 18 SERVICES-SALARY & FRINCES APPRV 0 0 0 0 0 0 0 0 22 23.00 02300 PASANLED ED PROM. (PIMAMACY) 846 0 47 0 470 23 18 18 18 18 18 18 18 1
22.00 02200 IARS SERVI CES-OTHER PREW COSTS APPRY 0 0 0 0 0 22
23.0 02300 PARAMED ED PROM-CPHARMACY) 846
IMPATI ENT ROUTINE SERVICE COST CENTERS 30,00 30,00 30,00 20,00 20,00 20,00 20,00 20,00 31
30.0 03000 ADULTS & PEDIATRICS 654, 673 25, 797 36, 351 293, 543 558, 469 30 31.0 0 310.0 1ATENSI VE CARE 41, 237 1, 826 2, 290 0 4, 461 31 41.0 0 410.0 SUBPROVI DEF - 1 FF 46, 125 2, 029 2, 561 18, 091 3, 170 41 42.0 0 0.0 0 0.0 0 0.0
31.01 0300 03100 INTENSIVE CARE UNIT 135, 918 4,725 7,547 27,974 10,907 31 31 01 2000 NEOMATIA INTENSIVE CARE 41, 237 1,826 2,290 0 4,461 31 34 30 4300 0300 NIRSERY 6,580 1,134 365
31.10 02060 NEONATAL INTENSIVE CARE 41, 237 1, 826 2, 290 0 4, 461 31 41.00 4100 SUBPROVIDER - IRF 6, 550 1, 134 365 18, 091 3, 170 41 43.00 04300 NURSERY 6, 550 1, 134 365 0 1, 879 43 43 43 43 43 43 43 4
41.00 04100 SUBPROVIDER - IRF 46, 125 2, 029 2, 561 18, 091 3, 170 41 43.00 04300 NURSERY 50 1, 134 3655 0 1, 170 41 43.00 04300 NURSERY 5050 1, 134 3655 0 1, 170 41 50.00 05000 OEPRATIN R ROWN 276, 230 0 15, 338 0 25, 595 50 51.00 05000 OEPRATIN R ROWN 138, 679 0 7, 700 16, 334 9, 510 51 52.00 05200 OEPRATIN R ROWN 138, 679 0 7, 700 16, 334 9, 510 51 52.00 05200 OEPRATIN R ROWN 138, 679 0 204 0 5, 181 53 54.00 05200 ANESTHEST OLOSY 3, 678 0 204 0 5, 181 53 54.00 05300 RADIOLOGY - DI AGNOSTIC 74, 476 0 4, 135 0 7, 514 54 55.00 05500 RADIOLOGY - THERAPEUTIC 53, 158 0 2, 952 0 1, 761 55 55.00 05500 RADIOLOGY - THERAPEUTIC 53, 158 0 2, 952 0 1, 761 55 55.00 05500 RADIOLOGY - THERAPEUTIC 53, 158 0 2, 952 0 1, 761 55 56.00 05500 RADIOLOGY - THERAPEUTIC 53, 158 0 2, 952 0 1, 761 55 56.00 05500 RADIOLOGY - THERAPEUTIC 53, 158 0 2, 952 0 1, 761 55 56.00 05500 RADIOLOGY - THERAPEUTIC 53, 158 0 2, 952 0 1, 761 55 56.00 05500 RADIOLOGY - THERAPEUTIC 53, 158 0 829 0 1, 057 56 56.00 05600 RADIOLOGY - THERAPEUTIC 53, 158 0 829 0 1, 212 0 2, 258 57 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 14, 931 0 829 0 1, 212 0 2, 258 57 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 14, 931 0 829 0 1, 212 0 2, 258 57 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 14, 931 0 829 0 1, 221 0 1, 22
ASON 04300 NURSERY
AMCILLARY SERVICE COST CENTERS
50.00
51.00 05100 RECOVERY ROOM 138, 679 0 7,700 16,334 9,510 51 52,00 05200 DELIVERY ROOM LABOR ROOM 57,448 0 3,190 7,434 3,522 52 53.00 05300 ANESTHESI OLOGY 3,678 0 204 0 5,518 53 54.00 05400 RADIOLOGY - DIAGNOSTIC 74,476 0 4,135 0 7,514 54 55.00 05500 RADIOLOGY - THERAPEUTIC 53,158 0 2,952 0 1,761 55 56.00 05500 RADIOLOGY - THERAPEUTIC 53,158 0 2,952 0 1,761 55 56.00 05500 RADIOLOGY - THERAPEUTIC 53,158 0 2,952 0 1,761 55 56.00 05500 RADIOLOGY - THERAPEUTIC 14,935 0 829 0 1,057 58 57 00 5700 CT SCAN 21,823 0 1,212 0 2,583 57 58 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 14,931 0 829 0 1,526 58 59 00 05900 CARDIAC CATHETERI ZATI ON 57,946 0 3,218 0 4,109 59 60 05900 CARDIAC CATHETERI ZATI ON 57,946 0 3,218 0 4,109 59 60 00 06000 LABORATORY 69,881 0 3,380 0 12,915 60 63 00 06000 LABORATORY 15,450 0 858 0 5,636 65 00 06000 LABORATORY 15,450 0 858 0 5,636 65 00 06000 PHYSI CAL THERAPY 15,450 0 858 0 5,636 65 00 06000 PHYSI CAL THERAPY 17,857 0 7,100 0 8,688 66 67,00 06000 PHYSI CAL THERAPY 17,857 0 7,100 0 8,688 66 67,00 06000 0 0 0 1,761 86 69 00 0 0 0 0 0 0 0 0
52.00 05.200 DELIVERY ROOM & LABOR ROOM 57, 448 0 3, 190 7, 434 3, 522 52 53.00 05.300 ANESTHESI OLOGY 3, 678 0 204 0 5, 518 53 54.00 05.400 RADI OLOGY-DI AGNOSTI C 74, 476 0 4, 135 0 7, 514 54 55.00 05.500 RADI OLOGY - THERAPEUTI C 53, 158 0 2, 952 0 1, 761 55 65.00 05.600 RADI OLOGY - THERAPEUTI C 53, 158 0 2, 952 0 1, 761 55 65.00 05.600 RADI OLOGY - THERAPEUTI C 53, 158 0 829 0 1, 057 56 57.00 05.000 CT SCAN 21, 823 0 1, 212 0 2, 583 57 58.00 05.800 MAGNETI C RESONANCE I MAGI NG (MRI) 14, 931 0 829 0 1, 526 58 59.00 05.900 CARDI AC CATHETERI ZATI ON 57, 946 0 3, 218 0 4, 109 59 60.00 06.000 LaBORATORY 69, 881 0 3, 880 0 12, 915 60 60.00 06.000 BLODD STORI NO, PROCESSI NG, & TRANS. 6, 031 0 335 0 587 63 64 60.00 66.00 RESPIRATORY 15, 450 0 8600 RESPIRATORY 15, 450 0 8560 RESPIRATORY 15, 450 0 8560 RESPIRATORY 15, 450 0 8560 RESPIRATORY 15, 450 0 858 0 5, 636 66 67.00 06.000 SPEECH PATHOLOGY 5, 530 0 307 0 1, 761 68 69 00 0 0 0 0 0 0 0 0
53.00 05300 ANESTHESI OLOGY 3, 678 0 204 0 5, 518 53 54.00 05400 RADI OLOGY - THERAPEUTI C 53, 158 0 2, 952 0 1, 761 55 55.00 05500 RADI OLOGY - THERAPEUTI C 53, 158 0 2, 952 0 1, 761 55 56.00 05600 RADI OLOGY - THERAPEUTI C 53, 158 0 2, 952 0 1, 761 55 56.00 05600 RADI OLOGY - THERAPEUTI C 53, 158 0 2, 952 0 1, 761 55 56.00 05600 RADI OLOGY - THERAPEUTI C 2, 253 57 58.00 05500 MARINETI C RESONANCE MAGING MRI) 14, 931 0 829 0 1, 526 58 59 00 50500 CARDI AC CATHETERI ZATI ON 57, 946 0 3, 218 0 4, 109 59 60.00 6000 LABORATORY 69, 881 0 3, 880 0 12, 915 60 60.00 60600 LABORATORY 69, 881 0 3, 880 0 12, 915 60 63.00 60400 INTRAVENOUS THERAPY 20, 669 0 1, 148 0 587 64 65.00 60600 PHYSI CAL THERAPY 15, 450 0 858 0 5, 636 65 66.00 60600 PHYSI CAL THERAPY 17, 857 0 7, 100 0 0 8, 688 66 67.00 60600 SPECH PATHOLOGY 5, 530 0 307 0 1, 996 67 69 60 60 60 60 60 60 60
54.00 05400 RADI OLOGY - THERAPEUTI C 53, 158 0 2, 952 0 1, 761 55 55.00 05500 RADI OLOGY - THERAPEUTI C 53, 158 0 2, 952 0 1, 761 55 55.00 05500 RADI OLOGY - THERAPEUTI C 53, 158 0 2, 952 0 1, 761 55 56.00 05600 RADI OLOGY - THERAPEUTI C 53, 158 0 829 0 1, 057 56 57.00 05700 CT SCAN 21, 823 0 1, 212 0 2, 563 57 58.00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 14, 931 0 829 0 1, 256 58 59.00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 14, 931 0 829 0 1, 256 58 59.00 05900 CARDI AC CATHETERI ZATI ON 57, 946 0 3, 218 0 4, 109 59 60.00 06000 LABORATORY 69, 881 0 3, 218 0 4, 109 59 63.00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 031 0 335 0 587 64 64 00 06400 INTRAVENOUS THERAPY 20, 669 0 1, 148 0 587 64 65 00 06500 RESPI RATORY THERAPY 15, 450 0 858 0 5, 636 65 66 00 06500 RESPI RATORY THERAPY 17, 857 0 7, 100 0 8, 688 66 67, 00 06700 0CCUPATI ONAL THERAPY 9, 702 0 539 0 1, 96 67 68 00 06600 SPEECH PATHOLOGY 5, 530 0 307 0 1, 761 68 69 00 06900 ELECTROCARDI OLOGY 5, 530 0 307 0 1, 761 68 69 00 06900 ELECTROCARDI OLOGY 5, 530 0 554 0 5, 64 00 0. 72 0. 71, 00 0700 ELECTROCARDI OLOGY 5, 549 0 0 0 0 0 0 0 0 0
55.00 05500 RADIOLOGY - THERAPEUTIC 53, 158 0 2,952 0 1,761 55 56 50 05600 RADIOLOGY - THERAPEUTIC 14,935 0 829 0 1,057 56 57 56 57 50 05700 CT SCAN 21,823 0 1,212 0 2,583 57 58 00 05800 MAGNETIC RESONANCE I IMAGING (MRI) 14,931 0 829 0 1,526 58 59 00 05900 CARDIA C CATHETER ZATION 57,946 0 3,218 0 4,109 59 60 00 00 00 00 1,2915 60 63 00 06000 LABORATORY 69,881 0 3,880 0 12,915 60 63 00 6300 BLODD STORING, PROCESSING, & TRANS. 6,031 0 335 0 587 64 65 00 06400 INTRAVENOUS THERAPY 20,669 0 1,148 0 587 64 65 00 06400 INTRAVENOUS THERAPY 15,450 0 858 0 5,636 65 66 00 06600 PHST LOLA L THERAPY 17,450 0 858 0 5,636 65 66 00 06600 PHST LOLA L THERAPY 127,857 0 7,100 0 0 8,688 66 67 00 06700 0CCUPATIONAL THERAPY 9,702 0 539 0 1,996 67 68 00 06900 ELECTROCARDI LOGY 52,549 0 2,918 0 5,048 69 00 06900 ELECTROCARDI LOGY 52,549 0 2,918 0 5,048 69 00 00 0 0 0 0 0 0 0
56.00 05600 RADI OI SOTOPE 14, 935 0 829 0 1, 057 55 57.00 05700 CT SCAN 21, 823 0 1, 212 0 2, 583 55 55 00 05700 CT SCAN 21, 823 0 1, 212 0 2, 583 55 55 00 05900 CARDI AC CATHETERI ZATI ON 57, 946 0 3, 218 0 4, 109 56 60 00 06000 LABORATORY 69, 881 0 3, 880 0 12, 915 60 63.00 06300 BLOOD STORI NG, PROCESSING, & TRANS. 6, 031 0 335 0 587 63 64 60 00 06400 NTRAVRONUS THERAPY 20, 669 0 1, 148 0 587 64 65 00 06500 RESPIRATORY THERAPY 15, 450 0 858 0 5, 636 65 66 00 06600 PHYSI CAL THERAPY 17, 857 0 7, 100 0 8, 688 66 66 00 06600 PHYSI CAL THERAPY 17, 857 0 7, 100 0 8, 688 66 66 00 06000 SPEECH PATHOLOGY 5, 530 0 307 0 1, 796 68 00 06900 ELECTROEACHOLOGY 5, 530 0 307 0 1, 796 68 00 06900 ELECTROEACHOLOGY 5, 530 0 307 0 1, 751 68 69 00 07000 CUELTROEACHOLOGY 5, 530 0 307 0 1, 751 68 69 00 07000 DELICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 0 72 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0
57,00 05700 CT SCAN 21,823 0 1,212 0 2,583 57 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 14,931 0 829 0 1,526 58 59.00 05900 CARDIA C CATHETERI ZATION 57,946 0 3,218 0 4,109 59 60.00 06000 LABORATORY 69,881 0 3,880 0 12,915 60 63.00 03000 5000 STORI NG, PROCESSING, & TRANS. 6,031 0 335 0 587 63 64.00 06400 INTRAVENOUS THERAPY 20,669 0 1,148 0 587 64 65.00 06500 RESPIRATORY THERAPY 15,450 0 858 0 5,636 65 66.00 06600 PNYSICAL THERAPY 17,857 0 7,100 0 8,688 66 67.00 06700 OCCUPATIONAL THERAPY 9,702 0 539 0 1,996 67 68.00 06800 SPEECH PATHOLOGY 5,530 0 307 0 1,761 68 69.00 06900 ELECTROCARDI OLOGY 52,549 0 2,918 0 5,048 69 69 0 0 0 0 0 0 0 0 0
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 14, 931 93 0 829 0 1,526 58 59. 00 05900 CARDIAC CATHETERIZATION 57, 946 0 3,218 0 4,109 59 60. 00 06000 LABORATORY 69,881 0 3,880 0 12,915 60 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 6,031 0 335 0 587 63 64. 00 06400 INTRAVENOUS THERAPY 20,669 0 1,148 0 587 64 65. 00 06500 RESPIRATORY THERAPY 15,450 0 858 0 5,636 65 66. 00 06600 PHYSI CAL THERAPY 127,857 0 7,100 0 8,888 66 66. 00 06600 PHYSI CAL THERAPY 127,857 0 7,100 0 8,888 66 67. 00 06700 OCUPATI ONAL THERAPY 9,702 0 539 0 1,761 68 69. 00 06900 ELECTROCARDI OLOGY 5,530 0 307 0 1,761 68 69. 00 06900 ELECTROCARDI OLOGY 52,549 0 2,918 0 5,648 69 71. 00 07000 THECTROENCEPHALOGRAPHY 9,880 0 554 0 1,526 70 73. 00 07000 THELL DEV. CHARGED TO PATI ENTS 0
59,00 05900 CARDI AC CATHETERIZATION 57,946 0 3,218 0 4,109 59 60.00 06000 LABORATORY 69,881 0 3,880 0 12,915 60 63.00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6,031 0 335 0 587 64 65.00 06400 INTRAVENOUS THERAPY 20,669 0 1,148 0 587 64 65.00 06500 RESPI RATORY THERAPY 15,450 0 858 0 5,636 65 66 0 0600 PHYSI CAL THERAPY 15,450 0 858 0 5,636 65 66 0 0600 PHYSI CAL THERAPY 17,457 0 0 0 0 0 0 0 0 0
60.00 06000 LABORATORY 69, 881 0 3,880 0 12,915 60 63.00 06300 BLODD STORING, PROCESSING, & TRANS. 6, 031 0 335 0 587 63 64.00 06400 INTRAVENOUS THERAPY 20, 669 0 1,148 0 587 64 65.00 06500 RESPIRATORY THERAPY 15, 450 0 888 0 5, 636 65 66.00 06600 PHYSI CAL THERAPY 127, 857 0 7, 100 0 0 8, 688 66 67.00 06700 00CUPATI ONAL THERAPY 127, 857 0 7, 100 0 0 539 0 1, 761 68 69 69.00 06800 SPECH PATHOLOGY 5, 530 0 307 0 1, 761 68 69 69.00 06900 ELECTROCARDIOLOGY 52, 549 0 2, 918 0 5, 048 69 69.00 07000 ELECTROCARDIOLOGY 5, 549 0 2, 918 0 5, 048 69 69.00 07000 ELECTROCARDIOLOGY 5, 549 0 0 0 0 0 0 0 0 0
63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 6,031 0 335 0 587 63 64.00 06400 INTRAVENOUS THERAPY 20,669 0 1,148 0 587 63 65.00 06500 RESPIRATORY THERAPY 15,450 0 858 0 5,636 65 66.00 06600 PHYSI CAL THERAPY 127,857 0 7,100 0 8,688 66 67.00 06700 OCCUPATIONAL THERAPY 9,702 0 539 0 1,996 67 68.00 06800 SPEECH PATHOLOGY 5,530 0 307 0 1,761 67 69.00 06900 ELECTROCARDIOLOGY 52,549 0 2,918 0 5,048 69 70.00 07000 ELECTROENCEPHALOGRAPHY 9,980 0 554 0 1,526 70 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 19,410 0 1,078 0 5,870 73 74.00 07400 RENAL DI ALVISI S 4,320 0 240 0 2,235 74 76.97 07697 CARDIAC REHABILITATION 16,761 0 931 0 1,174 76 79.00 09000 CLIN IC 0 0 0 0 0 0 79.00 09000 DEMERGENCY 92,680 0 5,146 15,287 13,032 91 79.00 09100 EMERGENCY 92,680 0 5,146 15,287 13,032 91 79.00 O9100 DEMERGENCY 0 0 0 0 0 70.00 DITHER REI BRUBRSABLE COST CENTERS 70.01 SUBTOTALS (SUM OF LINES 1 through 117) 2,191,340 35,511 120,537 378,663 220,960 118 70.00 NONREI MBURSABLE COST CENTERS 70.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 4,483 0 249 0 0 15,261 191,00 191,00 191,00 191,00 191,00 191,00 191,00 191,00 191,00 191,00 191,00 191,00 19200 0 0 0 0 0 0 0 117 192.00 192,0
64. 00 06400 INTRAVENOUS THERAPY
65. 00 06500 RESPI RATORY THERAPY 15, 450 0 858 0 5, 636 65 66. 00 06600 PHYSI CAL THERAPY 127, 857 0 7, 100 0 8, 688 66 67. 00 06700 OCCUPATI ONAL THERAPY 9, 702 0 539 0 1, 996 67 68. 00 06800 SPEECH PATHOLOGY 5, 530 0 307 0 1, 761 68 69. 00 06900 ELECTROCARDI OLOGY 52, 549 0 2, 918 0 5, 048 69 70. 00 07000 ELECTROENCEPHALOGRAPHY 9, 980 0 554 0 1, 526 70 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 71 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72 73. 00 07300 DRUGS CHARGED TO PATI ENTS 19, 410 0 1, 078 0 5, 870 73 74. 00 07400 RENAL DI ALYSIS 4, 320 0 240 0 235 74 76. 97 07697 CARDI AC REHABI LITATI ON 16, 761 0 931 0 1, 174 76 07697 CARDI AC REHABI LITATI ON 16, 761 0 931 0 1, 174 76 07697 CARDI AC REHABI LITATI ON 16, 761 0 931 0 1, 174 76 07697 CARDI AC REHABI LITATI ON 16, 761 0 931 0 1, 174 76 07697 CARDI AC REHABI LITATI ON 16, 761 0 931 0 1, 174 76 07697 CARDI AC REHABI LITATI ON 16, 761 0 931 0 1, 174 76 07697 CARDI AC REHABI LITATI ON 16, 761 0 931 0 1, 174 76 07697 CARDI AC REHABI LITATI ON 16, 761 0 931 0 1, 174 76 07697 CARDI AC REHABI LITATI ON 16, 761 0 92, 680 0 5, 146 15, 287 13, 032 91 92, 680 0 0 0 0 0 0 0 0 0
66.00 06600 PHYSI CAL THERAPY 127, 857 0 7, 100 0 8, 688 66 67.00 06700 0CCUPATI ONAL THERAPY 9, 702 0 539 0 1, 996 67 68.00 06800 SPECH PATHOLOGY 5, 530 0 307 0 1, 976 67 69.00 06900 ELECTROCARDI OLOGY 52, 549 0 2, 918 0 5, 048 69 70.00 07000 ELECTROCARDI OLOGY 9, 980 0 554 0 1, 526 70 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 0 72 73.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 19, 410 0 1,078 0 5, 870 73 74.00 07400 RENAL DI ALYSI S 4, 320 0 240 0 235 74 76.00 7697 CARDIA CREHABI LI TATI ON 16, 761 0 931 0 1,174 76 76 76 76 76 76 76
67. 00 06700 OCCUPATIONAL THERAPY 9, 702 0 539 0 1, 996 67 68. 00 06800 SPEECH PATHOLOGY 5, 530 0 307 0 1, 761 68 00 06800 SPEECH PATHOLOGY 5, 530 0 307 0 1, 761 68 09 0 6900 ELECTROCARDIOLOGY 52, 549 0 2, 918 0 5, 048 69 70. 00 07000 ELECTROCARDIOLOGY 9, 980 0 554 0 1, 526 70 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0 71 71 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72 73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 410 0 1, 078 0 5, 870 73 74. 00 07400 RENAL DIALYSIS 4, 320 0 240 0 235 74 76. 97 07697 CARDIAC REHABILITATION 16, 761 0 931 0 1, 174 76 001704TIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 92, 680 0 5, 146 15, 287 13, 032 91 92. 00 09000 EMERGENCY 92, 680 0 5, 146 15, 287 13, 032 91 92. 00 09000 DRUGS CHARGED TO PATIENT SERVICE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 10 0 101 0100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 101 0100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 101 0100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
68. 00
69. 00 06900 ELECTROCARDI OLOGY 52, 549 0 2, 918 0 5, 048 69 70. 00 07000 ELECTROENCEPHALOGRAPHY 9, 980 0 554 0 1, 526 70 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 71 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72 73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 410 0 1, 078 0 5, 870 73 74. 00 07400 RENAL DI ALYSI S 4, 320 0 240 0 235 74 76. 97 CARDI AC REHABILITATI ON 16, 761 0 931 0 1, 174 76 76 77 77 77 77 77
70. 00 07000 ELECTROENCEPHALOGRAPHY 9, 980 0 554 0 1, 526 70 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 71 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 19, 410 0 1, 078 0 5, 870 73 74. 00 07400 RENAL DI ALYSIS 4, 320 0 240 0 235 74 76. 97 07697 CARDI AC REHABI LI TATI ON 16, 761 0 931 0 1, 174 76 76 77 78 78 78 78 78
70. 00 07000 ELECTROENCEPHALOGRAPHY 9, 980 0 554 0 1, 526 70 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 71 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 19, 410 0 1, 078 0 5, 870 73 74. 00 07400 RENAL DI ALYSIS 4, 320 0 240 0 235 74 76. 97 07697 CARDI AC REHABI LI TATI ON 16, 761 0 931 0 1, 174 76 76 77 78 78 78 78 78
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72 73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 410 0 1,078 0 5,870 73 74. 00 07400 RENAL DIALYSIS 4,320 0 240 0 235 74 76. 97 07697 CARDI AC REHABILITATION 16, 761 0 931 0 1,174 76 OUTPATIENT SERVICE COST CENTERS 90. 00 0 0 0 0 0 91. 00 09100 EMERGENCY 92, 680 0 5,146 15, 287 13, 032 91 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 OTHER REIMBURSABLE COST CENTERS 90. 00 0 0 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 191, 340 35, 511 120, 537 378, 663 220, 960 118 NONREI MBURSABLE COST CENTERS 190. 00 19100 RESEARCH 2, 112 0 117 0 1, 526 191 192. 00 19200 PHYSI CIANS' PRI VATE OFFICES 209, 244 0 11, 619 0 117 192
73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 410 0 1,078 0 5,870 73 74.00 07400 RENAL DI ALYSI S 4,320 0 240 0 235 74 76.97 07697 CARDI AC REHABI LI TATI ON 16, 761 0 931 0 1,174 76 0 0 0 0 0 0 0 1,174 76 0 0 0 0 0 0 0 0 0
74. 00 07400 RENAL DI ALYSI S 4, 320 0 240 0 235 74 76 76. 97 07697 CARDI AC REHABI LI TATI ON 16, 761 0 931 0 1, 174 76 76 76 76 76 76 77 76 77 77 78 78
74. 00 07400 RENAL DI ALYSI S 4, 320 0 240 0 235 74 76. 97 07697 CARDI AC REHABI LI TATI ON 16, 761 0 931 0 1, 174 76 0 0 0 0 0 0 0 0 0
OUTPATI ENT SERVICE COST CENTERS O O O O O O O O O
OUTPATI ENT SERVICE COST CENTERS O O O O O O O O O
90. 00 09000 CLI NI C 11, 899 0 661 0 3, 522 90 91. 00 09100 EMERGENCY 92, 680 0 5, 146 15, 287 13, 032 91 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92 00 01010 HER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 101 0100 NONE I MBURSABLE COST CENTERS 18. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 2, 191, 340 35, 511 120, 537 378, 663 220, 960 118 NONNE I MBURSABLE COST CENTERS 190. 00 19000 GI FT , FLOWER, COFFEE SHOP & CANTEEN 4, 483 0 249 0 0 190 191. 00 19100 RESEARCH 2, 112 0 117 0 1, 526 191 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 209, 244 0 11, 619 0 117 192
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 191, 340 35, 511 120, 537 378, 663 220, 960 118 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 4, 483 0 249 0 0 190 191.00 19100 RESEARCH 2, 112 0 117 0 1, 526 191 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 209, 244 0 11, 619 0 117 192
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 4,483 0 249 0 0 19000 19100 19100 RESEARCH 2,112 0 117 0 1,526 19100 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 209,244 0 11,619 0 117 19200 1
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 4,483 0 249 0 0 19000 19100 19100 RESEARCH 2,112 0 117 0 1,526 19100 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 209,244 0 11,619 0 117 19200 1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 4,483 0 249 0 0 190 191. 00 19100 RESEARCH 2,112 0 117 0 1,526 191 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 209, 244 0 11,619 0 117 192
191. 00 19100 RESEARCH 2, 112 0 117 0 1, 526 191 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 209, 244 0 11, 619 0 117 192
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 209, 244 0 11, 619 0 117 192
194. 01 07951 ADVERTI SI NG 0 0 0 0 0 194
194. 02 07952 RETAIL PHARMACY 6, 588 0 366 0 1, 174 194
194. 02 07932 RETAIL PHARWACT 6, 586 0 360 0 1, 174 194 194. 03 07953 FI TNESS POI NTE 171, 670 0 9, 532 0 0 194
194. 05 07955 EI NSTEI N BAGELS 2, 245 0 125 0 0 194
194. 06 07956 NONRTHWESTERN I MAGI NG 9, 828 0 546 0 0 194

Health Financial Systems	COMMUNITY HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-0125	Peri od: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Prep 11/23/2021 10:	

						11/23/2021 10): 28 am
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
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)	2, 629, 223	35, 511	144, 852	378, 663	223, 777	202.00

Provider CCN: 15-0125

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2020 | Part II |
| To 06/30/2021 | Date/Time Prepared: | 11/23/2021 | 10:28 am

					'`	06/30/2021	11/23/2021 10	
		Cost Center Description	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
			TERSONNEL	ADMINI STRATION	SUPPLY		LI BRARY	
	CENED	AL CEDIUSE COCT CENTEDO	12.00	13. 00	14. 00	15. 00	16. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		PURCHASING & RECEIVING STORES						5. 01
5.02		ADMITTING						5. 02
5. 03 5. 04	1	CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMIN & GENERAL						5. 03 5. 04
6.00	1	MAINTENANCE & REPAIRS						6.00
7. 00	1	OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8. 00
9.00	1	HOUSEKEEPI NG						9.00
10. 00 11. 00	1	DI ETARY CAFETERI A						10. 00 11. 00
12. 00	1	MAINTENANCE OF PERSONNEL	0					12. 00
13. 00	1	NURSI NG ADMI NI STRATI ON	0	278, 010				13. 00
14.00		CENTRAL SERVICES & SUPPLY	0	0	0			14. 00
15.00	1	PHARMACY	0	0	0	0	o.o	15. 00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	0	0	0	54, 269	16. 00 17. 00
17.00		NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRV	0	Ö	o	Ö	0	21. 00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	О	0	22. 00
23. 00		PARAMED ED PRGM-(PHARMACY)	0	0	0	0	0	23. 00
20.00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS		11/ 025		ما	4 100	20.00
30. 00 31. 00		ADULIS & PEDIATRICS INTENSIVE CARE UNIT	0	116, 025 33, 577	0	0	4, 109 897	1
31. 00		NEONATAL INTENSIVE CARE	0	8, 934		o	852	•
41.00	1	SUBPROVI DER - I RF	0	6, 189	0	o	187	41.00
43. 00		NURSERY	0	3, 816	0	0	149	43. 00
FO 00		LARY SERVICE COST CENTERS		FO 010		ام	7 / 47	F0 00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	0	50, 819 18, 804	0	0	7, 647 865	50. 00 51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	6, 950		o	246	1
53. 00	1	ANESTHESI OLOGY	0	0	O	ō	1, 274	•
54.00		RADI OLOGY-DI AGNOSTI C	0	0	0	o	2, 187	1
55. 00		RADI OLOGY - THERAPEUTI C	0	0	0	0	1, 231	1
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	0	0	0	901 3, 220	56. 00 57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1, 670	1
59. 00		CARDI AC CATHETERI ZATI ON	0	Ö	Ö	Ö	4, 055	•
60.00	06000	LABORATORY	0	0	0	o	6, 471	60.00
63.00	1	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	326	1
64. 00 65. 00	1	I NTRAVENOUS THERAPY	0	0	0	0	97 585	64. 00 65. 00
66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0	0	ol Ol	947	•
67. 00	1	OCCUPATI ONAL THERAPY	0	Ö		Ö	309	
68. 00		SPEECH PATHOLOGY	0	0	0	О	137	
69. 00		ELECTROCARDI OLOGY	0	0	0	0	2, 050	1
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	491	l
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1, 908 2, 452	1
73. 00		DRUGS CHARGED TO PATIENTS	0	0	Ö	o	4, 031	1
74.00		RENAL DIALYSIS	0	0	0	o	214	•
76. 97		CARDIAC REHABILITATION	0	0	0	0	85	76. 97
00.00		TIENT SERVICE COST CENTERS		(012		ام	255	00.00
90. 00 91. 00	1	CLINIC EMERGENCY	0	6, 913 25, 983		0	355 4, 083	•
92. 00		OBSERVATION BEDS (NON-DISTINCT PART		23, 703		o o	4, 003	92.00
		REIMBURSABLE COST CENTERS						
101.00		HOME HEALTH AGENCY	0	0	0	0	238	101. 00
440.00		AL PURPOSE COST CENTERS	1 0	070 040		ما	F.4.0/0	140.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	278, 010	0	0	54, 269	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		RESEARCH	0	0	ol	ol		191. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	o	o	0	192. 00
		OTHER NONREI MBURSEABLE	0	0	0	0		194. 00
		ADVERTI SI NG	0	0	0	0		194. 01
		RETAIL PHARMACY FITNESS POINTE	0	0		0		194. 02 194. 03
		FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	ol	ol		194. 04
		EINSTEIN BAGELS	0	O	o	ō		194. 05
				'	,			

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
					From 07/01/2020		
					To 06/30/2021	Date/Time Pre	epared:
						11/23/2021 10): 28 am
	Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL	ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		12.00	13.00	14.00	15. 00	16.00	
194.00	07956 NONRTHWESTERN I MAGING	0	0		0 0	0	194. 06
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)	0	278, 010)	0 0	54, 269	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2020 | Part II |
| To 06/30/2021 | Date/Time Prepared: | 11/23/2021 | 10:28 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0125

