	Y HOSPITAL SOUTH In Lieu of Form CMS-2552-1							
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)								
payments made since the beginning of the cost reporting period								
	EXPIRES 03-31-2022							
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC AND SETTLEMENT SUMMARY	CATION Provider CCN: 15-0128 Period: From 01/01/2021 Worksheet S To 12/31/2021 Date/Time Prepared: 5/30/2022 2: 34 pm							
PART I – COST REPORT STATUS								
Provider 1. [X] Electronically prepared cost report	Date: 5/30/2022 Time: 2:34 p							
use only 2. [] Manually prepared cost report								
4. [F] Medicare Utilization. Enter "F" for full								
Contractor 5. [1] Cost Report Status 6. Date Received:	10. NPR Date:							
use only (1) As Submitted 7. Contractor No.	eport for this Provider CCN 12. [0]If line 5, column 1 is 4: Enter							
(3) Settled with Audit 9. [N] Final Report	ort for this Provider CCN number of times reopened = 0-9.							
(4) Reopened	Humber of trines respended = 0 7.							
(5) Amended								
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI								
	NED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND							
	LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE							
	ILY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND							
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.								
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	RATOR OF PROVIDER(S)							
I HEREBY CERTLEY that I have read the above certificat	ation statement and that I have examined the accompanying							
electronically filed or manually submitted cost report								
	ITY HOSPITAL SOUTH (15-0128) for the cost reporting period							
beginning 01/01/2021 and ending 12/31/2021 and to the	e best of my knowledge and belief, this report and statement							
are true, correct, complete and prepared from the book								
	certify that I am familiar with the laws and regulations							
	that the services identified in this cost report were							
provided in compliance with such laws and regulations.	š							
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX ELECTRONI C							
1	2 SI GNATURE STATEMENT							
1	I have read and agree with the above certification 1							
L Jolly / Allord	Y statement. I certify that I intend my electronic							
Holly Millard	signature on this certification be the legally							

	1 101	ly Ivillard	binding equivalent of my original signature.	
2	Signatory Printed Name	Holly Millard		2
3	Signatory Title	SVP FINANCE		3
4	Date	(Dated when report is electronica		4
	•		· · · · ·	

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	1, 081, 000	-146, 041	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200. 00 Total	0	1, 081, 000	-146, 041	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	<u>Financial Systems</u> TAL AND HOSPITAL HEALTH CARE COMPLEX I	COMMUNITY HOS DENTIFICATION DATA				Peri od:		Workshe		2552-10
						From 01/01/2 To 12/31/2	2021	Part I Date/Ti		
	1.00	2.00		3.00		4	. 00	5/30/20)22 2:3	4 pm
	Hospital and Hospital Health Care Con									
1.00 2.00	Street: 1402 EAST COUNTY LINE ROAD SO City: INDIANAPOLIS	UTH PO Box: State: IN	Zip Code	e: 4622 ⁻	7 Count	y: MARION				1.00
		Component Name	CCN	CBSA	N Provi der	Date		nt Syst		
			Number	Numbe	er Type	Certified	I, V	0, or XVIII		-
		1.00	2.00	3.00	4.00	5.00	6.00	7.00		
3.00	Hospital and Hospital-Based Componen Hospital	t Identification: COMMUNITY HOSPITAL	150128	26900	0 1	07/01/1966	N	Р	Р	3.00
		SOUTH	100120	2070						
4.00 5.00	Subprovi der – IPF Subprovi der – IRF									4.00
b. 00	Subprovider - (Other)									6.00
. 00	Swing Beds - SNF									7.00
. 00	Swing Beds - NF									8.00
0.00 0.00	Hospi tal -Based SNF Hospi tal -Based NF									10.00
1.00										11.00
2.00										12.00
	Separately Certified ASC Hospital-Based Hospice									13.00 14.00
	Hospital -Based Health Clinic - RHC									15.00
	Hospital-Based Health Clinic - FQHC									16.00
7.00	Hospital-Based (CMHC) I Renal Dialysis									17.00 18.00
	Other									19.00
						From:		То		
0 00	Cost Reporting Period (mm/dd/yyyy)					1.00	21	2.0		20.00
	Type of Control (see instructions)					2				21.00
				-	1.00	2.00		3. (20	-
	Inpatient PPS Information					-		0.0		
22.00	Does this facility qualify and is it disproportionate share hospital adjust	3 0 1	2		Y	N				22.00
	§412. 106? In column 1, enter "Y" for									
	facility subject to 42 CFR Section §4		endment							
22. 01	hospital?) In column 2, enter "Y" for Did this hospital receive interim und		ts for thi	\$	Y	Y				22.01
2.01	cost reporting period? Enter in colu				·					22.01
	the portion of the cost reporting per									
	Enter in column 2, "Y" for yes or "N' reporting period occurring on or after			ost						
22. 02	Is this a newly merged hospital that		,	e	Ν	N				22. 02
	payments to be determined at cost rep			s)						
	Enter in column 1, "Y" for yes or "N' cost reporting period prior to Octobe									
	or "N" for no, for the portion of the									
	October 1.									
22.03	Did this hospital receive a geographi rural as a result of the OMB standard				N	N		N		22.03
	adopted by CMS in FY2015? Enter in co									
	for the portion of the cost reporting	g period prior to Octob	er 1. Ente							
	in column 2, "Y" for yes or "N" for reporting period occurring on or after									
	Does this hospital contain at least		,	s						
	counted in accordance with 42 CFR 412									
2. 04	yes or "N" for no. Did this hospital receive a geographi	ic roclassification fro	m urban to		Ν	N		N		22. 04
2.04	rural as a result of the revised OMB				IN IN					22.04
	adopted by CMS in FY 2021? Enter in o									
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for i			r						
	reporting period occurring on or after									
	Does this hospital contain at least	100 but not more than 4	99 beds (a							
	counted in accordance with 42 CFR 412 yes or "N" for no.	2.105)? Enter in colum	n 3, "Y" f	or						
	5	dicaid days on lines 24	and/or 25			3 N				23.00
23.00	Which method is used to determine Med									
23. 00	below? In column 1, enter 1 if date of	of admission, 2 if cens	us days, o							
23. 00		of admission, 2 if cens of identifying the days	us days, o in this c							

1001.11	Financial Systems COMMUN FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provider CC	N: 15-0128	Peri od:			sheet	t S-2	2552-1
						/31/2021	Date 5/30	e/Time)/2022	2 2:3	pared: 4 pm
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d			Oth Medic day	ai d	
		1.00	2.00	3.00	4.00	5. C		6.0		
4. 00 5. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	1, 616				7 S 0	9, 027 0		30	24. 0 25. 0
		1		11		/Rural S	5 Date		eogr	
26.00	Enter your standard geographic classification (not wa	ade) status	at the bec	unning of t		. 00	1	2.00		26.00
7.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassifi	r rural. age) status r "2" for r	at the end ural. If ap	l of the cos			1			27.00
35.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status in			0			35.00
	errect fill the cost reporting perrou.				<u>v</u>	nni ng:	E	ndi ng	:	
6.00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb		. 00		2.00		36.0
7. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.					о			37.0
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)									37.0
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.					()				38.0
						<u>Y/N</u> . 00		Y/N 2.00		
9.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob), (İi), or the mileage i)? Enter n adjustmen	(iii)? Ent requiremen in column 2 t? Enter "Y	er in colum nts in ? "Y" for ye " for yes c	n s	N Y		N N		39. 0 40. 0
	no in column 2, for discharges on or after October 1.									
						V 1. C			XI X 3. 00	
5. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	(see inst	ructions)		accordanc	1.0	0 2.			45.0
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	(see inst	ructions) roportionat extraordina	e share in ry circumst	ances	e N N	0 2.	00 3	3.00	45. C 46. C
6. 00 7. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of	(see inst nt for disp eption for t. L, Pt. I capital? E	ructions) roportionat extraordina II and Wkst nter "Y for	e share in Try circumst L-1, Pt.	ances I through for no.	e N N N	0 2.	00 3 1 1	8. 00 N N N	46. 0 47. 0
5.00 7.00 3.00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	(see inst nt for disp eption for t. L, Pt. I capital? Et t? Enter "	ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes	e share in nry circumst . L-1, Pt. yes or "N" or "N" for	ances I through for no. no.	e N N N N N		00 3 1 1 1 1	8. 00 N N	46. 0 47. 0 48. 0
5.00 7.00 3.00 5.00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col	(see inst int for disp eption for t. L, Pt. I capital? Enter "" approved G e to column rograms in cable CRs) I umn 2.	ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y WA direct G	e share in nry circumst L-1, Pt. or "N" for or "N" for or if this rear or penu ME payment	ances I through for no. no. for yes hospital I timate reduction	e N N N or Y ?		00 3 1 1	8. 00 N N N	46. (47. (48. (56. (
6.00 7.00 8.00 6.00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pi year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col	(see inst int for disp eption for t. L, Pt. I capital? En capital? En enter "" approved G e to column rograms in f cable CRs) I umn 2. beriod durin ryes or "N th of this of (", complete ", complete"	ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct G ng which re " for no in cost report e Worksheet	e share in ary circumst L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this year or penu ME payment esidents in a column 1. ting period?	ances I through for no. no. for yes hospital Itimate reduction approved If column ' Enter "	e N N N N Or Y ? N 1 Y"		00 3 1 1 1 1	8. 00 N N N	46. (47. (48. (56. (
6.00 7.00 8.00 6.00 7.00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete WKSP Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pu year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "Y"	(see inst (see inst applied for disp (t. L, Pt. I (see instance) (t. L, Pt. I (see instance) (t. L, Pt. I (see instance) (see	ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y WA direct G mg which re " for no in cost report e Worksheet cable. or physicia	e share in ry circumst L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this rear or penu ME payment esidents in n column 1. ing period? E-4. If co	ances I through for no. no. for yes hospital Itimate reduction approved If column Enter " Iumn 2 is	e N N N N Or Y ? N 1 Y"		00 3 1 1 1 1	8. 00 N N N	46. 0 47. 0

lealth Financial Systems COMMUNI	TY HOSI	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	5/30/2022 2:3 Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	see If column 1	N			60.00
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	(1.00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.05
 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.10
 special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see 				0.00		61. 20
instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
			(1150.1)		1.00	
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital				od for which	0.00	62.00
your hospital received HRSA PCRE funding (see instructed from a during in this cost reporting period of HRSA THC prog	tions) Teachi ram. (s	ing Health Cent see instruction	ter (THC) into			62.01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	3.00 Teporting	
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June y train -priman all nor l non-pr n column	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00			64.00

SPITAL AND HOSPITAL HEALTH CARE CON	MPLEX IDENTIFICATION [Fr	eriod: 	Worksheet S-2 Part I	
			To	0 12/31/2021	Date/Time Pre 5/30/2022 2:3	pared 4 pm
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	позрі таї	4))	
	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
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 i column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column						
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/	
			Nonprovi der	Hospi tal	(2))	
			Si te	•		
			1.00	2.00	3.00	
Section 5504 of the ACA Curren beginning on or after July 1,		in Nonprovider Settir	ngsEffective fo	or cost report	ing periods	
FTEs attributable to rotations	occurring in all non		0.00	2. 18	s 0.00000	66.1
	occurring in all non f unweighted non-prim ital. Enter in column	provider settings. ary care resident 3 the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
FTEs attributable to rotations Enter in column 2 the number o FTEs that trained in your hosp (column 1 divided by (column 1	occurring in all non f unweighted non-prim ital. Enter in column + column 2)). (see i Program Name 1.00	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	-
FTEs attributable to rotations Enter in column 2 the number o FTEs that trained in your hosp (column 1 divided by (column 1 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 attributabl to rotations occurring in all non-provider settings. Enter i 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	occurring in all non f unweighted non-prim ital. Enter in column + column 2)). (see i Program Name 1.00 FAMILY MEDICINE	provider settings. ary care resident 3 the ratio of nstructions) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
FTEs attributable to rotations Enter in column 2 the number o FTEs that trained in your hosp (column 1 divided by (column 1 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 attributabl to rotations occurring in all non-provider settings. Enter i column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3	occurring in all non f unweighted non-prim ital. Enter in column + column 2)). (see i Program Name 1.00 FAMILY MEDICINE	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unwei ghted FTEs in Hospi tal 4.00 6.45	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 5 0.000000	-
 FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hosp (column 1 divided by (column 1 OO 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 attributabl to rotations occurring in all non-provider settings. Enter i 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) 	e n	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 5 0.000000	-
 FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hosp (column 1 divided by (column 1 OO 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 attributabl to rotations occurring in all non-provider settings. Enter i 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) 	occurring in all non f unweighted non-prim ital. Enter in column + column 2)). (see i Program Name 1.00 FAMILY MEDICINE e n	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00 1350	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 6.45	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 5 0.000000 5 0.000000 6 0.0000000	67.0
FTEs attributable to rotations Enter in column 2 the number o FTEs that trained in your hosp (column 1 divided by (column 1 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 attributabl to rotations occurring in all non-provider settings. Enter i column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	<pre>occurring in all non f unweighted non-prim ital. Enter in column + column 2)). (see i Program Name 1.00 FAMILY MEDICINE FAMILY MEDICINE e n FAMILY MEDICINE Psychiatric Facility no. id the facility have before November 15, Column 2: Did this fa CFR 412.424 (d)(1)(ii dicate which program)</pre>	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00 1350 (IPF), or does it cor an approved GME teach 2004? Enter "Y" for cility train resident i)(D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 6.45 6.45 1.0 rovi der? N he most o. (see ing o.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 5 0.000000 5 0.000000 6 0.0000000	70. (
 FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hosp (column 1 divided by (column 1 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 attributabl to rotations occurring in all non-provider settings. Enter i 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) Inpatient Psychiatric Facility Enter "Y" for yes or "N" for use this facility an Inpatient Enter "Y" for yes or "N" for ac CFR 412.424(d)(1)(iii)(c)) program in accordance with 42 Column 3: If column 2 is Y, in 	occurring in all non f unweighted non-prim ital. Enter in column + column 2)). (see i Program Name 1.00 FAMILY MEDICINE 6 FAMILY MEDICINE 7 PS PSychiatric Facility no. 1 d the facility have 5 before November 15, Column 2: Did this fa CFR 412.424 (d)(1)(ii di cate which program 1 ty PPS	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00 1350 (IPF), or does it cor an approved GME teach 2004? Enter "Y" for cility train resident i) (D)? Enter "Y" for year began during thi	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 6.45 6.45 1.0 rovi der? N he most o. (see ing o.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 5 0.0000000 5 0.0000000 6 2.00 3.00 0 2.00 3.00	-

Heal th	Financial Systems COMMUNITY HOSPITAL SOUTH		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-01		eriod:	Worksheet S-2	2
			rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	epared:
				5/30/2022 2:3	
				1.00	-
	Long Term Care Hospital PPS			1.00	
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost repo	orting	period? Enter	N	81.00
	"Y" for yes and "N" for no. TEFRA Providers				-
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for	ves o	or "N" for no.	N	85.00
	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR S				86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				
	Is this hospital an extended neoplastic disease care hospital classified under sec	ction		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V	XI X	
			1.00	2.00	1
	Title V and XIX Services			1	
	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y"	for	N	Y	90.00
	yes or "N" for no in the applicable column.	in	N	N	91.00
	Is this hospital reimbursed for title V and/or XIX through the cost report either full or in part? Enter "Y" for yes or "N" for no in the applicable column.	1 1 1	IN	IN	91.00
	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (se	ee		N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.				
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? En	nter	N	N	93.00
94 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the		N	N	94.00
74.00	applicable column.				74.00
	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the		N	N	96.00
	applicable column.		0.00	0.00	97.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents po	nst	Y 0.00	0.00 N	97.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no i				/0.00
	column 1 for title V, and in column 2 for title XIX.				
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on		Y	Y	98. 01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 title XIX.	2 TOF			
	Does title V or XIX follow Medicare (title XVIII) for the calculation of observati	on	Y	Y	98.02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column	า 1			
	for title V, and in column 2 for title XIX.		N	N	00.00
	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in col		N	N	98.03
	for title V, and in column 2 for title XIX.	Giniti			
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of		N	N	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V,	and			
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowand	on on	Y	Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, a		1	1	70.05
	column 2 for title XIX.				
	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. [Y	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	ו			
	Rural Providers		1		
	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of pa	ayment			106.00
107 00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I	٥D			107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions				107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an	- /			
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?				
	Enter "Y" for yes or "N" for no in column 2. (see instructions)	- 40	N		100.00
	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? Se CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e 42	N		108.00
	Physical Occupa	ti onal	Speech	Respi ratory	
	1.00 2.0	00	3.00	4.00	
	If this hospital qualifies as a CAH or a cost provider, are				109.00
	therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
			<u> </u>		
				1.00	
	Did this hospital participate in the Rural Community Hospital Demonstration projec			N	110.00
	Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200				
	applicable.	tin out	yı 210, us		