				0 06/30/2021	11/23/2021 10	
			INTERNS &	RESI DENTS		
Cost Center Description	SOCI AL SERVI CE	NONPHYSICIAN	SERVI CES-SALAR	SEDVI CES_OTHED	PARAMED ED	
cost center bescription	SOCIAL SERVICE	ANESTHETI STS	Y & FRI NGES		PRGM-(PHARMACY	
			APPRV	APPRV)	
	17. 00	19. 00	21.00	22. 00	23.00	
GENERAL SERVICE COST CENTERS	1					
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01 00505 PURCHASING & RECEIVING STORES						5. 01
5. 02 00506 ADMI TTI NG						5. 02
5. 03 00507 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5.04 OO508 OTHER ADMIN & GENERAL						5. 04
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
12. 00 01200 MAINTENANCE OF PERSONNEL						12. 00
13.00 01300 NURSING ADMINISTRATION						13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	27, 529					16. 00 17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	27, 327	0				19.00
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	o o) o			21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0			0		22. 00
23.00 O2300 PARAMED ED PRGM-(PHARMACY)	0				6, 246	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	T	Г			Г	
30. 00 03000 ADULTS & PEDI ATRI CS	19, 998	ł				30.00
31. 00 03100 INTENSI VE CARE UNIT 31. 01 02060 NEONATAL INTENSI VE CARE	3, 663 1, 416	l				31. 00 31. 01
41. 00 04100 SUBPROVI DER - RF	1, 573	ł				41.00
43. 00 04300 NURSERY	879					43. 00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	l				50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0					51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0					55. 00
56. 00 05600 RADI 01 SOTOPE	0					56. 00
57. 00 05700 CT SCAN	0					57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	0					58. 00 59. 00
60. 00 06000 LABORATORY	0					60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	o o					63. 00
64.00 06400 INTRAVENOUS THERAPY	0					64. 00
65. 00 06500 RESPI RATORY THERAPY	0					65. 00
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0					67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					73.00
74. 00 07400 RENAL DI ALYSI S 76. 97 07697 CARDI AC REHABI LI TATI ON	0					74. 00 76. 97
OUTPATIENT SERVICE COST CENTERS						70.97
90. 00 09000 CLINIC	0					90.00
91. 00 09100 EMERGENCY	0					91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	1					101 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0					101. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	27, 529	О	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS	2,,,02,		,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
191. 00 19100 RESEARCH	0					191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0					192. 00
194. 00 07950 OTHER NONREI MBURSEABLE 194. 01 07951 ADVERTI SI NG						194. 00 194. 01
194. 01 07951 ADVERTISING 194. 02 07952 RETALL PHARMACY						194. 01
194. 03 07953 FI TNESS POINTE						194. 02
		•	•		•	·

Heal th Financial Systems

COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0125
From 07/01/2020
To 06/30/2021
Date/Time Prepared:

						11/23/2021 10	: 28 am
				INTERNS &	RESI DENTS		
	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
			ANESTHETI STS	Y & FRINGES	PRGM COSTS	PRGM-(PHARMACY	
				APPRV	APPRV)	
		17. 00	19. 00	21.00	22. 00	23. 00	
194. 04 07954	FITNESS POINTE SPA/PRO SHOP/DIETARY	0					194. 04
194. 05 07955	EINSTEIN BAGELS	0					194. 05
194. 06 07956	NONRTHWESTERN I MAGING	0					194. 06
200. 00	Cross Foot Adjustments		0	0	0	6, 246	200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	27, 529	0	0	0	6, 246	202. 00

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0125

Cost Center Prescription						То	06/30/2021	Date/Time Pro	
STEPRING SPRINGER COST CENTERS		Cost Center Description	Subtotal		Total			1172372021 10	7. 20 am
Charles Service COST CENTERS 24 00 26 00									
DEMINDLE SERVICE COST CERTIESS									
TO TO TO TO TO TO TO TO			24 00		26.00				
2.00			211 00	20.00	20.00				
4.00									1
5D1 DROOD PURCHASING A RECEIT VINE STORIES 501 502 DROOD CLASH FEW RECEITS RECEIVED F 501 503 DROOD CLASH FEW RECEITS RECEIVED F 501 504 DROOD CLASH FEW RECEIVED F 501 505 DROOD CLASH FEW RECEIVED F 501 507 DROOD CLASH FEW RECEIVED F 501 507 DROOD CLASH FEW RECEIVED F 501 500 DROOD CLASH F 501 500 DROOD CLASH FEW RECEIVED F 501 500 DROOD CLASH F 501 5		1 1							1
5.03 000007 CASHI FIRM KAZACIOMIST SECTI VABILE 5.03 6.00 000006 MAINTEAMER & REPAIRS 5.00 7.00 000006 MAINTEAMER & REPAIRS 6.00 7.00 000006 MAINTEAMER & REPAIRS 7.00 7.00 000006 MAINTEAMER & REPAIRS 7.00 7.00 000006 DUSEREETH IN SERVICE 7.00 7.00		00505 PURCHASING & RECEIVING STORES							1
0.00508 OTHER ADM N & CENERAL		1 1							1
0.00 00-000 IMI NETAINANCE & REPAIRS		1 1							1
8.00 00000 LANDRY & LINEN SERVICE									1
9.00 0.009 INJEKTEP IN		1							1
10.00 01000 DETARY									1
12.00 10200 MAINTENANCE OF PERSONNEL									1
13.00 1300 MIRSI NA ADMINI STRATION 14.00 1400		1							1
14.00 01400 CENTRAL SERVICES & SUPPLY		1 1							•
15.00 1500 PHARMACY		1							1
17.0 0.0 1700 NORPHYSI CAN AMESTHETISTS 19.0 0.0 1700 0.0 1700 0.0 187. SERVICES-SALARY & FRINGES APPRV 21.0 0.0 20.0 0.2000 1.88 SERVICES-SALARY & FRINGES APPRV 22.0 0.0 20.0 1.88 SERVICES-SHLER PREGU COSTS APPRV 22.0 0.0 20.0 1.88 SERVICES-SHLER PREGU COSTS APPRV 22.0 0.0 20									1
9.00 01900 MONIPHYSICIAN AMESTHETISTS 21.00 220 187 SERVICES-SALARY & FIN MOSE APPRY 22.00 2200 187 SERVICES-OTHER PROM COSTS APPRY 22.00 2200 187 SERVICES-OTHER PROM COSTS APPRY 22.00 2200 187 SERVICES-OTHER PROM COSTS APPRY 23.00 23.00 2300 2000		1							1
21.00									1
23.00									1
INPAIL ENT ROUTH NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDITATICS 4,674,751 0 4,674,751 31.00 3									1
0.000 0.0000 ADULTS & PEDI ATRIC S 4, 674, 751 0 4, 674, 751 30. 00 31. 01 0.0010 INTENSIVE CARE UNIT 1, 607, 821 31. 00 31. 01 0.005 0.	23. 00								23.00
13.1 0 02600 NEONATAL INTENSIVE CARE 347, 103 0 347, 103 31, 101	30. 00		4, 674, 751	O	4, 674,	751			30. 00
A1. 00 04100 SUBPROVI DER - I FF 296, 706 0 296, 706 0 43, 918 43, 00 A30, 00 A300 MIRSERY 49, 348 43, 00 A30, 00 A300 OFERATI NG ROOM 4, 991, 529 50, 00 5000 OPERATI NG ROOM 4, 991, 529 50, 00 51, 00 05100 OPERATI NG ROOM 40, 995, 194 51, 00 51, 00 05100 RECOVERY ROOM & LABOR ROOM 403, 063 52, 00 520 05200 DELIVERY ROOM & LABOR ROOM 403, 063 52, 00 53, 00 05300 DELIVERY ROOM & LABOR ROOM 403, 063 52, 00 520 05500 DELIVERY ROOM & LABOR ROOM 40, 30, 63 52, 00 55, 00 05500 APRITHESI OLGGY 230, 717 0 230, 717 53, 00 55, 00 05500 RADI OLGGY - 10 AGNOSTI C 1, 782, 078 0 2, 249, 489 55, 00 55, 00 05500 RADI OLGGY - 1 THERAPEUTI C 2, 249, 489 0 2, 249, 489 55, 00 56, 00 56500 RADI OLGGY - 1 THERAPEUTI C 344, 768 0 344, 768 56, 00 5600 RADI OLGGY - 1 THERAPEUTI C 344, 768 0 344, 768 56, 00 5600 CARDIAC CATHETERI ZATI LON 1, 683, 135 0 1, 700, 170 57, 00 59, 00 05900 CARDIAC CATHETERI ZATI LON 1, 683, 135 0 1, 683, 135 59, 00 0600 LARDRATORY PROCESSING, & TRANS. 69, 086 0 69, 086 63, 00 64, 00 6		1 1		1					1
43.00 A30.00 A3				1					1
ANCIL LLARY SERVICE COST CENTERS 50.00		1 1		1					1
51.00 05100 RECOVERY ROOM 255, 194 0 955, 194 51.00		ANCILLARY SERVICE COST CENTERS							
52.00 05200 DELLYERY ROOM & LABOR ROOM 403,063 52.00									1
54. 00		1 1		l					1
55.00 05500 RADIO LOGY - THERAPEUTI C 2, 249, 489 0 2, 249, 489 55.00 65.00 656.00 656.00 6500 RADIO IOSTOTPE 344, 768 0 344, 768 56.00 57.00 05700 CT SCAN 1, 170, 170 0 1, 170, 170 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 765, 770 0 765, 770 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 765, 770 0 765, 770 58.00 05900 CARDIA C CATHETERI ZATI ON 1, 683, 135 0 1, 683, 135 59.00 60.00 06000 LABORATORY 1310, 406 0 1, 310, 406 60.00		05300 ANESTHESI OLOGY	230, 717	o	230,	717			53. 00
56.00 05600 RADI OI SOTOPE 344, 768 0 344, 768 56.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 765, 770 0 765, 770 58.00 59.00 05900 CARDIA C CATHETERI ZATI ON 1.683, 135 0 1.683, 135 59.00 63.00 05900 LABORATORY 1.310, 406 0 1.310, 406 60.00 63.00 05000 LABORATORY 1.310, 406 0 1.310, 406 60.00 63.00 05000 LABORATORY 1.310, 406 0 69.086 63.00 64.00 04640 INTRAVENOUS THERAPY 108, 581 0 108, 581 64.00 65.00 05900 PHYSI CAL THERAPY 221, 443 0 221, 443 65.00 66.00 66.00 PHYSI CAL THERAPY 822, 350 0 822, 350 66.00 66.00 66.00 PHYSI CAL THERAPY 77, 768 0 77, 768 67.00 68.00 05900 ELECTROCARDIOLOGY 804, 448 0 80, 448 68.00 69.0									1
57. 00 05700 CT SCAN 1,170,170 0 1,170,170 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 765,770 0 765,770 0 765,770 58. 00 05900 CARDI AC CATHETERI ZATI ON 1,683,135 0 1,683,135 59. 00 0600 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000				1					1
59.00 05900 CARDIAC CATHETERIZATION 1,683,135 0 1,683,135 0 0.0	57. 00	05700 CT SCAN		l .	1, 170,	170			57. 00
60.00 06000 LABORATORY 1, 310, 406 0 1, 310, 406 63.00				1					•
63. 00 66300 BLOOD STORING, PROCESSING, & TRANS. 69,086 0 69,086 0 64.00 64.00 06400 INTRAVENOUS THERAPY 108,581 0 108,581 0 108,581 64.00 65.00 06500 RESPIRATORY THERAPY 221,443 0 221,443 0 221,443 65.00 66.00 06600 PHYSI CAL THERAPY 822,350 0 822,350 66.00 67.00 06700 0CCUPATI ONAL THERAPY 77,768 0 77,768 67.00 68.00 06800 SPEECH PATHOLOGY 80,448 0 80,448 68.00 69.00 06900 ELECTROCARDI OLOGY 898,160 0 898,160 69.00 71.00 07000 07000 ELECTROCROBIOLOGY 898,160 0 898,160 99.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 129,784 0 129,784 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 167,692 0 167,692 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 522,157 0 522,157 73.00 74.00 07400 RENAL DIALYSIS 31,034 0 31,034 74.00 76.97 07697 CARDI AC REHABILITATI ON 131,086 0 131,086 76.97 76.97 07697 CARDI AC REHABILITATI ON 131,086 0 31,034 79.00 79.00 09100 EMERGENCY 797,095 0 797,095 91.00 79.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 797,095 0 70.00 07000 MEDI EALTH AGENCY 27,888 0 27,888 0 27,888 101.00 79.00 09000 CLI NI C 797,095 0 27,179,557 10 79.00 01000 MEDI EALTH AGENCY 27,888 0 27,888 0 27,888 101.00 79.00 09000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 22,605 0 24,256 191.00 791.00 01000 MESECRACH 24,256 0 24,256 191.00 792.00 09000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 222,043 0 222,043 194.00 794.00 07950 ADVERTISING 1,209 0 1,209 194.01 794.00 07952 RETAIL PHARMACY 87,727 0 87,727 194.00				1					1
65. 00 06500 RESPI RATORY THERAPY 221, 443 0 221, 443 66. 00 066		1 1		1					1
66. 00 06600 PHYSI CAL THERAPY 822, 350 0 822, 350 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 77, 768 0 77, 768 67. 00 68. 00 06800 SPEECH PATHOLOGY 89, 448 0 80, 448 68. 00 69. 00 06900 ELECTROCARDI OLOGY 898, 160 0 898, 160 69. 00 70. 00 07000 ELECTROCARDI OLOGY 138, 093 0 138, 093 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 129, 784 0 129, 784 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 167, 692 0 167, 692 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 522, 157 0 522, 157 73. 00 74. 00 07400 RENAL DI ALYSI S 3 31,034 0 31,034 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 131,086 0 131,086 76. 97 90. 00 09000 CLI NI C 94,844 0 94,844 90. 00 91. 00 09000 DEREGENCY 797,095 0 797,095 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 91. 00 SUBSTALE COST CENTERS 101.00 118. 00 SUBSTALE COST CENTERS 101.00 119. 00 19100 RESEARCH 22,605 0 22,605 190.00 191. 00 19100 GIFT, FLOWER, COFFEE SHOP & CANTEEN 22,605 0 22,605 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1,956,625 0 1,056,625 192. 00 194. 00 07950 OTHER NONREI MBURSABLE 222,043 0 222,043 194. 00 194. 00 07951 ADVERTISI NG 1,209 0 1,209 194. 01 194. 01 07951 ADVERTISI NG 1,209 0 1,209 194. 01 194. 02 07952 RETAI L PHARMACY 87,727 0 87,727 194.00				i -					1
67. 00 06700 0CCUPATI ONAL THERAPY 77, 768 0 77, 768 68. 00 06800 SPECH PATHOLOGY 80, 448 0 80, 448 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 898, 160 0 898, 160 69. 00 07000 ELECTROCARDI OLOGY 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 898, 160 0 138, 093 0 138, 093 0 138, 093 0 138, 093 0 1000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 129, 784 0 129,				1					1
69. 00 06900 ELECTROCARDIOLOGY 898, 160 0 898, 160 0 70. 00 7000 ELECTROENCEPHALOGRAPHY 138, 093 0 138, 093 70. 00 70. 00 70100 MEDI CAL SUPPLIES CHARGED TO PATIENT 129, 784 0 129, 784 71. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 167, 692 0 167, 692 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 522, 157 0 522, 157 73. 00 74. 00 7									
70. 00 07000 ELECTROENCEPHALOGRAPHY 138, 093 0 138, 093 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 129, 784 0 129, 784 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 167, 692 0 167, 692 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 522, 157 0 522, 157 73. 00 74. 00 07400 RENAL DI ALYSI S 31, 034 0 31, 034 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 131, 086 0 131, 086 0 0017PATI ENT SERVI CE COST CENTERS 790. 00 09000 CLI NI C 94, 844 0 94, 844 90. 094, 844 90. 094, 844 90. 092. 00 09200 BMERGENCY 797, 095 0 797, 095 0 797, 095 91. 00 09000 DEMERGENCY 090000 DEMERGENCY 090000 DEMERGENCY 09000 DEMERGENCY 090000 DEMERGENCY 090000 DEMERGENCY 09000 DEMERGENCY 090000 DEMERGENCY 090000 DEMERGENCY 090000000 DEMERGENCY 09000000000 DEMERGENCY 090000000000000000000000000000000000				1					
71. 00		1 1							
73. 00				1					
74. 00		07200 IMPL. DEV. CHARGED TO PATIENTS		1					
76. 97 O7697 CARDI AC REHABI LITATI ON 131, 086 0 131, 086 76. 97 OUTPATI ENT SERVI CE COST CENTERS 90. 00 O9000 CLI NI C 94, 844 0 94, 844 0 97, 095 0 797, 095 91. 00 99100 EMERGENCY 977, 095 0 797, 095 91. 00 99200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 27, 888 0 27, 888 101. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 27, 179, 557 0 27, 179, 557 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 24, 256 0 24, 256 191. 00 191. 00 19100 RESEARCH 24, 256 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 056, 625 0 1, 056, 625 192. 00 194. 00 107951 ADVERTI SI NG 1, 209 194. 00 194. 02 07952 RETAIL PHARMACY 87, 727 0 87, 727 194. 02									
OUTPATI ENT SERVICE COST CENTERS OUTPATI ENT SEVEN SERVICE COST CENTERS OUTPATI ENT SERVICE COST CENTERS OUTPATI			·	l					
91. 00		OUTPATIENT SERVICE COST CENTERS							
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0				l					
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 27,888 0 27,888 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 27,179,557 0 27,179,557 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 22,605 0 22,605 190.00 19100 RESEARCH 24,256 0 24,256 191.00 19200 PHYSI CI ANS' PRI VATE OFFICES 1,056,625 0 1,056,625 192.00 194.00 07950 07HER NONREI MBURSEABLE 222,043 0 222,043 194.00 194.01 07951 ADVERTI SI NG 1,209 0 1,209 194.01 194.02 07952 RETAIL PHARMACY 87,727 194.02			797, 093		191,	093			
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 27, 179, 557 O 27, 179, 557 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 27, 179, 557 O 27, 179, 557 Subtotal Sub		OTHER REIMBURSABLE COST CENTERS							
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 27, 179, 557 0 27, 179, 557 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 22, 605 0 22, 605 190. 00 19100 RESEARCH 24, 256 0 24, 256 191. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 056, 625 0 1, 056, 625 192. 00 19200 19	101.00		27, 888	0	27,	888			101. 00
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 22, 605 0 22, 605 191. 00 19100 RESEARCH 24, 256 0 24, 256 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 1, 056, 625 0 1, 056, 625 192. 00 194. 00 07950 OTHER NONREI MBURSEABLE 222, 043 0 222, 043 194. 00 194. 01 07951 ADVERTI SI NG 1, 209 0 1, 209 194. 01 194. 02 07952 RETAI L PHARMACY 87, 727 0 87, 727 194. 02	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	27, 179, 557	0	27, 179,	557			118. 00
191. 00 19100 RESEARCH 24, 256 0 24, 256 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 056, 625 0 1, 056, 625 192. 00 194. 00 07950 OTHER NONREI MBURSEABLE 222, 043 0 222, 043 194. 00 194. 01 194. 02 07952 RETAI L PHARMACY 87, 727 0 87, 727 194. 02	190.00		22, 605	O	22,	605			190. 00
194. 00 07950 OTHER NONREI MBURSEABLE 222, 043 0 222, 043 194. 00 194. 01 07951 ADVERTI SI NG 1, 209 0 1, 209 194. 01 194. 02 07952 RETAI L PHARMACY 87, 727 0 87, 727 194. 02		1		1	24,	256			1
194. 01 07951 ADVERTI SI NG 1, 209 0 1, 209 194. 01 194. 02 07952 RETAI L PHARMACY 87, 727 0 87, 727 194. 02				1					1
194. 02 07952 RETAI L PHARMACY 87, 727 0 87, 727 194. 02									
194. 03 07953 FITNESS POINTE 980, 092 0 980, 092 194. 03	194. 02	07952 RETAIL PHARMACY	87, 727	o	87,	727			194. 02
	194. 03	3 07953 FITNESS POINTE	980, 092	0	980,	092			194. 03

Health Financial Systems	tems COMMUNITY HOSPITAL				
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCI		Peri od: From 07/01/2020 To 06/30/2021	
Cost Center Description	Subtotal F	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25. 00	26. 00		
194. 04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	37, 394	0	37, 39	94	194. 04
194. 05 07955 EINSTEIN BAGELS	18, 904	O	18, 90)4	194. 05
194.06 07956 NONRTHWESTERN IMAGING	406, 234	0	406, 23	34	194. 06
200.00 Cross Foot Adjustments	6, 246	o	6, 24	16	200. 00
201.00 Negative Cost Centers	o	O		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	30, 042, 892	o	30, 042, 89	92	202. 00

	Financial Systems	COMMUNITY		ON 45 0405 5		eu of Form CMS	
COST	ALLOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pre	pared:
		CAPITAL REI	L LATED COSTS			11/23/2021 10	:28 am
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	DEPARTMENT (GROSS SALARI ES)	PURCHASING & RECEIVING STORES (COSTED REQ)	ADMI TTI NG (GROSS REVENUE)	
	T	1.00	2.00	4. 00	5. 01	5. 02	
1 00	GENERAL SERVI CE COST CENTERS	040 217	1	I			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	940, 217	40, 783, 861				1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 099			7		4. 00
5. 01	00505 PURCHASING & RECEIVING STORES	8, 316					5. 01
5.02	00506 ADMI TTI NG	6, 896	36, 312	4, 093, 539	6	2, 029, 817, 649	
5. 03	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE	10, 841	l .		0	0	
5. 04 6. 00	00508 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS	60, 611	1, 851, 772	15, 504, 502	270	1	
7. 00	00700 OPERATION OF PLANT	142, 031	1, 165, 381	3, 851, 685		0	1
8.00	00800 LAUNDRY & LINEN SERVICE	1, 566		96, 188		Ō	1
9.00	00900 HOUSEKEEPI NG	3, 973	l .			0	
10.00	01000 DI ETARY	11, 417			62	l e	
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	11, 806	0	1, 157, 061	0 0	1	11. 00
13. 00	01300 NURSING ADMINISTRATION	3, 319	428, 989	5, 666, 854			1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	(0	l .	14. 00
15.00	01500 PHARMACY	0	0	(0	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 794			0	1	16. 00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	1, 136	0	849, 850	0	0	17. 00 19. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV		0			0	1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	Ö		o o	· ·	22. 00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	228	0	289, 261	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	176, 396 36, 622					
31. 00	02060 NEONATAL INTENSIVE CARE	11, 111					1
41. 00	04100 SUBPROVI DER - I RF	12, 428					1
43.00	04300 NURSERY	1, 773	0	1, 213, 053	0	5, 530, 509	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	74 400	0.275.242	15 710 170	1 210	202.077.742	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	74, 428 37, 366					1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	15, 479	1				1
53.00	05300 ANESTHESI OLOGY	991	440, 579			l	
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 067					
55. 00 56. 00	O5500 RADI OLOGY - THERAPEUTI C O5600 RADI OI SOTOPE	14, 323				45, 584, 339	1
57. 00	05700 CT SCAN	4, 024 5, 880	l ·				
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 023					1
	05900 CARDI AC CATHETERI ZATI ON	15, 613		2, 993, 570	471	l	1
60.00	06000 LABORATORY	18, 829					
63. 00 64. 00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	1, 625 5, 569					
65. 00	06500 RESPIRATORY THERAPY	4, 163				1	1
66. 00	06600 PHYSI CAL THERAPY	34, 450				35, 086, 846	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 614		1, 441, 502	2 8		
68. 00	06800 SPEECH PATHOLOGY	1, 490				5, 077, 157	•
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	14, 159 2, 689					
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,009	l .	020, 099		l e	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	_		0		
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 230	751, 592	4, 272, 741	51	149, 305, 181	73. 00
74. 00	07400 RENAL DIALYSIS	1, 164	l .	1.20,000			
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	4, 516	101, 430	761, 042	2 2	3, 162, 317	76. 97
90. 00	09000 CLINIC	3, 206	18, 275	2, 205, 595	5 60	13, 154, 401	90.00
91.00	09100 EMERGENCY	24, 972	1			1	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
101 00	OTHER REIMBURSABLE COST CENTERS			4 207 543	1	0 021 004	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	4, 207, 543	3 1	8, 831, 894	1101.00
118.00		822, 233	39, 351, 339	181, 372, 357	5, 650	2, 029, 817, 649	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 208	0	(0	•	190. 00
	19100 RESEARCH	569					191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	56, 379	l .	65, 207			192.00
	07950 OTHER NONREI MBURSEABLE 07951 ADVERTI SI NG	7, 063			0 0		194. 00 194. 01
	- I - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		1	1	-1 0	· · · · · ·	1.71.01

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552			
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0125	Peri od:	Worksheet B-1		

From 07/01/2020 To 06/30/2021 Date/Time Prepared: 11/23/2021 10:28 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** PURCHASING & ADMI TTI NG Cost Center Description (SQUARE FEET) (DOLLAR VALUE) **BENEFITS** RECEI VI NG (GROSS DEPARTMENT STORES REVENUE) (GROSS (COSTED REQ) SALARI ES) 1.00 2.00 4.00 5. 01 5. 02 194. 02 07952 RETAIL PHARMACY 1, 775 5, 744 671, 509 0 194. 02 6 194. 03 07953 FITNESS POINTE 938, 290 0 194. 03 46, 255 269, 387 194. 04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY 1, 482 19, 672 249, 150 11 0 194. 04 194. 05 07955 EINSTEIN BAGELS 605 18, 639 17, 954 0 0 194. 05 194.06 07956 NONRTHWESTERN I MAGING 300, 216 2 0 194. 06 2, 648 886, 722 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 16, 187, 671 28, 372, 265 202.00 Cost to be allocated (per Wkst. B, 13, 855, 221 731, 625 5, 378, 021 202. 00 Part I) 0. 153592 203.00 Unit cost multiplier (Wkst. B, Part I) 128. 988893 0. 002650 203. 00 14. 736195 0.396914 204.00 Cost to be allocated (per Wkst. B, 64, 752 123, 338 117, 601 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000351 21. 745063 0. 000058 205. 00 II) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207. 00 Parts III and IV)

Health Financial Systems		COMMUNITY H	OSPI TAL		In Lie	u of Form CMS-	
COST ALLOCATION - STATISTICAL BAS	SIS		Provi der Co		Peri od:	Worksheet B-1	
					From 07/01/2020 o 06/30/2021	Date/Time Pre	nared.
						11/23/2021 10	
Cost Center Descripti	i on	CASHI ERI NG/ACC R	econciliation	OTHER ADMIN &	MAINTENANCE &	OPERATION OF	
		OUNTS		GENERAL	REPAI RS	PLANT	
		RECEI VABLE		(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	
		(GROSS					
		REVENUE)	5A. 04	E 04	4 00	7.00	
GENERAL SERVICE COST CENTE	DC	5.03	3A. U4	5. 04	6. 00	7. 00	
1. 00 O0100 CAP REL COSTS-BLDG &							1.00
2. 00 00200 CAP REL COSTS-MVBLE E							2.00
4.00 00400 EMPLOYEE BENEFITS DEF							4. 00
5. 01 00505 PURCHASING & RECEIVING							5. 01
5. 02 00506 ADMITTING							5. 02
5. 03 00507 CASHI ERI NG/ACCOUNTS F	RECEI VABLE	2, 029, 817, 649					5. 03
5.04 00508 OTHER ADMIN & GENERAL		0	-61, 454, 916	407, 512, 359			5. 04
6.00 00600 MAINTENANCE & REPAIRS	S	0	0	(6. 00
7.00 00700 OPERATION OF PLANT		0	0	17, 970, 586		708, 423	7. 00
8. 00 00800 LAUNDRY & LINEN SERVI	ICE	0	0	1, 637, 584			1
9. 00 00900 HOUSEKEEPI NG		0	0			3, 973	1
10. 00 01000 DI ETARY		0	0	4, 511, 161		11, 417	
11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSON	MMEI	0	0		11, 806	11, 806 0	11. 00 12. 00
13. 00 01300 NURSI NG ADMI NI STRATI (0	0		3, 319	3, 319	1
14. 00 01400 CENTRAL SERVICES & SU		0	0	0,310,177	3, 319	3, 319	14. 00
15. 00 01500 PHARMACY	JI I L I		0			0	15. 00
16. 00 01600 MEDI CAL RECORDS & LIE	BRARY	0	0	5, 071, 464	1, 794	1, 794	1
17. 00 01700 SOCIAL SERVICE	5.0		0	1, 092, 901		1, 136	
19. 00 01900 NONPHYSICIAN ANESTHET	TLSTS	o	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ol	0	
21. 00 02100 L&R SERVI CES-SALARY 8		O	0		ol	0	
22. 00 02200 1 &R SERVICES-OTHER PF		o	0	(o	0	22. 00
23.00 02300 PARAMED ED PRGM-(PHAF	RMACY)	o	0	353, 256	228	228	23. 00
INPATIENT ROUTINE SERVICE	COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS		152, 198, 522	0	50, 805, 352	176, 396	176, 396	30. 00
31.00 03100 INTENSIVE CARE UNIT		33, 217, 899	0			36, 622	
31. 01 02060 NEONATAL INTENSIVE CA	ARE	31, 547, 609	0			11, 111	
41. 00 04100 SUBPROVI DER - I RF		6, 922, 136	0				
43. 00 O4300 NURSERY	TEDC	5, 530, 509	0	1, 798, 460	1, 773	1, 773	43. 00
ANCILLARY SERVICE COST CENT 50. 00 05000 OPERATING ROOM	IEKS	302, 976, 642	0	41, 193, 864	74, 428	74, 428	50.00
51. 00 05100 RECOVERY ROOM		302, 976, 642	0			74, 428 37, 366	
52. 00 05200 DELI VERY ROOM & LABOR	R BUOM	9, 122, 201	0				
53. 00 05300 ANESTHESI OLOGY	N NOOW	47, 166, 913	0	1		991	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		81, 014, 836	0	9, 425, 270		20, 067	1
55. 00 05500 RADI OLOGY - THERAPEUT	TIC	45, 584, 339	0	1		14, 323	1
56. 00 05600 RADI 0I SOTOPE		33, 364, 758	0	3, 030, 485		4, 024	
57.00 05700 CT SCAN		119, 247, 733	0	5, 120, 903	5, 880	5, 880	57. 00
58.00 05800 MAGNETIC RESONANCE IN		61, 854, 704	0	3, 224, 490	4, 023	4, 023	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI	ION	150, 199, 817	0	9, 663, 449	15, 613	15, 613	59. 00
60. 00 06000 LABORATORY		239, 666, 764	0				1
63. 00 06300 BLOOD STORING, PROCES	SSING, & TRANS.	12, 079, 357	0			1, 625	
64. 00 06400 I NTRAVENOUS THERAPY		3, 596, 373	0			5, 569	
65. 00 06500 RESPIRATORY THERAPY		21, 657, 600	0	5, 697, 945		4, 163	1
66. 00 06600 PHYSI CAL THERAPY		35, 086, 846	0			34, 450	
67. 00 06700 OCCUPATIONAL THERAPY		11, 461, 359	0	2, 508, 983		2, 614	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		5, 077, 157	0	,		1, 490	
70. 00 07000 ELECTROCARDI OLOGY	JV	75, 943, 704 18, 179, 355	0	1 -, - : - ,		14, 159 2, 689	
71. 00 07100 MEDICAL SUPPLIES CHAR		70, 655, 752	0	29, 380, 174		2,009	71.00
72. 00 07200 I MPL. DEV. CHARGED TO		90, 832, 034	0	37, 980, 731		0	72.00
73. 00 07300 DRUGS CHARGED TO PATI		149, 305, 181	0			5, 230	73. 00
74. 00 07400 RENAL DIALYSIS	. 2.110	7, 931, 011	0				
76. 97 07697 CARDI AC REHABI LI TATI (ON	3, 162, 317	0			4, 516	
OUTPATIENT SERVICE COST CE						•	1
90. 00 09000 CLI NI C		13, 154, 401	0	3, 260, 060	3, 206	3, 206	90.00
91. 00 09100 EMERGENCY		151, 225, 772	0	12, 402, 065	24, 972	24, 972	91. 00
92.00 09200 OBSERVATION BEDS (NON							92.00
OTHER REIMBURSABLE COST CE	NTERS						
101.00 10100 HOME HEALTH AGENCY		8, 831, 894	0	6, 199, 554	0	0	101. 00
SPECIAL PURPOSE COST CENTE		T		1			
118.00 SUBTOTALS (SUM OF LIN		2, 029, 817, 649	-61, 454, 916	386, 831, 863	732, 470	590, 439	J118. 00
NONREI MBURSABLE COST CENTE				47.00	1 000	4 000	100.00
190. 00 19000 GIFT, FLOWER, COFFEE	SHUP & CANTEEN	0	0	17, 801			190.00
191. 00 19100 RESEARCH	DEEL CES	0	0	1, 564, 995			191.00
192. 00 19200 PHYSI CLANS' PRI VATE (0	0	1, 195, 648			192. 00 194. 00
194. 00 07950 OTHER NONREI MBURSEABL 194. 01 07951 ADVERTI SI NG	LL		0	863, 202 300, 498			194. 00
194. 01 07951 ADVERTI SING 194. 02 07952 RETALL PHARMACY		0	0	1			194. 01
194. 03 07953 FITNESS POINTE		0	0	1			194. 02
		<u>, </u>		2, ., 0, 040	.0, 200	.0, 200	

Health Financial Systems	COMMUNITY HOSP	PI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2020	Worksheet B-1	
			Т	o 06/30/2021	Date/Time Prep 11/23/2021 10:	
Cost Center Description	CASHI ERI NG/ACC Reco	onciliation	OTHER ADMIN &	MAINTENANCE &	OPERATION OF	
	OUNTS		GENERAL	REPAIRS	PLANT	

				''	0 00/30/2021	11/23/2021 10	
	Cost Center Description	CASHI ERI NG/ACC	Reconciliation	OTHER ADMIN &	MAINTENANCE &	OPERATION OF	
	· ·	OUNTS		GENERAL	REPAI RS	PLANT	
		RECEI VABLE		(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	
		(GROSS					
		REVENUE)					
		5. 03	5A. 04	5. 04	6. 00	7. 00	
194. 04 0795	54 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	401, 696	1, 482	1, 482	194. 04
194. 05 0795	55 EINSTEIN BAGELS	0	0	53, 437	605	605	194. 05
194. 06 0795	NONRTHWESTERN IMAGING	0	0	1, 178, 082	2, 648	2, 648	194. 06
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	6, 100, 930		61, 454, 916	0	20, 680, 640	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 003006		0. 150805	0.000000	29. 192502	203. 00
204.00	Cost to be allocated (per Wkst. B,	159, 755		1, 639, 483	0	2, 629, 223	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000079		0. 004023	0.000000	3. 711374	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Provider CCN: 15-0125

				To	06/30/2021	Date/Time Pre 11/23/2021 10	
	Cost Center Description	LAUNDRY & LINEN SERVICE (TOTAL PATIENT		DIETARY (PATIENT MEALS)	CAFETERI A (FTES)	MAINTENANCE OF PERSONNEL (NUMBER	. 20 am
		DAYS) 8. 00	9. 00	10. 00	11. 00	HOUSED) 12. 00	
	GENERAL SERVICE COST CENTERS						1.00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FLXT OO200 CAP REL COSTS-MVBLE EQUIP					I	1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
5. 01	00505 PURCHASING & RECEIVING STORES					I	5. 01
5. 02	00506 ADMI TTI NG					1	5. 02
5. 03 5. 04	OO507 CASHI ERI NG/ACCOUNTS RECEI VABLE OO508 OTHER ADMI N & GENERAL					I	5. 03 5. 04
6. 00	00600 MAI NTENANCE & REPAI RS					I	6. 00
7.00	00700 OPERATION OF PLANT					I	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	86, 181	702 994			1	8. 00 9. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY			310, 675		I	10.00
11. 00	01100 CAFETERI A	0	1	0	1, 906	I	11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	_	0	0	0	
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON	0	3, 319	0	74 0	0	
15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY			0	0	0	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	_	Ö	0	Ö	
	01700 SOCIAL SERVICE	0	1, 136	0	14	0	
	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	_	0	0	0	
21. 00 22. 00	02200 &R SERVICES-SALARY & FRINGES APPRV		-	0	0	0	
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	0		0	4	Ö	1
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 31. 00	03000 ADULTS & PEDIATRICS	62, 605 11, 468		240, 839 22, 951	498 144	0	
31.00	03100 INTENSI VE CARE UNIT 02060 NEONATAL INTENSI VE CARE	4, 432		22, 9 51	38	0	1
41. 00	04100 SUBPROVI DER – I RF	4, 924		14, 843	27	0	
43. 00	04300 NURSERY	2, 752	1, 773	0	16	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	74, 428	O	218	0	50.00
51. 00	05100 RECOVERY ROOM			13, 401	81	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1	6, 099	30	0	1
53. 00	05300 ANESTHESI OLOGY	0	991	0	47	0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	0		0	64 15	0	
56. 00	05600 RADI OI SOTOPE		,	0	9	0	
57. 00	05700 CT SCAN	0	1	0	22	0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	13	0	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	15, 613 18, 829	0	35 110	0	59. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.		1, 625	0	5	0	1
64. 00	06400 I NTRAVENOUS THERAPY	0		0	5	0	
65. 00	06500 RESPI RATORY THERAPY	0		0	48	_	
	06600 PHYSI CAL THERAPY	0	34, 450 2, 614	0	74 17	0 0	
68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY		1, 490	0	15	0	
	06900 ELECTROCARDI OLOGY	0	14, 159	Ö	43	0	1
	07000 ELECTROENCEPHALOGRAPHY	0	2, 689	0	13	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0		0	0	0	
	07300 DRUGS CHARGED TO PATIENTS		5, 230	0	50	0	1
	07400 RENAL DI ALYSI S	0	1	0	2	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	4, 516	0	10	0	76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	3, 206	0	30	0	90.00
	09100 EMERGENCY			12, 542	111	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART			·			92. 00
404.00	OTHER REIMBURSABLE COST CENTERS		ı a				
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0) 0	0	0	0	101. 00
118. 00		86, 181	584, 900	310, 675	1, 882	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190.00
	19100 RESEARCH 19200 PHYSLCLANS' PRIVATE OFFICES		569 56, 379	0	13 1		191. 00 192. 00
	07950 OTHER NONREIMBURSEABLE		7, 063	o	0		194. 00
194. 01	07951 ADVERTI SI NG	0	o	0	0		194. 01
	07952 RETAIL PHARMACY	0	1, 775	0	10		194. 02
	07953 FITNESS POINTE 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0		0	0		194. 03 194. 04
	The state of the s	<u>'</u>	1, 192	٩	<u> </u>		1

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

Peri od: Worksheet B-1 From 07/01/2020 To 06/30/2021 Date/Time Prepared:

						11/23/2021 10	<u>: 28 am</u>
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
		LINEN SERVICE	(SQUARE FEET)	(PATI ENT	(FTES)	PERSONNEL	
		(TOTAL PATIENT		MEALS)		(NUMBER	
		DAYS)				HOUSED)	
		8. 00	9. 00	10.00	11. 00	12.00	
194. 05 07955	EINSTEIN BAGELS	0	605	0	0	0	194. 05
194. 06 07956	NONRTHWESTERN I MAGING	0	2, 648	0	0	0	194. 06
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 930, 255	6, 904, 325	5, 636, 905	1, 360, 503	0	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	22. 397686	9. 822851	18. 144057	713. 800105	0.000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	35, 511	144, 852	378, 663	223, 777	0	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 412051	0. 206082	1. 218840	117. 406611	0.000000	205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0125 Peri od: Worksheet B-1 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/23/2021 10:28 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE RECORDS & ADMI NI STRATI ON SERVICES & (COSTED REO) **SUPPLY** LI BRARY (TOTAL PATIENT (NURSI NG (COSTED REO) (GROSS DAYS) REVENUE) HOURS) 17.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00505 PURCHASING & RECEIVING STORES 5.01 5.01 00506 ADMITTING 5.02 5.02 00507 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 5.04 00508 OTHER ADMIN & GENERAL 5.04 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7 00 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 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 2, 480, 011 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 2, 029, 817, 649 16.00 16.00 01700 SOCIAL SERVICE 0 17.00 86, 181 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 19 00 19 00 Ω 0 0 0 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 0 23.00 02300 PARAMED ED PRGM-(PHARMACY) 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 035, 009 0 152, 198, 522 62, 605 30.00 03100 INTENSIVE CARE UNIT 299, 529 0 0 33, 217, 899 31.00 11, 468 31.00 02060 NEONATAL INTENSIVE CARE 79, 695 0 31, 547, 609 4, 432 31.01 31.01 0 4, 924 04100 SUBPROVIDER - IRF 0 6, 922, 136 41.00 55, 212 Ω 41.00 04300 NURSERY 34,041 0 5, 530, 509 2, 752 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 302, 976, 642 50.00 453, 336 0 05100 RECOVERY ROOM 167, 740 0 32, 022, 154 51.00 Ω 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 62,000 9, 122, 201 52.00 52.00 05300 ANESTHESI OLOGY 53.00 0 0 0 47, 166, 913 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 81, 014, 836 54.00 0 54.00 0 55.00 05500 RADI OLOGY - THERAPEUTI C 0 45, 584, 339 0 55.00 56,00 05600 RADI OI SOTOPE 0 33, 364, 758 56.00 05700 CT SCAN 119, 247, 733 57.00 57.00 61, 854, 704 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 58.00 Λ 59.00 05900 CARDIAC CATHETERIZATION 000000000000 150, 199, 817 59.00 60.00 06000 LABORATORY 239, 666, 764 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 12, 079, 357 0 63.00 0 0 63.00 0 64.00 06400 INTRAVENOUS THERAPY 0 3, 596, 373 0 64.00 65.00 06500 RESPIRATORY THERAPY 21, 657, 600 65.00 06600 PHYSI CAL THERAPY 0 35, 086, 846 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 11, 461, 359 67.00 C 0 67.00 68.00 06800 SPEECH PATHOLOGY 5, 077, 157 0 68.00 06900 ELECTROCARDI OLOGY 69.00 75, 943, 704 0 69.00 07000 ELECTROENCEPHALOGRAPHY 18, 179, 355 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 70, 655, 752 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 90, 832, 034 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 149, 305, 181 0 73.00 0 0 74 00 07400 RENAL DIALYSIS Ω 7, 931, 011 0 74 00 07697 CARDIAC REHABILITATION 76.97 C 0 3, 162, 317 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 61, 669 0 13, 154, 401 0 90.00 0 91 00 09100 EMERGENCY 231, 780 0 151, 225, 772 91 00 Ω 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 8, 831, 894 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 2, 480, 011 0 0 2, 029, 817, 649 86, 181 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 C 0 190, 00 0 191. 00 19100 RESEARCH 0 C 0 0 0 191, 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 0 0 194. 00 07950 OTHER NONREI MBURSEABLE 0 0 0 194.00 194. 01 07951 ADVERTI SI NG 0 0 194, 01 0 0 194. 02 07952 RETAIL PHARMACY 0 0 0 194. 02 194.03 07953 FITNESS POINTE 0 0 194. 03

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

					00/00/2021	11/23/2021 10	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED REQ)	RECORDS &		
			SUPPLY		LI BRARY	(TOTAL PATIENT	
		(NURSI NG	(COSTED REQ)		(GROSS	DAYS)	
		HOURS)			REVENUE)		
		13.00	14.00	15. 00	16.00	17. 00	
194. 04 07954	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	0	0	0	194. 04
194. 05 07955	EINSTEIN BAGELS	0	0	0	0	0	194. 05
194. 06 07956	NONRTHWESTERN IMAGING	0	0	0	0	0	194. 06
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	9, 745, 706	0	0	5, 906, 259	1, 312, 031	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 929703	0. 000000	0.000000	0. 002910	15. 224133	203.00
204.00	Cost to be allocated (per Wkst. B,	278, 010	0	0	54, 269	27, 529	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 112100	0. 000000	0.000000	0.000027	0. 319432	205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

					o 06/30/2021	Date/Time Prepared:
			INTERNS & RESIDENTS			11/23/2021 10:28 am
	Cost Center Description	NONPHYSI CI AN	SERVI CES-SALAR	SERVICES_OTHER	R PARAMED ED	
	oust deficer beschiptron	ANESTHETI STS	Y & FRINGES	PRGM COSTS	PRGM-(PHARMACY	
		(ASSI GNED TIME)	APPRV (ASSI GNED	APPRV (ASSI GNED	(ASSI GNED	
			TIME)	TIME)	TIME)	
	GENERAL SERVICE COST CENTERS	19. 00	21.00	22. 00	23. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 01	00505 PURCHASING & RECEIVING STORES					5. 01
5. 02 5. 03	00506 ADMITTING 00507 CASHIERING/ACCOUNTS RECEIVABLE					5. 02 5. 03
5. 04	00508 OTHER ADMIN & GENERAL					5. 04
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT					6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A					10. 00 11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL					12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE					16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0				19. 00
21. 00 22. 00	O2100 I&R SERVICES-SALARY & FRINGES APPRV O2200 I&R SERVICES-OTHER PRGM COSTS APPRV		0			21.00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)				100	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	0		0	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	ő			31.00
31. 01 41. 00	02060 NEONATAL INTENSIVE CARE 04100 SUBPROVIDER - IRF	0	0	(31. 01 41. 00
43.00	04300 NURSERY	0	0			43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	(0	50.00
51. 00	05100 RECOVERY ROOM	0	Ö	•		51. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	(52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0			54. 00
55. 00 56. 00	O5500 RADI OLOGY - THERAPEUTI C O5600 RADI OI SOTOPE	0	0	(55. 00 56. 00
57.00	05700 CT SCAN	0	0			57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		-	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0				59. 00 60. 00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0			63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0		(0	64. 00 65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(0	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0				67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	O		0	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	70. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Č	0	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	(100	73. 00 74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	Ö			76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0		0	90.00
91.00	09100 EMERGENCY	0	0			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	(0	101. 00
110 00	SPECIAL PURPOSE COST CENTERS	0			100	110,00
118.00	NONREI MBURSABLE COST CENTERS	0	0	(100	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0	(190. 00 191. 00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192. 00
	07950 OTHER NONREIMBURSEABLE 07951 ADVERTISING	0	0	(194. 00 194. 01
174.0	I O TO TENDER IT OF INC	0	<u> </u>	1	,, 0	

Health Finan	cial Systems	COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der Co		Peri od:	Worksheet B-1		
					From 07/01/2020		norod.	
					To 06/30/2021	Date/Time Pre 11/23/2021 10	pareu: ·28 am	
			I NTERNS &	RESI DENTS		1172072021 10	20 4111	
Cost Center Description		NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHE	R PARAMED ED			
		ANESTHETI STS	Y & FRINGES	PRGM COSTS	PRGM-(PHARMACY			
		(ASSI GNED	APPRV	APPRV)			
		TIME)	(ASSI GNED	(ASSI GNED	(ASSI GNED			
			TIME)	TIME)	TIME)			
		19. 00	21. 00	22. 00	23. 00			
	RETAIL PHARMACY	C	0)	0		194. 02	
	FITNESS POINTE	C	0		0		194. 03	
	FITNESS POINTE SPA/PRO SHOP/DIETARY	C	0		0		194. 04	
	EINSTEIN BAGELS	C	0		0		194. 05	
	NONRTHWESTERN I MAGING	C	0		0		194. 06	
	Cross Foot Adjustments						200. 00	
201.00	Negative Cost Centers	_	_				201. 00	

0. 000000

0.000000

0.000000

0.000000

0.000000

0.000000

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

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Part II)

(per Wkst. B-2)

Parts III and IV)

11)

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

202.00

203.00

204.00

205.00

206.00

207.00

202. 00 203. 00

204. 00

205. 00

206. 00

207. 00

418, 280

6, 246

62. 460000

0.000000

4, 182. 800000

From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:28 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 76, 939, 977 76, 939, 977 103, 577 77.043.554 03100 INTENSIVE CARE UNIT 23, 761, 044 23, 761, 044 14, 174 23, 775, 218 31.00 31.00 02060 NEONATAL INTENSIVE CARE 31.01 6, 537, 363 6, 537, 363 6, 324 6, 543, 687 31.01 04100 SUBPROVI DER - I RF 4.878.183 4, 878, 183 4, 878, 183 41.00 41.00 04300 NURSERY 43.00 2, 403, 672 2, 403, 672 2, 403, 672 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 53, 128, 177 53, 128, 177 7, 391 53, 135, 568 50.00 05100 RECOVERY ROOM 12, 829, 851 12, 829, 851 12, 829, 851 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 5, 013, 855 5, 013, 855 4, 832 5, 018, 687 52.00 53.00 05300 ANESTHESI OLOGY 5, 030, 428 5, 030, 428 5, 030, 428 53.00 05400 RADI OLOGY-DI AGNOSTI C 11, 911, 005 11, 911, 005 11, 274 11, 922, 279 54.00 54.00 05500 RADI OLOGY - THERAPEUTI C 7, 198, 758 55.00 7, 198, 758 6, 216 7, 204, 974 55.00 56.00 05600 RADI OI SOTOPE 3, 748, 010 3, 748, 010 3, 748, 010 56.00 57.00 05700 CT SCAN 6, 485, 286 6, 485, 286 0 6, 485, 286 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 4, 056, 993 4 056 993 0 4, 056, 993 58 00 59.00 05900 CARDIAC CATHETERIZATION 12, 191, 956 12, 191, 956 4,853 12, 196, 809 59.00 06000 LABORATORY 28, 431, 109 28, 431, 109 25, 426 28, 456, 535 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 3, 455, 567 3, 455, 567 3, 455, 567 63.00 0 993, 480 993, 480 06400 I NTRAVENOUS THERAPY 993, 480 64 00 0 64 00 65.00 06500 RESPIRATORY THERAPY 6,816,931 6, 816, 931 1,089 6, 818, 020 65.00 66.00 06600 PHYSI CAL THERAPY 12, 177, 388 12, 177, 388 12, 177, 388 66.00 67 00 06700 OCCUPATIONAL THERAPY 3 034 824 Ω 3, 034, 824 0 3, 034, 824 67 00 68.00 06800 SPEECH PATHOLOGY 2, 205, 890 2, 205, 890 0 2, 205, 890 68.00 06900 ELECTROCARDI OLOGY 7, 360, 129 7, 360, 129 7, 360, 129 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 168, 872 2, 168, 872 2, 292 2, 171, 164 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 34, 016, 459 71 00 34, 016, 459 34, 016, 459 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 43, 972, 736 43, 972, 736 43, 972, 736 72.00 07300 DRUGS CHARGED TO PATIENTS 27, 786, 383 27, 786, 383 770 27, 787, 153 73.00 73.00 74.00 07400 RENAL DIALYSIS 2, 266, 329 2, 266, 329 2, 266, 329 74.00 07697 CARDIAC REHABILITATION 1, 503, 754 1, 503, 754 76. 97 76.97 1, 503, 754 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4, 178, 810 4, 178, 810 17,831 4, 196, 641 90.00 91.00 09100 EMERGENCY 16, 904, 338 16, 904, 338 16, 904, 338 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 15, 546, 038 15, 546, 038 92.00 15, 546, 038 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 7, 160, 179 7, 160, 179 7, 160, 179 101. 00 456, 093, 774 456, 299, 823 200. 00 Subtotal (see instructions) 0 456, 093, 774 206, 049 200.00

15, 546, 038

440, 547, 736

15, 546, 038

440, 547, 736

206, 049

15, 546, 038 201. 00

440, 753, 785 202. 00

201.00

202.00

Less Observation Beds

Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0125 Peri od: Worksheet C From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:28 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 106, 655, 185 106, 655, 185 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 33, 217, 899 33, 217, 899 31.00 02060 NEONATAL INTENSIVE CARE 31, 547, 609 31.01 31, 547, 609 31.01 41.00 04100 SUBPROVI DER - I RF 6, 922, 136 6, 922, 136 41.00 04300 NURSERY 5, 530, 509 43.00 5, 530, 509 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 103, 776, 168 199, 200, 474 302, 976, 642 0 175354 0.000000 50.00 05100 RECOVERY ROOM 25, 443, 551 32, 022, 154 0.400655 0.000000 51.00 51.00 6.578.603 05200 DELIVERY ROOM & LABOR ROOM 8, 003, 783 0.000000 52.00 1, 118, 418 9, 122, 201 0.549632 52 00 53.00 05300 ANESTHESI OLOGY 14, 124, 468 33, 042, 445 47, 166, 913 0.106652 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 446, 229 69, 568, 607 81, 014, 836 0.147023 0.000000 54.00 43, 365, 490 0. 157922 05500 RADI OLOGY - THERAPEUTI C 45, 584, 339 0.000000 55.00 2, 218, 849 55.00 56.00 05600 RADI OI SOTOPE 3, 581, 589 29, 783, 169 33, 364, 758 0.112334 0.000000 56.00 57.00 05700 CT SCAN 34, 672, 731 84, 575, 002 119, 247, 733 0.054385 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 13, 655, 194 48, 199, 510 61, 854, 704 0.065589 0.000000 58.00 05900 CARDIAC CATHETERIZATION 50. 545. 908 99, 653, 909 150, 199, 817 0.081172 59 00 0.000000 59 00 60.00 06000 LABORATORY 71, 261, 794 168, 404, 970 239, 666, 764 0. 118628 0.000000 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 7, 437, 291 4, 642, 066 12, 079, 357 0. 286072 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 54, 644 3, 541, 729 3, 596, 373 0.276245 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 18, 922, 309 2, 735, 291 21, 657, 600 0.314759 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 10, 360, 223 24, 726, 623 35, 086, 846 0.347064 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 67.00 7, 977, 618 3, 483, 741 11, 461, 359 0.264787 0.000000 67.00 68 00 06800 SPEECH PATHOLOGY 1 814 277 3, 262, 880 5, 077, 157 0.000000 68 00 0 434473 69.00 06900 ELECTROCARDI OLOGY 23, 412, 539 52, 531, 165 75, 943, 704 0.096916 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 2,008,311 16, 171, 044 18, 179, 355 0.119304 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 34, 507, 945 36, 147, 807 70, 655, 752 0.481439 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 50, 279, 457 40, 552, 577 72.00 90, 832, 034 0.484110 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 91, 375, 905 57, 929, 276 149, 305, 181 0. 186105 0.000000 73.00 74.00 07400 RENAL DIALYSIS 6, 537, 131 1, 393, 880 7, 931, 011 0.285755 0.000000 74.00 345, 173 2, 817, 144 76 97 07697 CARDIAC REHABILITATION 3, 162, 317 0.475523 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 429, 409 12, 724, 992 13, 154, 401 0. 317674 0.000000 90.00 91.00 09100 EMERGENCY 48, 470, 714 102, 755, 058 151, 225, 772 0.111782 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 341346 0.000000 92.00 92 00 5, 179, 432 40, 363, 905 45, 543, 337 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 8, 831, 894 8, 831, 894 101.00 200.00 Subtotal (see instructions) 812, 851, 032 1, 216, 966, 617 2, 029, 817, 649 200.00

812, 851, 032 1, 216, 966, 617 2, 029, 817, 649

201 00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0125	Peri od: Worksheet C From 07/01/2020 Part I To 06/30/2021 Date/Time Prepared:

			To 06/30/2021	Date/Time Prepared: 11/23/2021 10:28 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
31. 01 02060 NEONATAL INTENSIVE CARE				31. 01
41. 00 04100 SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 175378			50.00
51.00 05100 RECOVERY ROOM	0. 400655			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 550162			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 106652			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 147162			54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 158058			55.00
56. 00 05600 RADI 0I SOTOPE	0. 112334			56.00
57. 00 05700 CT SCAN	0. 054385			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 065589			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 081204			59.00
60. 00 06000 LABORATORY	0. 118734			60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 286072			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 276245			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 314810			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 347064			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 264787			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 434473			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 096916			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 119430			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 481439			71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 484110			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 186110			73. 00
74. 00 07400 RENAL DIALYSIS	0. 285755			74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 475523			76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 319029			90.00
91. 00 09100 EMERGENCY	0. 111782			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 341346			92.00
OTHER REIMBURSABLE COST CENTERS	·			
101.00 10100 HOME HEALTH AGENCY				101.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	'			1

Provider CCN: 15-0125 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:28 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 76, 939, 977 76, 939, 977 103, 577 77.043.554 03100 INTENSIVE CARE UNIT 23, 761, 044 23, 761, 044 14, 174 23, 775, 218 31.00 31.00 02060 NEONATAL INTENSIVE CARE 31.01 6, 537, 363 6, 537, 363 6, 324 6, 543, 687 31.01 04100 SUBPROVI DER - I RF 4.878.183 4, 878, 183 4, 878, 183 41.00 41.00 04300 NURSERY 43.00 2, 403, 672 2, 403, 672 2, 403, 672 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 53, 128, 177 53, 128, 177 7, 391 53, 135, 568 50.00 05100 RECOVERY ROOM 12, 829, 851 12, 829, 851 12, 829, 851 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 5, 013, 855 5, 013, 855 4, 832 5, 018, 687 52.00 53.00 05300 ANESTHESI OLOGY 5, 030, 428 5, 030, 428 5, 030, 428 53.00 05400 RADI OLOGY-DI AGNOSTI C 11, 911, 005 11, 911, 005 11, 274 11, 922, 279 54.00 54.00 05500 RADI OLOGY - THERAPEUTI C 7, 198, 758 55.00 7, 198, 758 6, 216 7, 204, 974 55.00 56.00 05600 RADI OI SOTOPE 3, 748, 010 3, 748, 010 3, 748, 010 56.00 57.00 05700 CT SCAN 6, 485, 286 6, 485, 286 0 6, 485, 286 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 4, 056, 993 4 056 993 0 4, 056, 993 58 00 59.00 05900 CARDIAC CATHETERIZATION 12, 191, 956 12, 191, 956 4,853 12, 196, 809 59.00 06000 LABORATORY 28, 431, 109 28, 431, 109 25, 426 28, 456, 535 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 3, 455, 567 3, 455, 567 3, 455, 567 63.00 0 993, 480 993, 480 06400 I NTRAVENOUS THERAPY 993, 480 64 00 0 64 00 65.00 06500 RESPIRATORY THERAPY 6, 816, 931 6, 816, 931 1,089 6, 818, 020 65.00 66.00 06600 PHYSI CAL THERAPY 12, 177, 388 12, 177, 388 12, 177, 388 66.00 67 00 06700 OCCUPATIONAL THERAPY 3 034 824 Ω 3, 034, 824 0 3, 034, 824 67 00 68.00 06800 SPEECH PATHOLOGY 2, 205, 890 2, 205, 890 0 2, 205, 890 68.00 06900 ELECTROCARDI OLOGY 7, 360, 129 7, 360, 129 7, 360, 129 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 168, 872 2, 168, 872 2, 292 2, 171, 164 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 34, 016, 459 71 00 34, 016, 459 34, 016, 459 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 43, 972, 736 43, 972, 736 43, 972, 736 72.00 07300 DRUGS CHARGED TO PATIENTS 27, 786, 383 27, 786, 383 770 27, 787, 153 73.00 73.00 74.00 07400 RENAL DIALYSIS 2, 266, 329 2, 266, 329 2, 266, 329 74.00 07697 CARDIAC REHABILITATION 1, 503, 754 76. 97 76.97 1,503,754 1, 503, 754 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4, 178, 810 4, 178, 810 17,831 4, 196, 641 90.00 91.00 09100 EMERGENCY 16, 904, 338 16, 904, 338 16, 904, 338 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 15, 546, 038 15, 546, 038 92.00 15, 546, 038 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 7, 160, 179 7, 160, 179 7, 160, 179 101. 00 456, 093, 774 456, 299, 823 200. 00 Subtotal (see instructions) 0 456, 093, 774 206, 049 200.00 15, 546, 038 201. 00 201.00 Less Observation Beds 15, 546, 038 15, 546, 038

440, 547, 736

440, 547, 736

206, 049

440, 753, 785 202. 00

202.00

Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0125 Peri od: Worksheet C From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:28 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 106, 655, 185 106, 655, 185 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 33, 217, 899 33, 217, 899 31.00 02060 NEONATAL INTENSIVE CARE 31, 547, 609 31.01 31, 547, 609 31.01 41.00 04100 SUBPROVI DER - I RF 6, 922, 136 6, 922, 136 41.00 04300 NURSERY 5, 530, 509 43.00 5, 530, 509 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 103, 776, 168 199, 200, 474 302, 976, 642 0 175354 0.000000 50.00 05100 RECOVERY ROOM 25, 443, 551 32, 022, 154 0.400655 0.000000 51.00 51.00 6.578.603 05200 DELIVERY ROOM & LABOR ROOM 8, 003, 783 0.000000 52.00 1, 118, 418 9, 122, 201 0.549632 52 00 53.00 05300 ANESTHESI OLOGY 14, 124, 468 33, 042, 445 47, 166, 913 0.106652 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 446, 229 69, 568, 607 81, 014, 836 0.147023 0.000000 54.00 43, 365, 490 0. 157922 05500 RADI OLOGY - THERAPEUTI C 2, 218, 849 45, 584, 339 0.000000 55.00 55.00 56.00 05600 RADI OI SOTOPE 3, 581, 589 29, 783, 169 33, 364, 758 0.112334 0.000000 56.00 57.00 05700 CT SCAN 34, 672, 731 84, 575, 002 119, 247, 733 0.054385 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 13, 655, 194 48, 199, 510 61, 854, 704 0.065589 0.000000 58.00 05900 CARDIAC CATHETERIZATION 50. 545. 908 99, 653, 909 150, 199, 817 0.081172 59 00 0.000000 59 00 60.00 06000 LABORATORY 71, 261, 794 168, 404, 970 239, 666, 764 0. 118628 0.000000 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 7, 437, 291 4, 642, 066 12, 079, 357 0. 286072 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 54, 644 3, 541, 729 3, 596, 373 0.276245 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 18, 922, 309 2, 735, 291 21, 657, 600 0.314759 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 10, 360, 223 24, 726, 623 35, 086, 846 0.347064 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 67.00 7, 977, 618 3, 483, 741 11, 461, 359 0.264787 0.000000 67.00 68 00 06800 SPEECH PATHOLOGY 1 814 277 3, 262, 880 5, 077, 157 0.000000 68 00 0 434473 69.00 06900 ELECTROCARDI OLOGY 23, 412, 539 52, 531, 165 75, 943, 704 0.096916 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 2,008,311 16, 171, 044 18, 179, 355 0.119304 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 34, 507, 945 36, 147, 807 70, 655, 752 0.481439 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 50, 279, 457 40, 552, 577 72.00 90, 832, 034 0.484110 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 91, 375, 905 57, 929, 276 149, 305, 181 0. 186105 0.000000 73.00 74.00 07400 RENAL DIALYSIS 6, 537, 131 1, 393, 880 7, 931, 011 0.285755 0.000000 74.00 345, 173 2, 817, 144 76 97 07697 CARDIAC REHABILITATION 3, 162, 317 0.475523 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 429, 409 12, 724, 992 13, 154, 401 0. 317674 0.000000 90.00 91.00 09100 EMERGENCY 48, 470, 714 102, 755, 058 151, 225, 772 0.111782 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 341346 0.000000 92.00 92 00 5, 179, 432 40, 363, 905 45, 543, 337 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 8, 831, 894 8, 831, 894 101.00 200.00 Subtotal (see instructions) 812, 851, 032 1, 216, 966, 617 2, 029, 817, 649 200.00

812, 851, 032 1, 216, 966, 617 2, 029, 817, 649

201 00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0125	Peri od: Worksheet C From 07/01/2020 Part I To 06/30/2021 Date/Time Prepared:

			To 06/30/2021	Date/Time Prepared: 11/23/2021 10:28 am
		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 INTENSIVE CARE UNIT				31.00
31. 01 02060 NEONATAL INTENSIVE CARE				31. 01
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 175378			50. 00
51. 00 05100 RECOVERY ROOM	0. 400655			51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 550162			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 106652			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 147162			54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 158058			55. 00
56. 00 05600 RADI 01 SOTOPE	0. 112334			56. 00
57. 00 05700 CT SCAN	0. 054385			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 065589			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 081204			59. 00
60. 00 06000 LABORATORY	0. 118734			60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 286072			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 276245			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 314810			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 347064			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 264787			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 434473			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 096916			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 119430			70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 481439			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 484110			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 186110			73.00
74. 00 07400 RENAL DI ALYSI S	0. 285755			74. 00 76. 97
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0. 475523			76. 97
90. 00 09000 CLINIC	0. 319029			90.00
91. 00 09100 EMERGENCY	0. 319029			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 111782			92.00
OTHER REIMBURSABLE COST CENTERS	0. 341340			92.00
101. 00 10100 HOME HEALTH AGENCY				101. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds	1			200.00
202.00 Total (see instructions)				202. 00
202.00] [1014] (000 111011 4011 0110)	1			1202.00

| Peri od: | Worksheet C | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Provi der CCN: 15-0125 REDUCTIONS FOR MEDICALD ONLY

					o 06/30/2021	Date/lime Pre 11/23/2021 10	
			Ti tl	e XIX	Hospi tal	PPS	. 20 am
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	53, 128, 177	4, 991, 529			_	50.00
51.00	05100 RECOVERY ROOM	12, 829, 851	955, 194			_	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 013, 855	403, 063			0	52. 00
53.00	05300 ANESTHESI OLOGY	5, 030, 428	230, 717			0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 911, 005	1, 782, 078			0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	7, 198, 758	2, 249, 489			0	55. 00
56.00	05600 RADI OI SOTOPE	3, 748, 010	344, 768			0	56. 00
57.00	05700 CT SCAN	6, 485, 286	1, 170, 170	5, 315, 116	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 056, 993	765, 770	3, 291, 223	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	12, 191, 956	1, 683, 135		0	0	59. 00
60.00	06000 LABORATORY	28, 431, 109	1, 310, 406	27, 120, 703	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	3, 455, 567	69, 086	3, 386, 481	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	993, 480	108, 581	884, 899	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	6, 816, 931	221, 443	6, 595, 488	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	12, 177, 388	822, 350	11, 355, 038	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	3, 034, 824	77, 768	2, 957, 056	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	2, 205, 890	80, 448	2, 125, 442	. 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	7, 360, 129	898, 160	6, 461, 969	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 168, 872	138, 093	2, 030, 779	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	34, 016, 459	129, 784	33, 886, 675	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	43, 972, 736	167, 692	43, 805, 044	. 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	27, 786, 383	522, 157	27, 264, 226	0	0	73. 00
74.00	07400 RENAL DIALYSIS	2, 266, 329	31, 034	2, 235, 295	0	0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 503, 754	131, 086	1, 372, 668	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	4, 178, 810	94, 844	4, 083, 966	0	0	90. 00
91.00	09100 EMERGENCY	16, 904, 338	797, 095	16, 107, 243	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	15, 546, 038	943, 287	14, 602, 751	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	7, 160, 179	27, 888	7, 132, 291	0	0	101. 00
200.00	Subtotal (sum of lines 50 thru 199)	341, 573, 535	21, 147, 115	320, 426, 420	0		200. 00
201.00	Less Observation Beds	15, 546, 038	943, 287	14, 602, 751	0		201. 00
202.00	Total (line 200 minus line 201)	326, 027, 497	20, 203, 828	305, 823, 669	0	0	202. 00

Health Financial Systems	COMMUNITY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO	CHARGE RATIOS NET OF	Provider CCN: 15-0125	Peri od:	Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 07/01/2020	

Cost Center Description	NEDOCTIONS FOR WEDIGHT ONE!				To 06/30/20	Date/Time Prepared: 11/23/2021 10:28 am
Capit tal and Operating Cost Part . col um Ratio (col. 6 Reduction Part . col um Ratio (col. 7 Part Part . col um Ratio (col. 6 Reduction Part . col um Ratio (col. 7 Part Part . col um Part .					Hospi tal	PPS
ANCILLARY SERVICE COST CENTERS	Cost Center Description					
Reduction						
SOLITION					6	
ANCILLARY SERVICE COST CENTERS						
50. 00 050		6. 00	7. 00	8. 00		
51. 00 05100 RECOVERY ROOM 12, 829, 851 32, 022, 154 0, 400655 51. 00 05200 DELIVERY ROOM & LABOR ROOM 5, 013, 855 9, 122, 201 0, 549632 52. 00 53. 00 05300 ANESTHESI OLOGY 5, 030, 428 47, 166, 913 0, 106652 53. 00 05300 ANESTHESI OLOGY 5, 030, 428 47, 166, 913 0, 106652 53. 00 05500 RADIOLOGY - THERAPEUTI C 11, 911, 005 81, 014, 836 0, 147023 54. 00 56. 00 05600 RADIOLOGY - THERAPEUTI C 7, 198, 758 45, 854, 339 0, 157922 55. 00 05600 RADIOLOGY - THERAPEUTI C 7, 198, 758 45, 843, 39 0, 157922 55. 00 05600 RADIOLOGY - THERAPEUTI C 7, 198, 758 45, 844, 339 0, 157922 55. 00 05600 RADIOLOGY - THERAPEUTI C 7, 198, 758 45, 844, 339 0, 157922 55. 00 05700 CT SCAN 64, 85, 286 119, 247, 733 0, 0543385 57. 00 05700 CT SCAN 64, 85, 286 119, 247, 733 0, 0543385 57. 00 05800 RADIOLOGY - THERAPEUTI C 2, 191, 956 150, 199, 817 0, 081172 59. 00 06000 LABORATORY 28, 431, 109 239, 666, 764 0, 18628 60. 00 06000 LABORATORY 28, 431, 109 239, 666, 764 0, 18628 60. 00 06400 LABORATORY 140, 140, 140, 140, 140, 140, 140, 140,						
52.00 05200 DELIVERY ROOM & LABOR ROOM 5, 013, 855 9, 122, 201 0. 549632 52.00 05300 ANESTHESI OLOGY 5, 030, 428 47, 166, 913 0. 106652 53.00 55.00 05400 RADI OLOGY - DI AGNOSTI C 11, 911, 005 81, 014, 836 0. 147023 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 7, 198, 758 45, 584, 339 0. 157922 55.00 56.00 05600 RADI OLOGY - THERAPEUTI C 7, 198, 758 45, 584, 339 0. 157922 55.00 57.00 05700 CT SCAN 6, 485, 286 119, 247, 733 0. 054385 57.00 05700 CT SCAN 6, 485, 286 119, 247, 733 0. 054385 57.00 05900 CARDI AC CATHETERI ZATI ON 12, 191, 956 150, 199, 817 0. 081172 59.00 05900 CARDI AC CATHETERI ZATI ON 12, 191, 956 150, 199, 817 0. 081172 59.00 05000 CARDI AC CATHETERI ZATI ON 12, 191, 956 150, 199, 817 0. 081172 59.00 06000 LABORATORY 28, 431, 109 239, 666, 764 0. 118628 60.00 06000 LABORATORY 6, 816, 931 21, 079, 357 0. 286072 63.00 06000 RESPI RATIORY THERAPY 6, 816, 931 21, 079, 357 0. 286072 63.00 06000 RESPI RATIORY THERAPY 6, 816, 931 21, 773, 388 35, 086, 846 0. 347064 66.00 06000 PHYSI CAL THERAPY 12, 177, 388 35, 086, 846 0. 347064 66.00 06000 PHYSI CAL THERAPY 3, 034, 824 11, 461, 359 0. 264787 67.00 07000 CCUPATI ONAL THERAPY 3, 034, 824 11, 461, 359 0. 264787 67.00 07000 CLECTROCARDI OLOGY 7, 360, 129 75, 943, 704 0. 096916 0. 00000 06000 ELECTROCARDI OLOGY 7, 360, 129 75, 943, 704 0. 096916 0. 00000 07000 ELECTROCARDI OLOGY 7, 360, 129 75, 943, 704 0. 096916 0. 00000 07000 ELECTROCARDI OLOGY 7, 360, 129 75, 943, 704 0. 096916 0. 00000 07000 ELECTROCARDI OLOGY 0. 00000 07000						
53. 00 0500 ABSTHESI OLOGY 5. 030, 428 47, 166, 913 0. 106652 55. 00						
54.00 05400 RADI OLOGY - DI ACNOSTI C 11, 911, 005 81, 014, 836 0, 147023 55.00 05500 RADI OLOGY - THERAPEUTI C 7, 198, 758 45, 584, 339 0, 157922 55.00 05600 RADI OLOGY - THERAPEUTI C 3, 748, 010 33, 364, 758 0, 112334 56.00 05600 RADI OLOGY - THERAPEUTI C 3, 748, 010 33, 364, 758 0, 112334 56.00 05700 CT SCAN 6, 485, 286 119, 247, 733 0, 054385 57.00 05900 CARDI AC CATHETERI ZATI ON 12, 191, 956 150, 199, 817 0, 081172 59.00 05900 CARDI AC CATHETERI ZATI ON 12, 191, 956 150, 199, 817 0, 081172 59.00 06000 LABORATORY 28, 431, 109 239, 666, 764 0, 118628 60.00 06000 LABORATORY 28, 431, 109 239, 666, 764 0, 118628 60.00 06000 INTRAVENOUS THERAPY 93, 480 12, 079, 357 0, 286072 63.00 66.00 06600 PhySi CAL THERAPY 6, 816, 931 21, 657, 600 0, 314759 65.00 06500 RESPI RATORY THERAPY 12, 177, 388 35, 806, 846 0, 347064 66.00 06600 PhySi CAL THERAPY 3, 034, 824 11, 461, 359 0, 264787 67.00 06700 0CUIPATI ONAL THERAPY 2, 168, 872 18, 179, 355 0, 119304 70.00 07000 ELECTROCARDI OLOGY 7, 360, 129 75, 943, 704 0, 096916 69.00 070, 00 07000 ELECTROCARDI OLOGY 7, 360, 129 75, 943, 704 0, 096916 69.00 070, 00 07000 ELECTROCARDI OLOGY 7, 360, 129 75, 943, 704 0, 096916 69.00 070, 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 27, 786, 383 149, 305, 181 0, 186105 73.00 73.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 27, 786, 383 149, 305, 181 0, 186105 73.00 73.00 07000 EMERGENCY 0, 16, 94, 388 151, 225, 772 0, 111782 91.00 07000 EMERGENCY 0, 16, 94, 388 151, 225, 772 0, 111782 91.00 09000 EMERGENCY 16, 904, 338 151, 225, 772 0, 111782 91.00 09000 EMERGENCY 16, 904, 338 151, 225, 772 0, 111782 91.00 09000 EMERGENCY 16, 904, 338 151, 225, 772 0, 111782 91.00 09000 EMERGENCY 16, 904, 338 151, 255, 772 0, 111782 91.00						
55.00 05500 RADI OLOGY - THERAPEUTI C 7, 198, 758 Roll 45, 584, 339 Solution 0.157922 55.00 56.00 05600 RADI OLOGY - THERAPEUTI C 3, 748, 010 33, 364, 758 Solution 0.112334 Solution 56.00 57.00 05700 CT SCAN 6, 485, 286 119, 247, 733 Colostage 0.054385 Solution 57.00 58.00 05800 MARONETI C RESONANCE I IMAGI NG (MRI) 4, 056, 993 61, 854, 704 Colostage 0.065589 Solution 58.00 60.00 0600 LABORATORY 28, 431, 109 239, 666, 764 Colostage 0.81172 Colostage 60.00 63.00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 3, 455, 567 12, 079, 357 Colostage 0.286072 Colostage 63.00 65.00 06500 RESPI RATORY THERAPY 993, 480 3, 596, 373 Colostage 0.276245 Colostage 64.00 66.00 06600 PHYSI CAL THERAPY 12, 177, 388 35, 086, 846 Colostage 0.347064 Colostage 65.00 67.00 06700 OCCUPATI ONAL THERAPY 12, 177, 388 35, 086, 846 Colostage 0.347064 Colostage 67.00 68.00 06800 SPEECH PATHOLOGY 2, 205, 890 5, 077, 157 Colostage 0.434473 Colostage 68.00 69.00 06900 ELECTROCARDI OLOGY 7, 360, 129 75, 943, 704 Colostage 0.0444139 Colostage 0.0444110 Colostage						
56. 00 05600 RADIOI SOTOPE 3, 748, 010 33, 364, 758 0. 112334 56. 00 05700 CT SCAN 6, 485, 286 119, 247, 733 0. 054385 57. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 4, 056, 993 61, 854, 704 0. 065589 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 4, 056, 993 61, 854, 704 0. 065589 58. 00 06000 LABORATORY 28, 431, 109 239, 666, 764 0. 118628 60. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 3, 455, 567 12, 079, 357 0. 286072 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 3, 455, 567 12, 079, 357 0. 286072 63. 00 06500 RESPI RATORY THERAPY 993, 480 3, 596, 373 0. 276245 64. 00 06500 PHYSI CAL THERAPY 6, 816, 931 21, 1657, 600 0. 314759 65. 00 06500 PHYSI CAL THERAPY 12, 177, 388 35, 086, 846 0. 347064 66. 00 06600 PHYSI CAL THERAPY 3, 034, 824 11, 461, 359 0. 264787 67. 00 06600 ELECTROCARDI OLOGY 2, 205, 890 5, 077, 157 0. 434473 68. 00 06600 ELECTROCARDI OLOGY 2, 205, 890 5, 077, 157 0. 434473 68. 00 06600 ELECTROENCEPHALOGRAPHY 2, 168, 872 18, 179, 355 0. 119304 70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 168, 872 18, 179, 355 0. 119304 70. 00 70. 00 IMPL. DEV. CHARGED TO PATI ENTS 43, 972, 736 90, 832, 034 0. 484110 72. 00 73. 00 7400 RENAL OLAS SUPPLIES CHARGED TO PATI ENTS 27, 786, 383 149, 305, 181 0. 186105 73. 00 7400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 70. 00 ELECTROENCEPHALOGRAPHY 1, 503, 754 3, 162, 317 0. 475523 76. 97 0. 00 09000 EMERGENCY 16, 904, 338 151, 225, 772 0. 111782 91. 00 99. 00 09000 EMERGENCY 16, 904, 338 151, 225, 772 0. 111782 91. 00 99. 00 09000 EMERGENCY 7, 160, 179 8, 831, 894 0. 810718 0. 810718 0. 00 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000						
57. 00 05700 CT SCAN 6, 485, 286 119, 247, 733 0. 0.54385 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 4, 056, 993 61, 854, 704 0. 065589 58. 00 05900 CARDIAC CATHETERI ZATI ON 12, 191, 956 150, 199, 817 0. 081172 59. 00 05900 CARDIAC CATHETERI ZATI ON 12, 191, 956 150, 199, 817 0. 081172 59. 00 06000 LABORATORY 28, 431, 109 239, 666, 764 0. 118628 60. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 3, 455, 567 12, 079, 357 0. 286072 63. 00 06400 INTRAVENOUS THERAPY 993, 480 3, 596, 373 0. 276245 64. 00 06400 INTRAVENOUS THERAPY 12, 177, 388 35, 086, 846 0. 347064 66. 00 06500 RESPI RATORY THERAPY 12, 177, 388 35, 086, 846 0. 347064 66. 00 06000 PHYSI CAL THERAPY 3, 34, 824, 834, 835 0. 264787 67. 00 0700 0CCUPATI ONAL THERAPY 3, 304, 824 11, 461, 359 0. 264787 67. 00 06000 SPEECH PATHOLOGY 2, 205, 890 5, 077, 157 0. 434473 68. 00 06900 ELECTROCARDIOLOGY 7, 360, 129 75, 943, 704 0. 096916 69. 00 07000 ELECTROCARDIOLOGY 7, 360, 129 75, 943, 704 0. 096916 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 34, 016, 459 70, 655, 752 0. 481439 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 34, 972, 736 90, 832, 034 0. 484110 72. 00 07300 DRUGS CHARGED TO PATI ENTS 27, 786, 383 149, 305, 181 0. 186105 73. 00 07400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 07400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 07400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 07400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 07400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 07400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 07400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 07400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 07400						
58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 4,056,993 61,854,704 0.065589 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 12,191,956 150,199,817 0.081172 59.00 63. 00 06000 LABORATORY 28,431,109 239,666,764 0.118628 60.00 63. 00 06300 BLODD STORI NG, PROCESSI NG, & TRANS. 3,455,567 12,079,357 0.286072 63.00 64. 00 06400 I INTRAVENOUS THERAPY 993,480 3,596,373 0.276245 64.00 65. 00 06500 RESPI RATORY THERAPY 6,816,931 21,657,600 0.314759 65.00 66. 00 06600 PHYSI CAL THERAPY 12,177,388 35,086,846 0.347064 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 3,034,824 11,461,359 0.264787 67.00 69. 00 06800 SPEECH PATHOLOGY 2,205,890 5,077,157 0.434473 68.00 69. 00 07000 ELECTROCARDI OLOGY 7,360,129 75,943,704 0.096916 0.990916 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 34,						
59. 00 05900 CARDI AC CATHETERI ZATI ON 12, 191, 956 150, 199, 817 0. 081172 59. 00 60. 00 06000 LABORATORY 28, 431, 109 239, 666, 764 0. 118628 60. 00 63. 00 06300 BLODO STORI NG, PROCESSI NG, & TRANS. 3, 455, 567 12, 079, 357 0. 286072 63. 00 64. 00 06400 I NTRAVENOUS THERAPY 993, 480 3, 596, 373 0. 276245 64. 00 65. 00 06500 RESPI RATORY THERAPY 6, 816, 931 21, 657, 600 0. 314759 65. 00 66. 00 06600 PHYSI CAL THERAPY 12, 177, 388 35, 086, 846 0. 347064 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 3, 034, 824 11, 461, 359 0. 264787 67. 00 68. 00 06800 SPEECH PATHOLOGY 2, 205, 890 5, 077, 157 0. 434473 68. 00 69. 00 06900 ELECTROCARDI OLOGY 7, 360, 129 75, 943, 704 0. 096916 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT						
60. 00 06000 LABORATORY 28, 431, 109 239, 666, 764 0. 118628 60. 00 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 3, 455, 567 12, 079, 357 0. 286072 63. 00 64. 00 06400 INTRAVENOUS THERAPY 993, 480 3, 596, 373 0. 276245 64. 00 06500 RESPI RATORY THERAPY 6, 816, 931 21, 657, 600 0. 314759 65. 00 06600 PHYSI CAL THERAPY 12, 177, 388 35, 086, 846 0. 347064 66. 00 06600 PHYSI CAL THERAPY 3, 034, 824 11, 461, 359 0. 264787 67. 00 06700 0CCUPATI ONAL THERAPY 3, 034, 824 11, 461, 359 0. 264787 67. 00 06900 CELECTROCARDI OLOGY 7, 360, 129 75, 943, 704 0. 096916 69. 00 06900 ELECTROENCEPHALOGRAPHY 2, 168, 872 18, 179, 355 0. 119304 70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 168, 872 18, 179, 355 0. 1481439 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 34, 912, 736 90, 832, 034 0. 484110 72. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 43, 972, 736 90, 832, 034 0. 484110 72. 00 73. 00 07200 ENDAGE CHARGED TO PATIENTS 27, 786, 383 149, 305, 181 0. 186105 73. 00 74. 00 07400 RENAL DI ALYSIS 2, 266, 329 7, 931, 011 0. 285755 74. 00 74. 00 0797 CARDI AC REHABI LITATI ON 1, 503, 754 3, 162, 317 0. 475523 76. 97 0747		4, 056, 993	61, 854, 704	0. 06558	39	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 3, 455, 567 12, 079, 357 0. 286072 63. 00 64. 00 06400 INTRAVENOUS THERAPY 993, 480 3, 596, 373 0. 276245 64. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67	59. 00 05900 CARDI AC CATHETERI ZATI ON	12, 191, 956	150, 199, 817	0. 08117	'2	
64. 00 06400 INTRAVENOUS THERAPY 993,480 3,596,373 0.276245 64. 00 65. 00 06500 RESPI RATORY THERAPY 6,816,931 21,657,600 0.314759 65. 00 66. 00 06600 PHYSI CAL THERAPY 12,177,388 35,086,846 0.347064 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 3,034,824 11,461,359 0.264787 67. 00 68. 00 06800 SPEECH PATHOLOGY 2,205,890 5,077,157 0.434473 68. 00 69. 00 06900 ELECTROCARDI OLOGY 7,360,129 75,943,704 0.096916 69. 00 07000 ELECTROENCEPHALOGRAPHY 2,168,872 18,179,355 0.119304 77. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 34,016,459 70,655,752 0.481439 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 43,972,736 90,832,034 0.484110 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 27,786,383 149,305,181 0.186105 73. 00 74. 00 07400 RENAL DI ALYSI S 2,266,329 7,931,011 0.285755 74. 00 07697 CARDI AC REHABI LI TATI ON 1,503,754 3,162,317 0.475523 76. 97 00TPATI ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C 4,178,810 13,154,401 0.317674 90.00 9100 EMERGENCY 16,904,338 151,225,772 0.111782 91.00 92.00 09SERVATI ON BEDS (NON-DISTINCT PART 15,546,038 45,543,337 0.341346 92. 00 09000 Less Observation Beds 7,60,179 8,831,894 0.810718 0.810718 0.00 00000 0.0		28, 431, 109				
65. 00 06500 RESPI RATORY THERAPY 6,816,931 21,657,600 0.314759 65. 00 66. 00 66. 00 PHYSI CAL THERAPY 12,177,388 35,086,846 0.347064 66. 00 67. 00 06600 PHYSI CAL THERAPY 3,034,824 11,461,359 0.264787 67. 00 68. 00 06800 SPEECH PATHOLOGY 2,205,890 5,077,157 0.434473 68. 00 06900 ELECTROCARDI OLOGY 7,360,129 75,943,704 0.096916 69. 00 07000 ELECTROENCEPHALOGRAPHY 2,168,872 18,179,355 0.119304 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 34,016,459 70,655,752 0.481439 71. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 43,972,736 90,832,034 0.484110 72. 00 07300 DRUGS CHARGED TO PATI ENTS 27,786,383 149,305,181 0.186105 73. 00 07400 RENAL DI ALYSI S 2,266,329 7,931,011 0.285755 74. 00 07400 RENAL DI ALYSI S 2,266,329 7,931,011 0.285755 74. 00 07697 CARDI AC REHABI LI TATI ON 1,503,754 3,162,317 0.475523 76. 97 00179471 ENT SERVI CE COST CENTERS 90000 CLI NI C 16,904,338 151,225,772 0.111782 91. 00 09100 EMERGENCY 16,904,338 151,225,772 0.111782 91. 00 09100 EMERGENCY 16,904,338 45,543,337 0.341346 92. 00 0000 CLI NI C 09100 BOSERVATI ON BEDS (NON-DI STI NCT PART 15,546,038 45,543,337 0.341346 92. 00 0000 CLI NI C 000000	63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	3, 455, 567	12, 079, 357	0. 28607	'2	63. 00
66. 00	64. 00 06400 I NTRAVENOUS THERAPY	993, 480	3, 596, 373	0. 27624	15	64. 00
67. 00	65. 00 06500 RESPIRATORY THERAPY	6, 816, 931	21, 657, 600	0. 31475	59	65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	12, 177, 388	35, 086, 846	0. 34706	54	66. 00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	3, 034, 824	11, 461, 359	0. 26478	37	67. 00
70. 00	68. 00 06800 SPEECH PATHOLOGY	2, 205, 890	5, 077, 157	0. 43447	' 3	68. 00
71. 00	69. 00 06900 ELECTROCARDI OLOGY	7, 360, 129	75, 943, 704	0. 09691	6	69. 00
72. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 168, 872	18, 179, 355	0. 11930)4	70.00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	34, 016, 459	70, 655, 752	0. 48143	39	71. 00
74. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	43, 972, 736	90, 832, 034	0. 48411	0	72. 00
76. 97 O7697 CARDI AC REHABILITATION 1, 503, 754 3, 162, 317 0. 475523 76. 97 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC 4, 178, 810 13, 154, 401 0. 317674 90. 00 91. 00 O9100 EMERGENCY 16, 904, 338 151, 225, 772 0. 111782 91. 00 92. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART 15, 546, 038 45, 543, 337 0. 341346 92. 00 OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 7, 160, 179 8, 831, 894 0. 810718 101. 00 200. 00 Subtotal (sum of lines 50 thru 199) 341, 573, 535 1, 845, 944, 311 200. 00 201. 00 Less Observation Beds 15, 546, 038 0 201. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	27, 786, 383	149, 305, 181	0. 18610)5	73. 00
76. 97 O7697 CARDI AC REHABILITATION 1, 503, 754 3, 162, 317 0. 475523 76. 97 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC 4, 178, 810 13, 154, 401 0. 317674 90. 00 91. 00 O9100 EMERGENCY 16, 904, 338 151, 225, 772 0. 111782 91. 00 92. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART 15, 546, 038 45, 543, 337 0. 341346 92. 00 OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 7, 160, 179 8, 831, 894 0. 810718 101. 00 200. 00 Subtotal (sum of lines 50 thru 199) 341, 573, 535 1, 845, 944, 311 200. 00 201. 00 Less Observation Beds 15, 546, 038 0 201. 00	74. 00 07400 RENAL DIALYSIS	2, 266, 329	7, 931, 011	0. 28575	55	74.00
90. 00						76. 97
91. 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>				
91. 00	90. 00 09000 CLI NI C	4, 178, 810	13, 154, 401	0. 31767	4	90.00
92. 00	91. 00 09100 EMERGENCY			0. 11178	32	91.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 7, 160, 179 8, 831, 894 0. 810718 101. 00 200. 00 Subtotal (sum of lines 50 thru 199) Less Observation Beds 341, 573, 535 1, 845, 944, 311 1, 845, 944, 311 201. 00 200. 00 201. 00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					
101.00 10100 HOME HEALTH AGENCY 7, 160, 179 8, 831, 894 0. 810718 101.00 200.00 Subtotal (sum of lines 50 thru 199) 341, 573, 535 1, 845, 944, 311 200.00 15, 546, 038 0 201.00		., ., ,				
200.00 Subtotal (sum of lines 50 thru 199) 341,573,535 1,845,944,311 200.00 201.00 Less Observation Beds 15,546,038 0 201.00		7, 160, 179	8, 831, 894	0. 81071	8	101.00
201.00 Less Observation Beds 15,546,038 0 201.00						
	202.00 Total (line 200 minus line 201)		l e			

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	APITAL COSTS	Provider Co		Period: From 07/01/2020 Fo 06/30/2021	Worksheet D Part I Date/Time Pre 11/23/2021 10	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal Rel ated Cost	Swing Bed Adjustment	Reduced Capital	Total Patient Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B,	/ Aug us timorre	Related Cost		0 7 001 . 1)	
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	5			'		
30. 00 ADULTS & PEDIATRICS	4, 674, 751	0	4, 674, 75	78, 431	59. 60	30. 00
31.00 INTENSIVE CARE UNIT	1, 607, 821		1, 607, 82	1 11, 468	140. 20	31. 00
31.01 NEONATAL INTENSIVE CARE	347, 103		347, 103	4, 432	78. 32	31. 01
41.00 SUBPROVIDER - IRF	296, 706	0	296, 700	4, 924	60. 26	
43. 00 NURSERY	49, 348		49, 348	· ·	17. 93	
200.00 Total (lines 30 through 199)	6, 975, 729		6, 975, 729	9 102, 007		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		7.00				
30. 00 ADULTS & PEDIATRICS	26, 597	1, 585, 181				30.00
31. 00 INTENSIVE CARE UNIT	4, 143					31. 00
31. 01 NEONATAL INTENSIVE CARE	1,110	1	1			31. 01
41. 00 SUBPROVI DER - I RF	3, 612					41. 00
43. 00 NURSERY	0	1	1			43. 00
200.00 Total (lines 30 through 199)	34, 352	2, 383, 689	·			200. 00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 07/01/2020	Part II	
				To 06/30/2021	Date/Time Pre 11/23/2021 10	pared:
		Title	· XVIII	Hospi tal	PPS	. 20 alli
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 991, 529					
51.00 05100 RECOVERY ROOM	955, 194				75, 340	
52.00 05200 DELIVERY ROOM & LABOR ROOM	403, 063				207	52. 00
53. 00 05300 ANESTHESI OLOGY	230, 717				25, 656	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 782, 078				27, 757	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	2, 249, 489			·	34, 530	
56. 00 05600 RADI 0I SOTOPE	344, 768				16, 542	56. 00
57. 00 05700 CT SCAN	1, 170, 170				143, 041	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	765, 770				66, 015	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 683, 135				· ·	1
60. 00 06000 LABORATORY	1, 310, 406				155, 404	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	69, 086				16, 692	l
64. 00 06400 I NTRAVENOUS THERAPY	108, 581	1 ' '			0	64. 00
65. 00 06500 RESPI RATORY THERAPY	221, 443				75, 593	
66. 00 06600 PHYSI CAL THERAPY	822, 350				83, 755	
67. 00 06700 OCCUPATI ONAL THERAPY	77, 768				16, 673	
68. 00 06800 SPEECH PATHOLOGY	80, 448			·	9, 187	68. 00
69. 00 06900 ELECTROCARDI OLOGY	898, 160				122, 662	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	138, 093				· ·	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	129, 784				27, 229	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	167, 692				47, 924	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	522, 157				121, 451	73. 00
74. 00 07400 RENAL DI ALYSI S	31, 034				13, 564	1
76. 97 O7697 CARDI AC REHABI LI TATI ON	131, 086	3, 162, 317	0. 04145	3 142, 142	5, 892	76. 97
OUTPATIENT SERVICE COST CENTERS		1	T .			
90. 00 09000 CLI NI C	94, 844				1, 068	1
91. 00 09100 EMERGENCY	797, 095					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	943, 287					92.00
200.00 Total (lines 50 through 199)	21, 119, 227	1, 837, 112, 417		258, 982, 021	2, 239, 480	J200. 00

ealth Financial Systems PPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COS	TS Provider C		Peri od: From 07/01/2020 To 06/30/2021	Date/Time Pre	
		T: 41 -		11: 4-1	11/23/2021 10 PPS): 28 an
Cost Center Description	Nursing Cohool		XVIII	Hospi tal		
cost center bescription	Post-Stepdown	INUI SI IIG SCIIDOI	Post-Stepdow	Allied Health Cost	Medical	
	Adj ustments		Adjustments	COST	Education Cost	
	1A	1. 00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	0.00	
0. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.0
1. 00 03100 NTENSI VE CARE UNI T	0			0 0	0	
1. 01 02060 NEONATAL NTENSI VE CARE	0			0 0	0	
1. 00 04100 SUBPROVI DER - RF	0	0		0 0	0	
3. 00 04300 NURSERY	0			0 0	0	
00.00 Total (lines 30 through 199)	0			0 0	0	200. 0
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpatient	
'	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	_			
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDI ATRI CS	0	0	78, 43	0.00	26, 597	30.0
1.00 03100 INTENSIVE CARE UNIT		0	11, 46			
1.01 02060 NEONATAL INTENSIVE CARE		0	4, 43			1
1.00 04100 SUBPROVI DER - I RF	0	0	4, 92			
3. 00 04300 NURSERY		0	2, 75			
00.00 Total (lines 30 through 199)		0	102, 00	17	34, 352	200. C
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					

30. 00 31. 00 31. 01 41. 00 43. 00

200.00

INPATIENT ROUTINE SERVICE COST CENTERS

Total (lines 30 through 199)

30. 00 03000 ADULTS & PEDIATRIC S
31. 00 03100 INTENSIVE CARE UNIT
31. 01 02060 NEONATAL INTENSIVE CARE
41. 00 04100 SUBPROVIDER - IRF
43. 00 04300 NURSERY

200.00

Health Financial Systems	COMMUNITY HOS	SPI TAL	In Lieu of I		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0125	Peri od:	Worksheet D	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0125
From 07/01/2020
To 06/30/2021
Date/Time Prepared: 11/23/2021 10: 28 am

					11/23/2021 10	: 28 am_	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	(0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57.00	05700 CT SCAN	0	0	1	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0	59. 00
60.00	06000 LABORATORY	0	0	1	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	l	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	1	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	418, 280	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74.00
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76, 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0	0	90.00
91.00	09100 EMERGENCY	0	0		0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00		0	0	d	0	418, 280	1

Health Financial Systems	COMMUNITY HOS	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0125	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/23/2021 10:28 am