Heal th Financial Systems COMMUNITY HOSPITAL SOUTH			eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide	r CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021		epared:
111.00 If this facility qualifies as a CAH, did it participate in the Frontie Health Integration Project (FCHIP) demonstration for this cost reporti "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participating Enter all that apply: "A" for Ambulance services; "B" for additional b for tele-health services.	ng period? Enter Y, enter the jin column 2.	1.00 N	2.00	111.00
	1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N N			112.00
115.00 Is this an all -inclusive rate provider? Enter "Y" for yes or "N" for n in column 1. If column 1 is yes, enter the method used (A, B, or E onl in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based o the definition in CMS Pub. 15-1, chapter 22, §2208.1.	y)			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00 s this facility legally-required to carry malpractice insurance? Ente "Y" for yes or "N" for no.	er Y			117.00
118.00 Is the mal practice insurance a claims-made or occurrence policy? Enter	1	1		118.00
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:	1.00	2.00	3.00	0118.01
			0.00	_
118.02 Are malpractice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein.		1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies fo Hold Harmless provision in ACA §3121 and applicable amendments? (see i	"Y" for yes or or the Outpatient		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable dev	vices charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e the Worksheet A line number where these taxes are included.				122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for yes and	"N" for no lf	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the ce				126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 f this is a Medicare certified heart transplant center, enter the cer				127.00
in column 1 and termination date, if applicable, in column 2. 128.00 f this is a Medicare certified liver transplant center, enter the cer				128.00
in column 1 and termination date, if applicable, in column 2. 129.00 f this is a Medicare certified lung transplant center, enter the cert		n		129.00
column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center, enter the				130.00
date in column 1 and termination date, if applicable, in column 2. 131.00 f this is a Medicare certified intestinal transplant center, enter th				131.00
date in column 1 and termination date, if applicable, in column 2. 132.00 f this is a Medicare certified islet transplant center, enter the cer				132.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the OPO numb				133. 00 134. 00
and termination date, if applicable, in column 2. All Providers				-

Health Financial Systems	COMMUNI T	Y HOSPI	TAL SOUTH				In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Ą	Provider CC	N: 15-01			1/01/2021 2/31/2021	Worksheet S-2 Part I Date/Time Pre 5/30/2022 2:3	epared:
1.00		2.00					3.00	573072022 2.3	
If this facility is part of a chair		er on li			the nam	ne and		of the	
home office and enter the home offi 141.00Name: COMMUNI TY HEALTH NETWORK	<u>ce contractor name</u> Contractor's Name				ractor	'c Nu	mbor, 0010	1	141.00
141.00 Name: COMMUNITY HEALTH NETWORK	Contractor S Na		ICES	ANSCOTT	ractor	S NUI		/ 1	141.00
142.00 Street: 1500 NORTH RITTER AVENUE	PO Box:	02.00	1 020						142.00
143.00 City: INDIANAPOLIS	State:	IN		Zip	Code:		4621	9-3095	143.00
								1.00	-
144.00 Are provider based physicians' cost	s included in Works	heet A?						1.00 Y	144.00
144. Oprie provider based physicialis cost		neet A:						•	144.00
							1.00	2.00	
145.00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl	for yes or "N" for u ude Medicare utiliz	no in c	olumn 1. lfc	olumn 1			Y		145.00
period? Enter "Y" for yes or "N" f 146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	changed from the p	Pub. 15					Ν		146. 00
	· ////// ···· •••· ••·· _·					1			
		6						1.00	4 4 7 7 7
147.00Was there a change in the statistic 148.00Was there a change in the order of								N N	147.00 148.00
149.00 Was there a change to the simplifie					' for n	i0		N	148.00
			Part A	Part			tle V	Title XIX	
			1.00	2.0			3.00	4.00	
Does this facility contain a provid or charges? Enter "Y" for yes or "N 155.00Hospital					tB. (S				155.00
156. 00 Subprovi der – TPF			N	N			N	N	156.00
157.00 Subprovider - IRF			N	N			N	N	157.00
158. 00 SUBPROVI DER									158.00
159.00 SNF			N	N			N	N	159.00
160.00HOME HEALTH AGENCY 161.00CMHC			N	N			N N	N N	160.00 161.00
				11		1			101.00
Multicompus								1.00	
Multicampus 165.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	pus hospital that h	as one	or more campu	ses in a	di ffere	ent CB	SAs?	N	165.00
	Name		County	State		Code	CBSA	FTE/Campus	
	0		1.00	2.00	3.	00	4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0. 00	166. 00
								1.00	-
Health Information Technology (HIT)	incentive in the A	meri can	Recovery and	Reinve	stment	Act		1.00	
167.00 Is this provider a meaningful user						1.0 1		Y	167.00
168.00 If this provider is a CAH (line 105	is "Y") and is a m	eani ngf	ul user (line			enter	the		168.00
reasonable cost incurred for the HI					c				1 (0 01
168.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?						nard	snip		168. 01
169.00 If this provider is a meaningful us transition factor. (see instruction	er (line 167 is "Y")					l"), e	nter the	9.99	9169.00
						<u> </u>	gi nni ng	Endi ng	-
170.00 Enter in columns 1 and 2 the EHR be	ginning date and en	ding da	te for the re	porting			1.00	2.00	170.00
period respectively (mm/dd/yyyy)									
							1.00	2.00	-
171.00 If line 167 is "Y", does this provi	der have anv davs f	or indi	viduals enrol	led in			N		171.00
section 1876 Medicare cost plans re "Y" for yes and "N" for no in colum 1876 Medicare days in column 2. (se	ported on Wkst. S-3 n 1. If column 1 is	, Pt. I	, line 2, col	. 6? Ent					

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pro 5/30/2022 2:3	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente	er all dates in t	he	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	instructions)			
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare Pu	rogrom2 lf	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in column voluntary or "l" for involuntary.	n 3, "V" for				
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3. 0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports				02/21/2222	- · -
. 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A	03/31/2022	4.0
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reco		N			5.0
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for a nursing program? Column 2 is the legal operator of the program?	3	s the provider			6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.		ed during the	e N		7. C 8. C
. 00	Are costs claimed for Interns and Residents in an approved g	graduate medic	al education	Y		9.0
D. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated of cost reporting periods is not set in the program initiated of		he current	Ν		10. 0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
					Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes,	saa instruct	ions		Y	12.0
	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	N	13. (
	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement		*		Ν	14. (
5.00	Did total beds available change from the prior cost reportin	<u>v</u> .			N + P	15.0
		Par Y/N	t A Date	Par Y/N	t B Date	-
	-	1.00	2.00	3.00	4.00	
	PS&R Data					
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Ν		N		16. (
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	05/02/2022	Y	05/02/2022	17. (
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

Health Financial	Systems
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COMMUNITY HOSPITAL SOUTH

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	SPITAL SOUTH	eu of Form CMS-2552-10									
NOSTINE AND NOSTINE HEALTH ONCE RELIVIDURSENTENT QUESTIUNIVALIKE	Provider C	1	Period: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time I							
				5/30/2022							
		iption	Y/N	Y/N							
	(0	1.00	3.00							
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00						
	Y/N	Date	Y/N	Date							
	1.00	2.00	3.00	4.00							
21.00 Was the cost report prepared only using the provider's	N		N		21.00						
records? If yes, see instructions.											
CONDUCTED DV COST DELUDUDGED AND TEEDA HOSDUTAL & ONLY (EVO				1.00	_						
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPI CHILDRENS H	USPITALS)									
22.00 Have assets been relifed for Medicare purposes? If yes, see	ainstructions				22.00						
23.00 Have changes occurred in the Medicare depreciation expense		als made duri	na the cost		22.00						
reporting period? If yes, see instructions.			ig the cost		23.00						
24.00 Were new leases and/or amendments to existing leases enter	ed into during	this cost rep	orting period?		24.00						
If yes, see instructions	5		5 1								
25.00 Have there been new capitalized leases entered into during	the cost repor	ting period?	lfyes, see		25.00						
instructions.											
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? If	yes, see		26.00						
instructions. 27.00 Has the provider's capitalization policy changed during the	a cost roportin	a period? If	une submit		27.00						
copy.		g perious IT	yes, subill t		27.00						
Interest Expense											
28.00 Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporting		28.00						
period? If yes, see instructions.		5	1 5								
29.00 Did the provider have a funded depreciation account and/or		bt Service Re	serve Fund)		29.00						
treated as a funded depreciation account? If yes, see inst											
30.00 Has existing debt been replaced prior to its scheduled mate	urity with new	debt? If yes,	see		30.00						
instructions. 31.00 Has debt been recalled before scheduled maturity without is	ssuance of now	dobt? If yos	600		31.00						
instructions.	ssuance of new	debt? IT yes,	366		31.00						
Purchased Servi ces											
32.00 Have changes or new agreements occurred in patient care se	rvi ces furni she	d through con	tractual		32.00						
arrangements with suppliers of services? If yes, see instru	uctions.	0									
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainin	ig to competiti	ive bidding? If		33.00						
no, see instructions.					_						
Provi der-Based Physicians 34.00 Are services furnished at the provider facility under an a	rrangement with	providor bac	ad physicians?		34.00						
If yes, see instructions.	rrangement with		eu physicians?		34.00						
35.00 If line 34 is yes, were there new agreements or amended ex	isting agreemen	ts with the p	rovi der-based		35.00						
physicians during the cost reporting period? If yes, see in	nstructions.		ovraol babba								
			Y/N	Date							
			1.00	2.00							
Home Office Costs											
36.00 Were home office costs claimed on the cost report?	nononod by th	home off			36.00						
37.00 If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	nume office?			37.00						
38.00 If line 36 is yes, was the fiscal year end of the home of	fice different	from that of			38.00						
the provider? If yes, enter in column 2 the fiscal year end					30.00						
39.00 If line 36 is yes, did the provider render services to oth					39.00						
see instructions.		3									
40.00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see			40.00						
instructions.											
	1.	00	2.	00							
Cost Report Preparer Contact Information			1								
Cost Report Preparer Contact Information	SHIRIEV		BI SHOP		<u>⊿1 ∩∩</u>						
41.00 Enter the first name, last name and the title/position	SHI RLEY		BI SHOP		41.00						
	SHI RLEY		BI SHOP		41.00						
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SHI RLEY COMMUNI TY HEAL	TH NETWORK	BI SHOP		41.00						
 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 		TH NETWORK			42.00						
 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report 		TH NETWORK	BI SHOP SBI SHOP@ECOMMU	NI TY. COM							

Heal th	Financial Systems CON	MUNITY HOS	SPITAL SOUTH	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIO	NNAI RE	Provider CCN: 15-0128	Peri od:	Worksheet S-2	
				From 01/01/2021 To 12/31/2021		
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/pos	sition	NETWORK DIRECTOR OF			41.00
	held by the cost report preparer in columns 1, 2,	, and 3,	REIMBURSEMENT			
	respecti vel y.					
42.00	Enter the employer/company name of the cost report	rt				42.00
	preparer.					
43.00	Enter the telephone number and email address of	the cost				43.00
	report preparer in columns 1 and 2, respectively.					

	Financial Systems	COMMUNITY HOSE				u of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/30/2022 2:3	pared:
	0-mail - mail	Wasterstein		Dad Davis		I/P Days / O/P <u>Visits / Trips</u> Title V	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	intre v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	157	57, 30	0. 00	0	
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.00 3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		157	57, 30	0.00	0	6.00 7.00
8.00 9.00 10.00 11.00 12.00	INTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	31.00	12	4, 3	30 0.00	0	8.00 9.00 10.00 11.00 12.00
12.00 13.00 14.00 15.00 16.00 17.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF	43. 00	169	61, 6	35 0.00	0 0 0	12.00 13.00 14.00 15.00 16.00 17.00
18.00 19.00 20.00 21.00 22.00	SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY						18.00 19.00 20.00 21.00 22.00
23.00 24.00 24.10 25.00	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	30. 00					23.00 24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	89. 00	169 0		0	0	27.00
33.00	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-0128		eriod: com 01/01/2021 o 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/30/2022 2:3	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E	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 2.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	10, 289 9, 850	1, 465 8, 048	36, 70	66			1.00 2.00
3.00	HMO I PF Subprovi der	0	0					3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0	0		0			4.00 5.00
6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0	0		0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	10, 289	1, 465	36, 76	66			7.00
8.00	INTENSIVE CARE UNIT	935	0	3, 1 ⁻	10			8.00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00 12.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)							11.00 12.00
12.00	NURSERY		1, 455	2, 59	07			13.00
14.00	Total (see instructions)	11, 224	2, 920	42, 4		8.63	899.02	14.00
15.00	CAH visits	0	2, 720	τ <u></u> , τ	0	0.05	077.02	15.00
16.00	SUBPROVIDER - IPF		Ū		Ŭ			16.00
17.00	SUBPROVIDER - IRF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20. 00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPICE							24.00
24.10	HOSPICE (non-distinct part)			C	97			24.10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC				~	0.00	0.00	26.00
26.25 27.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00 8.63	0.00 899.02	
27.00	Total (sum of lines 14-26) Observation Bed Days		833	5,44	11	0.03	099.02	27.00
29.00	Ambul ance Trips	0	000	5, 4	41			29.00
30.00	Employee discount days (see instruction)	0		4	65			30.00
31.00	Employee discount days (see first detroit)				0			31.00
32.00	Labor & delivery days (see instructions)	0	30	6'	15			32.00
32.01	Total ancillary labor & delivery room	J	00	Ū	0			32.01
	outpatient days (see instructions)				-			
33.00	LTCH non-covered days	0						33.00
33.01	LTCH site neutral days and discharges	0						33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Prep 5/30/2022 2:34	pared:
		Full Time Equivalents		Di s	charges	0,00,2022 2.0	
	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 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 22.00 23.00 24.00 24.00 25.00 26.25 27.00 28.00 29.00 30.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0.00	0	2, 4	07 258 22 1, 926 0 0	9, 419	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 26.00 27.00 28.00 29.00 30.00 20.00 21.00 21.00 21.00 22.00 23.00 24.00 23.00 24.00 25.00 26.00 27.00 27.00 28.00 20.00 21.00 25.00 26.00 26.00 27.00 27.00 28.00 29.00 20.0
32.00 32.01 33.00 33.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		32.00 32.01 33.00 33.01