THROUGH COS	STS				To 06/30/2021	Date/Time Pre 11/23/2021 10	
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	· ·	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	LLARY SERVICE COST CENTERS	_		T			
	O OPERATING ROOM	0	0		302, 976, 642		1
	O RECOVERY ROOM	0	0	1	32, 022, 154		1
	O DELIVERY ROOM & LABOR ROOM	0	0	1	9, 122, 201	0. 000000	1
	O ANESTHESI OLOGY	0	0	1	47, 166, 913		1
	O RADI OLOGY-DI AGNOSTI C	0	0	1	81, 014, 836		1
	O RADI OLOGY - THERAPEUTI C	0	0	1	45, 584, 339		1
	O RADI OI SOTOPE	0	0	1	33, 364, 758		
	O CT SCAN	0	0	1	119, 247, 733		
58. 00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	61, 854, 704	0. 000000	58. 00
59. 00 0590	O CARDIAC CATHETERIZATION	0	0	1	150, 199, 817	0. 000000	59. 00
60.00 06000	O LABORATORY	0	0		239, 666, 764	0.000000	60.00
63.00 0630	D BLOOD STORING, PROCESSING, & TRANS.	0	0		12, 079, 357	0.000000	63.00
64. 00 0640	O INTRAVENOUS THERAPY	0	0		3, 596, 373	0.000000	64. 00
65. 00 0650	O RESPIRATORY THERAPY	0	0)	21, 657, 600	0.000000	65. 00
66. 00 0660	O PHYSI CAL THERAPY	0	0		35, 086, 846	0.000000	66. 00
67. 00 0670	O OCCUPATIONAL THERAPY	0	0		11, 461, 359	0.000000	67.00
68. 00 0680	O SPEECH PATHOLOGY	0	0		5, 077, 157	0.000000	68. 00
69. 00 0690	O ELECTROCARDI OLOGY	0	0)	75, 943, 704	0.000000	69. 00
70.00 0700	O ELECTROENCEPHALOGRAPHY	0	0)	18, 179, 355	0.000000	70. 00
71. 00 0710	OMEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	70, 655, 752	0. 000000	71. 00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0	Ö	1	90, 832, 034	0. 000000	72. 00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0	418, 280	418, 28	149, 305, 181	0. 002802	73. 00
74. 00 0740	O RENAL DIALYSIS	0	O		7, 931, 011	0. 000000	74.00
76. 97 0769 ⁻	7 CARDIAC REHABILITATION	0	o	,	3, 162, 317	0. 000000	76. 97
	ATIENT SERVICE COST CENTERS			,			1
90.00 09000		0	О		13, 154, 401	0.000000	90. 00
91.00 0910		0			151, 225, 772		
	O OBSERVATION BEDS (NON-DISTINCT PART	0		,	45, 543, 337		1
200.00	Total (lines 50 through 199)	0	418, 280	418, 28	1, 837, 112, 417		200. 00

Heal th	Financial Systems	COMMUNITY F	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	Provi der CC		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/23/2021 10	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9, 00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	1			1		
50.00	05000 OPERATI NG ROOM	0. 000000	40, 797, 188		0 53, 604, 552	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	2, 525, 723		0 7, 088, 981	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	4, 693		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	5, 244, 397		0 8, 692, 482	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 261, 858		0 15, 506, 498	0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0. 000000	699, 715		0 17, 052, 350	0	55.00
56.00	05600 RADI OI SOTOPE	0. 000000	1, 600, 845		0 11, 413, 341	0	56.00
57.00	05700 CT SCAN	0. 000000	14, 576, 635		0 25, 372, 547	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	5, 332, 382		0 13, 679, 682	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	27, 885, 918		0 44, 145, 177	0	59. 00
60.00	06000 LABORATORY	0. 000000	28, 420, 712		0 17, 283, 312	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	2, 918, 628		0 1, 440, 877	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 1, 996, 440	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	7, 392, 925		961, 548	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	3, 573, 486		0 394, 837	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	2, 457, 349		0 188, 455	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	579, 791		0 291, 737	0	68. 00
	0.000 51 5075000 5551 01 0007		40 074 005	i .	04 470 044		1 , 0 00

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10, 371, 385

14, 822, 642

25, 961, 186

34, 730, 089

3, 466, 357

142, 142

148, 129

20, 647, 359

2, 581, 587

258, 982, 021

838, 900

Ω 70.00

0 71.00

0 72.00

0

0 76. 97

0

0

0 92.00

68, 124 200. 00

68, 124

69.00 0

73.00

74.00

90. 00 91. 00

21, 173, 314

4, 138, 541

12, 502, 037

14, 669, 370

24, 312, 646

799, 419

1, 246, 639

6, 604, 851

17, 201, 318

11, 355, 452

333, 116, 403

0

0

0

0

0

97, 314

97, 314

69. 00 06900 ELECTROCARDI OLOGY

71.00

73.00

74.00

76. 97

200.00

90. 00 09000 CLI NI C

91. 00 | 09100 | EMERGENCY

70. 00 07000 ELECTROENCEPHALOGRAPHY

07400 RENAL DIALYSIS

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS

07697 CARDIAC REHABILITATION

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/23/2021 10	pared: :28 am
		Title	: XVIII	Hospi tal	PPS	
		·	Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00	2. 00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 175354	53, 604, 552		0 0	9, 399, 773	50.00
51. 00 05100 RECOVERY ROOM	0. 400655		•	0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 549632	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 106652	8, 692, 482		0 0	927, 071	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 147023	15, 506, 498		0 0	2, 279, 812	1
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 157922	17, 052, 350		0 0	2, 692, 941	1
56. 00 05600 RADI 0I SOTOPE	0. 112334	11, 413, 341		0 0	1, 282, 106	
57. 00 05700 CT SCAN	0. 054385	25, 372, 547		0 0	1, 379, 886	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 065589	13, 679, 682		0 0	897, 237	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 081172	44, 145, 177		0 16, 992	3, 583, 352	
60. 00 06000 LABORATORY	0. 118628	17, 283, 312		0 0	2, 050, 285	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 286072	1, 440, 877		0	412, 195	63. 00
64.00 06400 INTRAVENOUS THERAPY	0. 276245	1, 996, 440		0 0	551, 507	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 314759	961, 548		0	302, 656	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 347064	394, 837	•	0	137, 034	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 264787	188, 455		0	49, 900	
68. 00 06800 SPEECH PATHOLOGY	0. 434473	291, 737		0	126, 752	
69. 00 06900 ELECTROCARDI OLOGY	0. 096916		•	0	2, 052, 033	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 119304	4, 138, 541		0	493, 744	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 481439		•	0	6, 018, 968	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 484110	14, 669, 370		0 0	7, 101, 589	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 186105			0 59, 535		1
74. 00 07400 RENAL DI ALYSI S	0. 285755			0 0	228, 438	
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0. 475523	1, 246, 639		0 0	592, 806	76. 97
90. 00 O9000 CLINIC	0. 317674	6, 604, 851	I	0 0	2, 098, 189	90.00
91. 00 09100 EMERGENCY	0. 317674			0 0	1, 922, 798	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 341346	11, 355, 452		0 0	3, 876, 138	
200.00 Subtotal (see instructions)	0. 341340	333, 116, 403		0 76, 527	57, 822, 151	
201.00 Less PBP Clinic Lab. Services-Program		333, 110, 403		0 70, 327	37,022,131	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		333, 116, 403		0 76, 527	57, 822, 151	202. 00

Health Financial Systems	COMMUNITY HOS	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0125	Peri od:	Worksheet D

To 06/30/2021 Date/Time Prepared: 11/23/2021 10: 28 am Titl<u>e XVIII</u> Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 0 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 55.00 05500 RADI OLOGY - THERAPEUTI C 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 59 00 1, 379 60.00 06000 LABORATORY 0 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 67.00 06700 OCCUPATI ONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 11, 080 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 07697 CARDIAC REHABILITATION 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 0 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 91.00 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 200.00 Subtotal (see instructions) 12, 459 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

12, 459

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0125	Peri od:	Worksheet D	
			00N 45 T405	From 07/01/2020		
		Component	CCN: 15-T125	To 06/30/2021	Date/Time Prep 11/23/2021 10	
		Title	: XVIII	Subprovi der -	PPS	. 20 aiii
		11 11 0	, ,,,,,,,	IRF	113	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
· ·	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)		,	
	26)	ŕ				
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	4, 991, 529					50.00
51.00 05100 RECOVERY ROOM	955, 194				285	
52.00 05200 DELIVERY ROOM & LABOR ROOM	403, 063	9, 122, 201			0	52. 00
53. 00 05300 ANESTHESI OLOGY	230, 717	47, 166, 913			159	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 782, 078	81, 014, 836	0. 02199	77 138, 462	3, 046	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	2, 249, 489					
56. 00 05600 RADI 0I SOTOPE	344, 768					
57. 00 05700 CT SCAN	1, 170, 170	119, 247, 733	0. 00981	191, 800	1, 882	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	765, 770				1, 131	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 683, 135					
60. 00 06000 LABORATORY	1, 310, 406				4, 825	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	69, 086					63.00
64. 00 06400 I NTRAVENOUS THERAPY	108, 581					
65. 00 06500 RESPIRATORY THERAPY	221, 443					65. 00
66. 00 06600 PHYSI CAL THERAPY	822, 350					
67. 00 06700 OCCUPATI ONAL THERAPY	77, 768					
68. 00 06800 SPEECH PATHOLOGY	80, 448					
69. 00 06900 ELECTROCARDI OLOGY	898, 160					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	138, 093					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	129, 784					71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	167, 692					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	522, 157					
74. 00 07400 RENAL DIALYSIS	31, 034					
76. 97 O7697 CARDI AC REHABI LI TATI ON	131, 086	3, 162, 317	0. 04145	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	94, 844				·	
91. 00 09100 EMERGENCY	797, 095					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00 Total (lines 50 through 199)	20, 175, 940	1, 837, 112, 417	I	8, 182, 828	87, 485	J200. 00

Health Financial Systems	COMMUNITY HOS	SPI TAL	In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0125 Component CCN: 15-T125	Peri od: From 07/01/2020 To 06/30/2021		
		Title XVIII	Subprovi der -	PPS	

		Title	xVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	IRF Allied Health	Allied Health	
oust deliter beserver on		Post-Stepdown	liver string scribbin	Post-Stepdown	Airrea near th	
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	•	•	•	•		
50. 00 05000 OPERATING ROOM	0	0	C	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	C	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	C	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	C	0	0	56.00
57. 00 05700 CT SCAN	0	0	C	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	C	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	C	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	418, 280	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	C	0	0	74. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	C	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	0	0	90.00
91. 00 09100 EMERGENCY	0	0	C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		[C)	0	92. 00
200.00 Total (lines 50 through 199)	0	0	C	0	418, 280	200. 00

APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0125 Period: From 07/01/2020 Part I V Date/Time Prepared: 11/23/2021 10.28 am	Health Financi	al Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
Component CCN: 15-1126 To O6/30/2021 Date/Time Prepared Pr		OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	S Provider C				
Cost Center Description				· ·	CCN: 15-T125	To 06/30/2021	Date/Time Pre	
Medical Education Cost 1, 2, 3, and Cost (sum of col s. Cost Cost (sum of col s. Cost (sum of col s. Cost				Ti tl e	e XVIII		PPS	
Education Cost 1, 2, 3, and Cost (sum of cols. 2, 3), and 4) Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2, 3), and 4, 75 Cost (sum of cols. 2,	Co	ost Center Description				Total Charges	Ratio of Cost	
A				,				
ANCILLARY SERVICE COST CENTERS			Education Cost					
ANCILLARY SERVICE COST CENTERS				4)		8)		
ANCILLARY SERVICE COST CENTERS					and 4)			
ANCILLARY SERVICE COST CENTERS Service C			4.00	5.00	6.00	7 00		
50.00	ANCLLLA	RY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
51.00 05100 RECOVERY ROOM 0 0 0 0 32, 022, 154 0, 000000 51.00			0	0		0 302, 976, 642	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 9,122, 201 0,000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 47,166,913 0,000000 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 45,584,339 0,000000 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 0 45,584,339 0,000000 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 0 33,364,758 0,000000 55.00 05700 CT SCAN 0 0 0 0 119,247,733 0,000000 55.00 05700 CT SCAN 0 0 0 0 0 119,247,733 0,000000 57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0			-		l .			
53.00 05300 ANESTHESI OLOGY 0 0 0 47, 166, 913 0.000000 53.00 54.00 05400 RADI OLOGY - DI AGNOSTIC 0 0 0 81, 014, 836 0.000000 55.00 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 45, 584, 339 0.000000 55.00 56.00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 33, 364, 758 0.000000 56.00 57.00 05700 CT SCAN 0 0 0 119, 247, 733 0.000000 56.00 58.00 05800 MARRITI C RESONANCE I MAGI NG (MRI) 0 0 0 16, 1854, 704 0.000000 58.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 150, 199, 817 0.000000 59.00 60.00 06000 LABORATORY 0 0 0 12, 079, 357 0.000000 69.00 64.00 06400 INTAVIDUDIA REPRACESING, & TRANS. 0			0	l o	1			
54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 0 81,014,836 0.000000 54.00			0	l o				
56. 00 05600 RADI OI SOTOPE 0 0 0 33, 364, 758 0.000000 56. 00 57. 00 57. 00 5700 CT SCAN 0 0 0 0 0 119, 247, 733 0.000000 57. 00 58. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 150, 199, 817 0.000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0	54. 00 05400 RA	ADI OLOGY-DI AGNOSTI C	0	l c				54.00
57. 00 05700 CT SCAN 0 0 0 119,247,733 0.000000 57.00 58. 00 05800 MAGNETIC RESONANCE I IMAGING (MRI) 0 0 0 61,854,704 0.000000 58.00 59. 00 05900 CARDIA C CATHETERI ZATI ON 0 0 0 150,199,817 0.000000 59.00 60. 00 06000 LABORATORY 0 0 0 239,666,764 0.000000 60.00 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 12,079,357 0.000000 60.00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 21,657,600 0.000000 64.00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 21,657,600 0.000000 66.00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 35,086,846 0.000000 66.00 67. 00 06900 DCCUPATHOLOGY 0 0	55. 00 05500 RA	ADIOLOGY - THERAPEUTIC	0	0		0 45, 584, 339	0.000000	55. 00
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 0 0 161, 854, 704 0.000000 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 150, 199, 817 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 0 239, 666, 764 0.000000 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 0 0 0 12, 079, 357 0.000000 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 3, 596, 373 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 21, 657, 600 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 35, 086, 846 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 11, 461, 359 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 5, 077, 157 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 75, 943, 704 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 70, 655, 752 0.000000 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 79, 331, 101 0.000000 74. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 3, 162, 317 0.000000 76. 97 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 13, 154, 401 0.000000 76. 97 79. 00 09000 CLI NI C 0 0 0 151, 125, 772 0.000000 91. 00 91. 00 09100 EMERGENCY 0 0 0 45, 543, 337 0.000000 92. 00 92. 00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 45, 543, 337 0.000000 92. 00 92. 00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 45, 543, 337 0.0000000 92. 00 92. 00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 45, 543, 337 0.0000000 92. 00 92. 00 09200 095ERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0 92. 00 09000 091. 00 092. 00 09000 092. 00 93. 00 09000 09000 09000 090000 090. 00 090000000000	56. 00 05600 RA	ADI OI SOTOPE	0	0)	0 33, 364, 758	0. 000000	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 150, 199, 817 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 239, 666, 764 0.000000 60. 00 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 12, 079, 357 0.000000 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 3, 596, 373 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 21, 657, 600 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 35, 086, 846 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 11, 461, 359 0.000000 67. 00 68. 00 08900 SPECH PATHOLOGY 0 0 0 5, 077, 157 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 75, 943, 704 0.000000 69. 00 70. 00	57. 00 05700 C	Γ SCAN	0	0		0 119, 247, 733	0. 000000	57.00
60. 00 06000 LABORATORY 0 0 0 0 12,079,357 0,000000 60. 00 63. 00 640. 00 640. 00 17,079,357 0,000000 60. 00 0 17,079,357 0,000000 63. 00 0 17,079,357 0,000000 63. 00 0 17,079,357 0,000000 63. 00 0 0,00000 17,000000 17,000 0,00000 0,00000 17,000 0,00000 17,000 0,00000 17,000 0,00000 17,000 0,00000 17,000 0,00000 17,000 0,00000 17,000 0,00000 0,00000 0,00000 0,000 0,00000 0,000 0			0	O	1			
63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 12, 079, 357 0.000000 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 3, 596, 373 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 21, 657, 600 0.000000 65.00 66.00 06500 PHYSI CAL THERAPY 0 0 0 0 35, 086, 846 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 11, 461, 359 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 5, 077, 157 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 5, 077, 157 0.000000 69.00 07000 ELECTROCARDIOLOGY 0 0 0 18, 179, 355 0.000000 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 18, 179, 355 0.000000 70.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 70, 655, 752 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 418, 280 418, 280 149, 305, 181 0.002802 73.00 74.00 07400 RENAL DIALYSIS 0 418, 280 418, 280 149, 305, 181 0.002802 73.00 76.97 CARDIA CREHABILITATION 0 0 0 0 13, 162, 317 0.000000 76.97 0.00 09000 CLINIC 0 0 0 0 151, 225, 772 0.000000 90.00 09000 CLINIC 0 0 0 0 0 151, 225, 772 0.000000 91.00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0)			
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 3,596,373 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 21,657,600 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 35,086,846 0.000000 66. 00 0 0 0 0 0 0 0 0 0			0	0				
65. 00			0	0	1			
66. 00 06600 PHYSI CAL THERAPY 0 0 0 35, 086, 846 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 11, 461, 359 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 5, 077, 157 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 75, 943, 704 0.000000 69. 00 70. 00 07000 ELECTROECEPHALOGRAPHY 0 0 0 0 18, 179, 355 0.000000 71. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 70, 655, 752 0.000000 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 90, 832, 034 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 418, 280 418, 280 149, 305, 181 0.002802 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 7, 931, 011 0.000000 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 3, 162, 317 0.000000 76. 97 00TPATI ENT SERVI CE COST CENTERS 0 0 0 151, 225, 772 0.000000 91. 00 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 45, 543, 337 0.000000 92. 00			0	0				
67. 00			0	0	1			
68. 00 06800 SPEECH PATHOLOGY 0 0 0 5, 077, 157 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 75, 943, 704 0. 000000 69. 00 070, 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 18, 179, 355 0. 000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 70, 655, 752 0. 000000 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0, 832, 034 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 418, 280 418, 280 149, 305, 181 0. 002802 73. 00 74. 00 76. 97 CARDI AC REHABI LI TATI ON 0 0 0 3, 162, 317 0. 000000 74. 00 76. 97 000000 0000000 000000000000000			0	0				
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 75, 943, 704 0.000000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 18, 179, 355 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 70, 655, 752 0.000000 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 90, 832, 034 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 418, 280 418, 280 149, 305, 181 0.002802 73. 00 74. 00 74. 00 76. 97 CARDI AC REHABI LI TATI ON 0 0 0 3, 162, 317 0.000000 74. 00 76. 97 000000 CLI NI C 0 0 0 0 13, 154, 401 0.000000 90. 00 91. 00 92. 00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 45, 543, 337 0.000000 92. 00 00000000000000000000000000000000			0			, , ,		
70. 00			0					
71. 00			0		1			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 90, 832, 034 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 418, 280 418, 280 149, 305, 181 0.002802 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 7, 931, 011 0.000000 74. 00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 3, 162, 317 0.000000 76. 97 000000 CLINIC 0 0 0 0 13, 154, 401 0.000000 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 151, 225, 772 0.000000 92. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 45, 543, 337 0.000000 92. 00 00000000000000000000000000000000			0					1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 418, 280 418, 280 149, 305, 181 0.002802 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 7, 931, 011 0.000000 74. 00 76. 97 OT697 CARDI AC REHABILITATI ON 0 0 0 3, 162, 317 0.000000 76. 97 OUTPATIENT SERVICE COST CENTERS 0 0 0 13, 154, 401 0.000000 90. 00 76. 97 OUTPATIENT SERVICE COST CENTERS 0 0 0 151, 225, 772 0.000000 77. 00 09100 EMERGENCY 0 0 0 151, 225, 772 0.000000 91. 00 78. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 45, 543, 337 0.000000 92. 00 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 79. 00 09200			0		1			
74. 00				418 280	1			
76. 97 O7697 CARDI AC REHABI LI TATI ON O O O 3, 162, 317 O. 000000 76. 97 OUTPATI ENT SERVI CE COST CENTERS 90. 00 O9100 CLI NI C O O O 13, 154, 401 O. 000000 91. 00 O1 O O O O O O O O O O O O O O O O O					1			
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 13, 154, 401 0.000000 90.00 91. 00 09100 EMERGENCY 0 0 0 151, 225, 772 0.000000 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 45, 543, 337 0.000000 92.00					1			
90. 00					1	0, 102, 017	0.00000	70.77
91. 00 09100 EMERGENCY			0	С		0 13, 154, 401	0.000000	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 45, 543, 337 0. 000000 92. 00			0		1			
200.00 Total (Lines 50 through 199) 0 418,280 418,280 1,837,112,417 200.00	92. 00 09200 08	SSERVATION BEDS (NON-DISTINCT PART	0	0)	0 45, 543, 337	0. 000000	92.00
	200. 00 To	otal (lines 50 through 199)	0	418, 280	418, 28	0 1, 837, 112, 417		200. 00

Health Financial Systems	COMMUNITY H	OSPI TAI		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der CO	CN: 15-0125	Peri od:	Worksheet D	2332 10
THROUGH COSTS			CCN: 15-T125	From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre 11/23/2021 10	pared: 0:28 am
		Title	XVIII	Subprovider -	PPS	
Cook Cooks Doors at the	0	1 +: +	1	IRF	0	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpati ent Program	Outpatient Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	char ges	Costs (col.		Costs (col. 9	
	7)		x col . 10)	0	x col. 12)	
	9,00	10. 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATI NG ROOM	0. 000000	227, 684		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	9, 569		0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	7, 307		0 0	Ö	
53. 00 05300 ANESTHESI OLOGY	0. 000000	32, 419		0 0	Ö	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	138, 462		0 0	0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	62, 667		0 0	Ö	1
56. 00 05600 RADI OI SOTOPE	0. 000000	15, 189		0 0	Ö	
57. 00 05700 CT SCAN	0. 000000	191, 800		0 0	0	
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000	91, 348		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	71, 010		0 0	ő	
60. 00 06000 LABORATORY	0. 000000	882, 327		0 0	ő	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	28, 250		0 0	Ö	63. 00
64. 00 06400 NTRAVENOUS THERAPY	0. 000000	20, 200		0 0	ő	
65. 00 06500 RESPIRATORY THERAPY	0. 000000	351, 743		0 0	0	1
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 775, 846		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 778, 910		0 0	Ö	
68. 00 06800 SPEECH PATHOLOGY	0. 000000	192, 441		0 0	Ō	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	67, 698		0 0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	8, 913		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	270, 381		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	27, 933		0 0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 002802	1, 704, 452	4, 7	76 0	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	318, 546		0 0	0	74. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>					
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90. 00
91. 00 09100 EMERGENCY	0. 000000	6, 250		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92. 00
200.00 Total (lines 50 through 199)		8, 182, 828	4, 7	76 0	0	200. 00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 15-0125	Period: From 07/01/2020 To 06/30/2021		pared: : 28 am_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 674, 751	[C	4, 674, 75	78, 431	59. 60	
31.00 INTENSIVE CARE UNIT	1, 607, 821		1, 607, 82	11, 468	140. 20	31. 00
31. 01 NEONATAL INTENSIVE CARE	347, 103		347, 10			
41. 00 SUBPROVI DER - I RF	296, 706	C	296, 70	06 4, 924	60. 26	41. 00
43. 00 NURSERY	49, 348		49, 34	8 2, 752	17. 93	43. 00
200.00 Total (lines 30 through 199)	6, 975, 729		6, 975, 72	102, 007		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 436					30. 00
31.00 INTENSIVE CARE UNIT	55	'	•			31. 00
31. 01 NEONATAL INTENSIVE CARE	619					31. 01
41. 00 SUBPROVI DER - I RF	6					41. 00
43. 00 NURSERY	139		•			43. 00
200.00 Total (lines 30 through 199)	2, 255	144, 631	1			200. 00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	narod:
				10 00/30/2021	11/23/2021 10:	pareu. :28 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOUNT ARM OF BUILDING COURT OF STATE O	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4 004 500	000 07/ //0	0.04/47	1 150 (00	10.000	F0 00
50. 00 05000 OPERATING ROOM	4, 991, 529				19, 090	
51. 00 05100 RECOVERY ROOM	955, 194			· ·	1, 874	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	403, 063				6, 160	
53. 00 05300 ANESTHESI OLOGY	230, 717				804	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 782, 078				5, 046	
55. 00 05500 RADI OLOGY - THERAPEUTI C	2, 249, 489				0	55. 00
56. 00 05600 RADI 0I SOTOPE	344, 768			· ·	211	56. 00
57. 00 05700 CT SCAN	1, 170, 170				3, 639	57. 00
58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)	765, 770			· ·	2, 319	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 683, 135				490	
60. 00 06000 LABORATORY	1, 310, 406				5, 797	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	69, 086				536	63.00
64. 00 06400 I NTRAVENOUS THERAPY	108, 581				0	64.00
65. 00 06500 RESPIRATORY THERAPY	221, 443			· ·	4, 114	65. 00
66. 00 06600 PHYSI CAL THERAPY	822, 350				3, 232	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	77, 768			· ·	588	67. 00
68. 00 06800 SPEECH PATHOLOGY	80, 448				1, 311	68. 00
69. 00 06900 ELECTROCARDI OLOGY	898, 160				2, 664	
70. 00 07000 ELECTROENCEPHALOGRAPHY	138, 093			· ·	418	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	129, 784				684	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	167, 692				549	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	522, 157				4, 696	
74. 00 07400 RENAL DI ALYSI S	31, 034				304	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	131, 086	3, 162, 317	0. 04145	3 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	04.044	12 154 401	0.00701		0	00 00
90. 00 09000 CLI NI C	94, 844				1 001	90.00
91. 00 09100 EMERGENCY	797, 095				· ·	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	943, 287			· ·	1, 200	
200.00 Total (lines 50 through 199)	21, 119, 227	1, 837, 112, 417		7, 025, 791	67, 607	200.00

Health Financial Systems	COMMUNI TY				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Period: From 07/01/2020 To 06/30/2021		pared: :28 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments		Post-Stepdowr Adjustments		Medical Education Cost	
INPATIENT ROUTINE SERVICE COST CENTERS	1A	1.00	2A	2. 00	3. 00	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 31. 01 02060 NEONATAL I NTENSI VE CARE	0	0		0 0	0	30. 00 31. 00 31. 01
41.00 04100 SUBPROVI DER - RF 43.00 04300 NURSERY	0	0		0 0	0	41. 00 43. 00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
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	
30. 00 03000 ADULTS & PEDI ATRICS 03100 NTENSI VE CARE UNIT 31. 01 02060 NEONATAL INTENSI VE CARE 41. 00 04100 SUBPROVI DER - IRF 43. 00 04300 NURSERY 04300 04300 NURSERY 04300 044300 NURSERY 04400 04	0	0	78, 43 11, 46 4, 43 4, 92 2, 75	8 0. 00 2 0. 00 4 0. 00	55 619 6	31. 00 31. 01 41. 00
200.00 Total (lines 30 through 199)						200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					

30.00

31. 00 31. 01 41. 00 43. 00

200.00

INPATIENT ROUTINE SERVICE COST CENTERS

Total (lines 30 through 199)

30. 00 03000 ADULTS & PEDI ATRI CS

200.00

31.00 | 03100 | INTENSI VE CARE UNI T 31.01 | 02060 | NEONATAL | INTENSI VE CARE 41.00 | 04100 | SUBPROVI DER - | IRF 43.00 | 04300 | NURSERY

Provi der CCN: 15-0125 THROUGH COSTS

			'		11/23/2021 10	: 28 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0) C	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0) C	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0) c	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0) c	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0) c	0	0	54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	C	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0) c	0	0	56. 00
57. 00 05700 CT SCAN	0	0) c	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0) c	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0) c	0	0	59. 00
60. 00 06000 LABORATORY	o	0	ol c	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	o	0	ol c	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	o	0	ol c	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	O	0	ıl c	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	O	0	ıl c	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	ol c	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	ol c	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	ol c	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	ol c	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	418, 280	73. 00
74. 00 07400 RENAL DIALYSIS	o	0		0	0	74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			,	•		
90. 00 09000 CLI NI C	0	0	C	0	0	90.00
91. 00 09100 EMERGENCY	o	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	l)	0	92. 00
200.00 Total (lines 50 through 199)		0	ا	0	418, 280	
			•	1		

Heal th Financial	Systems		(COMMUN	ITY HOS	PI TAL			In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF	I NPATI ENT/OUTPATI ENT	ANCILLARY S	SERVI CE	OTHER	PASS	Provi der (CCN:	15-0125	Peri od:	Worksheet D
THROUGH COSTS									From 07/01/2020	Part IV

THROUGH COSTS	VI OL OTHER TAO	o Trovider of		From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre 11/23/2021 10	pared: :28 am
			e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
ANOLILARY OFFICE COOT OFFITTED	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			1	000 07/ /40	0.00000	F0 00
50. 00 05000 OPERATING ROOM	0	0		302, 976, 642	0.000000	
51. 00 05100 RECOVERY ROOM	0	0		32, 022, 154	0.000000	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0		9, 122, 201	0.000000	
53. 00 05300 ANESTHESI OLOGY	0	0		47, 166, 913	0.000000	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		81, 014, 836	0.000000	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	1	0 45, 584, 339	0. 000000	
56. 00 05600 RADI 01 SOTOPE	0	0	1	33, 364, 758	0. 000000	
57. 00 05700 CT SCAN	0	0	1	119, 247, 733	0. 000000	
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0	1	0 61, 854, 704	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	150, 199, 817	0. 000000	
60. 00 06000 LABORATORY	0	0	1	239, 666, 764	0. 000000	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	1	12, 079, 357	0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1	3, 596, 373	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	1	21, 657, 600	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	1	35, 086, 846	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(11, 461, 359		
68.00 06800 SPEECH PATHOLOGY	0	0	(5, 077, 157	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		75, 943, 704	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		18, 179, 355	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		70, 655, 752	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		90, 832, 034	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	418, 280	418, 280		0. 002802	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		7, 931, 011	0. 000000	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	(3, 162, 317	0.000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		13, 154, 401	0. 000000	
91. 00 09100 EMERGENCY	0	0	(151, 225, 772		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(0 45, 543, 337	0. 000000	
200.00 Total (lines 50 through 199)	0	418, 280	418, 28	0 1, 837, 112, 417		200. 00

leal th Financial Systems COMMUNITY HOSPITAL				In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL THROUGH COSTS	ARY SERVICE OTHER PASS	Provider Co	CN: 15-0125	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/23/2021 10		
		Ti tl	e XIX	Hospi tal	PPS		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent		

THROUGH COSTS					o 06/30/2021	Date/Time Pre 11/23/2021 10	
			Titl	e XIX	Hospi tal	PPS	. 20 alli
Cost	t Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.	3	Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13.00	
	SERVI CE COST CENTERS						
	RATING ROOM	0. 000000	1, 158, 699	(0	0	50.00
51. 00 05100 RECC	OVERY ROOM	0. 000000	62, 826	(0	0	51.00
52. 00 05200 DELI	VERY ROOM & LABOR ROOM	0. 000000	139, 409	(0	0	52. 00
	STHESI OLOGY	0. 000000	164, 300	(0	0	53. 00
	OLOGY-DI AGNOSTI C	0. 000000	229, 402	(0	0	54.00
	OLOGY - THERAPEUTI C	0. 000000	0	(0	0	55. 00
56. 00 05600 RADI	OI SOTOPE	0. 000000	20, 451	(0	0	56. 00
57. 00 05700 CT S		0. 000000	370, 784	C	0	0	57.00
58. 00 05800 MAGN	NETIC RESONANCE IMAGING (MRI)	0. 000000	187, 296	C	0	0	58. 00
59. 00 05900 CARD	DI AC CATHETERI ZATI ON	0. 000000	43, 756	C	0	0	59. 00
60. 00 06000 LABO	DRATORY	0. 000000	1, 060, 174	C	0	0	60.00
63. 00 06300 BL00	DD STORING, PROCESSING, & TRANS.	0. 000000	93, 787	C	0	0	63.00
64. 00 06400 I NTF	RAVENOUS THERAPY	0. 000000	0	C	0	0	64. 00
65. 00 06500 RESF	PIRATORY THERAPY	0. 000000	402, 351	C	0	0	65. 00
66. 00 06600 PHYS	SI CAL THERAPY	0. 000000	137, 908	C	0	0	66. 00
67. 00 06700 OCCL	JPATI ONAL THERAPY	0. 000000	86, 664	C	0	0	67. 00
68. 00 06800 SPEE	ECH PATHOLOGY	0. 000000	82, 759	C	0	0	68. 00
69.00 06900 ELEC	CTROCARDI OLOGY	0. 000000	225, 286	C	0	0	69. 00
70. 00 07000 ELEC	CTROENCEPHALOGRAPHY	0. 000000	55, 069	C	0	0	70. 00
71. 00 07100 MEDI	CAL SUPPLIES CHARGED TO PATIENT	0. 000000	372, 321	C	0	0	71.00
72. 00 07200 I MPL	DEV. CHARGED TO PATIENTS	0. 000000	297, 414	C	0	0	72. 00
73. 00 07300 DRUG	GS CHARGED TO PATIENTS	0. 002802	1, 342, 731	3, 762	2	0	73. 00
74.00 07400 RENA	AL DIALYSIS	0. 000000	77, 695	C	0	0	74. 00
76. 97 07697 CARD	DIAC REHABILITATION	0. 000000	0	C	0	0	76. 97
	T SERVICE COST CENTERS						
90. 00 09000 CLI N		0. 000000	0	(0	0	90.00
91.00 09100 EMER		0. 000000	356, 778		0	0	
	ERVATION BEDS (NON-DISTINCT PART	0. 000000	57, 931		0	0	
200. 00 Tota	al (lines 50 through 199)		7, 025, 791	3, 762	0	0	200. 00

					6.5	
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	COMMUNITY	Provider C	ON 15 0105	Period:	u of Form CMS-: Worksheet D	2552-10
APPORTIONMENT OF INPATTENT ANCILLARY SERVICE CAPITA	AL CUS15	Provider C	UN: 15-0125	From 07/01/2020	Part II	
		Component	CCN: 15-T125	To 06/30/2021	Date/Time Pre	pared:
					11/23/2021 10	: 28 am
		litl	e XIX	Subprovi der -	PPS	
Cost Center Description	Capi tal	Total Charges	Patio of Cos	I RF t I npati ent	Capital Costs	
cost center bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	. Onal gcs	Cordiiir 4)	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	4, 991, 529	302, 976, 642	0. 01647	75 0	0	50. 00
51. 00 05100 RECOVERY ROOM	955, 194	32, 022, 154	0. 02982	29 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	403, 063	9, 122, 201			0	
53. 00 05300 ANESTHESI OLOGY	230, 717				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 782, 078				12	
55. 00 05500 RADI OLOGY - THERAPEUTI C	2, 249, 489		l .		0	
56. 00 05600 RADI 0I SOTOPE	344, 768				0	
57. 00 05700 CT SCAN	1, 170, 170				0	
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	765, 770				0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 683, 135				0	
60. 00 06000 LABORATORY	1, 310, 406					
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	69, 086				0	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	108, 581 221, 443				0 18	
66. 00 06600 PHYSI CAL THERAPY	822, 350				65	
67. 00 06700 OCCUPATI ONAL THERAPY	77, 768				16	1
68. 00 06800 SPEECH PATHOLOGY	80, 448				25	
69. 00 06900 ELECTROCARDI OLOGY	898, 160				4	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	138, 093		l .		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	129, 784				1	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	167, 692				Ó	
73.00 07300 DRUGS CHARGED TO PATIENTS	522, 157				13	1
74. 00 07400 RENAL DIALYSIS	31, 034			13 0	0	74. 00
76. 97 07697 CARDI AC REHABILI TATI ON	131, 086	3, 162, 317	0. 04145	53 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	94, 844	13, 154, 401			0	
91. 00 09100 EMERGENCY	797, 095				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00 Total (lines 50 through 199)	20, 175, 940	1, 837, 112, 417		17, 949	180	200. 00

Health Financial Systems	COMMUNITY HOS	SPI TAL	In Lieu of		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0125 Component CCN: 15-T125	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared:	
		demperient deit. 18 1128	10 00/ 00/ 2021	11/23/2021 10: 28 am	
		Title XIX	Subprovi der -	DDS	

			Ti tI	e XIX	Subprovi der -	PPS	<u> </u>
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0)	0	0	00.00
	05100 RECOVERY ROOM	0	0)	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0)	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54. 00
	05500 RADI OLOGY - THERAPEUTI C	0	0)	0	0	55. 00
	05600 RADI 0I S0T0PE	0	0)	0	0	56. 00
	05700 CT SCAN	0	0)	0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0	59. 00
	06000 LABORATORY	0	0)	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0)	0	0	63. 00
	06400 INTRAVENOUS THERAPY	0	0)	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0)	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0)	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0)	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0)	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0)	0	418, 280	73. 00
74.00	07400 RENAL DIALYSIS	0	0) (0	0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0)	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0)	0	0	90.00
91.00	09100 EMERGENCY	0	0)	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			D	0	92. 00
200.00	Total (lines 50 through 199)	0	0)	0 0	418, 280	200. 00

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI			CN: 15-0125	Peri od:	Worksheet D	
	SH COSTS	WIGE OTHER THO			From 07/01/2020	Part IV	
			'	CCN: 15-T125	To 06/30/2021	11/23/2021 10	
			Ti tl	e XIX	Subprovi der -	PPS	
	Cost Contan Decemintion	All Othor	Total Cost	Total	I RF	Doti o of Coot	
	Cost Center Description	All Other Medical	(sum of cols.	Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
		Education Cost	,	Cost (sum of		(col. 5 ÷ col.	
		Education Cost	1, 2, 3, and 4)	cols. 2, 3,	8)	7)	
			4)	and 4)	6)	(see	
				and 4)		instructions)	
		4. 00	5.00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50.00	05000 OPERATI NG ROOM	0	0		0 302, 976, 642	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0			0 32, 022, 154		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 9, 122, 201		
53. 00	05300 ANESTHESI OLOGY	0	0		0 47, 166, 913		1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 81, 014, 836		1
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	0		0 45, 584, 339	•	1
56. 00	05600 RADI OI SOTOPE	0	0		0 33, 364, 758		
57. 00	05700 CT SCAN	0	0		0 119, 247, 733		1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 61, 854, 704		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 150, 199, 817		
60.00	06000 LABORATORY	0	0		0 239, 666, 764		1
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 12, 079, 357		
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 3, 596, 373	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 21, 657, 600	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 35, 086, 846		1
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 11, 461, 359	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 5, 077, 157	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 75, 943, 704	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 18, 179, 355		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 70, 655, 752	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 90, 832, 034	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	418, 280	418, 28	149, 305, 181	0. 002802	73. 00
74.00	07400 RENAL DI ALYSI S	0	0		0 7, 931, 011	0.000000	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 3, 162, 317		76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 13, 154, 401		
91. 00	09100 EMERGENCY	0	0		0 151, 225, 772		1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 45, 543, 337		
200.00	Total (lines 50 through 199)	0	418, 280	418, 28	30 1, 837, 112, 417	1	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	COMMUNITY H	Provider C	ON 15 0105	Period:	eu of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	VICE UTHER PASS		CCN: 15-0125	From 07/01/2020 To 06/30/2021		pared: :28 am
		Titl	e XIX	Subprovi der – I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		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	0		0	0	
51.00 05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	537		0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	0		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	4, 695		0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	0		0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 737		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 756		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 288		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	1, 583		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	348		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	315		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 002802	3, 690	•	10 0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90. 00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0		
200.00 Total (lines 50 through 199)		17, 949	•	0	0	200. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552		
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0125	Peri od: From 07/01/2020	Worksheet D-1	
		To 06/30/2021	Date/Time Pre 11/23/2021 10	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

DART 1 - ALL PROVIDED COMPONENTS 1.00 Inpatient days (Including private room days and selling-bed days, excluding prexborn) 1.01 Inpatient days (Including private room days and selling-bed days, excluding selling-bed and deservation bed days) 1.02 Inpatient days (Including private room days, sexulading selling-bed and deservation bed days) 1.03 Privater committies (Including private room days, sexulading selling-bed and deservation bed days) 1.04 Privater committies (Including private room days) 2.05 Privater room days (excluding selling selling bed and deservation bed days) 2.06 Privater room days (excluding selling			Title XVIII	Hospi tal	PPS	
Inpatient days (Including private room days and seing-bed days, excluding newborn) 78,831 1.00 Impatient days (Including private room days, sectuding sating-bed and membern days) 78,431 2.00 Impatient days (Including private room days, sectuding sating-bed and reaction days) 78,431 2.00 Impatient days (Including private room days) 78,431 2.00 2.00 Impatient days (Including private room days) 78,431 2.00 2.		Cost Center Description		-	1 00	
Inpatt ent days (including private room days, and swing-bed days, excluding newborn) 78,431 1.00 1.		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (Including private room days, excluding swing-bed and neebborn days) 78,431 2.00 2.0						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, decluding swing-bed and observation bed days) Semi-private room days (excluding swing-bed and observation bed days) Semi-private room days (excluding swing-bed and observation bed days) Semi-private room days (excluding swing-bed with the swing swing-bed swing-						
do not complete this line. 4. OS Self-private room days (excluding swing-bed and observation bed days) 5. Diatal swing-bed SW type inpattent days (including private room days) after December 31 of the cost reporting period cost period (if calendar year, enter 0 on this line) 7. Diatal swing-bed SW type inpattent days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. Diatal swing-bed SW type inpattent days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. Diatal swing-bed SW type inpattent days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. Diatal inpattent days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. Diatal inpattent days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. Diatal inpattent days applicable to title sWill only (including private room days) 11. Diatal inpattent days applicable to title sWill only (including private room days) 12. Diatal inpattent days applicable to title sWill only (including private room days) 13. Diatal swing-bed SW type inpattent days applicable to title sWill only (including private room days) 14. Diatal swing-bed SW type inpattent days applicable to title sWill only (including private room days) 15. Diatal swing-bed SW type inpattent days applicable to title sWill only (including private room days) 16. Diatal swing-bed SW type inpattent days applicable to title sWill only (including private room days) 17. Diatal swing-bed SW type inpattent days applicable to title sWill only (including private room days) 18. Diatal swing-bed SW type inpattent days applicable to swing-bed swing-bed swing-bed days on the swing-bed SW type swing-bed SW type swing-bed SW type inpattent days applicable to swing-bed SW ty						
Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SkF type inpartient days (including private room days) after December 31 of the cost reporting period 6.00 Total swing-bed NF type inpartient days (including private room days) after December 31 of the cost reporting period 7.00 Total swing-bed NF type inpartient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting	3.00		ys). IT you have only pri	vate room days,	U	3.00
reporting period (1 cal calary (including private room days) after December 31 of the cost proporting period (1 cal calary 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 proporting period (1 cal calary year, enter 0 on this line) 8. 00 Total inpatient days including private room days) after December 31 of the cost proporting period (1 cal endary year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and private room days) after on the proporting period (1 cal endary year) 11. 00 Swing-bed SNF type inpatient days applicable to till to XVII only (including private room days) after on the proporting period (2 cal endary year) 12. 00 Swing-bed SNF type inpatient days applicable to till to XVII only (including private room days) after on the proporting period (2 cal endary year) 13. 00 Swing-bed SNF type inpatient days applicable to till to XVII only (including private room days) after on the proporting period (2 cal endary year, enter 0 on this line) 14. 00 Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 15. 00 Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 16. 00 North proporting days applicable to tilles V or XIX only (including private room days) 17. 00 Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 18. 00 North proporting days applicable to tilles V or XIX only (including private room days) 18. 00 North proporting days applicable to tilles V or XIX only (including private room days) 18. 00 North proporting days applicable to tilles V or XIX only (including private room days) 18. 00 North proporting days applicable to tilles V or XIX only (including private roo	4.00		ed days)		62, 605	4. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of total saing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if real endar year, enter 0 on this line)	5.00		om days) through December	31 of the cost	0	5.00
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 reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period if talendar year, enter 0 on this line) 9.00 Swing-bed SNF type inpatient days applicable to the Program (excluding awing-bed and newborn days) (see Instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 for through December 31 of the cost reporting period (including private room days) after 0 page 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 page 10.00 Swing-bed SNF type inpatient days applicable to titles V or XX only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 12.00 Swing-bed Swing-bed SWF services applicable to the Program (excluding swing-bed days) 12.00 Swing-bed Cost applicable Swing-bed Swi					_	
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 0 R.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 R.00 reporting period (if calendar year, enter 0 on this line) 10x1 Inpatient days including private room days applicable to the Program (excluding swing-bed and 26,597 9.00 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and 26,597 9.00 through December 31 of the cost reporting period (see instructions) 10x0 Wing-bed SWF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (see instructions) 10x0 Wing-bed SWF type inpatient days applicable to title XV or XIX only (including private room days) 11x0 0 Wing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 11x0 0 Wing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 11x0 0 Wing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 11x0 0 Wing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 11x0 0 Wing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 11x0 0 Wing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 11x0 0 10x0 0 Wing-bed NF type inpatient days applicable to services through December 31 of the cost 1 0.00 10x0 0 Wing-bed Wing-bed SWF type services applicable to services after December 31 of the cost 1 0.00 10x0 0 Wing-bed Wing-bed SWF type services applicable to services after December 31 of the cost 1 0.00 10x0 0 Wing-bed Cost applicable to SWF type services through December 31 of the cost reporting period (line 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00		om days) after December 3	31 of the cost	0	6. 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10. 00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 0 12. 00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13. 00 swing-bed SNF (title V or XIX only) (including swing-bed days) 0 15. 00 10 10 10 10 10 10 10 10 10 10 10 10	7. 00		m days) through December	31 of the cost	0	7. 00
reporting period (If callendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 wing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of the cost applicable to SNF type services through December 31 of the cost reporting period (line of the cost applicable to SNF type services through December 31 of the cost reporting period (line of the cost applicable to SNF type servic			,		_	
10.00 Swing-bed SMF type inpatitent days applicable to title XVIII only (including private room days) 0.00	8.00		m days) after December 31	of the cost	0	8. 00
newborn days) (see instructions) 10.00 wing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10.00 through December 31 of the cost reporting period (see instructions) 11.00 bing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost or eporting period 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line 6 or reporting period with period of the period of t	0.00		- the Donous (2/ 507	0.00
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25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 30. 00 Average private room per diem charge (line 29 ± line 3) 30. 00 Average semi-private room per diem charge (line 29 ± line 3) 31. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 36. 00 Private room cost differential (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37, nota) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37, nota) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Program general inpatient routine service cost per diem (see instructions) 38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 45. 00 Account of the private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24.00		r 31 of the cost reportir	ng period (line	0	24. 00
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions)					_	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 043, 554) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 Aoutine Charges 0 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 20.00 31.00 20.00 32.00		, ,			0	
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Pri vate room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30. 00 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) 30. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 043, 554) The program inus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 10. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 20. 0	27. 00		(line 21 minus line 26)		77, 043, 554	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 043, 554) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 32.00	28 00		d and observation hed cha	rnes)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 043, 554) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			d and observation bed ene	11 903)		
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 043, 554) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 36.00 0.00					0	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 043, 554) 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 (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, ,	÷ line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 043, 554) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,				
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77,043,554 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) 982.31 38.00 26,126,499 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			nus line 33)(see instruct	ions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 043, 554 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) 982.31 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				.1 0113)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 043, 554 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) 982.31 38.00 999.00 Program general inpatient routine service cost (line 9 x line 38) 26, 126, 499 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , ,	/			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 982.31 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		General inpatient routine service cost net of swing-bed cost	and private room cost dif	ferential (line	77, 043, 554	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 982.31 38.00 982.31 26,126,499 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 982.31 38.00 982.31 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 26, 126, 499 39.00 40.00	38 00				982 31	38 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) 26,126,499 41.00		,	-		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		26, 126, 499	41. 00

Heal th	Financial Systems	COMMUNITY F	IOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0125	Period: From 07/01/2020	Worksheet D-1	
					To 06/30/2021	Date/Time Pre 11/23/2021 10	
	Cost Contan Decemintion	Total	Ti tl e	XVIII	Hospi tal	PPS Program Cost	
	Cost Center Description	Total Inpati ent Cost I				(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	C				42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	23, 775, 218	11, 468	2, 073.	18 4, 143	8, 589, 185	43.00
43. 01	NEONATAL INTENSIVE CARE	6, 543, 687	4, 432			0	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk		,			52, 859, 286	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	nis)		87, 574, 970	49. 00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sur	n of Parts I and	2, 166, 030	50.00
51.00	<pre>Pass through costs applicable to Program inp and IV)</pre>	oatient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	2, 336, 794	51. 00
52.00	Total Program excludable cost (sum of lines					4, 502, 824	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		area, non-phy	rsician anesth	netist, and	83, 072, 146	53.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION	,					F 4 00
	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56.00	Target amount (line 54 x line 55)				50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tai	rget amount (I	ine 56 minus	line 53)	0 0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	endi ng 1996, ເ	pdated and co	ompounded by the		59. 00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	es 55, 59 or 60 e	enter the less	ser of 50% of		0	
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
	Relief payment (see instructions)	ŕ				0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see instruc	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Decer	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after Decembe	er 31 of the d	ost reportino	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	54 nlus line 6	5)(title XVII	Lonly) For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin						67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin					0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (ine 67 + line	: 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of				1		70.00
72.00	Program routine service cost (line 9 x line	71)					72. 00
73. 00 74. 00	Medically necessary private room cost application of the cost application of t						73. 00 74. 00
75. 00							75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	ıs line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						79. 00 80. 00
81.00	O Inpatient routine service cost per diem limitation						81. 00 82. 00
82. 00 83. 00							
84. 00	Program inpatient ancillary services (see in		<i>>)</i>				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85.00
00. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86. 00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			15, 826 982, 31	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•	11116 2)			15, 546, 038	
		,				•	

Health Financial Systems	COMMUNITY HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2020		
				To 06/30/2021	Date/Time Prep	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
	(1	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 THROU	GH COST					
90.00 Capital -related cost	4, 674, 751	77, 043, 554	0. 06067	7 15, 546, 038	943, 287	90.00
91.00 Nursing School cost	О	77, 043, 554	0.00000	0 15, 546, 038	0	91.00
92.00 Allied health cost	О	77, 043, 554	0.00000	0 15, 546, 038	0	92.00
93.00 All other Medical Education	0	77, 043, 554	0.00000	0 15, 546, 038	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0125	Peri od:	Worksheet D-1	
		From 07/01/2020		
	Component CCN: 15-T125	To 06/30/2021	Date/Time Pre	oared:
	· ·		11/23/2021 10	28 am
	Title XVIII	Subprovi der -	PPS	
		IRF		
0 1 0 1 D 1 11				

			I RF		
	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			4, 924	1.00
2.00	Inpatient days (including private room days, excluding swing-k			4, 924	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(S). If you have only priv	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		4, 924	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3°	1 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)				7.00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December (31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	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 s	swing-bed and	3, 612	9. 00
10.00	newborn days) (see instructions)	du (inaludina naivata na	am daya)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	i ons)		U	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		om days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter 0 on this line) om (excluding swing-bed da)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	iii (exer during swring bed de	193)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
17 00	SWING BED ADJUSTMENT Medicare rate for swing had SNE corvices applicable to corvice	os through Docombor 21 of	the cost	0.00	17. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of th	ne cost	0. 00	18. 00
19. 00	Medical d rate for swing-bed NF services applicable to services reporting period	s through December 31 of t	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of the	e cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		4, 878, 183	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 173	er 31 of the cost reportin	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	period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporting	g period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	នា of the cost reporting p	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)		·	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4, 878, 183	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
	General inpatient routine service charges (excluding swing-bed	l and observation bed char	rges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27 -	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instructi	ons)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	,	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		İ	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost difi	ferential (line	4, 878, 183	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			990. 70	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			3, 578, 408	39. 00
40.00	Medically necessary private room cost applicable to the Progra	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ IIne 40)	I	3, 578, 408	41.00

COMPUT	ATION OF INPATIENT OPERATING COST				Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre	pared:
			· ·	e XVIII	Subprovi der -	11/23/2021 10 PPS	
	Cost Center Description	Total Inpatient Costl	Total Total pati ent Davs	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4)	
42. 00	NURSERY (title V & XIX only)	0	0				42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	0	0.0	0 0	0	 43. 00
	NEONATAL INTENSIVE CARE		0	I		1	
44.00	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			•			46. 00 47. 00
.,. 00	Cost Center Description						171.00
49.00	Program inpatient ancillary service cost (Wk:	c+ D 2 col 2	Line 200)			1. 00 2, 050, 443	48. 00
	Total Program inpatient costs (sum of lines			ons)		5, 628, 851	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,			
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	n Wkst. D, sum	of Parts I and	217, 659	50.00
51. 00		atient ancillarv	services (fr	om Wkst. D. si	um of Parts II	92, 261	51.00
000	and IV)	,	33. 1. 333 (J. 111.0 C. D, O.		,2,20.	000
52.00	Total Program excludable cost (sum of lines					309, 920	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line 1	ding capital rel	ated, non-phy	sician anesth	etist, and	5, 318, 931	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient operation	ing cost and tar	get amount (I	ine 56 minus	ine 53)	Ö	1
	Bonus payment (see instructions)	· ·				0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	ndi ng 1996, ι	ipdated and coi	mpounded by the	0.00	59.00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upd	ated by the m	narket basket		0.00	60.00
	If line 53/54 is less than the lower of line	s 55, 59 or 60 e	nter the Less	er of 50% of		0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	matractions)				0	62.00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	her 31 of the	cost reporti	na neriod (See	0	64. 00
04.00	instructions)(title XVIII only)	ts thi ough becom	ber 51 of the	cost reportin	ig perrou (see	Ĭ	04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVII	only). For	0	66.00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost rep	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost repor	rting period	0	68.00
	(line 13 x line 20)				0.	_	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facility						70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (li					71.00
	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 v li	ne 35)			72.00
74. 00	Total Program general inpatient routine servi						74.00
75. 00	Capital-related cost allocated to inpatient				art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
	Program capital related costs (line 9 x line						77. 00
	Inpatient routine service cost (line 74 minus						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			*.	ıs line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for compa		St IIIII tati Ol	. (1116 /0 111111	23 TING 17)		81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine services (see in)				83. 00 84. 00
85.00	Program inpatient ancillary services (see in: Utilization review - physician compensation		s)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					0	07 00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)				87. 00 88. 00
00. UU							

	71 1 17 L		TIT LIC	u of Form CMS-2	332-10
	Provider CCN: 15-0125			Worksheet D-1	
	Component C				
	Title	XVIII	Subprovider -	PPS	
t Ro	outine Cost	column 1 ÷	Total	Observati on	
(fr	om line 21)	column 2	Observati on	Bed Pass	
	·		Bed Cost (from	Through Cost	
				4) (see	
				instructions)	
)	2. 00	3. 00	4. 00	5. 00	
96, 706	4, 878, 183	0. 06082	3 0	0	90.00
O	4, 878, 183	0.00000	0 0	0	91.00
O	4, 878, 183	0.00000	0 0	0	92.00
0	4, 878, 183	0. 00000	이	0	93. 00
	: Ro (fr	Component C Title Routine Cost (from line 21) 2.00 2.00 2.00 4,878,183 0 4,878,183 0 4,878,183	Provider CCN: 15-0125 Component CCN: 15-125 Title XVIII Routine Cost (from line 21)	Provider CCN: 15-0125	Provider CCN: 15-0125

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0125	Peri od: From 07/01/2020	Worksheet D-1	
		To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :28 am
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NDATI ENT. DAVE				1

		Title XIX	Hospi tal	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			78, 431	1. 00
2.00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		vata room dava	78, 431	2.00
3. 00	do not complete this line.	ys). IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		62, 605	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
	reporting period			ا	
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	days) tim sagi. bessings.	0. 0. 1 0001	١	7.00
8. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			4 404	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	1, 436	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private ro	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc		,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Volly (flictually private	e room days)	o l	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			2, 752 139	
10.00	SWING BED ADJUSTMENT			137	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of 1	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
17.00	reporting period	3 through becomber 31 of	the cost	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
04 00	reporting period	`		77 040 554	04 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ng period (line	77, 043, 554 0	21. 00 22. 00
22.00	5 x line 17)	or or the cost reporti	ng perrou (irric	١	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)			ا	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	r 31 of the cost reportir	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)			-	
	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		77, 043, 554	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation hed cha	arnes)	0	28. 00
	Private room charges (excluding swing-bed charges)	a and observation bed one	11 903)	0	
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 mi)	nus line 33)(see instruct	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	77, 043, 554	37. 00
	27 minus line 36)		,		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTAFATO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			200 21	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see	•		982. 31	38. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	-		1, 410, 597 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			1, 410, 597	
,	,	- · · · · · · · · · · · · · · · · · · ·	ı	,,	

Heal th	Financial Systems	COMMUNITY F	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0125	Peri od:	Worksheet D-1	
					From 07/01/2020	Data /Tima Dra	nanad.
					To 06/30/2021	Date/Time Pre 11/23/2021 10	
			Ti tl	e XIX	Hospi tal	PPS	. 20 am
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1	÷	(col. 3 x col.	
				col . 2)		4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	2, 403, 672	2, 752	873.	43 139	121, 407	42. 00
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	22 775 240	11 4/0	2.072	10 55	114 005	42.00
43.00		23, 775, 218	11, 468				
43. 01	NEONATAL INTENSIVE CARE CORONARY CARE UNIT	6, 543, 687	4, 432	1, 476.	46 619	913, 929	43. 01 44. 00
44. 00 45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description			I.			
	'					1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			1, 464, 199	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	see instructio	ns)		4, 024, 157	49. 00
	PASS THROUGH COST ADJUSTMENTS					1	
50. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	ı Wkst. D, sur	m of Parts I and	144, 269	50. 00
E1 00	Dass through costs applicable to Program inc	ationt andilla-	recorded (for	om Wks+ D	sum of Dorto II	71 2/0	51.00
51. 00	Pass through costs applicable to Program inpa and IV)	acrenic andiriary	y services (Tr	OIII WKSL. D, S	Sum OF PartS II	71, 369	31.00
52. 00	Total Program excludable cost (sum of lines!	50 and 51)				215, 638	52. 00
53. 00	Total Program inpatient operating cost exclude	,	ated, non-phy	sician anesth	netist, and	3, 808, 519	
	medical education costs (line 49 minus line !		, μ			, , , , , , , , , ,	
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					0	
55.00	Target amount per discharge						55. 00
56. 00	Target amount (line 54 x line 55)			. =	50)	0	
57. 00	Difference between adjusted inpatient operati	ing cost and tai	rget amount (I	ine 56 minus	Tine 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported	anding 1006 u	undated and co	ampounded by the	0.00	
37.00	market basket	Joi ting period t	enaring 1990, u	ipuateu anu ci	onipounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lines				the amount by	0	61.00
	which operating costs (line 53) are less than	n expected costs	s (lines 54 x	60), or 1% of	f the target		
	amount (line 56), otherwise enter zero (see i	nstructions)					
62.00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decer	mher 31 of the	cost reporti	ng period (See	0	64. 00
04.00	instructions)(title XVIII only)	ts through becer	ilber 31 of the	cost reporti	ng perrou (see	٥	04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line d	64 plus line 6	5)(title XVII	I only). For	0	66. 00
47.00	CAH (see instructions)		D 1 04	6 11			(7.00
67.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	or the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	a costs after Do	acember 31 of	the cost ren	orting period	0	68. 00
00.00	(line 13 x line 20)	e costs arter be	scelliber 31 01	the cost repo	or tring period	٥	00.00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (ine 67 + line	: 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY			
70. 00	Skilled nursing facility/other nursing facili	•		• • • • • • • • • • • • • • • • • • • •)		70.00
71.00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line 1)		(lino 14 v !:	no 25)			72.00
73. 00 74. 00	Medically necessary private room cost applications Total Program general inpatient routine servi						73.00
75. 00	Capital -related cost allocated to inpatient	•	,		Part II column		75. 00
. 5. 50	26, line 45)		(110m W		, GOI UIIII		1 . 5. 55
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79. 00	Aggregate charges to beneficiaries for excess			•	wo lis- 70)		79.00
80.00	Total Program routine service costs for compa		ust limitation	i (iine /8 mir	ius iine 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li		1				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (83. 00
84. 00	Program inpatient ancillary services (see in		-,				84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum						86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
87. 00	Total observation bed days (see instructions)		1: 2			15, 826	1
	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•	rine 2)			982. 31 15, 546, 038	
57.00	loppor ration ped cost (Time of Villie oo) (Sec	5 111311 4011 0113)				10,040,030	1 07.00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Prep 11/23/2021 10	
		Titl	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	4, 674, 751	77, 043, 554	0. 06067	7 15, 546, 038	943, 287	90.00
91.00 Nursing School cost	0	77, 043, 554	0.00000	15, 546, 038	0	91.00
92.00 Allied health cost	0	77, 043, 554	0.00000	15, 546, 038	0	92.00
93.00 All other Medical Education	0	77, 043, 554	0. 00000	15, 546, 038	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0125	Peri od: From 07/01/2020	Worksheet D-1
	Component CCN: 15-T125		
	Title XIX	Subprovi der -	PPS

		litie xix	I RF	PPS	
	Cost Center Description			I.	
	DATE AND DESIGNATION OF THE CONTRACTOR OF THE CO			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		4, 924	1. 00
2. 00	Inpatient days (including private room days, excluding swing-b			4, 924	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6 +6	4, 924	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through becembe	a 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	•			
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilibei s	i or the cost	U	6.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	6	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or	ulv (including private r	nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12.00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	dir (exer during swring bed	days)	2, 752	
16.00	Nursery days (title V or XIX only)				16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	as arter becomber or or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	6. 5			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		4, 878, 183	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
24 00	x line 20)			0	24 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 4, 878, 183	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(TITIE 21 IIII III 20)		1, 070, 100	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	11 00)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3)	÷ 11 ne 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instrud	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lir		,	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	4, 878, 183	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			990. 70	
39. 00	Program general inpatient routine service cost (line 9 x line			5, 944	
40.00	Medically necessary private room cost applicable to the Program			0 E 044	
41. 00	Total Program general inpatient routine service cost (line 39	+ 111le 40)	ļ	5, 944	41. 00

COMPUL	ATION OF INPATIENT OPERATING COST		Provider CC Component C	F	eriod: rom 07/01/2020 o 06/30/2021	Worksheet D-1 Date/Time Pre	
			·		Subprovi der -	11/23/2021 10: PPS	
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center bessirption	Inpatient Cost I	npatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0	5. 00	42. 00
12.00	Intensive Care Type Inpatient Hospital Units	<u> </u>	<u> </u>	0.00			12.00
	INTENSIVE CARE UNIT	0	0	0.00			
	NEONATAL INTENSIVE CARE CORONARY CARE UNIT	0	0	0.00	0	0	43. 01 44. 00
	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			4, 307	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	ee instruction	ns)		10, 251	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routino s	orvicos (from	Wkst D sum	of Darte L and	362	50.00
30. 00		attent routine s	ervices (IIOIII	WKSt. D, Suiii	or rarts r and	302	30.00
51. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fro	om Wkst. D, su	m of Parts II	190	51.00
F2 00	and IV)	50 L E4)				550	F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclu		ated non-phys	sician anesthe	tist and	552 9, 699	1
00.00	medical education costs (line 49 minus line !	52)	arou, non piny		erot, and	1, 011] 00.00
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F4 00
	Program discharges Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient operati	ng cost and tar	get amount (li	ne 56 minus I	i ne 53)	0	
	Bonus payment (see instructions)	nonting nonied o	nding 1007	doted and som	nounded by the	0.00	
59. 00	00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						
60. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	60.00
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see i		(TITIES 54 X C	50), 01 1% 01	the target		
62. 00	Relief payment (see instructions)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reportin	a period (See	0	64. 00
	instructions)(title XVIII only)	to thi dagii bodoii		oost ropertin	g po ou (ooo		0 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the co	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVIII	onLv). For	0	66. 00
	CAH (see instructions)				-		
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 of	f the cost rep	orting period	01	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost repor	ting period	0	68. 00
	(line 13 x line 20)				0 .		
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili						70. 00
71. 00	Adjusted general inpatient routine service co	ost per diem (li					71. 00
	Program routine service cost (line 9 x line 1 Medically necessary private room cost applications)	•	(lino 14 v lir	25)			72.00
74. 00	Total Program general inpatient routine servi			ie 35)			74.00
75. 00	Capital-related cost allocated to inpatient i			orksheet B, Pa	rt II, column		75. 00
74 00	26, line 45)	2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
	Inpatient routine service cost (line 74 minus						78. 00
	Aggregate charges to beneficiaries for excess			*.	- 1: 70		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		si iimitation	(iine /8 minu	s iinė 79)		80.00
82. 00	Inpatient routine service cost per drem rim						82. 00
83. 00	Reasonable inpatient routine service costs ()				83. 00
84. 00 85. 00	Program inpatient ancillary services (see insultilization review - physician compensation		e)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS		<u> </u>				
						,	
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of)	lino 2)			0 00	87. 00 88. 00