PITAL WAGE INDEX INFORMATION			Provider CC	F	Period: From 01/01/2021 Fo 12/31/2021		par
	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA SALARIES							1
0 Total salaries (see	200. 00	72, 647, 184	-353, 297	72, 293, 887	1, 869, 963. 00	38.66	1 1
instructions) Non-physician anesthetist	Dart	C	0	, c	0.00	0.00	
A	Part	Ĺ	0		0.00	0.00	∠
Non-physician anesthetist	Part	C	0	C	0.00	0. 00	
B 0 Physician-Part A -		704, 384	0	704, 384	4, 832. 00	145. 77	
Admi ni strati ve		701,001		, , , , , , , , , , , , , , , , , , , ,	1,002.00	110.77	
1 Physicians - Part A - Teac	chi ng	271 400	0	071 400			
0 Physician and Non Physician-Part B		371, 499	0	371, 499	4, 056. 00	91.59	Ę
0 Non-physician-Part B for		C	0	C	0.00	0.00	6
hospital-based RHC and FQH services	HC						
0 Interns & residents (in ar	n 21.00	C	0	c	0.00	0. 00	-
approved program)		-	_	-			
1 Contracted interns and residents (in an approved		Ĺ	0 0		0.00	0.00	
programs)							
0 Home office and/or related organization personnel	L L	C	0	C	0.00	0.00	8
0 SNF	44.00	C	0	C	0.00	0.00	
00 Excluded area salaries (se	ee	679, 384	-4, 923	674, 461	23, 572. 00	28. 61	10
instructions) OTHER WAGES & RELATED COST	-S						
00 Contract Labor: Direct Pat		4, 783, 557	0	4, 783, 557	60, 180. 00	79.49	1
Care		C	0		0.00	0.00	1.
00 Contract Labor: Top Level management and other		Ĺ	0	C	0.00	0.00	1.
management and administrat	ti ve						
services 00 Contract Labor: Physician-	Dart	1, 822, 248	0	1, 822, 248	22, 148. 00	82.28	1
A - Administrative		1, 022, 240		1, 022, 240	22, 140.00	02.20	
00 Home office and/or related	k	C	0	C	0.00	0.00	14
organization salaries and wage-related costs							
01 Home office salaries		38, 535, 628	0	38, 535, 628			
02 Related organization salar 00 Home office: Physician Par		C	0	0	0.00		
- Administrative		Ĺ	0		0.00	0.00	
00 Home office and Contract		C	0	C	0.00	0. 00	16
Physicians Part A - Teachi D1 Home office Physicians Par		C	0	, c	0.00	0.00	1
- Teachi ng			0		0.00	0.00	
02 Home office contract		C	0	C	0.00	0. 00	10
<u>Physicians Part A - Teachi</u> WAGE-RELATED COSTS	ng						
00 Wage-related costs (core)	(see	18, 070, 031	0	18, 070, 031			11
instructions) 00 Wage-related costs (other)							18
(see instructions)	,						
00 Excluded areas	Dont	214, 985	0	214, 985			19
00 Non-physician anesthetist	Part	C	0	C			20
Non-physician anesthetist	Part	C	0	C)		2
B DO Physician Part A -		58, 191	0	58, 191			22
Admi ni strati ve		50, 171	0	30, 171			
01 Physician Part A - Teachir	ng	0	0	0			22
00 Physician Part B 00 Wage-related costs (RHC/FC	онс)	48, 846		48, 846			23
00 Interns & residents (in ar		C	0	C			25
approved program)		E 444 044	_	E 444 044			
50 Home office wage-related (core)		5, 446, 846		5, 446, 846			25
51 Related organization		C	0	C			25
wage-related (core) 52 Home office: Physician Par	ct A	r					25
- Administrative -		Ĺ	, 0				25
wage-related (core)							1

Heal th	Financial Systems		COMMUNITY HOS	PITAL SOUTH		In Lie	eu of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II	pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es		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		C		25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4.00	0	0		0.00		26.00
27.00	Administrative & General	5.00	4, 481, 318					
28.00	Administrative & General under		4, 470, 122	0	4, 470, 12	2 35, 896. 00	124. 53	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0.00		29.00
30.00	Operation of Plant	7.00	843, 316	-2, 523				
31.00	Laundry & Linen Service	8.00	0	0		0. 00		
32.00	Housekeepi ng	9.00	1, 564, 564					
33.00	Housekeeping under contract		310, 733	0	310, 73	3 7, 072. 00	43.94	33.00
	(see instructions)							
34.00	Dietary	10.00	1, 376, 929					34.00
35.00	Dietary under contract (see		273, 690	0	273, 69	0 4, 160. 00	65.79	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	889, 585	889, 58			36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00		37.00
38.00	Nursing Administration	13.00	351, 881	-752	351, 12			38.00
39.00	Central Services and Supply	14.00	0	0		0. 00		39.00
40.00	Pharmacy	15.00	0	0		0. 00		40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	1	0.00	0.00	41.00
42.00	Social Service	17.00	1, 316, 014	-2, 240	1, 313, 77	4 31, 460. 00	41.76	42.00
43.00	Other General Service	18.00	0			0.00		43.00

Heal th	Financial Systems		COMMUNI TY HOSPI TAL SOUTH			In Lieu of Form CMS-2552-10			
HOSPI	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part III Date/Time Prep 5/30/2022 2:34		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from	(col.2 ± col.		col. 5)		
				Worksheet A-6)		col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-1			
1.00	Net salaries (see		77, 330, 230	-353, 297	76, 976, 93	3 1, 913, 035. 00	40. 24	1.00	
	instructions)								
2.00	Excluded area salaries (see instructions)		679, 384	-4, 923	674, 46	1 23, 572.00	28. 61	2.00	
3.00	Subtotal salaries (line 1		76, 650, 846	-348, 374	76, 302, 47	2 1, 889, 463. 00	40. 38	3.00	
	minus line 2)								
4.00	Subtotal other wages & related costs (see inst.)		45, 141, 433	0	45, 141, 43	3 556, 107.00	81. 17	4.00	
5.00	Subtotal wage-related costs (see inst.)		23, 575, 068	0	23, 575, 06	8 0.00	30. 90	5.00	
6.00	Total (sum of lines 3 thru 5)		145, 367, 347	-348, 374	145, 018, 97	3 2, 445, 570. 00	59, 30	6.00	
7.00	Total overhead cost (see		14, 988, 567					7.00	
,.00	instructions)		14, 700, 307	-27,002	14, 930, 70	400, 440. 00	57.50	7.00	

alth Financial Systems	COMM	UNITY HOSPITAL SOUTH	CN 15 0100		u of Form CMS-2	
SPITAL WAGE RELATED COSTS		Provider C	CN: 15-0128	Period: From 01/01/2021	Worksheet S-3 Part IV	
				To 12/31/2021		pared
					5/30/2022 2:3	
					Amount	
					Reported	<u> </u>
					1.00	
PART IV - WAGE RELATE	0 COSTS					-
Part A - Core List						-
RETIREMENT COST	utiono				2.045.744	1 1
00 401K Employer Contrib					2, 865, 746	
	(TSA) Employer Contribution Benefit Plan Cost (see instru	(ati and)			0	
	efit Plan Cost (see instructi				36, 890	
	OSTS (Paid to External Organi				30, 890	4.
00 401K/TSA PI an Admini s		24(101)			0	5.
	gement Fees-Pension Plan				618, 716	
	Program Administration Fees				010, 710	
HEALTH AND INSURANCE					0	
	chased or Self Funded)				0	8.
	f Funded without a Third Part	v Administrator)			0	
	f Funded with a Third Party A				6, 651, 675	
03 Heal th Insurance (Pur					0,001,070	
00 Prescription Drug Pla					2, 075, 965	
.00 Dental, Hearing and V					71, 688	
	ployee is owner or beneficiar	-v)			38, 921	
	f employee is owner or benefi				0	12.
	(If employee is owner or bene				563, 703	13.
	nce (If employee is owner or				0	14.
.00 'Workers' Compensatio		57			163, 835	15.
.00 Retirement Health Car	e Cost (Only current year, no	ot the extraordinary acc	crual require	ed by FASB 106.	0	16.
Non cumulative portio	n)			•		
TAXES						
.00 FICA-Employers Portic					5, 242, 504	
.00 Medicare Taxes - Empl					0	
.00 Unemployment Insuranc					0	
.00 State or Federal Unem	ployment Taxes				0	20.
OTHER						4
	mpensation (Other Than Retire	ement Cost Reported on I	ines 1 throu	ugh 4 above. (see	0	21.
instructions)) .00 Day Care Cost and All	0000000				_	22.
.00 Day Care Cost and All .00 Tuition Reimbursement					0 62, 408	
.00 Total Wage Related co					62, 408 18, 392, 051	
Part B - Other than C					10, 392, 051	∠4.
5. 00 OTHER WAGE RELATED CO						25.

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0128	Peri od:	Worksheet S-3	
		From 01/01/2021	Part V	
		To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
Cost Center Description		Contract Labor	Benefit Cost	4 pili
cost center bescription		1.00	2.00	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital -Based Component Ident	ification:			
1.00 Total facility's contract labor and benefit		4, 783, 557	18, 392, 051	1.00
2.00 Hospi tal	6031	4, 783, 557	18, 392, 051	
3.00 Subprovider - IPF		1, 700, 007	10, 072, 001	3.00
4.00 Subprovider - IRF				4.00
5.00 Subprovider - (Other)		0	0	
6.00 Swing Beds - SNF		0	0	
7.00 Swing Beds - NF		0	0	7.00
8.00 Hospital-Based SNF		0	Ū	8.00
9.00 Hospital -Based NF				9.00
10.00 Hospi tal -Based OLTC				10.00
11.00 Hospi tal -Based HHA				11.00
12.00 Separately Certified ASC				12.00
13.00 Hospi tal -Based Hospi ce				13.00
14.00 Hospital -Based Health Clinic RHC				14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospital -Based-CMHC				16.00
17.00 Renal Dialysis		0	0	
18.00 Other		0	0	
1		1		•

Heal th	Financial Systems COMMUNITY HOSPI	FAL SOUTH		In Lie	eu of Form CMS-:	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC		Period:	Worksheet S-1	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
					0/ 00/ 2022 2.0	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by lin	e 202 column	8)	0. 202246	1.00
	Medicaid (see instructions for each line)				•	
2.00	Net revenue from Medicaid				51, 010, 518	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			i d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medicaid			-15, 928, 632	5.00
6.00	Medi cai d charges				215, 324, 260	
7.00	Medicaid cost (line 1 times line 6)	(1) - 7			43, 548, 470	
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(IIne / minu	IS SUM OF IIN	es 2 and 5; IT	8, 466, 584	8.00
	<pre>Children's Health Insurance Program (CHIP) (see instructions 1</pre>	for each line)			
9,00	Net revenue from stand-al one CHIP)		0	9.00
10.00	Stand-al one CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 min	us line 9 i	f < zero then	0	
12.00	enter zero)				0	12.00
	Other state or local government indigent care program (see ins	structions fo	r each line)			
13.00	Net revenue from state or local indigent care program (Not in)	0	13.00
14.00	Charges for patients covered under state or local indigent ca				0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line	14)			0	15.00
16.00	Difference between net revenue and costs for state or local in	ndigent care	program (lin	e 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CH	HP and state	/local indig	ent care progra	ms (see	
17 00	instructions for each line)	Currenti un en entre enti				17 00
17.00 18.00	Private grants, donations, or endowment income restricted to Government grants, appropriations or transfers for support of				0	
18.00	Total unreimbursed cost for Medicaid , CHIP and state and loca			(cum of lines	8, 466, 584	
19.00	(8, 12 and 16)	ai murgent c	are programs	(Sull OF THES	0,400,504	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				1	
20.00	Charity care charges and uninsured discounts for the entire fa	acility	9, 206, 18	3 1, 692, 114	10, 898, 297	20.00
	(see instructions)				0 554 000	
21.00	Cost of patients approved for charity care and uninsured disc	ounts (see	1, 861, 91	4 1, 692, 114	3, 554, 028	21.00
22.00	instructions) Payments received from patients for amounts previously writte	n off as	54	6 0	546	22.00
22.00	charity care		54		540	22.00
23.00	Cost of charity care (line 21 minus line 22)		1, 861, 36	8 1, 692, 114	3, 553, 482	23.00
20.00			1,001,00	1,072,111	0,000,102	20.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pation	ent days beyo	nd a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent car	e program?	5	5		
25.00	If line 24 is yes, enter the charges for patient days beyond	the indigent	care program	's length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see in	,			13, 471, 210	
27.00	Medicare reimbursable bad debts for the entire hospital comple				173, 928	
27.01	Medicare allowable bad debts for the entire hospital complex	(see instruct	i ons)		267, 581	
28.00	Non-Medicare bad debt expense (see instructions)				13, 203, 629	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	xpense (see i	nstructions)		2, 764, 034	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				6, 317, 516	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	iine 30)			14, 784, 100	31.00