Provider CCN: 15-0125	Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
Component CCN: 15-T125	COMPUTATION OF INPATIENT OPERATING COST		Provi der CO				
			Component (Date/Time Pre	
			Ti tl	e XIX	'	PPS	
Cost Center Description Cost Routine Cost column 1 ÷ Total Observation	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
(from line 21) column 2 Observation Bed Pass			(from line 21)	column 2	Observati on	Bed Pass	
Bed Cost (from Through Cost					Bed Cost (from	Through Cost	
line 89) (col. 3 x col.							
4) (see						4) (see	
instructions)						instructions)	
1.00 2.00 3.00 4.00 5.00		1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST	COMPUTATION OF OBSERVATION BED PASS THROUGH C	COST					
90. 00 Capi tal -related cost 296, 706 4, 878, 183 0. 060823 0 0 90. 00	90.00 Capital -related cost	296, 706	4, 878, 183	0. 06082	3 0	0	90. 00
91. 00 Nursi ng School cost 0 4, 878, 183 0. 000000 0 0 91. 00	91.00 Nursing School cost	0	4, 878, 183	0.00000	0	0	91. 00
92. 00 Allied health cost 0 4,878,183 0.000000 0 92.00	92.00 Allied health cost	0	4, 878, 183	0.00000	0	0	92.00
93. 00 All other Medical Education 0 4,878,183 0.000000 0 93.00	93.00 All other Medical Education	0	4, 878, 183	0. 00000	0 0	0	93. 00

COMMUNITY HOSP	PLTAL		In Lie	u of Form CMS-2	2552-10
	Provi der C		From 07/01/2020	Worksheet D-3 Date/Time Preprint 11/23/2021 10:	pared:
	Ti tl e	XVIII	Hospi tal	PPS	
			Program		
		1.00	2. 00	3. 00	
			Provider CCN: 15-0125 Title XVIII Ratio of Cos To Charges	Provider CCN: 15-0125 Period: From 07/01/2020 To 06/30/2021 Title XVIII Hospital Ratio of Cost Inpatient Program Charges Charges Charges Period: From 07/01/2020 Promote	Provider CCN: 15-0125

	Cost Center Description	Ratio of Cost	I npati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	
30. 00	03000 ADULTS & PEDI ATRI CS		45, 127, 473		30. 00
31.00	03100 I NTENSI VE CARE UNI T		12, 570, 973		31. 00
31. 01	02060 NEONATAL INTENSIVE CARE		C)	31. 01
41. 00	04100 SUBPROVI DER - I RF		C)	41. 00
43.00	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 175378	40, 797, 188	7, 154, 929	50.00
51.00	05100 RECOVERY ROOM	0. 400655	2, 525, 723	1, 011, 944	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 550162	4, 693	2, 582	52. 00
53.00	05300 ANESTHESI OLOGY	0. 106652	5, 244, 397	559, 325	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 147162	1, 261, 858	185, 698	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0. 158058	699, 715	110, 596	55. 00
56.00	05600 RADI OI SOTOPE	0. 112334	1, 600, 845	179, 829	56.00
57.00	05700 CT SCAN	0. 054385	14, 576, 635	792, 750	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 065589	5, 332, 382		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 081204	27, 885, 918		59.00
60.00	06000 LABORATORY	0. 118734	28, 420, 712		l
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 286072	2, 918, 628		
64.00	06400 I NTRAVENOUS THERAPY	0. 276245	C		64.00
65. 00	06500 RESPI RATORY THERAPY	0. 314810	7, 392, 925	2, 327, 367	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 347064	3, 573, 486		•
67. 00	06700 OCCUPATI ONAL THERAPY	0. 264787	2, 457, 349		1
68. 00	06800 SPEECH PATHOLOGY	0. 434473	579, 791		1
69. 00	06900 ELECTROCARDI OLOGY	0. 096916	10, 371, 385		
	07000 ELECTROENCEPHALOGRAPHY	0. 119430	838, 900		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 481439	14, 822, 642		1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 484110	25, 961, 186	1	•
	07300 DRUGS CHARGED TO PATIENTS	0. 186110	34, 730, 089		73. 00
74. 00	07400 RENAL DIALYSIS	0. 285755	3, 466, 357		
	07697 CARDI AC REHABI LI TATI ON	0. 475523	142, 142		76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	0.473323	142, 142	. 07, 372	70.77
90 00	09000 CLI NI C	0. 319029	148, 129	47, 257	90.00
91. 00	09100 EMERGENCY	0. 111782	20, 647, 359		
		0. 341346	2, 581, 587		
200.00		0. 541540	258, 982, 021		
201.00			230, 702, 021		201.00
202.00			258, 982, 021	•	202.00
202.00	proceedings (Title 200 millions Title 201)	1	200, 702, 021	I	1202.00

ealth Financial Systems COMML NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	JNI TY HOSPI TAL Provi der C	CN: 15-0125	Peri od:	u of Form CMS-2 Worksheet D-3	
		CCN: 15-T125	From 07/01/2020 To 06/30/2021	Date/Time Pre	
	·			11/23/2021 10	
	Title	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	<u>'</u>	Ratio of Cos		I npati 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	
30. 00 03000 ADULTS & PEDIATRICS					30.0
81. 00 03100 NTENSI VE CARE UNIT					31. 0
31. 01 02060 NEONATAL INTENSIVE CARE					31.0
11. 00 04100 SUBPROVI DER - I RF			5, 113, 092		41.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 17537		39, 931	1
51. 00 O5100 RECOVERY ROOM		0. 40065	· ·	3, 834	
52. OO O5200 DELIVERY ROOM & LABOR ROOM		0. 55016		0	
53. 00 05300 ANESTHESI OLOGY		0. 10665	· ·	3, 458	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 1471 <i>6</i> 0. 15805	· ·	20, 376 9, 905	
66. 00 05600 RADI 0I SOTOPE		0. 13803		1, 706	
67. 00 05700 CT SCAN		0. 05438		10, 431	1
58. OO O5800 MAGNETI C RESONANCE MAGING (MRI)		0. 06558	· ·	5, 991	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08120		0	
50. 00 06000 LABORATORY		0. 11873		104, 762	
3.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 28607	28, 250	8, 082	63.0
04. 00 06400 I NTRAVENOUS THERAPY		0. 27624	15 0	0	64.0
55. 00 06500 RESPI RATORY THERAPY		0. 31481	· ·	110, 732	
66. 00 06600 PHYSI CAL THERAPY		0. 34706		616, 332	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 26478		471, 032	
98. 00 06800 SPEECH PATHOLOGY		0. 43447	· ·	83, 610	
99. 00 06900 ELECTROCARDI OLOGY		0. 09691	· ·	6, 561	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 11943		1, 064	
72.00 07100 MPL. DEV. CHARGED TO PATIENTS		0. 48143 0. 48411	· ·	130, 172 13, 523	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4841		317, 216	
74. 00 07400 RENAL DI ALYSI S		0. 28575		91, 026	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 47552		71, 020	1
OUTPATIENT SERVICE COST CENTERS		0. 17002	-0		70.7
00. 00 09000 CLI NI C		0. 31902	29 0	0	90. C
01. 00 09100 EMERGENCY		0. 11178		699	1
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 34134	· ·	0	92.0
Total (sum of lines 50 through 94 and 96 through	98)		8, 182, 828	2, 050, 443	200. C
201.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201. 0
Net charges (line 200 minus line 201)			8, 182, 828		202. 0

Health Financial Systems	COMMUNI	TY HOSPI TAL		In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST AS	PPORTI ONMENT	Provider CCN: 15-	.0125 Period	Worksheet D-3

Health Financial Systems	COMMUNITY HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 07/01/2020	D-+- /T: D	
			To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: ·28 am
	Ti tl	e XIX	Hospi tal	PPS	. 20 am
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			4 045 540		
30. 00 03000 ADULTS & PEDI ATRI CS			1, 345, 519		30.00
31. 00 03100 NTENSI VE CARE UNI T			343, 280		31.00
31. 01 02060 NEONATAL INTENSIVE CARE			4, 211, 736		31. 01
41. 00 04100 SUBPROVI DER - RF			050.010		41.00
43. 00 04300 NURSERY			253, 810		43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0. 17537	1, 158, 699	203, 210	50.00
51. 00 05100 RECOVERY ROOM		0. 17537		203, 210 25, 172	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 55016		76, 698	
53. 00 05300 ANESTHESI OLOGY		0. 10665		· ·	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 14716		17, 523 33, 759	
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 15805		33, 739	55.00
56. 00 05600 RADI 0LOGT - THERAPEUTI C		0. 11233		2, 297	56.00
57. 00 05700 CT SCAN		0. 11233		2, 297 20, 165	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 06558		12, 285	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08120		3, 553	1
60. 00 06000 LABORATORY		0. 11873		125, 879	1
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 28607		26, 830	1
64. 00 06400 I NTRAVENOUS THERAPY		0. 27624		20, 830	1
65. 00 06500 RESPI RATORY THERAPY		0. 27624		126, 664	1
66. 00 06600 PHYSI CAL THERAPY		0. 34706		47, 863	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26478		22, 948	
68. 00 06800 SPEECH PATHOLOGY		0. 43447		35, 957	1
69. 00 06900 ELECTROCARDI OLOGY		0. 43447		21, 834	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 04041		6, 577	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 11943		179, 250	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 48411		143, 981	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 48411		249, 896	
74. 00 07400 RENAL DI ALYSI S		0. 18611		22, 202	1
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 47552		22, 202	1
OUTPATIENT SERVICE COST CENTERS		0.47332	.5 0	0	70. 77
90. 00 09000 CLINIC		0. 31902	9 0	0	90.00
91. 00 09100 EMERGENCY		0. 11178		39, 881	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 34134		19, 775	1
200.00 Total (sum of lines 50 through 94 and 96	through 98)]	7, 025, 791	1, 464, 199	
201.00 Less PBP Clinic Laboratory Services-Prog			0	., .= ., .,	201.00
202.00 Net charges (line 200 minus line 201)	3 2 3 3 2 0 10 2 17		7, 025, 791		202. 00

Health Financial Systems COMMUI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	NI TY HOSPI TAL	CN: 15-0125	Peri od:	u of Form CMS-2 Worksheet D-3	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN. 15-0125	From 07/01/2020	WOLKSHEET D-3	
	Component	CCN: 15-T125	To 06/30/2021	Date/Time Pre 11/23/2021 10	
	Ti tI	e XIX	Subprovi der - I RF	PPS	
Cost Center Description	·	Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS		I			30.0
31. 00 03100 NTENSIVE CARE UNIT					31. 0
31. 01 02060 NEONATAL INTENSIVE CARE					31.0
41. 00 04100 SUBPROVI DER - I RF			7, 830		41.0
43. 00 04300 NURSERY			7,000		43. 0
ANCI LLARY SERVI CE COST CENTERS					1
50. 00 05000 OPERATING ROOM		0. 17537	78 0	0	50.0
51.00 05100 RECOVERY ROOM		0. 40065	55 0	0	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 55016	52 0	0	52.0
53. 00 05300 ANESTHESI OLOGY		0. 10665		0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14716	52 537	79	54.0
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 15805	58 0	0	55.0
56. 00 05600 RADI 0I SOTOPE		0. 11233		0	56. 0
57.00 05700 CT SCAN		0. 05438		0	57.0
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 06558		0	58. 0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08120		0	59. 0
60. 00 06000 LABORATORY		0. 11873	· ·	557	60.0
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 28607		0	63.0
64. 00 06400 I NTRAVENOUS THERAPY		0. 27624		0	64.0
65. 00 06500 RESPI RATORY THERAPY		0. 31481	· ·	547	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY		0. 3470 <i>6</i> 0. 26478	· ·	957 606	66. 0 67. 0
68. 00 06800 SPEECH PATHOLOGY		0. 43447		688	
69. 00 06900 SPEECH PATHOLOGY		0. 09691		34	ı
70. 00 07000 ELECTROCARD GEOGRAPHY		0. 11943		0	70.0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 48143		152	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 48411		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 18611		687	
74. 00 07400 RENAL DI ALYSI S		0. 28575		0	74.0
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 47552		0	
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLI NI C		0. 31902	29 0	0	90.0
91. 00 09100 EMERGENCY		0. 11178		0	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 34134	16 0	0	92.0
Total (sum of lines 50 through 94 and 96 through	98)		17, 949	4, 307	200. 0
201.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201. 0
202.00 Net charges (line 200 minus line 201)			17, 949		202.00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0125	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 10:28 am

		T: +1 o V/// / /	Hooni tal	11/23/2021 10	28 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			_	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring pr	rior to October 1 (s	see	0 17, 776, 350	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on	or after October	l (see	53, 942, 463	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for dis	scharges occurring p	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for dis	scharges occurring o	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see i			320, 729	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (se	e instructions)		975, 348 0	2. 04 3. 00
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting	ported (see instru	stions)	341. 61	4. 00
4.00	Indirect Medical Education Adjustment	perrou (see mistru	LITOTIS)	341.01	4.00
5. 00	FTE count for allopathic and osteopathic programs for the most rece or before 12/31/1996. (see instructions)	ent cost reporting p	period ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the cri	teria for an add-o	n to the cap for	0.00	6. 00
7. 00	new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified under	42 CER 8412 105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CF cost report straddles July 1, 2011 then see instructions.	. , ,		0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic a affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots un report straddles July 1, 2011, see instructions.	nder § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots fr lunder § 5506 of ACA. (see instructions)	om a closed teachi	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, linstructions)	8,01 and 8,02) (see	0. 00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current ye	ear from your record	ds	0. 00	10. 00
	FTE count for residents in dental and podiatric programs.			0. 00	
	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year end otherwise enter zero.	led on or after Sep	tember 30, 1997,	0. 00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
	Adjustment for residents displaced by program or hospital closure				17. 00
	Adjusted rolling average FTE count			0.00	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	
22. 01	IME payment adjustment - Managed Care (see instructions)	ho MMA		0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of t Number of additional allopathic and osteopathic IME FTE resident ca		FR 412. 105	0. 00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
	If the amount on line 24 is greater than -0-, then enter the lower instructions)	of line 23 or line	24 (see	0. 00	
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
	IME add-on adjustment amount (see instructions)			0	28. 00
	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
	Total IME payment (sum of lines 22 and 28)			0	29. 00
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
	Percentage of SSI recipient patient days to Medicare Part A patient	days (see instruc	tions)	3. 04	
31. 00	Percentage of Medicaid patient days (see instructions)			18. 45	
	Sum of lines 30 and 31			21. 49	
33.00	Allowable disproportionate share percentage (see instructions)			6. 94	
34.00	Disproportionate share adjustment (see instructions)		I	1, 244, 322	34.00

	Financial Systems COMMUNITY	HOSPI TAL		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125	Peri od: From 07/01/2020 To 06/30/2021		
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
25 00	Uncompensated Care Adjustment		0.350.500.007	0 200 014 521	1 25 00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000300351	8, 290, 014, 521 0. 000370892	
35. 02	Hospital uncompensated care payment (If line 34 is zero, er instructions)	nter zero on this line) (se		l e	
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35		630, 453 2, 930, 158		35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary				
40. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, instructions)	684 and 685. (see	0		40.00
	THIS CLUSTON SY		Before 1/1	On/After 1/1	
41 00	Total FCDD Modicage discharges evaluding MC DDCs (F2 (02	(02 (04 on (05 (oos	1. 00	1. 01	11 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions) Total ESRD Medicare covered and paid discharges excluding N	•	0		41. 00
	an 685. (see instructions)				
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00	l	42. 00 43. 00
44. 00	<pre>instructions) Ratio of average length of stay to one week (line 43 divide days)</pre>	ed by line 41 divided by 7	0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00	0.00	45.00
46. 00	Total additional payment (line 45 times line 44 times line	41.01)	0		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	77, 189, 370		47.00
	only. (see instructions)				
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction			77, 189, 370	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L, F		1	5, 845, 137 0	1
52. 00	Direct graduate medical education payment (from Wkst. E-4,			ő	
53. 00	Nursing and Allied Health Managed Care payment			59, 373	
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			557, 803 0	1
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	e 69)			1
56. 00	Cost of physicians' services in a teaching hospital (see in			0	
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	
58. 00	Ancillary service other pass through costs from Wkst. D, Pt	t. IV, col. 11 line 200)		97, 314	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			83, 748, 997 5, 454	
61. 00	Total amount payable for program beneficiaries (line 59 mir	nus line 60)		83, 743, 543	
62. 00	Deductibles billed to program beneficiaries	,		5, 907, 116	1
63. 00	Coinsurance billed to program beneficiaries			301, 151	1
64. 00	Allowable bad debts (see instructions)			720, 092	1
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in	petructions)		468, 060 271, 728	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	isti ucti olis)		78, 003, 336	
68. 00	Credits received from manufacturers for replaced devices for	or applicable to MS-DRGs (s	see instructions)	0	1
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96	6).(For SCH see instruction	ns)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration		instructions)	0	
70. 87 70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	1
70. 89	Pioneer ACO demonstration payment adjustment amount (see in				70.89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	*		0	70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	
	Bundled Model 1 discount amount (see instructions)			0 -132, 384	
70. 92				- 1.37 .384	
70. 92 70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-1, 625, 042	

		FFY ((yyyy)	Amount	
			0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in 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 column 0		0	0	70. 97
	the corresponding federal year for the period ending on or after 10/1)				
70. 98	Low Volume Payment-3			0	70. 98
70. 99	HAC adjustment amount (see instructions)			0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			76, 245, 910	
71. 01	Sequestration adjustment (see instructions)			0	1
71. 01				0	1
	, , , , , , , , , , , , , , , , , , , ,			U	1
71. 03	Sequestration adjustment-PARHM pass-throughs			74 0/5 0/5	71. 03
	Interim payments			74, 965, 865	
	Interim payments-PARHM				72. 01
73. 00	Tentative settlement (for contractor use only)			0	
73. 01	Tentative settlement-PARHM (for contractor use only)				73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and			1, 280, 045	74. 00
	[73]				
74.01	Balance due provider/program-PARHM (see instructions)				74. 01
75.00	Protested amounts (nonallowable cost report items) in accordance with			1, 650, 019	75. 00
	CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03			0	90.00
	plus 2.04 (see instructions)				
91. 00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92. 00				0	1
93. 00	Capital outlier reconciliation adjustment amount (see instructions)			0	1
	The rate used to calculate the time value of money (see instructions)			0.00	1
	1				1
95.00	Time value of money for operating expenses (see instructions)			0	
96. 00	Time value of money for capital related expenses (see instructions)		5	0	96. 00
			Prior to 10/1	On/After 10/1	
			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				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101. 00
102.00	INVER adjustment amount for UCD benue novement (ass instructions)		o	0	1100 00
	HARP adjustment amount for his bonus payment (see instructions)		U	U	102.00
	HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment		<u> </u>	0	1102.00
103. 00	HRR Adjustment for HSP Bonus Payment				
	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)		0.0000	0.0000	103. 00
	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	etment		0.0000	
104.00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus		0.0000	0.0000	103. 00 104. 00
104.00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the		0.0000	0.0000	103. 00
104.00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no.		0.0000	0.0000	103. 00 104. 00
104.00 200.00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement		0.0000	0.0000	103. 00 104. 00 200. 00
104. 00 200. 00 201. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)		0.0000	0.0000	103. 00 104. 00 200. 00 201. 00
200. 00 201. 00 202. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions)		0.0000	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00
200. 00 201. 00 202. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustified the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	ne 21st	0. 0000	0.0000	103. 00 104. 00 200. 00 201. 00
200. 00 201. 00 202. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustis this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of	ne 21st	0. 0000	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00
200. 00 201. 00 202. 00 203. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod)	ne 21st	0. 0000	0.0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
200. 00 201. 00 202. 00 203. 00 204. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount	ne 21st	0. 0000	0.0000 0	103. 00 104. 00 200. 00 201. 00 202. 00
200. 00 201. 00 202. 00 203. 00 204. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod)	ne 21st	0. 0000	0.0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustist his the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ne 21st	0. 0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustist his the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ne 21st	0. 0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustist his the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ne 21st	0. 0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustist the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	ne 21st	0. 0000	0.0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Line 59)	ne 21st	0. 0000	0.0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions)	ne 21st	0. 0000	0.0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ne 21st	0. 0000	0.0000 0	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the \$410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ne 21st	0. 0000	0.0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ne 21st	0. 0000	0.0000 0	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare PPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	ne 21st	0. 0000	0. 0000 0	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustist the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)	of the current	0. 0000	0.0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)	of the current	0. 0000	0.0000 0	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00 213. 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustist the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)	of the current	0. 0000	0.0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00

				11/23/2021 10	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			12, 459	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction	ns)		57, 754, 027	2. 00
3.00	OPPS payments			55, 740, 722	3. 00
4.00	Outlier payment (see instructions)			68, 984	4. 00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructi	one)		0. 000	4. 01 5. 00
6. 00	Line 2 times line 5	oris)		0.000	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. IV,	col. 13, line 200		68, 124	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			12, 459	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			76, 527	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)	•		76, 527	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for pay			0	15.00
16. 00	Amounts that would have been realized from patients liable for p had such payment been made in accordance with 42 CFR §413.13(e)	ayment for services on	a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			76, 527	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	e 11) (see	64, 068	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	e 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			12, 459	21. 00
22. 00	Interns and residents (see instructions)			12, 437	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruc	tions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	*		55, 877, 830	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	4.66 0411		0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 2 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	•		9, 789, 677 46, 100, 612	26. 00 27. 00
27.00	instructions)	is the sum of fittes 22	and 23] (See	40, 100, 012	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			46, 100, 612	30. 00
31.00	Primary payer payments			18, 684	31.00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		46, 081, 928	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11))		0	33. 00
34. 00	Allowable bad debts (see instructions)			795, 961	34. 00
35.00	Adjusted reimbursable bad debts (see instructions)			517, 375	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		449, 905	36. 00
37. 00	Subtotal (see instructions)			46, 599, 303	
38. 00	MSP-LCC reconciliation amount from PS&R			-144	38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 00 39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced	devices (see instruct	i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	`	, l	0	39. 99
40.00	Subtotal (see instructions)			46, 599, 447	40. 00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			46, 751, 312	40. 03 41. 00
41. 01	Interim payments Interim payments-PARHM			40, 731, 312	41. 01
42. 00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43. 00	Balance due provider/program (see instructions)			-151, 865	
43. 01	Balance due provider/program-PARHM (see instructions)		h	_ :	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2, c	napter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92. 00	The rate used to calculate the Time Value of Money			0. 00	92. 00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)		ļ	0	94. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | Part | | Date/Time Prepared: | 11/23/2021 | 10: 28 am | PPS Health Financial Systems

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

-		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm /dd /\ 0.0.0.4	Amount	mm /dd /\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Amount	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider	1.00	74, 502, 247	3.00	46, 011, 558	1. 00
2.00	Interim payments payable on individual bills, either		463, 618		739, 754	2. 00
2.00	submitted or to be submitted to the contractor for		100,010		707, 701	2.00
	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER		0			3. 01
3. 02			0			3. 02
3. 04			0		0	3. 04
3. 05			Ö		0	3. 05
0.00	Provider to Program		<u> </u>		, and the second	0.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4. 00	3. 50-3. 98)		74 0/5 0/5		44 751 212	4. 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		74, 965, 865		46, 751, 312	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	Г				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Provider to Program		0		0	5. 03
5. 50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	TENTALI VE TO TROOKAW		0			5. 50
5. 52			o o		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		o	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 PROVI DER		1, 280, 045		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		151, 865	6. 02
7. 00	Total Medicare program liability (see instructions)		76, 245, 910	Controlt	46, 599, 447	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor			55	2.00	8. 00
	T. Control of the Con	'			, ,	

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0125 Component CCN: 15-T125 Title XVIII **IRF**

				TRF		
		Inpatien	t Part A	Par	t B	
		/	A	/ - - /	A	
		mm/dd/yyyy	Amount 2.00	mm/dd/yyyy	Amount	
1 00	Total interim normante noid to provider	1.00	7, 025, 982	3. 00	4. 00	1. 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		7, 025, 982 0		0	2.00
2.00	submitted or to be submitted to the contractor for		0		U	2.00
	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
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER		0			3. 02
3. 02			0		0	3. 02
3. 04			0			3. 03
3. 05			0		0	3. 04
3.03	Provider to Program				U	3.03
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADJUST WENTS TO TROOKAW		0			
3. 52			0			3. 52
3. 53			0			3. 53
3. 54			0			3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0			3. 99
3. 77	3. 50-3. 98)		U		U	3.77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		7, 025, 982		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		7,023,702		o o	7.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	<u> </u>				ĺ
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		18, 221		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		7, 044, 203		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	To the second se	()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	u of Form CMS-	2552-10				
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0125 Period: W From 07/01/2020 P					
			To 06/30/2021	Date/Time Pre		
				11/23/2021 10): 28 am	
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				Ī	
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00	
7. 00	CAH only - The reasonable cost incurred for the purchase of c		Wkst. S-2. Pt. I		7. 00	
	line 168		, ,			
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	I NPATIENT HOSPITAL SERVICES UNDER THE I PPS & CAH	,			1	
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
	Other Adjustment (specify) 31.00					

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

30. 00 31. 00 32. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125		Worksheet E-3
	Component CCN: 15-T125	From 07/01/2020	
	Component Con. 13-1125	10 00/30/2021	11/23/2021 10: 28 am
	Title XVIII	Subprovi der -	PPS
		LDE	

	IRF	113	
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	6, 911, 502	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0236	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	120, 260	3. 00
4. 00	Outlier Payments	73, 910	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5. 00
0.00	to November 15, 2004 (see instructions)	0.00	0.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7. 00
	teaching program" (see instructions)		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8. 00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	13. 490411	10. 00
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0	12. 00
13.00	Total PPS Payment (see instructions)	7, 105, 672	
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	
15. 00	,		15. 00
16. 00		0	
17. 00	Subtotal (see instructions)	7, 105, 672	
18. 00		0	18. 00
	Subtotal (line 17 less line 18).	7, 105, 672	
20. 00	Deducti bl es	33, 296	
	Subtotal (line 19 minus line 20)	7, 072, 376	
	Coi nsurance	33, 820	
23. 00		7, 038, 556	
	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1, 340	
25. 00	·	871	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
	Subtotal (sum of lines 23 and 25)	7, 039, 427	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	4, 776	
	Outlier payments reconciliation	0	
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
31. 99 32. 00	Demonstration payment adjustment amount before sequestration		31. 99 32. 00
	Total amount payable to the provider (see instructions)	7, 044, 203	
32. 01	Sequestration adjustment (see instructions)	0	
32. 02	Demonstration payment adjustment amount after sequestration	0 7, 025, 982	32. 02 33. 00
34. 00	Interim payments Tentative settlement (for contractor use only)	7,025,962	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	18, 221	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	10, 221	36.00
30.00	§115. 2	ا	30.00
	TO BE COMPLETED BY CONTRACTOR		
50 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	73, 910	50.00
	Outlier reconciliation adjustment amount (see instructions)	73, 710	
52. 00		0.00	
	Time Value of Money (see instructions)		53. 00
55. 55	1	, 0,	. 55. 55

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

Peri od:
From 07/01/2020 Part VII
To 06/30/2021 Date/Time Prepared:
11/23/2021 10: 28 am
PPS Title XIX

		Title XIX	Hospi tal	PPS	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		o	0	4.00
5.00	Inpatient primary payer payments		o		5. 00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		o	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		6, 154, 345		8. 00
9.00	Ancillary service charges		7, 025, 791	0	9. 00
10.00	Organ acquisition charges, net of revenue		o		10.00
11. 00	Incentive from target amount computation		o		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		13, 180, 136	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13. 00
	basis	3			
14.00	Amounts that would have been realized from patients liable for p	payment for services on	o	0	14.00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		13, 180, 136	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	13, 180, 136	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16))	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide	rs.		
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		3, 762	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)		3, 762	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		3, 762	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3, 762	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	3, 762	0	36.00
37.00	ZERO OUT SETTLEMENT		-3, 762	0	37. 00
38.00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-1		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0125	Peri od: From 07/01/2020	Worksheet E-3	
	Component CCN: 15-T125			
	Title XIX	Subprovi der -	PPS	

		II tie xix	I RF	PPS	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
П	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	20 1 011 11 1220 1 011 717	02		1
	Inpatient hospital/SNF/NF services		0		1.00
	Medical and other services			0	
-	Organ acquisition (certified transplant centers only)		0	ŭ	3.00
	Subtotal (sum of lines 1, 2 and 3)		o	0	
	Inpatient primary payer payments		0	ŭ	5. 0
	Outpatient primary payer payments			0	
-	Subtotal (line 4 less sum of lines 5 and 6)		o	0	
	COMPUTATION OF LESSER OF COST OR CHARGES		- 1		
	Reasonable Charges				1
	Routine service charges		7, 830		1 8.0
	Ancillary service charges		17, 949	0	
-	Organ acquisition charges, net of revenue		0	ŭ	10.0
	Incentive from target amount computation		0		11. 0
	Total reasonable charges (sum of lines 8 through 11)		25, 779	0	
	CUSTOMARY CHARGES		20, , , ,		1 .2.0
	Amount actually collected from patients liable for payment for se	ervices on a charge	O	0	13.00
	basis	. Trose on a onarge		ŭ	
	Amounts that would have been realized from patients liable for pa	vment for services on	o	0	14.0
	a charge basis had such payment been made in accordance with 42 (
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.0
	Total customary charges (see instructions)		25, 779	0	1
	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	25, 779	0	17. C
	line 4) (see instructions)				
00	Excess of reasonable cost over customary charges (complete only i	f line 4 exceeds line	o	0	18.0
	16) (see instructions)				
00	Interns and Residents (see instructions)		0	0	19.0
00	Cost of physicians' services in a teaching hospital (see instruct	i ons)	0	0	20.0
00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provide	rs.		
00	Other than outlier payments		0	0	22.0
00	Outlier payments		0	0	23.0
00	Program capital payments		0		24.0
00	Capital exception payments (see instructions)		0		25.0
	Routine and Ancillary service other pass through costs		10	0	
	Subtotal (sum of lines 22 through 26)		10	0	
00	Customary charges (title V or XIX PPS covered services only)		0	0	
00	Titles V or XIX (sum of lines 21 and 27)		10	0	29. C
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Excess of reasonable cost (from line 18)		0	0	30.0
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		10	0	31.0
00	Deducti bl es		0	0	32.0
00	Coi nsurance		0	0	33.0
00	Allowable bad debts (see instructions)		0	0	34.0
00	Utilization review		0		35.0
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	10	0	36.0
00	ZERO OUT SETTLEMENT		-10	0	37.0
00	Subtotal (line 36 ± line 37)		0	0	38. 0
00	Direct graduate medical education payments (from Wkst. E-4)		0		39. (
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. (
00	Interim payments		0	0	41.0
00	Balance due provider/program (line 40 minus line 41)		0	0	42.0
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2	ol	0	43. C
	riotested amounts (nonarrowable cost report riems) in accordance	WI TH GWO I GD IS Z,	l ol	U	1