BFCL ASSLEFICATION: AME ADJISTMENTS OF TRLAL RALANCE OF FAPPINES Provider: Cole: 15:010 Perrod: 10:010 Workshmet A Upper Cole: 10:010 Cost Genter Description Salaries Uther Iotal (Col. 2) Note Lass IF add (Col. 3) Note Lass IF add (Col. 3) <th>Health Financial Systems</th> <th>COMMUNI TY HOSP</th> <th>ITAL SOUTH</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Health Financial Systems	COMMUNI TY HOSP	ITAL SOUTH		In Lie	u of Form CMS-2	2552-10
Image: Cost Centor Description Subaries Other Total Cost Centor Description Subaries 1.00 2.00 3.00 4.00 5.00 Final Balance Fi		F EXPENSES	Provider CC			Worksheet A	
Image: space of the second space of the second space of the							
DEMERAL SERVICE COST CENTERS 1 00 2.00 3.00 4.00 5.00 1.00 DOTOLO, ME EL COST CENTERS 0 <t< td=""><td>Cost Center Description</td><td>Sal ari es</td><td>Other</td><td></td><td></td><td>Trial Balance (col. 3 +-</td><td></td></t<>	Cost Center Description	Sal ari es	Other			Trial Balance (col. 3 +-	
1.00 00100 (CAP REL COSTS-HUNG FAUL PS 0 0 0 0.73,4,69 10,274,659		1.00	2.00	3.00	4.00		
2.00 002000 CAP REL COSTS - WHILE FOUP 0 0 7, 724, 831 2, 734, 831 2, 734, 831 2, 734, 831 2, 734, 831 5, 734, 831 2, 734, 831 5, 734, 831 2, 734, 831 5, 736, 734 5, 734, 831 5, 736, 734 5, 734, 831 5, 736, 734 5, 736, 734 5, 736, 734 5, 736, 734 5, 736 5, 736 5, 736			I				
3.00 000000 DHER CAR FEL COSTS 0 </td <td></td> <td></td> <td>Ű</td> <td></td> <td></td> <td></td> <td></td>			Ű				
4.00 COMODI DIMPLOYCE BENNET IS DEPARTMENT 0 2.81 2.00 2.80 0.00 2.80 4.00 7.00 COTOD OPERATION OF PLANT 84.3,118 4.012,107 4.855,2021,16 0-399,35 75,522,337 5.00 0.00 COTOD OPERATION OF PLANT 84.3,118 4.012,107 4.855,2021,16 0-399,35 75,522,337 5.00 0.00 COTOD OPERATION OF PLANT 1.564,929 2.991,164 -1,942,764 0 1,941,665 1,000 10.00 10.00 10.00 0 0 1.942,682 1.942,783 1.665,767 -1,942,784 1.663,797 1.663,767 -1,958 1.663,299 17.00 17.00 17.00 0 0 0 0 0 0 0 0 0 0.52,002 1.653,797 -1,938 1.683,799 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00			0				
7.00 00700 OPERATION OF PLANT 843.316 4.012.107 4.885.423 1-31.457 4.723.966 7.00 9.00 00500 HUMBY & LINES SERVICE 1.564.564 1.118.97 2.662.901 44 -1.74.665 0.00		0	28	-	-		
0.00 000800 LANNEY & LINES SERVICE 0 077, 661 671, 661 671, 661 0 677, 667 0 0 0.00 00000 DUSEKEEPIN 1, 354, 564 1, 183, 397 2, 682, 961 -1, 31, 85 2, 697, 76 0 10.00 01000 DIETARY 1, 316, 397, 20 1, 643, 758 1, 643, 729 1, 643, 769 1, 643, 729		4, 481, 318					
9.00 00900 MOUSELEEPTING 1.564,564 1.118,397 2.622,901 452,763 1.687,774 0. 11.00 01100 CAFETERIA 0		843, 316					
10.00 01000 01000 01000 01000 01000 01000 01000 01000 01000 01000		1 564 564					
11 00 01100 CARETERIA 0 0 0 1.914.65c <							
16.00 01600 MEDICAL RECORDS & LIBRARY 0 </td <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td>		0	0	0			
17.00 01700 SOCIAL SERVICES 1.316,014 3497,753 1.685,767 -1.838 1.683,929 17.00 02.00 02200 IAR SERVICES-SALARY & FINGES APPRVD 0 0 0 0 0 21.00 02000 IAR SERVICES-STHER PROM COSTS APPRVD 0 0 0 0 0 0 0 21.00 0100 03000 ADULTS & PEDIATRICS 25.59,484 19.826,947 45.366,431 -5.866,296 39,510,135 30.00 0100 03000 AUUES & PEDIATRICS 25.59,484 19.826,947 45.366,431 -5.866,296 39,510,135 30.00 0100 03000 AUUES & PEDIATRICS 25.59,484 19.826,947 4.661,227 4.661,227 4.661,227 4.661,227 4.661,224 4.661,224 4.661,224 50.00		351, 881	84, 398	436, 279	0	436, 279	13.00
21:00 02:00 1AR SERVICES-SALARY & FRINCES APRYD 0		0	0	0	0	-	
22.00 02200 LAR SERVIC COST CENTERS 0 0 0 0 22.00 00.00 03000 ADULTS & PEDIATRICS 25.539, 484 19.826, 947 45.366, 431 -5.865, 256 39.710, 135 30.00 01.00 03100 INTENSIV C CAST CENTERS -460, 523 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7783, 201 7794, 121 50.00 5000 [PERSIVE CONST CENTERS -246, 191, 44, 455, 306, 701 3, 480, 349 4, 131, 655 52.00 52.00 52.00 [RADI CONCY - HERAPEUTIC 669, 295 1, 862, 179 2, 31, 474 -1, 860, 292 2, 768, 62, 55 50.00 550.00 550.00 550.00 730, 741, 721 55.00 50500 [RADI CONCY - HERAPEUTIC 669, 295 1, 862, 179 2, 31, 474 -1, 860, 703 1, 921, 726, 557.00 570.00 550.00 550.00 550.00 550.00 550.00 550.00 550.00 550.00 550.00 550.00 55		1, 316, 014	369, 753	1, 685, 767	-1, 838		
INPATI ENT ROUTI NE SERVICE COST CENTERS		0	0	0	0		
31.00 03100 INTENSI VE CARE UNI T 3, 536, 328 1, 653, 406 5, 199, 734 -460, 523 4, 729, 211 31.00 MOLLARY SERVI CE COST CENTERS - - 783, 201 783, 783 783, 201 783, 783							22.00
43.00 0 4300 NURSERY 0 0 0 783.201 783							
ANCI LLARY SERVICE COST CENTERS Non-transmission 0.00 05000 DEPERATING ROOM 3,897,668 18,916,116 22,813,784 -15,019,663 7,794,121 50.00 51,000 05000 RECOVERY ROOM 3,216,996 1,464,229 4,681,225 -2,46,191 4,435,034 51.00 54,00 05400 RADI LLOGY-THERAPEUTI C 6.69,295 1,962,177 2,51,474 -1,282,925 2,768,629 54.00 55,00 05500 RADI LLOGY-THERAPEUTI C 6.69,925 1,862,177 2,51,474 -1,282,925 2,768,625 57.00 58,00 063600 MAGNETI C RESONANCE I MAGI NG (MRI) 481,807 1,214,741 2,049,548 -83,293 1,066,255 57.00 59,00 05600 CREDI AC CATHERN ZATION 1,454,470 8,569,013 10,113,483 -7,104,456 3,009,027 59.00 60,00 06000 LHRANENOUS THERAPY 0 0 0 0 0 0 0 64.00 61,00 06000 DELECERNONCHAUSTHERAPY 2,347,291 1,204,268 3,551,559 -4149,151 3,132,408							
50. 00 05000 (OPERATING ROOM 3, 897, 668 18, 916, 116 22, 813, 784 -15, 019, 663 7, 794, 121 50. 00 51. 00 05000 (DECUVERY ROOM 3, 216, 996 1, 464, 229 4, 681, 225 -246, 191 4, 435, 033 44, 435, 035 55. 00 0500 (PADI DLGY - THERAPEVTI C 2, 92, 882 1, 958, 972 4, 081, 554 -1, 282, 925 57. 00 57. 00 05700 (T SCAN B34, 807 1, 214, 741 2, 049, 548 -1, 282, 925 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 77. 949 77. 70. 94 77. 70. 06 58. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 69. 00 0 0 64. 00 64. 00 66. 00 7		0	0	0	/83, 201	/83, 201	43.00
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73.00 07300 DRUGS CHARGED TO PATIENTS 3, 230, 228 9, 458, 633 12, 688, 861 -61, 450 12, 627, 411 73.00 74.00 07400 RENAL DI ALYSI S 0 557, 886 557, 886 -1, 568 556, 318 74.00 76.00 03950 ENDOSCOPY 708, 952 1, 142, 427 -738, 625 1, 112, 847 76.00 76.07 07697 CARDI AC REHABILITATION 346, 356 131, 545 477, 901 -23, 235 454, 666 76.97 70.00 07000 CLINIC 0 0 0 90.00 09000 0.01 NC 90.00 90.01 90.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
74.00 07400 RENAL DI ALYSI S 0 557,886 -557,886 -1,568 556,318 74.00 76.00 03950 ENDOSCOPY 708,952 1,142,520 1,851,472 -738,625 1,112,847 76.06 76.97 07697 CARDI AC REHABI LI TATI ON 346,356 131,545 477,901 -23,235 454,666 76.97 000 07000 CLINIC 0 0 0 0 90.02 94951 ANTI-COAGULATI ON CLINIC 564,577 183,668 748,245 -13,993 734,252 90.02 90.03 90.92 94953 SPI NE CENTER 226,699 161,058 387,757 -70,103 317,654 90.04 92.00 92.00 9200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92.00 910.00 90.04 910.00 92.00 <td< td=""><td></td><td>Ŭ</td><td>Ű</td><td>-</td><td></td><td></td><td></td></td<>		Ŭ	Ű	-			
76. 06 03330 I MAGI NG CENTER 982, 838 1, 036, 483 2, 019, 321 -455, 991 1, 563, 330 76. 06 76. 97 07697 CARDI AC REHABI LI TATI ON 346, 356 131, 545 477, 901 -23, 235 454, 666 76. 97 90. 00 09000 CLI NI C 0 0 0 0 90. 00 90. 01 90. 00 09000 CLI NI C 0 0 0 0 90. 00 90. 01 90. 01 90. 02 04951 DI ABETI C CARE CENTER 90. 00 90. 01 90. 02 04952 PALLI ATI VE CARE 0 0 0 0 90. 02 90. 03 93. 734, 252 90. 03 90. 03 90. 03 9452 PALLI ATI VE CARE 226, 699 161, 058 387, 757 -70, 103 317, 654 90. 04 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 91. 00 93. 872 91. 00 93. 872 91. 00 93. 872 91. 00 93. 872 91. 00 93. 872 93. 872 91. 00 93. 93 <td>74.00 07400 RENAL DIALYSIS</td> <td>0</td> <td>557, 886</td> <td>557, 886</td> <td>-1, 568</td> <td>556, 318</td> <td>74.00</td>	74.00 07400 RENAL DIALYSIS	0	557, 886	557, 886	-1, 568	556, 318	74.00
76. 97 O7697 CARDI AC REHABILITATION 346,356 131,545 477,901 -23,235 454,666 76.97 90. 00 OUTPATIENT SERVICE COST CENTERS 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
90.00 09000 CLINIC 0		340, 356	131, 545	477,901	-23, 235	454,000	10.91
90. 02 04951 ANTI - COAGULATI ON CLINIC 564, 577 183, 668 748, 245 -13, 993 734, 252 90. 02 90. 03 04952 PALLI ATI VE CARE 0 0 0 0 0 0 90. 03 90. 04 04953 SPI NE CENTER 226, 699 161, 058 387, 757 -70, 103 317, 654 90. 04 91. 00 OP100 EMERGENCY 5, 744, 876 3, 985, 053 9, 729, 929 -376, 057 9, 353, 872 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STINCT PART) SPECIAL PURPOSE COST CENTERS 91. 00 92. 00 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>90.00</td>		0	0	0	0	0	90.00
90.03 04952 PALLI ATI VE CARE 0<		-	0	0	0		
90. 04 04953 SPI NE CENTER 226, 699 161, 058 387, 757 -70, 103 317, 654 90. 04 91. 00 09100 EMERGENCY 5, 744, 876 3, 985, 053 9, 729, 929 -376, 057 9, 353, 872 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STINCT PART) SPECIAL PURPOSE COST CENTERS 90. 04 92. 00		564, 577	183, 668	748, 245	-13, 993		
91.00 09100 EMERGENCY 5,744,876 3,985,053 9,729,929 -376,057 9,353,872 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 91.00 92.00 <td></td> <td></td> <td>141 050</td> <td>0 רשר הסנ</td> <td>0</td> <td></td> <td></td>			141 050	0 רשר הסנ	0		
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 71,967,800 177,321,570 249,289,370 -7,303 249,282,067 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 19100 RESEARCH 0 0 0 191.00 191.00 192.00 191.05 111,520 111,520 192.00 193.00 193.00 193.00 0 0 0 0 193.00 193.00 194.00 0 0 0 194.00 0 0 0 194.00 194.06 0 0 0 0 194.00 194.06 0 0 0 194.06 194.08 05958 MISC NONREI MBURSABLE COST CENTERS 679,384 682,629 1,362,013 7,303 1,369,316 194.08							
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 71,967,800 177,321,570 249,289,370 -7,303 249,282,067 INDREL MBURSABLE COST CENTERS 190.00 197.00 0 0 0 118.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 190.00 0 0 190.00 0 0 190.00 0 0 0 190.00 0 <t< td=""><td></td><td>0, , , , , 0, 0</td><td>0, ,00, 000</td><td>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</td><td>0,0,00,</td><td>,,000,0,2</td><td></td></t<>		0, , , , , 0, 0	0, ,00, 000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,0,00,	,,000,0,2	
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 111, 520 111, 520 111, 520 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 HOME OFFI CE 0 0 0 0 194.00 194.00 07950 HOME OFFI CE 0 0 0 0 194.06 194.08 07958 MI SC NONREI MBURSABLE COST CENTERS 679, 384 682, 629 1, 362, 013 7, 303 1, 369, 316 194.08	SPECIAL PURPOSE COST CENTERS						
190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 111,520 111,520 0 111,520 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 HOME OFFI CE 0 0 0 0 194.06 194.08 07958 MI SC NONREI MBURSABLE COST CENTERS 679, 384 682, 629 1, 362, 013 7, 303 1, 369, 316 194.08		71, 967, 800	177, 321, 570	249, 289, 370	-7, 303	249, 282, 067	118.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 111, 520 111, 520 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 HOME OFFICE 0 0 0 0 194.00 194.06 07956 LEASED OFFICE SPACE 0 0 0 194.00 194.08 07958 MI SC NONREI MBURSABLE COST CENTERS 679, 384 682, 629 1, 362, 013 7, 303 1, 369, 316 194.08	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 194.00 07950 HOME OFFICE 0 0 0 0 194.00 194.06 07956 LEASED OFFICE SPACE 0 0 0 0 194.00 194.08 07958 MISC NONREI MBURSABLE COST CENTERS 679, 384 682, 629 1, 362, 013 7, 303 1, 369, 316 194.08	191. 00 19100 RESEARCH	0	0	0	0		
194.00 07950 HOME OFFICE 0 0 0 194.00 194.06 07956 LEASED 0FFICE SPACE 0 0 0 194.00 194.08 07958 MISC NONREI MBURSABLE COST CENTERS 679, 384 682, 629 1, 362, 013 7, 303 1, 369, 316 194.08	192. UU 19200 PHYSICIANS PRIVALE OFFICES	0	111, 520	111, 520	0		
194.06 07956 LEASED OFFICE SPACE 0 0 0 0 194.06 194.08 07958 MISC NONREI MBURSABLE COST CENTERS 679, 384 682, 629 1, 362, 013 7, 303 1, 369, 316 194.08			0	0	0		
194. 08 07958 MISC NONREI MBURSABLE COST CENTERS 679, 384 682, 629 1, 362, 013 7, 303 1, 369, 316 194. 08		0	0	0	0		
200. 00 TOTAL (SUM OF LINES 118 through 199) 72, 647, 184 178, 115, 719 250, 762, 903 0 250, 762, 903 200. 00	194.08 07958 MISC NONREI MBURSABLE COST CENTERS					1, 369, 316	194. 08
	200.00 TOTAL (SUM OF LINES 118 through 199)	72, 647, 184	178, 115, 719	250, 762, 903	0	250, 762, 903	200. 00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	COMMUNITY HOSE EXPENSES	PITAL SOUTH Provider CCN: 15-0128	Peri od:	u of Form CMS-2552-1 Worksheet A
				From 01/01/2021 To 12/31/2021	Date/Time Prepared:
	Cost Center Description		Net Expenses For Allocation 7.00		5/30/2022 2:34 pm
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-2, 673, 609	7, 601, 050		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 572, 482	9, 307, 313		2.00
3.00 4.00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	0 3, 573, 039	0 3, 573, 067		3.00
5.00	00500 ADMINI STRATI VE & GENERAL	-36, 321, 839	42, 200, 532		5.00
. 00	00700 OPERATION OF PLANT	1, 105, 064	5, 829, 030		7.0
8.00	00800 LAUNDRY & LINEN SERVICE	0	671, 661		8.0
. 00	00900 HOUSEKEEPI NG	0	2, 669, 776		9.0
0.00 1.00	01000 DI ETARY 01100 CAFETERI A	-21, 764 -1, 208, 535	1, 026, 950 706, 121		10.0
	01300 NURSI NG ADMI NI STRATI ON	2, 206, 328	2, 642, 607		13.0
	01600 MEDICAL RECORDS & LIBRARY	1, 517, 927	1, 517, 927		16.0
	01700 SOCIAL SERVICE	0	1, 683, 929		17.0
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	914, 558	914, 558		21.0
2.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	1, 237, 603	1, 237, 603		22.0
0.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	-6, 223, 683	33, 286, 452		30.0
1.00	03100 I NTENSI VE CARE UNI T	-0, 223, 005	4, 729, 211		31.0
	04300 NURSERY	0	783, 201		43.0
	ANCI LLARY SERVICE COST CENTERS	1			
	05000 OPERATING ROOM	-44, 800	7, 749, 321		50.0
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	4, 435, 034 4, 131, 050		51.0
2.00 4.00	05400 RADI OLOGY-DI AGNOSTI C	-311, 994	2, 456, 635		52. 0 54. 0
5.00	05500 RADI OLOGY-THERAPEUTI C	0	1, 171, 291		55.0
7.00	05700 CT SCAN	О	1, 966, 255		57. C
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	771, 008		58.0
	05900 CARDI AC CATHETERI ZATI ON	0	3,009,027		59.0
0.00 4.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	8, 148, 596 0		60. 0 64. 0
5.00	06500 RESPI RATORY THERAPY	0	3, 132, 408		65.0
6.00	06600 PHYSI CAL THERAPY	-35,084	3, 312, 798		66. C
7.00	06700 OCCUPATI ONAL THERAPY	0	890, 148		67. C
8.00	06800 SPEECH PATHOLOGY	0	192, 031		68.0
	06900 ELECTROCARDI OLOGY	157 002	1, 647, 355		69.0
0.00 1.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157, 992 1, 175, 479	921, 354 15, 147, 100		70.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	9, 718, 482		72.0
	07300 DRUGS CHARGED TO PATIENTS	125, 507	12, 752, 918		73.0
	07400 RENAL DI ALYSI S	0	556, 318		74.0
	03950 ENDOSCOPY	0	1, 112, 847		76.0
	03330 I MAGI NG CENTER 07697 CARDI AC REHABI LI TATI ON	-93 0	1, 563, 237 454, 666		76. 0 76. 9
0. 77	OUTPATIENT SERVICE COST CENTERS	9	434,000		70. 5
0. 00	09000 CLINIC	0	0		90. C
	04950 DI ABETI C CARE CENTER	0	0		90.0
	04951 ANTI-COAGULATION CLINIC	-334, 219	400, 033		90.0
	04952 PALLI ATI VE CARE 04953 SPI NE CENTER	0	0 317, 654		90. 0 90. 0
	09100 EMERGENCY	599, 291	9, 953, 163		90.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,,,2,1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		92.0
	SPECIAL PURPOSE COST CENTERS				
18.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-32, 990, 350	216, 291, 717		118. 0
90. NN	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 0
	19100 RESEARCH	0	0		190.0
	19200 PHYSICIANS' PRIVATE OFFICES	0	111, 520		192. 0
	19300 NONPALD WORKERS	0	0		193. C
					404.0
94.00	07950 HOME OFFICE	0	0		
94.00 94.06	07950 HOME OFFICE 07956 LEASED OFFICE SPACE 07958 MISC NONREIMBURSABLE COST CENTERS	0	0 0 1, 369, 316		194. 0 194. 0 194. 0

	Financial Systems		COMMUNITY HOS	SPITAL SOUTH Provider CCN: 15-0		u of Form CMS-2552-10 Worksheet A-6
REULAS	STFICATIONS			Provider CCN: 15-0	From 01/01/2021 To 12/31/2021	Date/Time Prepared:
		Increases			<u> </u>	5/30/2022 2:34 pm
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - Chargeable Medical Suppli	es				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13, 116, 310		1.00
2.00		0.00	0	0		2.00
3.00 4.00		0.00 0.00	0	0		3.00 4.00
5.00		0.00	0	0		5.00
6.00 7.00		0.00 0.00	0	0		6.00 7.00
8.00		0.00	0	0		8.00
9. 00 10. 00		0.00 0.00	0 0	0		9.00 10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0.00 0.00	0	0		12.00 13.00
14.00 15.00		0.00 0.00	0 0	0		14.00
15.00 16.00		0.00	0	0		15.00 16.00
17.00 18.00		0.00 0.00	0 0	0		17.00 18.00
19.00 19.00		0.00	0	0		19.00
20.00			0	<u> </u>		20.00
	B - Implantable Device Reclas			L L		
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9, 718, 482		1.00
2.00		0.00	0	0		2.00
3.00 4.00		0.00 0.00	0 0	0		3.00 4.00
	TOTALS C - Drugs Charges to Pat		0	9, 718, 482		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	8, 518		1.00
2.00 3.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS	69.00 73.00	0	21, 002 502, 358		2.00 3.00
4.00		0.00	0	0		4.00
5.00 6.00		0.00 0.00	0	0		5.00 6.00
7.00		0.00	0	0		7.00
8.00 9.00		0.00 0.00	0 0	0		8.00 9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0.00 0.00	0 0	0		11.00 12.00
13.00 14.00		0.00 0.00	0 0	0 0		13.00 14.00
15.00		0.00	0	0		15.00
16. 00 17. 00		0.00 0.00	0 0	0		16.00 17.00
18.00		0.00	0	0		18.00
19.00	TOTALS		0	0000		19.00
1 00	D - Depreciation Expense CAP REL COSTS-MVBLE EQUIP	2.00				1.00
1.00 2.00	CAP REL CUSIS-MUBLE EQUIP	2.00 0.00	0 0	9, 292, 649 0		1.00 2.00
3.00 4.00		0.00 0.00	0 0	0		3.00 4.00
5.00		0.00	0	0		5.00
6.00 7.00		0.00 0.00	0	0		6.00 7.00
8.00		0.00	0	0		8.00
9. 00 10. 00		0.00 0.00	0	0		9.00 10.00
11.00		0.00	0	0		11.00
12.00 13.00		0.00 0.00	0 0	0		12.00 13.00
14.00		0.00	0	0		14.00
15.00 16.00		0.00 0.00	0 0	0		15.00 16.00
17.00		0.00	0	0		17.00
18.00 19.00		0.00 0.00	0 0	0		18.00 19.00
20.00		0.00	0	0		20.00
21.00 22.00		0.00 0.00	0 0	0		21.00 22.00
		•	· · ·			

	Financial Systems SIFICATIONS		COMMUNITY HOSP	Provi der CCN: 15-0128	Peri od:	u of Form CMS-2552- Worksheet A-6
					From 01/01/2021 To 12/31/2021	Date/Time Prepared
						5/30/2022 2:34 pm
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
3.00		0.00	0	0		23.0
4.00 5.00		0.00 0.00	0	0		24. (25. (
5.00 6.00		0.00	0	0		26.0
7.00		0.00	0	Ō		27. (
B. 00	L	0.00	0	O		28.0
	TOTALS		0	9, 292, 649		
. 00	E - Interest Expense CAP REL COSTS-BLDG & FIXT	1.00	0	5, 094, 102		1. (
. 00	TOTALS		0	5,094,102		1. (
	F - Other Capital Rental					
. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3, 419, 862		1. (
. 00	MI SC NONREI MBURSABLE COST CENTERS	194.08	0	17, 000		2.0
. 00	CENTERS	0.00	o	0		3. (
. 00		0.00	o	0		4. 0
. 00		0.00	О	0		5.0
. 00		0.00	0	0		6. (
. 00		0.00	0	0		7. (
. 00		0.00	0	0		8. (
. 00 0. 00		0.00 0.00	0	0 0		9. (
1. 00		0.00	0	0		10.0
2.00		0.00	0	0		12.0
3.00		0.00	0	0		13.
4.00		0.00	0	0		14.
5.00		0.00	0	0		15.
6.00		0.00	0	0		16.
7.00		0.00	0	0		17.
8.00 9.00		0.00 0.00	0	0		18. 19.
9.00 D.00		0.00	0	0		20.0
1.00		0.00	0	0		21. (
2.00	L	0.00	0	O		22.0
	TOTALS		0	3, 436, 862		
. 00	G - STD BENEFIT ADMINISTRATIVE & GENERAL	5.00	0	15, 041		1. (
. 00	OPERATION OF PLANT	7.00	0	2, 523		2.0
. 00	HOUSEKEEPING	9.00	Ő	2, 958		3. (
. 00	DI ETARY	10.00	О	6, 348		4.0
. 00	NURSING ADMINISTRATION	13.00	0	752		5.0
. 00	SOCIAL SERVICE	17.00	0	2, 240		6.0
. 00	ADULTS & PEDIATRICS	30.00	0	153, 252		7.0
. 00 . 00	INTENSIVE CARE UNIT OPERATING ROOM	31.00 50.00	0	41, 970 19, 546		8.0
. 00 D. 00	RECOVERY ROOM	51.00	0	6, 952		9.
1.00	RADI OLOGY-DI AGNOSTI C	54.00	o	18, 194		11.0
2.00	RADI OLOGY-THERAPEUTI C	55.00	0	3, 222		12.
3.00	CT SCAN	57.00	0	4, 269		13.
4.00	CARDIAC CATHETERIZATION	59.00	0	454		14.
5.00	RESPIRATORY THERAPY	65.00	0	15, 827		15.
6.00 7.00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	8, 466 5, 359		16. 17.
7.00 3.00	DRUGS CHARGED TO PATIENTS	73.00	0	5, 359 13, 521		17.
9.00 9.00	IMAGING CENTER	76.06	0	3, 475		10.
). 00). 00	ANTI-COAGULATION CLINIC	90.02	ő	6, 439		20.
1.00	EMERGENCY	91.00	0	17, 566		21.
2.00	MISC NONREIMBURSABLE COST	194.08	0	4, 923		22.
	CENTERS	\vdash — — \downarrow				
	TOTALS H - Labor and Delivery		U	353, 297		
00	NURSERY	43.00	563, 425	219, 776		1.0
00	DELIVERY ROOM & LABOR ROOM	52.00	2, 503, 718	976, 631		2. (
	TOTALS		3, 067, 143	1, 196, 407		
	I - Cafeteria					
00			889, 585	1,025,071		1.0
	TOTALS		889, 585	1, 025, 071		
. 00	J - Therapy OCCUPATIONAL THERAPY	67.00	676, 451	213, 697		1. (
	UUUUUFATTUNAL ITEKAPT	07.00	070,401	213,07/		I. U
. 00	SPEECH PATHOLOGY	68.00	145, 930	46, 101		2.0

Heal th	Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lieu of Form CMS-2552-10			
RECLAS	SIFICATIONS			Provider (CCN: 15-0128	Period:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/30/2022 2:	epared: 34 pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	K - Building Depreciation							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4, 977, 680				1.00
	TOTALS		0	4, 977, 680				
	L - Capital Insurance Costs	· · · ·	· · · ·					1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	202, 877				1.00
	TOTALS		0	202, 877				
	M - Radiology Support Staff							
1.00	RADI OLOGY-THERAPEUTI C	55.00	64, 847	50, 180				1.00
2.00	CT SCAN	57.00	160, 864	124, 483				2.00
3.00	MAGNETIC RESONANCE IMAGING	58.00	33, 429	25, 869				3.00
	(MRI)							
	TOTALS		259, 140	200, 532				
500.00	Grand Total: Increases		5, 038, 249	49, 405, 945				500.00

COMMUNITY HOSPITAL SOUTH

Heal th	Financial Systems		COMMUNITY HOS	PITAL SOUTH		In Lie	eu of Form CMS-2552-10
RECLAS	SIFICATIONS			Provi der		Period:	Worksheet A-6
						From 01/01/2021 To 12/31/2021	Date/Time Prepared:
		Decreaces					5/30/2022 2:34 pm
	Cost Center	Decreases Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
	A - Chargeable Medical Suppli						
1.00 2.00	DI ETARY ADULTS & PEDI ATRI CS	10. 00 30. 00	0	198 1, 135, 375			1.00
3.00	INTENSIVE CARE UNIT	30.00	0	274, 59			3.00
4.00	OPERATING ROOM	50.00	0	5, 793, 04			4.00
5.00	RECOVERY ROOM	51.00	О	189, 669			5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	425, 202			6.00
7.00 8.00	RADI OLOGY-THERAPEUTI C CT SCAN	55.00 57.00	0	910, 37! 106, 839			7.00
9.00	MAGNETIC RESONANCE IMAGING	58.00	0	13, 13			9.00
	(MRI)						
10.00	CARDI AC CATHETERI ZATI ON	59.00	0	3, 040, 893			10.00
11. 00 12. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	391, 039 2, 698			11.00
12.00	ELECTROCARDI OLOGY	69.00	0	9, 152	-		13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	7, 27			14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	57, 789			15.00
16.00	RENAL DI ALYSI S	74.00	0	1,049			16.00
17. 00 18. 00	ENDOSCOPY I MAGI NG CENTER	76. 00 76. 06	0	488, 270 34, 870			17.00 18.00
19.00	CARDI AC REHABI LI TATI ON	76.97	0	2, 55			19.00
20.00	EMERGENCY	<u>91.</u> 00	0	232, 279			20.00
	TOTALS		0	13, 116, 310	0		
1.00	B - Implantable Device Reclas	50.00	0	6,079,62	7 0	ป	1.00
2.00	RADI OLOGY-THERAPEUTI C	55.00	0	313, 118			2.00
3.00	CARDI AC CATHETERI ZATI ON	59.00	0	3, 325, 476	6 0		3.00
4.00	ENDOSCOPY	<u>76.</u> 00	0	26	<u>+ </u>		4.00
	TOTALS C - Drugs Charges to Pat	I	0	9, 718, 482	2		
1.00	ADULTS & PEDIATRICS	30.00	0	44, 542	2 0)	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	8, 912			2.00
3.00	OPERATING ROOM	50. 00 51. 00	0	4, 470			3.00
4.00 5.00	RECOVERY ROOM RADI OLOGY-DI AGNOSTI C	51.00	0	10, 328 115, 199			4.00 5.00
6.00	RADI OLOGY-THERAPEUTI C	55.00	0	58			6.00
7.00	CT SCAN	57.00	0	203, 279	9 C		7.00
8.00	MAGNETIC RESONANCE IMAGING	58.00	0	6, 65	1 C		8.00
9.00	(MRI) CARDI AC CATHETERI ZATI ON	59.00	o	61, 63	7 0		9.00
10.00	RESPI RATORY THERAPY	65.00	0	320			10.00
11.00	PHYSI CAL THERAPY	66.00	0	1,00			11.00
12.00 13.00	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO	70. 00 71. 00	0	270 21, 669			12.00 13.00
13.00	PATIENTS	71.00	0	21,00	7 (13.00
14.00	RENAL DI ALYSI S	74.00	0	519			14.00
15.00	ENDOSCOPY	76.00	0	34			15.00
16. 00 17. 00	IMAGING CENTER ANTI-COAGULATION CLINIC	76.06 90.02	0	29, 73! 7			16.00 17.00
18.00	EMERGENCY	91.00	0	17, 46			18.00
19.00	MISC NONREIMBURSABLE COST	194.08	о	5, 399	9 0		19.00
	CENTERS		— — — _d	531, 878		-	
	D - Depreciation Expense		0		<u> </u>	I	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	3, 907, 93			1.00
2.00	OPERATION OF PLANT	7.00	0	126, 06			2.00
3.00 4.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	4, 220 27, 780			3.00
5.00	SOCI AL SERVI CE	17.00	0	1, 80			5.00
6.00	ADULTS & PEDIATRICS	30.00	0	362, 222			6.00
7.00	INTENSIVE CARE UNIT	31.00	0	177, 012			7.00
8.00	OPERATING ROOM	50.00 51.00	0	2, 396, 879			8.00
9. 00 10. 00	RECOVERY ROOM RADI OLOGY-DI AGNOSTI C	51.00 54.00	0	42, 270 282, 852			9.00 10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	o	251, 54			11.00
12.00	CT SCAN	57.00	0	20, 602	2 0		12.00
13.00	MAGNETIC RESONANCE IMAGING	58.00	0	47, 418	в с		13.00
14.00	(MRI) CARDIAC CATHETERIZATION	59.00	о	675, 038	в		14.00
15.00	LABORATORY	60.00	0	2, 17:			15.00
16.00	RESPIRATORY THERAPY	65.00	О	27,65			16.00
17.00 18.00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	112, 68 ⁻ 137, 584			17.00 18.00
18.00 19.00	ELECTROENCEPHALOGRAPHY	70.00	0	7, 54			18.00
			5	., 51		i.	