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

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

Provider CCN: 15-0125

Peri od: Worksheet G From 07/01/2020 To 06/30/2021 Date/Ti me Prepared: 11/23/2021 10: 28 am

oni y)					11/23/2021 10): 28 am
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	10, 265		0	0	1
2. 00 3. 00	Temporary investments	0			0	
4. 00	Notes recei vabl e Accounts recei vabl e	75, 481, 065	1		0	
5. 00	Other recei vabl e	0 75, 461, 665			0	
6. 00	Allowances for uncollectible notes and accounts receivable	0		0	0	
7.00	Inventory	14, 518, 977	'	0	0	
8.00	Prepaid expenses	0	(0	0	
9.00	Other current assets	7, 512, 155	1	0	0	
10.00	Due from other funds Total current assets (sum of lines 1-10)	07 522 442	1	0	0	1
11. 00	FIXED ASSETS	97, 522, 462		U U	U	11. 00
12. 00	Land	0		0	0	12. 00
13. 00	Land improvements	Ö			0	
14.00	Accumulated depreciation	0		0	0	14. 00
15.00	Bui I di ngs	190, 347, 223	s (0	0	15. 00
16.00	Accumulated depreciation	0	1	0	0	1
17. 00	Leasehold improvements	0)	0	0	
18.00	Accumulated depreciation	0		0	0	
19.00	Fixed equipment	0			0	
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	0			0	
22. 00	Accumulated depreciation		1		0	
23. 00	Major movable equipment	ĺ	1	0	0	
24.00	Accumul ated depreciation	0		0	0	
25.00	Mi nor equi pment depreci able	0) (0	0	25. 00
26. 00	Accumul ated depreciation	0) (0	0	
27. 00	HIT designated Assets	0)	0	0	
28. 00	Accumulated depreciation	0	1	0	0	
29. 00	Minor equipment-nondepreciable	100 247 222	1	0	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	190, 347, 223		0	U	30.00
31. 00	Investments	0		0	0	31.00
32. 00	Deposits on Leases	Ö			0	
33.00	Due from owners/officers	0) (0	0	33. 00
34.00	Other assets	9, 139, 264	. (0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	9, 139, 264	1	٦ - ١	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	297, 008, 949) (0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	3, 705, 805	:	0	0	37. 00
38. 00	Salaries, wages, and fees payable	29, 981, 753			0	•
39. 00	Payroll taxes payable	27,701,700		0	0	
40.00	Notes and Loans payable (short term)	0		0	0	•
41.00	Deferred income	0) (0	0	41.00
42.00	Accel erated payments	0)			42. 00
43.00	Due to other funds	0) (0	0	1
44.00	Other current liabilities	65, 911, 202	1	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	99, 598, 760) (0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	1		0	0	46. 00
47. 00	Notes payable		1		0	
48. 00	Unsecured Loans	Ö			0	1
49.00	Other long term liabilities	30, 293, 699		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	30, 293, 699		0	0	
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	129, 892, 459) (0	0	51.00
52.00	General fund balance	167, 116, 490				52. 00
53.00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant		1	0	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	
55. 50	replacement, and expansion					55.00
59. 00	Total fund balances (sum of lines 52 thru 58)	167, 116, 490) (0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	297, 008, 949		0	0	60.00
	[59]	l	I			1

Provider CCN: 15-0125

					10 06/30/2021	11/23/2021 10	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
					Г		
		1.00	2. 00	3.00	4.00	5. 00	
1.00	Fund balances at beginning of period	1.00	176, 554, 268		4.00		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		87, 664, 861		`	1	2.00
3.00	Total (sum of line 1 and line 2)		264, 219, 129				3. 00
4. 00	Additions (credit adjustments) (specify)	0	201/21//12/		0	1 0	4. 00
5. 00	RESTRICTED CONTRIBUTIONS	110, 000			0	0	5. 00
6.00	INVESTMENT INCOME	6,000			o	0	6. 00
7. 00	NET ASSETS RELEASED	0			o	0	
8.00	OTHER	0			0	0	8. 00
9.00		o			0	0	9. 00
10.00	Total additions (sum of line 4-9)		116, 000			ol	10.00
11.00	Subtotal (line 3 plus line 10)		264, 335, 129				11. 00
12.00	Deductions (debit adjustments) (specify)	o			0	0	12.00
13.00	NET ASSETS TRANSFERRED	97, 070, 000			0	0	13. 00
14.00	PENSION RELATED ADJUSTMENT	O			0	0	14. 00
15.00	NET ASSETS RELEASED	148, 639			0	0	15. 00
16.00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		97, 218, 639		(18. 00
19. 00	Fund balance at end of period per balance		167, 116, 490				19. 00
	sheet (line 11 minus line 18)		51	L			
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0.00	7.00	0.00	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)	o			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00	RESTRI CTED CONTRI BUTI ONS		0				5. 00
6.00	INVESTMENT INCOME		0				6. 00
7.00	NET ASSETS RELEASED		0				7. 00
8.00	OTHER		0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	NET ASSETS TRANSFERRED		0				13. 00
14. 00	PENSI ON RELATED ADJUSTMENT		0				14. 00
15. 00	NET ASSETS RELEASED		0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0			U		19. 00
	sheet (line 11 minus line 18)	I I		I	I		

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

		T	o 06/30/2021	Date/Time Pre	
	Cost Center Description	Inpati ent	Outpati ent	11/23/2021 10 Total	: 28 am
	cost denter bescription	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	110, 199, 170)	110, 199, 170	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	6, 806, 580)	6, 806, 580	3. 00
4.00	SUBPROVI DER			., ,	4. 00
5.00	Swing bed - SNF)	0	5. 00
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)	117, 005, 750)	117, 005, 750	10.00
	Intensive Care Type Inpatient Hospital Services	, ,	·	,	
11. 00	INTENSIVE CARE UNIT	33, 957, 846	,	33, 957, 846	11. 00
11. 01	NEONATAL INTENSIVE CARE	31, 627, 060)	31, 627, 060	11. 01
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	65, 584, 906	,	65, 584, 906	16. 00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	182, 590, 656	,	182, 590, 656	17. 00
18.00	Ancillary services	630, 268, 234	. 0	630, 268, 234	18. 00
19.00	Outpati ent servi ces	C		1, 209, 396, 232	19. 00
20.00	RURAL HEALTH CLINIC		0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22.00	HOME HEALTH AGENCY		8, 834, 694	8, 834, 694	22. 00
23.00	AMBULANCE SERVI CES				23. 00
24.00	CMHC				24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27.00	PHYSI CI AN OFFI CES	23, 968, 016	45, 994, 504	69, 962, 520	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	836, 826, 906	1, 264, 225, 430	2, 101, 052, 336	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		520, 167, 791		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)	0			37. 00
38. 00		C			38. 00
39. 00		C			39. 00
40. 00		C			40. 00
41. 00		C	1		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		520, 167, 791		43. 00
	to Wkst. G-3, line 4)	1			I

eal th	Financial Systems COM	MMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-1
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0125	Peri od:	Worksheet G-3	
			From 07/01/2020 To 06/30/2021	Date/Time Pre	narod
			10 00/30/2021	11/23/2021 10	
				1. 00	
. 00	Total patient revenues (from Wkst. G-2, Part I, colu			2, 101, 052, 336	
. 00	Less contractual allowances and discounts on patien	ts' accounts		1, 525, 372, 904	
. 00	Net patient revenues (line 1 minus line 2)			575, 679, 432	
. 00	Less total operating expenses (from Wkst. G-2, Part			520, 167, 791	
. 00	Net income from service to patients (line 3 minus li	ine 4)		55, 511, 641	5.
00	OTHER INCOME Contributions, donations, bequests, etc			1, 328, 288	6.
. 00	Income from investments				
. 00	Revenues from telephone and other miscellaneous com	munication sorvices		284, 079 0	1
. 00	Revenue from television and radio service	iluiti Cati on Sei vi ces		0	
0. 00	Purchase di scounts			0	
1. 00	Rebates and refunds of expenses			- 1	11.
2. 00	· '			0	1
3. 00	Revenue from Laundry and Linen service			0	ı
4. 00				1, 582, 734	
	Revenue from rental of living quarters			0	1
6. 00	9 '	to other than patients		0	
	Revenue from sale of drugs to other than patients	, , , , , , , , , , , , , , , , , , ,		12, 975, 566	
	Revenue from sale of medical records and abstracts			0	18.
9. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.
0. 00	Revenue from gifts, flowers, coffee shops, and cante	een		0	20.
1. 00	Rental of vending machines			15, 776	21.
2. 00	Rental of hospital space			1, 088, 092	22.
3. 00	The state of the s			0	23.
4. 00	REVENUE - CLASSES			1, 111	
4. 01	ASSETS RELEASED FROM RESTRICTION			153, 306	
4. 02	FITNESS POINTE/BEAUTY SHOP INCOME			2, 079, 135	24.
4. 03	GAINS ON SALE OF ASSETS			176, 402	
1. 04	OTHER INCOME			181, 183	
1. 05	GRANT I NCOME			2, 606, 207	
1. 50	COVI D-19 PHE Fundi ng			9, 681, 341	
5. 00				32, 153, 220	
	Total (line 5 plus line 25)			87, 664, 861	1
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)	•		07 ((4 0(1	
9. UU	Net income (or loss) for the period (line 26 minus l	iine zoj		87, 664, 861	29.

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

0

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5, 237, 001

C

266, 225

0

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O

0

5, 503, 226

20.00

21.00

22.00

23 00

23.50

24.00

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

Home Delivered Meals Program

20.00

21.00

22.00

23.00

23. 50

ST A	LLOCATION - HHA GENERAL SERVICE	COST		Provi der C	CN: 15-0125	Peri od: From 07/01/2020	Worksheet H-1 Part I	
				HHA CCN:	15-7487	To 06/30/2021	Date/Time Prep 11/23/2021 10	pared: : 28 ar
						Home Health Agency I	PPS	
			Capital Rela	ated Costs				
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	PI ant Operation & Mai ntenance		Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4. 00	4A. 00	
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	O	O				0	1.0
	Fi xtures							
00	Capital Related - Movable Equipment	0		0			0	2.0
00	Plant Operation & Maintenance	9, 768	О	0	9, 70		0	3. 0
00 00	Transportation Administrative and General	0 1, 695, 627	0	0	9, 70	0 0 68 0	1, 705, 395	4. C
55	HHA REIMBURSABLE SERVICES							
00	Skilled Nursing Care	1, 596, 493	0	0	l .	0 0	1, 596, 493 1, 256, 207	1
00 00	Physical Therapy Occupational Therapy	1, 256, 297 418, 811	0	0		0 0	1, 256, 297 418, 811	
00	Speech Pathology	100, 305	O	0		0 0	100, 305	9. (
. 00	Medical Social Services Home Health Aide	2, 472 64, 054	0	0		0 0	2, 472 64, 054	1
. 00	Supplies (see instructions)	359, 399	0	0		0 0	359, 399	1
. 00	Drugs	0	0	0		0	0	
. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	1	0 0	0	14. (
. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15. (
. 00	Respiratory Therapy	0	0	0		0 0	0	
. 00	Private Duty Nursing Clinic	0	0	0			0	
. 00	Health Promotion Activities	0	0	0		0 0	0	19. (
. 00	Day Care Program Home Delivered Meals Program	0	0	0		0 0	0	
. 00	Homemaker Service	0	0	0		0 0	0	1
. 00	All Others (specify)	0	0	0		0 0	0	20. 1
. 50 . 00	Telemedicine Total (sum of lines 1-23)	0 5, 503, 226	0	0	9, 70	0 68 0	0 5, 503, 226	23.5
. 00	Trotal (Sam of Trines 1 20)	Admi ni strati ve			, , , ,	00	0,000,220	21. (
		& General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	3.00	0.00					
00	Capital Related - Bldg. & Fixtures							1. (
00	Capital Related - Movable							2. (
00	Equipment Plant Operation & Maintenance							3. (
00	Transportation							3. 4.
00	Administrative and General	1, 705, 395						5.
00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	716, 897	2, 313, 390					6.
00	Physi cal Therapy	564, 133	1, 820, 430					7.
00 00	Occupational Therapy	188, 065 45, 041	606, 876					8.
. 00	Speech Pathology Medical Social Services	45, 041 1, 110	145, 346 3, 582					9. 10.
. 00	Home Health Aide	28, 763	92, 817					11.
. 00 . 00	Supplies (see instructions) Drugs	161, 386 0	520, 785 0					12. 13.
. 00	DME	0	0					14.
00	HHA NONREI MBURSABLE SERVI CES							1.
. 00	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 16.
. 00	Private Duty Nursing	0	0					17.
	Clinic	0	0					18.
. 00	Health Promotion Activities Day Care Program	0	0					19. 20.
. 00	Home Delivered Meals Program	Ö	o					21.
. 00	Homemaker Service	0	0					22.
. 00 . 50	All Others (specify) Telemedicine	0	0					23.
	1		5, 503, 226					24.

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Li€	eu of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BA	SLS		Provi der	CCN: 15-0125	Peri od:	Worksheet H-1	
				HHA CCN:	15-7487	From 07/01/2020 To 06/30/2021	Part II Date/Time Pre 11/23/2021 10	pared: :28 am
					Но		PPS	
						Agency I		
		Capital Rel	ated Costs					
		Bldgs & Fixtures	Movable Equipment	Plant Operation &		onReconciliation	Admi ni strati ve & General	
			(DOLLAR VALUE)	Maintenance (SQUARE FEET			(ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures	0				0		1. 00

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3, 797, 831

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418, 811

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359, 399

3, 797, 831

1, 705, 395

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Capital Related - Movable

Administrative and General

HHA REIMBURSABLE SERVICES

Transportation (see

Skilled Nursing Care

Occupational Therapy

Medical Social Services

Supplies (see instructions)

HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-23)

Cost To Be Allocated (per

Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

Physical Therapy

Speech Pathology

Home Health Aide

Respiratory Therapy

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

Private Duty Nursing

Drugs

Clinic

DMF

Plant Operation & Maintenance

Equi pment

instructions)

Health Financial Systems
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 11/23/2021 10:28 am Provi der CCN: 15-0125 Peri od: From 07/01/2020 To 06/30/2021 HHA CCN: 15-7487 Home Health

						Agency I	PPS	
			CAPITAL REI	LATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	PURCHASI NG & RECEI VI NG STORES	ADMI TTI NG	
		0	1. 00	2.00	4.00	5. 01	5. 02	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00 16.00 17.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 2, 313, 390 1, 820, 430 606, 876 145, 346 3, 582 92, 817 520, 785 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	187, 006 215, 183 176, 078 49, 481 10, 033 343 8, 121 0 0	129 0 0 0 0 0 0 0 0 0	23, 405 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00 19. 50 20. 00 21. 00	All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	0 0 5, 503, 226 CASHI ERI NG/ACC OUNTS	0 0 0 Subtotal	0	0 0 646, 245 MAI NTENANCE & REPAI RS	OPERATION OF PLANT	0 0 23, 405 LAUNDRY & LI NEN SERVI CE	19. 00 19. 50 20. 00 21. 00
		RECEI VABLE	FA 00	F 04	/ 00	7.00	0.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	5. 03 26, 549 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 03 237, 089 2, 528, 573 1, 996, 508 656, 357 155, 379 3, 925 100, 938 520, 785 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	381, 322 301, 083 98, 982 23, 432 592 15, 222 78, 537 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

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

Provider CCN: 15-0125 Worksheet H-2 From 07/01/2020 Part I HHA CCN: 15-7487 06/30/2021 Date/Time Prepared: To 11/23/2021 10:28 am Home Health PPS Agency I MAINTENANCE OF Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL ADMINISTRATION **PERSONNEL** SERVICES & SUPPLY 9.00 10.00 12.00 13.00 11.00 14.00 Administrative and General 1.00 0 2.00 Skilled Nursing Care 0 0000000000000000000 0 0 2.00 Physical Therapy 0 3.00 0 3.00 0 0 4.00 Occupational Therapy 4.00 Speech Pathology 0 0 0 5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 5.00 Medical Social Services 0 0 0 6.00 6.00 0 0 7.00 0 Home Health Aide 7.00 8.00 Supplies (see instructions) 0 0 8.00 9.00 Drugs 0 9.00 0 0 0 10 00 DMF 10 00 Home Dialysis Aide Services 0 0 11.00 11.00 12.00 Respiratory Therapy 12.00 0 13.00 Private Duty Nursing 0 0 13.00 0 0 Ω 14 00 Clinic 14 00 15.00 Health Promotion Activities 0 0 15.00 0 16.00 Day Care Program 0 16.00 0 0 17 00 Home Delivered Meals Program 0 17 00 18.00 Homemaker Service 0 18.00 19.00 All Others (specify) 19.00 0 19.50 Tel emedi ci ne 19.50 Total (sum of lines 1-19) (2) 20 00 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places INTERNS & RESI DENTS Cost Center Description PHARMACY MEDI CAL SOCIAL SERVICE NONPHYSI CI AN SERVI CES-SALAR SERVI CES-OTHER ANESTHETI STS RECORDS & Y & FRINGES PRGM COSTS LI BRARY **APPRV APPRV** 15. 00 16. 00 17.00 19.00 21.00 22.00 1.00 Administrative and General 25, 701 0 1.00 2.00 Skilled Nursing Care 0 0 0 0 2.00 0 0 3.00 Physical Therapy 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 3.00 0000000000000000 0 0 0 4 00 Occupational Therapy 4 00 0 5.00 Speech Pathology 0 5.00 Medical Social Services 6.00 6.00 0 0 0 0 7.00 Home Health Aide 0 7.00 0 8.00 Supplies (see instructions) 0 8.00 9.00 Drugs 0 0 9.00 0 0 10.00 10.00 Home Dialysis Aide Services 0 0 0 0 0 11.00 11.00 0 0 12.00 Respiratory Therapy 12.00 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 14.00 Health Promotion Activities 0 0 0 15.00 15.00 0 0 0 16.00 Day Care Program 16.00 Home Delivered Meals Program 17.00 17.00 Homemaker Service All Others (specify) 0 0 18.00 0 0 18.00 0 0 19.00 19.00 0 0 0 0 19.50 Tel emedi ci ne 19.50 25, 701 20.00 20.00 Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

⁽¹⁾ Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

Health Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CENT	ΓERS	Provider CO		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	pared:
					Home Health Agency I	PPS	
Cost Center Description	PARAMED ED PRGM-(PHARMACY)		Intern & Residents Cost & Post Stepdown Adjustments		Allocated HHA A&G (see Part II)	Total HHA Costs	
	23. 00	24. 00	25. 00	26. 00	27. 00	28. 00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) (2) 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 0 0 0 0 0 0 0	298, 544 2, 909, 895 2, 297, 591 755, 339 178, 811 4, 517 116, 160 599, 322 0 0 0 0 0 0 0 0 7, 160, 179	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	298, 54 2, 909, 89 2, 297, 59 755, 33 178, 81 4, 51 116, 16 599, 32	126, 607 1 99, 966 9 32, 864 1 7, 780 7 197 0 5, 054 2 26, 076 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 036, 502 2, 397, 557 788, 203 186, 591 4, 714 121, 214 625, 398 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50

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

Heal th Financial Systems COMMUNITY HOSPITAL

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-0125 Peri od: From 07/01/2020 To 06/30/2021 BASIS HHA CCN: 15-7487

					Home Health Agency I	PPS	20 4111
	CAPITAL REI	LATED COSTS			Agency 1		
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING & RECEIVING STORES (COSTED REQ)	ADMI TTI NG (GROSS REVENUE)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS REVENUE)	
	1. 00	2.00	4.00	5. 01	5. 02	5. 03	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Home Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 217, 548 1, 401, 001 1, 146, 404 322, 158 65, 325 2, 234 52, 873 0 0 0 0 0 0 0 0 0 0 0 4, 207, 543 646, 245 0, 153592	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 831, 894 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 831, 894 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21.00
		(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(TOTAL PATIENT DAYS)		
	5A. 04	5. 04	6. 00	7. 00	8. 00	9. 00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 528, 573 1, 996, 508 656, 357 155, 379 3, 925 100, 938 520, 785 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00

In Lieu of Form CMS-2552-10 Worksheet H-2 From 07/01/2020 Part II Date/Time Prepared: BASIS HHA CCN: 15-7487 То 06/30/2021 11/23/2021 10:28 am Home Health PPS Agency I DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL PHARMACY Cost Center Description SERVICES & (PATI ENT PERSONNEL ADMI NI STRATI ON (COSTED REQ) (FTES) (NUMBER SUPPLY MEALS) (NURSING (COSTED REQ) HOUSED) HOURS) 10.00 11.00 12.00 13.00 14.00 15.00 1.00 Administrative and General 1.00 0 2.00 ol 2.00 Skilled Nursing Care 3.00 Physical Therapy 0 3.00 4.00 Occupational Therapy 0 0 0 4.00 5.00 Speech Pathology 0 5.00 0 6.00 Medical Social Services 6.00 7.00 Home Heal th Aide 7.00 0 0 8.00 Supplies (see instructions) 8.00 9.00 0 0 Drugs 9.00 10.00 DME 0 10.00 11.00 Home Dialysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 0 12.00 0 0 0 01 Private Duty Nursing 13.00 13.00 14.00 Clinic 0 14.00 15.00 Health Promotion Activities 15.00

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0 16.00

0 18.00

0 19.00

0

17.00

19.50

20.00

	Total cost to be allocated	0	0	0	0	0	0	21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000	0. 000000			0. 000000	22. 00
					INTERNS &	RESI DENTS		
		MEDLON	COOLAL CEDULOE	NONDUNCTOLAN	CEDIU OEC CALAD	SERVILOES OTHER	DADAMED ED	
	Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	SERVICES-SALAR Y & FRINGES			
		RECORDS & LI BRARY	(TOTAL PATIENT		APPRV	PRGM COSTS APPRV	PRGM-(PHARMACY	
		(GROSS	DAYS)	TIME)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		REVENUE)	DATS)	IIIWL)	TIME)	TIME)	TIME)	
		16. 00	17. 00	19. 00	21.00	22. 00	23. 00	
1. 00	Administrative and General	8, 831, 894	0	0	0	0	0	1. 00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2. 00
3.00	Physi cal Therapy	0	0	0	0	0	0	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6. 00
7.00	Home Health Aide	0	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9.00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12.00	Respi ratory Therapy	0	0	0	0	0	0	12.00
	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	1 1	0	0	0	0	0	0	14.00
	Health Promotion Activities	0	0	0	0	0	0	15. 00
	Day Care Program	0	0	0	0	0	0	16. 00
	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00	4	0	0	0	0	0	0	18. 00
	All Others (specify)	0	0	0	0	0	0	19. 00
	Tel emedi ci ne	0	0	0	0	0	0	19. 50
	Total (sum of lines 1-19)	8, 831, 894	0	0	0	0	0	20. 00
21. 00		25, 701	0	0	0	0	0	21. 00
22. 00	Unit cost multiplier	0. 002910	0. 000000	0.000000	0.000000	0.000000	0. 000000	22. 00

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

20.00 | Total (sum of lines 1-19)

Home Delivered Meals Program

16.00

17.00

18.00

19.00

19.50

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST	S			CN: 15-0125	Peri od:	Worksheet H-3	
				HHA CCN:		From 07/01/2020 To 06/30/2021		pared:
				Ti tl e	e XVIII	Home Health Agency I	PPS	. 20 am
	Cost Center Description		Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line		Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	IITATION COST, OF	₹	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2. 00			3, 036, 50			
2.00	Physi cal Therapy	3.00		ł			171. 98	
3.00	Occupational Therapy	4.00		C	1			
4. 00 5. 00	Speech Pathology Medical Social Services	5. 00 6. 00		_	186, 59 4, 71		310. 47 181. 31	
6.00	Home Heal th Aide	7. 00			121, 21			
7. 00	Total (sum of lines 1-6)	7.00	6, 534, 781	C				7.00
7.00	Total (suil of Titles 1-0)		0, 554, 761		Program Visit			7.00
			1			art B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
					Deducti bl es Coi nsurance	& Deductibles		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	C	13, 50	06		8. 00
9.00	Physi cal Therapy		23844	C				9. 00
10.00	Occupati onal Therapy		23844	[C	1 -, -			10.00
11. 00	Speech Pathology		23844	C	1			11. 00
12.00	Medical Social Services		23844	C	1	7		12. 00
13.00	Home Health Aide		23844	C	1 .,			13. 00
14. 00	Total (sum of lines 8-13)			C				14. 00
	Cost Center Description		Facility Costs		Total HHA	Total Charges	Ratio (col. 3	
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa		1.00	2.00	0.00	1. 00	0.00	
15.00	Cost of Medical Supplies	8. 00	625, 398	C	625, 39	98 573, 361	1. 090758	15. 00
16.00	Cost of Drugs	9. 00	0	C		0 0	0. 000000	16. 00
	· · · · · · · · · · · · · · · · · · ·		Program Visits		Cost of Services			
			Par	t B	J Sel VI ces	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	μ		Deductibles &			Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	IITATION COST, OF	?	
	BENEFICIARY COST LIMITATION							1
4 60	Cost Per Visit Computation		10.55			0 4 700 555		4
1.00	Skilled Nursing Care	0			•	0 1, 738, 087		1.00
2.00	Physical Therapy	0				0 1, 230, 689		2.00
3.00	Occupational Therapy	0	-,		1	0 439, 450		3.00
4.00	Speech Pathology	0				0 96, 556		4.00
5.00	Medical Social Services	0				0 3, 082		5. 00
6.00	Home Health Aide	[0 0	.,			0 77, 564 0 3, 585, 428		6.00
7.00	Total (sum of lines 1-6) Cost Center Description	0	25, 743			0 3, 585, 428		7. 00
	cost center bescription	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation	0.00	7.00	0.00	7. 50	10.00		
8.00	Skilled Nursing Care							8. 00
9. 00	Physical Therapy							9. 00
10.00	Occupational Therapy		1					10.00
11.00	Speech Pathology							11. 00
12.00	Medi cal Soci al Servi ces							12. 00
13.00	Home Health Aide							13. 00
14.00	Total (sum of lines 8-13)							14. 00

	Financial Systems		COMMUNI TY				u of Form CMS-2	
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provider CO	CN: 15-0125 15-7487	Peri od: From 07/01/2020 To 06/30/2021	Worksheet H-3 Part I Date/Time Pre 11/23/2021 10	pared:
				Title	XVIII	Home Health Agency I	PPS	. 20 aiii
		Prog	ram Covered Cha	arges	Cost of Services	Agency 1		
	Cost Center Description	Part A	Not Subject to	Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7.00	8.00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Computa							
	Cost of Medical Supplies Cost of Drugs	0	558, 227 0	l .		0 608, 891 0	0	
	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	AGGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
	Cost Per Visit Computation]
1.00	Skilled Nursing Care	1, 738, 087						1.00
2.00	Physical Therapy	1, 230, 689						2. 00
3.00	Occupational Therapy	439, 450						3.00
4.00	Speech Pathology	96, 556						4.00
5.00	Medical Social Services	3, 082						5. 00
6. 00 7. 00	Home Health Aide Total (sum of lines 1-6)	77, 564 3, 585, 428						6. 00 7. 00
7.00	Cost Center Description	3, 303, 420						7.00
	cost center bescription	12. 00	-					1
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10. 00
11.00	Speech Pathology							11. 0
12.00	Medical Social Services							12.00
13.00	Home Heal th Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7487	From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	narod:
				TITIA CON.	15-7407	10 00/30/2021	11/23/2021 10	
				Title	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 347064	0)	0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy	67. 00	0. 264787	0	1	0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 434473	0	1	0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71.00	0. 481439	0	1	0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 186105	0)	0 col. 2, line 1	6. 00	5. 00

	Financial Systems COMMUNITY TION OF HHA REIMBURSEMENT SETTLEMENT	HOSPI TAL Provi der CO	N: 15-0125	Peri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7487	From 07/01/2020 To 06/30/2021	Part I-II Date/Time Pre	pare
		Title	XVIII	Home Health	11/23/2021 10 PPS	: 28
				Agency I Par	t B	
			Part A	Not Subject to	Subject to	
				Deductibles & Coinsurance	Deductibles & Coinsurance	
			1. 00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CL	JSTOMARY CHARGES	S			
	Reasonable Cost of Part A & Part B Services			ما ما		ļ.,
	Reasonable cost of services (see instructions) Total charges			0 0		
	Customary Charges			0 0	U	1
00	Amount actually collected from patients liable for payment	for services		0 0	0	1 :
	on a charge basis (from your records)					
	Amount that would have been realized from patients liable t			0 0	0	4
	for services on a charge basis had such payment been made i	in accordance				
	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	[
	Total customary charges (see instructions)		0.0000	0.000000	0.000000	1
	Excess of total customary charges over total reasonable cos	st (complete		0 0	0	
- 1	only if line 6 exceeds line 1)					
	Excess of reasonable cost over customary charges (complete	only if line		0 0	0	8
1	1 exceeds line 6)				0	١,
00	Primary payer amounts			0 0 Part A	Part B	(
				Servi ces	Servi ces	
				1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions) Total PPS Reimbursement – Full Episodes without Outliers			0	0 3, 513, 453	
	Total PPS Reimbursement - Full Episodes without outliers			0	665, 098	
	Total PPS Reimbursement - LUPA Episodes			0	69, 352	
	Total PPS Reimbursement - PEP Episodes			0	17, 996	
	Total PPS Outlier Reimbursement - Full Episodes with Outlie	ers		0	160, 197	
00	Total PPS Outlier Reimbursement - PEP Episodes			0	219	10
	Total Other Payments			0	0	1
1	DME Payments			0	0	1
	Oxygen Payments			0	0	1
	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coi	i neuranco)		U	0	1
	Subtotal (sum of lines 10 thru 20 minus line 21)	risul ance)		0	4, 426, 315	
	Excess reasonable cost (from line 8)			0	0	1
	Subtotal (line 22 minus line 23)			0	4, 426, 315	
00	Coinsurance billed to program patients (from your records)				0	
	Net cost (line 24 minus line 25)			0	4, 426, 315	
	Reimbursable bad debts (from your records)					2
	Reimbursable bad debts for dual eligible beneficiaries (see				4 407 045	28
	Total costs - current cost reporting period (line 26 plus l ADJUSTMENT	ine 27)		0		
	ADJUSIMENI Pioneer ACO demonstration payment adjustment (see instructi	ions)		0	3, 647 0	
1	Demonstration payment adjustment amount before sequestration	,		0	0	
	Subtotal (see instructions)	-		0		
	Sequestration adjustment (see instructions)			0	0	
4	Demonstration payment adjustment amount after sequestration	n		0	0	
	Interim payments (see instructions)			0	4, 429, 962	
	Tentative settlement (for contractor use only)			0	0	
. 00	Balance due provider/program (line 31 minus lines 31.01, 32			0	0	
4	Protested amounts (nonallowable cost report items) in accor		D. L 45 0	0	0	35

COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems COMMUNITY HANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED Peri od: From 07/01/2020 To 06/30/2021 Date/Ti me Prepared: 11/23/2021 10:28 am Provider CCN: 15-0125 TO PROGRAM BENEFICIARIES HHA CCN: 15-7487

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	4, 429, 962 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01				0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
3. 50	Provider to Program			ol	0	3. 50
3. 50				0		3. 50
3. 51				0		3. 52
3. 53				0	0	3. 53
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	l ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	4, 429, 962	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
г 01	Program to Provider			ما		F 01
5. 01 5. 02				0	0	5. 01 5. 02
5. 02				0		5. 02
0.00	Provider to Program			<u> </u>	J	0.00
5.50	The state of the s			0	0	5. 50
5. 51				o	0	5. 51
5.52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	4, 429, 962	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	Name of Contractor	()	1. 00	2. 00	9 00
8. 00	Name of Contractor			I	ı l	8. 00

	n Financial Systems COMMUNI LATION OF CAPITAL PAYMENT	TY HOSPITAL Provider CCN: 15-0125	Peri od:	u of Form CMS-2 Worksheet L	
			From 07/01/2020	Parts I-III	
			To 06/30/2021	Date/Time Pre	
		Title XVIII	Hospi tal	PPS	. 20 am
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			5, 542, 112	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			56, 401	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01	
3.00	Total inpatient days divided by number of days in the co	ost reporting period (see inst	ructions)	216. 56	3.00
4.00	Number of interns & residents (see instructions)			0.00	4.00
5.00	Indirect medical education percentage (see instructions))		0.00	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 l 1.01) (see instructions)	by the sum of lines 1 and 1.01	, columns 1 and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Pal 30) (see instructions)	rt A patient days (Worksheet E	, part A line	3. 04	7.00
8. 00	Percentage of Medicaid patient days to total days (see i	instructions)		18. 45	
9. 00	Sum of lines 7 and 8			21. 49	
10. 00		ctions)		4. 45	
11.00	, , , , , , , , , , , , , , , , , , ,			246, 624	
12. 00	Total prospective capital payments (see instructions)			5, 845, 137	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions	s)		0	1.00
2.00	Program inpatient ancillary capital cost (see instruction			0	
3.00	Total inpatient program capital cost (line 1 plus line 2	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	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs (see instructions)	mstances (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2	,		0	1
4. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line	4)		0.00	
6. 00	Percentage adjustment for extraordinary circumstances (0.00	
7. 00	Adjustment to capital minimum payment level for extraord	*	(line 6)	0	1
8. 00	Capital minimum payment level (line 5 plus line 7)		,	0	8.00
9.00	Current year capital payments (from Part I, line 12, as			0	9.00
10.00	Current year comparison of capital minimum payment level	I to capital payments (line 8	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level (Worksheet L, Part III, line 14)	over capital payment (from pri	or year	0	11.00
12.00	Net comparison of capital minimum payment level to capi			0	
13.00			,	0	
	Carryover of accumulated capital minimum payment level	over capital payment for the f	following period	0	14.00
	(if line 12 is negative, enter the amount on this line)				
14. 0015. 00	Current year allowable operating and capital payment (se			0	
14. 00 15. 00 16. 00	Current year allowable operating and capital payment (se			0 0 0	16. 00