	Cart C I	Decreases	Callan	0+6		
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
		7.00	8.00	9.00	10.00	
0. 00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	32, 106	0	20
1.00	DRUGS CHARGED TO PATIENTS	73.00	О	70, 702	0	2
	ENDOSCOPY	75.00	0	249, 284	0	
2.00	I MAGI NG CENTER	76.00	0		-	22
3.00			-	149, 979		
4.00	CARDIAC REHABILITATION	76.97	0	20, 678		2
5.00	ANTI-COAGULATION CLINIC	90.02	0	13, 922	0	2!
6.00	SPINE CENTER	90.04	0	14, 082	0	26
7.00	EMERGENCY	91.00	0	126, 306		27
8.00	MISC NONREIMBURSABLE COST	194.08	0	4, 298	0	28
	CENTERS					
	TOTALS		0	9, 292, 649		
	E - Interest Expense					
00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>5, 094, 1</u> 02		1
	TOTALS		0	5, 094, 102		
	F - Other Capital Rental					
00	ADMI NI STRATI VE & GENERAL	5.00	0	203, 339	10	1
00	OPERATION OF PLANT	7.00	0	5, 394	0	2
. 00	HOUSEKEEPI NG	9.00	0	8, 959	0	1 3
. 00	DI ETARY	10.00	0	106		4
. 00	SOCI AL SERVI CE	17.00	0	33		5
. 00	ADULTS & PEDIATRICS	30.00	0	50, 607	0	1
. 00	OPERATING ROOM	50.00	0	745, 640		
. 00	RECOVERY ROOM	51.00	0	3, 924	0	8
	RADI OLOGY-THERAPEUTI C		-		0	
. 00	CT SCAN	55.00	0	114	-	10
0.00		57.00	0	37, 920	0	10
1.00	CARDIAC CATHETERIZATION	59.00	0	1, 412	0	11
2.00	LABORATORY	60.00	0	11	0	12
3.00	RESPI RATORY THERAPY	65.00	0	133		13
4.00	PHYSI CAL THERAPY	66.00	0	366, 730	0	14
5.00	ELECTROCARDI OLOGY	69.00	0	105	0	15
6.00	ELECTROENCEPHALOGRAPHY	70.00	0	99, 681	0	16
7.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 179, 539	o	17
	PATI ENTS					
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	435, 317	0	18
9.00	ENDOSCOPY	76.00	0	469	0	19
0.00	I MAGI NG CENTER	76.06	Ö	241, 401	Ő	20
1.00	SPINE CENTER	90.04	0	56, 021	0	21
2.00		90.04		50, 021	0	22
2.00	EMERGENCY		0	3, 436, 862		24
	G - STD BENEFIT		U	3, 430, 602		-
. 00	ADMI NI STRATI VE & GENERAL	5.00	15, 041	0	0	1
				0		
. 00	OPERATION OF PLANT	7.00	2, 523			2
. 00	HOUSEKEEPING	9.00	2,958	0		3
. 00		10.00	6, 348	0		4
. 00	NURSING ADMINISTRATION	13.00	752	0	0	5
. 00	SOCI AL SERVI CE	17.00	2, 240	0		6
. 00	ADULTS & PEDIATRICS	30.00	153, 252	0	0	17
00	INTENSIVE CARE UNIT	31.00	41, 970	0		8
. 00	OPERATING ROOM	50.00	19, 546	0	0	9
0. 00	RECOVERY ROOM	51.00	6, 952	0	0	10
1.00	RADI OLOGY-DI AGNOSTI C	54.00	18, 194	0		11
2.00	RADI OLOGY-THERAPEUTI C	55.00	3, 222	0		12
3.00	CT SCAN	57.00	4, 269	0		13
	CARDI AC CATHETERI ZATI ON	59.00	4, 209	0		14
	1					
		65.00	15, 827	0		15
5.00	PHYSI CAL THERAPY	66.00	8, 466	0		16
5.00 6.00			5, 359	0		17
5.00 6.00 7.00	ELECTROCARDI OLOGY	69.00		0	-	18
5.00 6.00 7.00 8.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS	73.00	13, 521	0		1 10
5.00 5.00 7.00 3.00 9.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER	73.00 76.06	3, 475	0	0	19
5.00 6.00 7.00 3.00 9.00 0.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER ANTI -COAGULATI ON CLI NI C	73.00 76.06 90.02	3, 475 6, 439	0	0	20
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER	73.00 76.06	3, 475	0	0	20
5.00 6.00 7.00 8.00 9.00 0.00 1.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER ANTI -COAGULATI ON CLI NI C	73.00 76.06 90.02	3, 475 6, 439	0	0	20 21
5.00 6.00 7.00 8.00 9.00 0.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER ANTI -COAGULATI ON CLI NI C EMERGENCY	73.00 76.06 90.02 91.00	3, 475 6, 439 17, 566	0 0 0	0	20 21
5.00 6.00 7.00 3.00 9.00 0.00 1.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER ANTI -COAGULATI ON CLI NI C EMERGENCY MI SC NONREI MBURSABLE COST	73.00 76.06 90.02 91.00	3, 475 6, 439 17, 566 4, 923	0 0 0	0 0 0	20 21
5.00 6.00 7.00 3.00 9.00 0.00 1.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER ANTI - COAGULATI ON CLI NI C EMERGENCY MI SC NONREI MBURSABLE COST <u>CENTERS</u>	73.00 76.06 90.02 91.00	3, 475 6, 439 17, 566	0 0 0 0	0 0 0	20 21
5. 00 5. 00 7. 00 3. 00 9. 00 9. 00 1. 00 2. 00	ELECTROCARDIOLOGY DRUGS CHARGED TO PATIENTS I MAGI NG CENTER ANTI - COAGULATION CLINIC EMERGENCY MI SC NONREI MBURSABLE COST <u>CENTERS</u>	73.00 76.06 90.02 91.00 194.08	3, 475 6, 439 17, 566 4, 923 	0 0 0 0 0	0 0 0 	20 21 22
5. 00 6. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER ANTI - COAGULATI ON CLI NI C EMERGENCY MI SC NONREI MBURSABLE COST <u>CENTERS</u>	73.00 76.06 90.02 91.00 194.08 30.00	3, 475 6, 439 17, 566 4, 923	0 0 0 0 0 0 0 1, 196, 407	0 0 0 0 0	20 21 22
5. 00 5. 00 7. 00 3. 00 9. 00 9. 00 1. 00 2. 00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER ANTI - COAGULATI ON CLI NI C EMERGENCY MI SC NONREI MBURSABLE COST CENTERS	73.00 76.06 90.02 91.00 194.08	3, 475 6, 439 17, 566 4, 923 353, 297 3, 067, 143 0	0 0 0 0 0 0 0 1, 196, 407 0		20 21 22
5. 00 5. 00 7. 00 3. 00 9. 00 9. 00 1. 00 2. 00	ELECTROCARDIOLOGY DRUGS CHARGED TO PATIENTS IMAGING CENTER ANTI-COAGULATION CLINIC EMERGENCY MISC NONREIMBURSABLE COST CENTERS	73.00 76.06 90.02 91.00 194.08 30.00	3, 475 6, 439 17, 566 4, 923 	0 0 0 0 0 0 0 1, 196, 407		20 21 22
5.00 5.00 7.00 8.00 9.00 9.00 9.00 1.00 2.00	ELECTROCARDI OLOGY DRUGS CHARGED TO PATI ENTS I MAGI NG CENTER ANTI - COAGULATI ON CLI NI C EMERGENCY MI SC NONREI MBURSABLE COST CENTERS	73.00 76.06 90.02 91.00 194.08 30.00	3, 475 6, 439 17, 566 4, 923 353, 297 3, 067, 143 0	0 0 0 0 0 0 0 1, 196, 407 0		20 21 22

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0128

Heal th	Financial Systems	COMMUNITY HOSI	PITAL SOUTH		In Lieu of Form CMS-2552-10			
RECLAS	SIFICATIONS			Provi der	CCN: 15-0128	Peri od:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/30/2022 2:	epared: 34 pm
		Decreases			_			
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
	6. 00	7.00	8.00	9.00	10.00			
	J - Therapy							
1.00	PHYSI CAL THERAPY	66.00	822, 381	259, 798	3	0		1.00
2.00		0.00	0	0		0		2.00
	TOTALS		822, 381	259, 798	3			
	K - Building Depreciation							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4, 977, 680)	9		1.00
	TOTALS		0	4, 977, 680	D			
	L - Capital Insurance Costs							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	202, 877	71	2		1.00
	TOTALS		0	202, 877	7			
	M - Radiology Support Staff							
1.00	RADI OLOGY-DI AGNOSTI C	54.00	259, 140	200, 532	2	0		1.00
2.00		0.00	0	C	D	0		2.00
3.00		0.00	0	0		0		3.00
	TOTALS		259, 140	200, 532	2			
500.00	Grand Total: Decreases		5, 391, 546	49, 052, 648	3			500.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0128		01/01/2021		
				To '	12/31/2021	Date/Time Pre 5/30/2022 2:34	pared: 4 nm
			Acqui si ti or	is			1 pm
	Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
	Bal ances					Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	1, 821, 632	0		0	0	0	1.00
2.00 Land Improvements	2, 722, 362	139, 620		0	139, 620	-160, 380	2.00
3.00 Buildings and Fixtures	185, 616, 539	5, 527, 984		0	5, 527, 984	208, 845	3.00
4.00 Building Improvements	1, 737, 035	0		0	0	0	4.00
5.00 Fixed Equipment	0	0		0	0	0	5.00
6.00 Movable Equipment	84, 055, 268	3, 075, 097		0	3, 075, 097	838, 958	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	275, 952, 836	8, 742, 701		0	8, 742, 701	887, 423	
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	275, 952, 836	8, 742, 701		0	8, 742, 701	887, 423	10.00
	Endi ng Bal ance	Fully					
		Depreci ated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	1, 821, 632	0					1.00
2.00 Land Improvements	3, 022, 362	0					2.00
3.00 Buildings and Fixtures	190, 935, 678	0					3.00
4.00 Building Improvements	1, 737, 035	0					4.00
5.00 Fixed Equipment	0	0					5.00
6.00 Movable Equipment	86, 291, 407	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	283, 808, 114	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	283, 808, 114	0					10.00

Heal th	Financial Systems	COMMUNI TY HOSE	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0128	Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021		pared [.]
						5/30/2022 2:3	4 pm
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY OF	F CAPI TAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00	-			
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/30/2022 2:34	
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	197, 516, 707		197, 516, 70			1.00
2.00 CAP REL COSTS-MVBLE EQUIP	86, 291, 407	0	86, 291, 40	7 0. 304048	0	2.00
3.00 Total (sum of lines 1-2)	283, 808, 114		283, 808, 11			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-	1	1	1		
1.00 CAP REL COSTS-BLDG & FIXT	0			0 4, 977, 680		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	-		0 5, 887, 451		2.00
3.00 Total (sum of lines 1-2)	0	9		0 10, 865, 131	3, 419, 862	3.00
			JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				-1 -		
1.00 CAP REL COSTS-BLDG & FIXT	2, 420, 493		1	0 0	7,601,050	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	-		0 0	.,	2.00
3.00 Total (sum of lines 1-2)	2, 420, 493	202, 877	1	0 0	16, 908, 363	3.00

	Financial Systems MENTS TO EXPENSES		COMMUNITY HOS	SPITAL SOUTH Provider CCN: 15-0128	Period:	u of Form CMS-2 Worksheet A-8	2552-10
					From 01/01/2021 To 12/31/2021	Date/Time Prep 5/30/2022 2:34	
				Expense Classification c To/From Which the Amount i		10/00/2022 2.0	
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			CAP REL COSTS-BLDG & FIXT	1.00		1.00
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	В	-1, 174	ADMI NI STRATI VE & GENERAL	5.00	0	3. 00
4.00	(chapter 2) 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
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		C		0.00	0	7.00
8.00	21) Television and radio service		0		0.00	0	8. 00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-682, 930			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	9, 546, 876			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -1, 119, 305		0.00 11.00		13.00 14.00
15.00	Rental of quarters to employee and others		0		0.00		15.00
16. 00	Sale of medical and surgical supplies to other than patients		C)	0.00	0	16. 00
17.00	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, books, etc.)		C		0.00	0	19. 00
20.00	Vending machines		0		0.00		
21.00	Income from imposition of interest, finance or penalty		U		0.00	0	21.00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22. 00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	O	RESPI RATORY THERAPY	65.00		23. 00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		O	*** Cost Center Deleted **	* 114.00		25.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted **			28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C C	OCCUPATIONAL THERAPY	0.00 67.00		29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	O	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32.00
33.00	Depreciation and Interest Loss on Assets	А	0	OPERATING ROOM	50.00	0	33.00

Heal th	Financial Systems				In Lie	u of Form CMS (2EE2 10
	Financial Systems		COMMUNITY HOS			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2021	Worksheet A-8	
					To 12/31/2021	Date/Time Pre	nared
					10 12/31/2021	5/30/2022 2:3	
				Expense Classification or	Worksheet A		
				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	
33.01	Mi sc Revenue	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33.02	Mi sc Revenue	В		OPERATION OF PLANT	7.00	0	
33.02	Mi sc Revenue	B		DIETARY	10.00	0	
33.04	Mi sc Revenue	B		OPERATING ROOM	50.00	0	
33.04	Mi sc Revenue	B		RADI OLOGY-DI AGNOSTI C	54.00	0	
		B		PHYSICAL THERAPY			•
33.06	Misc Revenue				66.00	0	
33.07	Misc Revenue	В	0	MEDICAL SUPPLIES CHARGED TO	71.00	0	33.07
			0	PATIENTS	70.00		
33.08	Misc Revenue	В		DRUGS CHARGED TO PATIENTS	73.00	0	
33.09	Misc Revenue	В		I MAGI NG CENTER	76.06	0	
33.10	Misc Revenue	В		CARDIAC REHABILITATION	76.97	0	00.10
33.11	Purchased Discounts	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 12	Space Rental Income	В		OPERATION OF PLANT	7.00	0	
33.13	Investment Income	В		ADMI NI STRATI VE & GENERAL	5.00	0	
34.00	HAF Tax Offset	A		ADMI NI STRATI VE & GENERAL	5.00	0	
34.01	LOC Non-Allow Interest Expense	A	-28, 604	CAP REL COSTS-BLDG & FIXT	1.00	11	34.01
34.02	Non-Allowable Interest Expense	A	-35, 568	CAP REL COSTS-BLDG & FIXT	1.00	11	34.02
	00						
34.03	2012B Non- Allow Interest	A	-26, 248	CAP REL COSTS-BLDG & FIXT	1.00	11	34.03
	Expense						
34.05	12B Non-Allow Interest Expense	A		CAP REL COSTS-BLDG & FIXT	1.00	11	
34.06	50 BMO Loan Non- Allow	A	-33, 906	ADMI NI STRATI VE & GENERAL	5.00	0	34.06
	Interest Expense						
34.07	Non-Allowable Interest Expense	A	-1, 453, 857	CAP REL COSTS-BLDG & FIXT	1.00	11	34.07
	00						
34.08	00 Non-Allow Interest Expense	A		CAP REL COSTS-BLDG & FIXT	1.00	11	34.08
36.00	Meals on Wheels Cost	A	-89, 230	CAFETERIA	11.00	0	36.00
36.01	Bad Debt	A	-13, 355, 134	ADMI NI STRATI VE & GENERAL	5.00	0	36. 01
36. 02	APP	A	-334, 219	ANTI-COAGULATION CLINIC	90.02	0	36. 02
36.03	Misc Revenue	В	-440, 147	ADMINISTRATIVE & GENERAL	5.00	0	36.03
36.04	Misc Revenue	В	-3,000	OPERATION OF PLANT	7.00	0	36.04
36.05	Misc Revenue	В	-21, 764	DI ETARY	10.00	0	36.05
36.06	Misc Revenue	В	-437,216	RADI OLOGY-DI AGNOSTI C	54.00	0	36.06
36.07	Misc Revenue	В		PHYSICAL THERAPY	66.00	0	1
36.08	Mi sc Revenue	В		MEDICAL SUPPLIES CHARGED TO		0	
2.5.00			0, 221	PATI ENTS			
36.09	Mi sc Revenue	В	-46,800	DRUGS CHARGED TO PATIENTS	73.00	0	36.09
	Mi sc Revenue	B		I MAGI NG CENTER	76.06	0	
36, 11	Space Rental Income	B		OPERATION OF PLANT	7.00	0	
		A		ADULTS & PEDIATRICS	30.00	0	
50. 00	TOTAL (sum of lines 1 thru 49)		-32, 990, 350		00.00		50. 00
55.00	(Transfer to Worksheet A,		52, 770, 550				00.00
	column 6, line 200.)						
(1) Do	scription all chapter referen		ump portain to	CMS Dub 1E 1			

(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.

Heal th	Financial Systems	COMMUNITY HO	SPITAL SOUTH	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0128	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3. 00	4,00	5.00	
	A. COSTS INCURRED AND ADJUST					
	HOME OFFICE COSTS:				OEM MED	
1.00	21.00	I&R SERVICES-SALARY & FRINGE	RESI DENTS	914, 558	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COS	RESI DENTS	1, 237, 603	0	2.00
3.00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1, 572, 482	0	3.00
3.01		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3, 573, 039	0	3. 01
3.02		ADMINISTRATIVE & GENERAL	HOME OFFICE	34, 846, 473	40, 497, 910	3. 02
3.03		OPERATION OF PLANT	HOME OFFICE	1, 855, 957	0	3.03
3.04		NURSING ADMINISTRATION	HOME OFFICE	2, 206, 328	0	3.04
3.05		MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	1, 183, 703	0	3.05
3.06		MEDI CAL RECORDS & LI BRARY	HOME OFFICE	1, 517, 927	0	3.06
3.07		ADULTS & PEDIATRICS	HOME OFFICE	74, 310	0	3.07
3.08		RADI OLOGY-DI AGNOSTI C	HOME OFFICE	125, 222	0	3.08
3.09			HOME OFFICE	157, 992	0	3.09
3.10 4.00		DRUGS CHARGED TO PATIENTS ADMINISTRATIVE & GENERAL	HOME OFFICE CPN MEDIAL DIRECTOR	172, 307	0	3. 10 4. 00
4.00 4.01		EMERGENCY	CPN MEDIAL DIRECTOR	7, 594 599, 291	0	4.00 4.01
4.01 5.00	TOTALS (sum of lines 1-4).	EWERGENCT	CPN ON CALL	50, 044, 786	40, 497, 910	4.01 5.00
5.00	Transfer column 6, line 5 to			50, 044, 760	40, 477, 910	5.00
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
			3 ()		
Symbol (1)	Name	Percentage of	Name	Percentage of	
Symbol (1)	Name		Name		
		Ownership		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELAT	FED 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.

rerinbur					
6.00	С	CHNW	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	OTHER			100.00
	non-financial) specify:				

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0128	Period: Worksheet A-8-1 From 01/01/2021		
		To 12/31/2021 Date/Time Prepared:		

						5/30/2022 2:34	pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RE	LATED ORGANIZATIONS	OR CLAIMED	
	HOME OFFICE CO	STS:					
1.00	914, 558	0					1.00
2.00	1, 237, 603	0					2.00
3.00	1, 572, 482	9					3.00
3.01	3, 573, 039	0					3. 01
3.02	-5, 651, 437	0					3. 02
3.03	1, 855, 957	0					3.03
3.04	2, 206, 328	0					3.04
3.05	1, 183, 703	0					3.05
3.06	1, 517, 927	0					3.06
3.07	74, 310						3.07
3.08	125, 222						3.08
3.09	157, 992						3.09
3.10	172, 307						3.10
4.00	7, 594						4.00
4.01	599, 291						4.01
5.00	9, 546, 876						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 s not been posted to Worksheet A. columns 1 and/or 2. the amount allowable should be indicated in column 4 of this part

Tias	been posted to worksheet A,	COT UNITS	i anu/oi	Ζ,	the allou	IL ALLOWADLE	e snour u	be i	nui cateu	4 01	this part.	
	Rel ated Organi zati on(s)											
	and/or Home Office											
	Type of Business	1										
	6.00	1										
	B. INTERRELATIONSHIP TO RELA	TED ORGA	VI ZATI ON	(S) A	ND/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	6.00
7.00	6.00 7.00
8.00	8.00 9.00
9.00	9.00
10.00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	100. 00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Heal th	Financial Syste	ems	COMMUNI TY HO	SPITAL SOUTH		In Li	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-0128	Peri od:	Worksheet A-8	
						From 01/01/2021 To 12/31/2021 Date/Time Pr		epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	5/30/2022 2:3 Physi ci an/Prov	34 pm
	WRSt. A LINE π	I denti fi er	Remuneration	Component	Component		ider Component	
		T don't H of	Remarker are on	oomponent	oomponent		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		AGGREGATE-ADMI NI STRATI VE &	638, 130	638, 130		0 0		1.00
		GENERAL				-		
2.00	50.00	AGGREGATE-OPERATING ROOM	44, 800	44, 800		o 0	0	2.00
3.00	0.00		0	0		o 0	0	3.00
4.00	0.00		0	0		o 0	0	4.00
5.00	0.00		0	0		o 0	0	5.00
6.00	0.00		0	0		0 0	0	6.00
7.00	0.00		0	0		0 0	0	7.00
8.00	0.00		0	0		0 0	0	8.00
9.00	0.00		0	0		0 0	0	9.00
10.00	0.00		0	0		0 0	0	10.00
200.00			682, 930	682, 930		o	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE - ADMI NI STRATI VE &	0	0		0 0	0	1.00
0.00	50.00	GENERAL						0.00
2.00		AGGREGATE-OPERATING ROOM	0	0		0 0	-	
3.00	0.00		0	0		0 0	-	
4.00	0.00		0	0		0 0		
5.00	0.00		0	0		0 0		
6.00	0.00		0	0	·		0	
7.00			0	0				
8.00	0.00		0	0			0	
9. 00 10. 00	0. 00 0. 00		0	0			0	
200.00	0.00		0	0			, o	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WRSt. A LINE π	I denti fi er	Component	Limit	Di sal I owance			
		ruenti rici	Share of col.	Linit	Di Sai i Owanee			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	1	
1.00	5.00	AGGREGATE-ADMI NI STRATI VE &	0	0)	0 638, 130		1.00
		GENERAL						
2.00		AGGREGATE-OPERATING ROOM	0	0		0 44, 800		2.00
3.00	0.00		0	0		0 0		3.00
4.00	0.00		0	0		0 0		4.00
5.00	0.00		0	0		0 0		5.00
6.00	0.00		0	0		0 0		6.00
7.00	0.00		0	0		0 0		7.00
8.00	0.00		0	0		0 0		8.00
9.00	0.00		0	0		0 0		9.00
10.00	0.00		0	0		0 0		10.00
200.00			0	0		0 682, 930		200.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0128 P	eriod:	Worksheet B	
				rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	pared:
					5/30/2022 2:3	
		CAPITAL REL	_ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFI TS		
	Allocation			DEPARTMENT		
	(from Wkst A col. 7)					
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	7, 601, 050					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	9, 307, 313		9, 307, 313			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	3, 573, 067 42, 200, 532	0 393, 149	0 2, 351, 014	3, 573, 067 220, 741	45, 165, 436	4.00 5.00
7.00 00700 OPERATION OF PLANT	5, 829, 030	1, 400, 592		41, 555	7, 322, 526	7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE	671, 661	20, 644		0	692, 305	8.00
9.00 00900 HOUSEKEEPI NG	2, 669, 776	43, 845			2, 803, 812	
10. 00 01000 DI ETARY	1,026,950	87, 137		23, 773	1, 145, 167	
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	706, 121 2, 642, 607	159, 052 0	17, 641 0	43, 967 17, 354	926, 781 2, 659, 961	11.00 13.00
16. 00 01600 MEDICAL RECORDS & LI BRARY	1, 517, 927	0		17, 334	1, 517, 927	16.00
17. 00 01700 SOCIAL SERVICE	1, 683, 929	20, 378	1, 814	64, 932	1, 771, 053	1
21.00 02100 I & R SERVICES-SALARY & FRINGES APPRVD	914, 558	0	0	0	914, 558	21.00
22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	1, 237, 603	11, 662	0	0	1, 249, 265	22.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	33, 286, 452	1, 829, 993	199, 243	1, 103, 114	36, 418, 802	30.00
31. 00 03100 I NTENSI VE CARE UNI T	4, 729, 211	554, 144			5, 630, 718	
43. 00 04300 NURSERY	783, 201	49, 389			870, 041	
ANCI LLARY SERVI CE COST CENTERS				· · ·		
50.00 O5000 OPERATING ROOM	7, 749, 321	775, 638			10, 836, 548	50.00
51.00 05100 RECOVERY ROOM	4, 435, 034	160, 504			4, 799, 234	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 131, 050 2, 456, 635	219, 448 263, 170			4, 547, 948 3, 055, 477	
55. 00 05500 RADI OLOGY - THERAPEUTI C	1, 171, 291	203, 170	246, 590	36, 125	1, 454, 006	
57. 00 05700 CT SCAN	1, 966, 255	34, 842			2, 090, 189	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	771, 008	31, 794	15, 347	25, 465	843, 614	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3,009,027	209, 750			3, 731, 395	
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	8, 148, 596 0	97, 162 0	11 0	0	8, 245, 769	60.00 64.00
65. 00 06500 RESPIRATORY THERAPY	3, 132, 408	48, 202		115, 230	0 3, 321, 301	
66. 00 06600 PHYSI CAL THERAPY	3, 312, 798	16, 286		125, 475	4, 011, 651	
67.00 06700 OCCUPATI ONAL THERAPY	890, 148	4, 317	22, 321	33, 433	950, 219	67.00
68.00 06800 SPEECH PATHOLOGY	192, 031	941	4, 815		204, 999	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 647, 355	114, 082			1, 927, 196	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	921, 354 15, 147, 100	47, 220 219, 755		24, 476 25, 740	1, 098, 854 16, 588, 100	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 718, 482	0	0	23, 740	9, 718, 482	
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 752, 918			158, 983	13, 513, 209	
74.00 07400 RENAL DIALYSIS	556, 318			0	578, 332	1
76. 00 03950 ENDOSCOPY	1, 112, 847	0			1, 352, 508	76.00
76. 06 03330 I MAGI NG CENTER 76. 97 07697 CARDI AC REHABI LI TATI ON	1, 563, 237 454, 666	0	386, 174 15, 285		1, 997, 815 487, 069	
OUTPATIENT SERVICE COST CENTERS	434,000	0	15,205	17,110	407,007	/0. //
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90. 01
90. 02 04951 ANTI - COAGULATI ON CLINIC	400, 033	0	710	27, 585	428, 328	
90. 03 04952 PALLI ATI VE CARE 90. 04 04953 SPI NE CENTER	0 317, 654	0	0 69, 086	0 11, 204	0 397, 944	
91. 00 09100 EMERGENCY	9, 953, 163	•			10, 978, 676	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		,			0	
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	216, 291, 717	7, 589, 961	9, 307, 235	3, 539, 732	216, 247, 215	118.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	111, 520	0	0	0	111, 520	
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.0007950 HOME OFFICE	0	0	0	0		194.00
194. 06 07956 LEASED OFFICE SPACE	0	0	0	0		194.06
194.0807958MI SC NONREI MBURSABLE COST CENTERS200.00Cross Foot Adjustments	1, 369, 316	11, 089	78	33, 335	1, 413, 818 0	194.08 200.00
201.00 Negative Cost Centers		0	n	0		200.00
202.00 TOTAL (sum lines 118 through 201)	217, 772, 553	7, 601, 050	9, 307, 313	3, 573, 067	217, 772, 553	
						-

Heal th	Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	eu of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 2:3	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		-			-	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	45, 165, 436					5.00
7.00	00700 OPERATION OF PLANT	1, 916, 056					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	181, 153					8.00
9.00	00900 HOUSEKEEPING	733, 662					9.00
10.00		299, 651					1
11.00 13.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	242, 507 696, 021	253, 028 0		,	0	11.00 13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	397, 190			-	0	16.00
17.00	01700 SOCIAL SERVICE	463, 424			-	0	17.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	239, 309				0	21.00
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	326, 890				0	22.00
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	020,070	10,002		1,020	<u> </u>	22.00
30.00	03000 ADULTS & PEDIATRICS	9, 529, 589	2, 911, 252	423, 425	5 1, 149, 471	1, 500, 082	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 473, 367					31.00
43.00	04300 NURSERY	227,660	78, 571	7, 813	3 31, 023	0	43.00
	ANCI LLARY SERVI CE COST CENTERS	-		1	1		
50.00	05000 OPERATING ROOM	2, 835, 556					50.00
51.00	05100 RECOVERY ROOM	1, 255, 796					51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 190, 043				0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	799, 514				0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	380, 464				0	55.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	546, 931				0	57.00 58.00
58.00	05900 CARDI AC CATHETERI ZATI ON	220, 745 976, 379				-	59.00
60.00	06000 LABORATORY	2, 157, 637				0	60.00
64.00	06400 I NTRAVENOUS THERAPY	2, 137, 037	0			0	64.00
65.00	06500 RESPI RATORY THERAPY	869,072	-			0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 049, 713	25, 908	C	10, 230	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	248, 640				0	67.00
68.00	06800 SPEECH PATHOLOGY	53, 641	1, 497		-	0	68.00
69.00	06900 ELECTROCARDI OLOGY	504, 282					69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	287, 533				0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	4, 340, 542					71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 542, 996				0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	3, 535, 947					73.00 74.00
76.00	03950 ENDOSCOPY	151, 330 353, 905					76.00
76.06	03330 I MAGI NG CENTER	522, 760			-	0	76.06
76.97	07697 CARDI AC REHABI LI TATI ON	127, 449				0	76.97
	OUTPATIENT SERVICE COST CENTERS	·					1
90.00	09000 CLINIC	0	0	0	0 0	0	90.00
90.01	04950 DI ABETI C CARE CENTER	0	0	0	0 0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	112,079	0	0	0 0	0	90.02
90.03	04952 PALLI ATI VE CARE	0	0		0 0	0	90.03
90.04	04953 SPI NE CENTER	104, 128		(0	0	90.04
91.00	09100 EMERGENCY	2, 872, 746	1, 010, 680	170, 513	399, 053	0	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118.00		44, 766, 307	9, 220, 941	906, 299	3, 600, 259	1, 638, 173	118 00
110.00	NONREI MBURSABLE COST CENTERS	11,700,007	7,220,711	,00,277	0,000,207	1,000,170	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0 0	0	190.00
	19100 RESEARCH	0	0	(C	0 0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	29, 181	0	0	0 0		192.00
	19300 NONPAID WORKERS	0	0	() (0		193.00
	07950 HOME OFFICE	0	0		0		194.00
	07956 LEASED OFFICE SPACE	240 040	0				194. 06 194. 08
200.00	07958 MISC NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	369, 948	17, 641		6, 965	0	200.00
200.00		0	n –	r c		0	200.00
201.00	5	45, 165, 436	9, 238, 582	906, 299	3, 607, 224		

From 01/2012021 Part 1. (2)11/2021 Part 1. (2		Financial Systems	COMMUNITY HOS		L 1E 0120		u of Form CMS-	2552-10
Cost Center Description CAFETERIA NURSING ADMINISTRATION NEDICAL RECIDENTS ADMINISTRATION NEDICAL RECIDENTS ADMINISTRATION NURSING RECIDENTS ADMINISTRATION EARDAL SIMPLEE COST CONTROL 00000 CAP REL COSTS INFOLE EQUIP 0.00000 CAP REL COSTS INFOLE EQUIP 0.000000 CAP REL COSTS INFOLE EQUIP 0.000000 CAP REL COSTS INFOLE EQUIP 0.000000 CAPTRIX OF A FINT 0.000000 0000000000000000000000000000	CUST A	LLUCATION - GENERAL SERVICE CUSIS		Provider CCN	F		Date/Time Pre	pared:
Cost Center Description CAFETERIA NURSING JUNIN STRATEO SECURD S / HI COND S / LI DO SECURD S / LI DO		· · · · · · · · · · · · · · · · · · ·						4 pm
ADM MI STRATION RECORDS & LIBERATION Y & FRINCES 1.00 00000 CAP REL COSTS - NUCLES 11.00 13.00 16.00 17.00 21.00 2.00 00000 CAP REL COSTS - NUCLE SUP P 1.00 1.00 10.00 10.00 10.00 17.00 21.00 0.00000 CAP REL COSTS - NUCLE SUP P 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.01 1.00								
Image: space of the s		Cost Center Description	CAFETERI A			SOCI AL SERVI CE		
IDENDERAL SERVICE COST CENTERS 11.00 13.00 16.00 17.00 21.00 1.00 00100 (CAP REL COST NUEL EQUIP INT CONTROL COST MULE EQUIP INT SC 00 00200 (DAPR REL COST NUEL EQUIP INT SC 000 (SS 000 (DEPART INT RE SC 0CE COST CENTERS 00200 (DAPR REL RE RCUI COST CENTERS 00200 (DAPR RE RE RCUI COST CENTERS 00200 (DAPR RE RE RCUI COST CENTERS 00200 (DAPR RE RE RCUI COST CENTERS 0000 (DAPR RE RE RCUIP INT RE SC 000 (DAPR RE				ADMI NI STRATI ON			Y & FRINGES	
Description Description 0.00 00100 (DAP REL COST SUPPLIE SUPPLIE) 1.00 00100 (DAP REL COSTS-MPLIE EQUIP P 1.00 00100 (DAP REL COSTS-MPLIE) 0.00 00000 (DAUBEY AL INH STRATION 1.00 01100 (DAP ELERIN A 1.00 0100 (DAP ELERI			11.00	13.00		17.00	21.00	
2.00 0200 CAP REL COSTS.JPUBLE COIP P 4.00 02000 CHENTOVE BERNET TO BUPARITERY 5.00 02000 CHENTOVE BERNET TO BUPARITERY 5.00 02000 CHENTOVE BERNET TO BUPARITERY 6.00 01000 CHENTOVE BUPARITERY 6.00 0100								
4.00 00400 [PMLOVER BENEFITS DEPARTMENT 5.00 00500 (AURINISTRATION OF PLANT 7.00 00700 (PCERTIN OF PLANT 7.00 00700 (PCERTIN S FORMAL 7.00 00700 (PCERTIN S FORMAL 7.00 00700 (PCERTIN S FORMAL 7.00 01300 (NURSING ADAIN STRATION 1.1522,221 13.00 01300 (NURSING ADAIN STRATION 1.1522,221 13.00 01300 (NURSING ADAIN STRATION 1.153,867 1.00 01300 (NURSING S LUBRARY 0.0 0 0 0 0 0 1.195,117 1.00 01300 (NURSING S LUBRARY 0.0 0 0 0 0 0 0 0 0 0 1.195,117 1.00 01300 (NURSING S LUBRARY 0.0 0 0 0 0 0 0 0 0 0 1.153,867 1.153,867 1.00 01300 (NURSING S LUBRARY 0.0 0 0 0 0 0 0 1.153,867 1.00 01300 (NURSING S LUBRARY 0.0 0 0 0 0 0 0 1.153,867 1.153,867 1.00 01300 (NURSING S LUBRARY 0.0 0 0 0 0 0 0 1.153,867 1.153,877 1.153,877 1.153,877 1.153,877 1.153,877 1.153,877 1.153,877 1.153,877 1.153,877 1.153,877 1.155,241 1.155,								1.00
5.00 00500 AMM HISTRATIVE & GENERAL 7.00 00500 CAUNDRY & LINEN SERVICE 9.00 00500 CAUNDRY & LINEN SERVICE 9.00 00500 CAUNDRY & LINEN SERVICE 9.00 00500 CAUSERCEPTIN 1.522, 221 1.00 01000 DIFTARY 1.522, 222 1.00 02200 DIENT SERVICE SOST CENTERS 5.755, 662 2.300, 526 2.300, 526 2.001, 374 8.31, 64 3.00 00000 DIFTARY REVICES SOT CENTERS 1.2, 937 3.375, 662 1.00 05100 DIFTARY REVICES SOT CENTERS 1.2, 937 3.375, 662 1.2, 930 1.10, 950, 900 1.10, 900								2.00
7.00 00700 OPFRATION OF PLANT								4.00
8.00 00800 LANDRY & LINEN SERVICE								7.00
10. 00 01000 00000 00000 00000 00000 00000 000000 000000 000000 00000000 000000000000000000000000000000000000								8.00
11.00 01100 CARFEREIA 1,522,221 1 10.00 01600 NESN CAMINISTRATION 19,403 3,375,387 1,915,117 10.00 01600 NESN CAMINISTRATION 22,342 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>9.00</td>								9.00
13.00 01300 NURSI NC ADMINI STRATION 19,405 3.375,387 17.00 01700 SOCIAL SERVICES & LIBRARY 0 0 0 0 1,915,117 17.00 01700 SOCIAL SERVICES-SALARY & FINGES APPRVD 0			1 500 000					10.00
16. 00 01600 MEDICAL, RECORDS & LIBRARY 0 0 1, 915, 117 2, 312, 037 21. 00 02100 148 SERVICES-SALARY & FIN INCES APPRVD 0								11.00
17.00 00 TOO SOCIAL SERVICE 32,342 0 <			19, 40:		1 915 115	7		16.00
21:00 02:00 LAR SERVICES-SALARY & FRINCES APPRV 0			32, 342	S S				17.00
INPART ENT BOUTINE SERVICE COST CENTERS Impact 00 03000 ADUITS & PENDATRICS 575, 682 2. 390, 526 222, 697 2, 001, 374 631, 647 31:00 03300 INTERNIVE CARE UNIT 68, 996 286, 506 24, 365 109, 294 67, 056 00 05000 DEPART IN GROM 12, 937 53, 720 7, 282 141, 369 67 00 05000 DEPART IN GROM 73, 308 0 65, 602 0 55, 00 51:00 05000 DELVEPK PROMA 4, 8571 0 32, 360 0 0 52:00 05200 DELVEPK PROMA 4, 8591 0 32, 360 0 100, 92 50:00 05000 CHUSCHY PROMA 4, 8591 0 32, 360 0 100, 92 100, 92 100, 92 100, 93 100, 92 100, 92 100, 92 100, 92 100, 92 100, 92 100, 92 100, 92 100, 93 100, 92 100, 93 100, 92 100, 93 100, 92 100, 93 100, 93 100, 93 100, 93 100, 92 100, 9	21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		1 1	(0 0	1, 153, 867	21.00
30:0.0 03000 ADULTS & PEDIATRICS 575,662 2,390,520 232,697 2,001,374 831,64 43:0.0 04300 NURSERY 12,937 53,720 7,382 141,369 43:0.0 05000 OPERATING ROOM 73,308 0 65,602 24,465 169,924 67,055 40:0 05000 OPERATING ROOM 73,308 0 65,602 0 55,00 50:00 05200 OPERATING ROOM 73,308 0 66,602 0 0 50:00 05200 RADI LOCY-THERAPEUTIC 17,249 0 45,553 0 0 50:00 05500 RADI LOCY-THERAPEUTIC 17,249 0 45,553 0 0 51:00 05500 RADI LOCY-THERAPEUTIC 17,249 0 147,512 0 0 60:00 06500 CARDI ACCATHERERIZE HAGING (MRI) 15,093 0 26,787 0	22.00		(0	(0 0		22.00
31.00 03100 INTERSIVE CARE UNIT 66,996 226,505 24,365 169,294 67,057 30.00 04300 INRESERV 12,937 53,720 7,282 141,369 0 00.00 05000 OPERATING ROOM 109,962 0 235,666 0 55,090 51.00 0500 OPERATING ROOM 73,308 0 65,602 0 0 52.00 05200 DELVIEW ROOM & LABOR ROOM 58,215 0 32,360 0 0 50.00 0500 RADIOLOCY-THERAPEUTIC 17,249 0 45,553 0 0 0 59.00 05900 CARDIA C CATHETERIZATION 32,342 0 193,599 0	20.00		F7F (0)		222 (0	7 0 001 074	001 (47	1 20 00
43.00 04300 NURSERY 12,937 53,720 7,282 141,369 0 ANOLLARY SERVICE COST CENTES 50,00 05000 OPERATING ROOM 73,308 0 65,602 0 0 55,00 0 55,002 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
ANCILLARY SERVICE COST CENTERS 0.00 GOGO DEFRATINE ROOM 109, 962 0 235, 666 0 55, 09 51.00 05000 PECATINE ROOM 73, 308 0 65, 602 0 50 95 52.00 05200 PELIVERY ROOM LABOR ROOM 58, 215 0 323, 660 0 0 0 54.00 05400 RADIOLGY-PIREAPEUTIC 17, 249 0 45, 553 0 0 50 0 550 0 550 0 560 0 60 0 60 0 60 0 559, 90 0 0 0 130, 482 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>07,030</td> <td>•</td>							07,030	•
51.00 05100 PECOVERY ROOM 73.308 0 65,602 0 0 52.00 05200 PELIVERY ROOM ALBOR ROOM 58.215 0 32.360 0 54.00 OS400 RADIOLOGY-DI AGNOSTIC 49,951 69,621 0 0 57.00 OS700 CT SCAN 28.030 0 130.482 0 0 58.00 OS800 RARIAC CATHETERI ATION 32.342 0 193.599 0 0 0 60.00 06000 LIRRAVENDUS THERAPY 0								
52.00 05200 DELLVERV ROOM & LABOR ROOM 58,215 0 32,3c0 0 54.00 OSTO0 RADIOLOGY-THERAPEUTIC 17,249 0 45,553 0 55.00 05700 ROJOLOGY-THERAPEUTIC 17,249 0 45,553 0 0 58.00 DSSOO (ARADILOGY-THERAPEUTIC 17,249 0 130,482 0 0 59.00 OSSOO (ARADILAC CATHETERI ZATION 32,342 0 193,599 0							55, 090	•
54. 00 054.00 NADIOLOGY-DI AGNOSTIC 49, 591 0 66, 621 0 0 55.00 05500 RADIOLOGY-DIEARDEUTIC 17, 249 0 45, 553 0 0 58.00 05700 CT SCAN 28, 030 0 130, 482 0 0 59.00 05700 CARDIAC CATHETERIZATION 32, 342 0 193, 599 0 0 0 60.00 06000 LARARATORY 0				1 1			0	51.00
55.00 DS500 RADIOLOGY-THERAPEUTIC 17,249 0 45,553 0 0 57.00 DS700 CT SCAN 28,030 0 30,452 0 0 58.00 DS800 CARDIA C. CATHETERIZATION 32,342 0 130,452 0 0 60.00 LABORATORY 0 0 147,512 0				1 1			0	
57.00 05700 CT SCAN 28,030 0 130,482 0 0 58.00 05800 MAGNETIC RESONANCE HINGING (MRI) 15,093 0 26,787 0 0 59.00 05900 CARDIAC CATHETERIZATION 32,342 0 193,599 0 0 0 60.00 06000 INTRAVENOUS THERAPY 0				1 1			0	•
58.00 OSBOO AMANCE I CRESONANCE I MAGE (MRI) 15,093 0 26,787 0 60.00 CARDIA C CATHETERIZATION 32,342 0 193,599 0 0 60.00 CARDIA C CATHETERIZATION 32,342 0 193,599 0 <t< td=""><td></td><td></td><td></td><td>1 1</td><td></td><td></td><td>0</td><td>•</td></t<>				1 1			0	•
60.00 0 0 147.512 0 0 64.00 06400 INTRAVENUUS THERAPY 0	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)					0	58.00
64.00 Oc400 INTRAVENOUS THERAPY O O O O O 65.00 06500 RESPIRATORY THERAPY 51,747 O 36,728 O G 66.00 06600 PHYSI CAL THERAPY 28,030 O 19,815 O 32,983 67.00 05000 SPECH PATHOLOGY 4,312 O 1,171 O O 68.00 068000 SPECH PATHOLOGY 40,966 O 47,885 O <							0	
65.00 06500 RESPI RATORY THERAPY 51,747 0 36,728 0 66.00 06600 PHYSI CAL THERAPY 28,030 0 19,815 0 32,983 67.00 06700 OCUPATIONAL THERAPY 17,249 0 5,331 0 0 68.00 06800 SPEECH PATHOLOGY 4,312 0 1,171 0 0 69.00 69000 ELECTROENCEPHALOGRAPHY 12,937 0 10,337 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 12,937 0 10,337 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 22,554 0 0 72.00 07200 INPL, DEV. CHARGED TO PATIENTS 68,996 0 118,770 0					147, 512	2 0	0	60.00
66 00 06000 PHYSI CAL THERAPY 28,030 0 19,815 0 32,983 67.00 06700 OCCUPATI ONAL THERAPY 17,249 0 5,431 0 0 67.00 06600 SPEECH PATHOLOGY 4,312 0 1,171 0 <			-	-	36 729		0	64.00 65.00
67.00 06700 0CCUPATIONAL THERAPY 17,249 0 5,431 0 68.00 06800 SPECH PATHOLOGY 4,312 0 1,171 0 0 69.00 06900 ELECTROCARDIOLOGY 40,966 0 47,885 0 0 70.00 OTOO ELECTROENCEPHALOGRAPHY 12,937 0 10,337 0 0 71.00 OTOO MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 62,554 0 0 72.00 07300 REUGS CHARGED TO PATIENTS 68,996 0 118,770 0 0 74.00 07400 REVAL DIALYSIS 0 0 4,138 0 0 76.00 0330 INAGIN C ENTER 0 0 3,629 0 0 70.00 CLINIC 0 0 0 0 0 0 0 0 90.00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>							-	
69.00 06900 ELECTROCARDIOLOGY 40,966 0 47,885 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 12,937 0 10,337 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 21,551 0 59,712 0 0 72.00 073.00 DRUGS CHARGED TO PATIENTS 68,996 0 118,770 0 0 0 62,554 0 <td></td> <td></td> <td></td> <td>1 1</td> <td></td> <td></td> <td>0</td> <td>1</td>				1 1			0	1
70.00 07000 ELECTROENCEPHALOGRAPHY 12, 937 0 10, 337 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 21, 561 0 59, 712 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 62, 554 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 68, 996 0 118, 770 0 0 74.00 07400 RENAL DI ALYSI S 0 0 4, 138 0 0 76.00 0350 ENDSCOPY 15, 093 0 19, 288 0 0 76.00 07697 CARDI AC REHABI LI TATI ON 12, 937 0 3, 629 0 0 0 76.00 07697 CARDI AC REHABI LI TATI ON 12, 937 0 3, 629 0 <td></td> <td></td> <td>4, 312</td> <td>2 0</td> <td>1, 171</td> <td>1 0</td> <td>0</td> <td>68.00</td>			4, 312	2 0	1, 171	1 0	0	68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 21, 561 0 59, 712 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 62, 554 0 0 73.00 70300 R70300 RROS CHARGED TO PATIENTS 68, 996 0 118, 770 0 0 74.00 07400 RENAL DI ALYSI S 0 0 4, 138 0 0 76.00 0330 IMAGING CENTER 0 0 32, 278 0 0 76.07 07697 (CARDI AC REHABI LI TATI ON 12, 937 0 3, 629 0 0 0 0010 04950 DI ABETI C CARE CENTER 0				1 1			0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 62, 554 0 0 73.00 DRUGS CHARGED TO PATIENTS 68, 996 0 118, 770 0 0 74.00 74.00 RNAL DIALYSIS 0 0 4, 138 0 0 76.00 03950 ENDOSCOPY 15, 093 0 19, 288 0 0 76.07 04707 CARDAC REHABILITATION 12, 937 0 3, 629 0 0 0017401 ENTRE SERVICE COST CENTER 0 <							0	
73.00 07300 DRUGS CHARGED TO PATIENTS 668,996 0 118,770 0 0 74.00 07400 RENAL DI ALYSI S 0 0 4,138 0 0 76.00 03950 ENDOSCOPY 15,093 0 19,288 0 0 76.07 07697 CARDI AC REHABILITATION 12,937 0 3,629 0 0 0000 CLINIC 0 0 0 3,629 0			21, 50				0	
76.00 03950 ENDOSCOPY 15,093 0 19,288 0 0 76.06 0330 IMAGI NG CENTER 0 0 32,278 0 0 76.97 CARDI AC REHABILITATION 12,937 0 3,629 0 0 90.00 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 90.01 04950 DI ABETI C CARE CENTER 0 </td <td></td> <td></td> <td>68, 996</td> <td>S S</td> <td></td> <td></td> <td>0</td> <td>•</td>			68, 996	S S			0	•
76.06 03330 I MAGI NG CENTER 0 32,278 0 76.97 CARDI AC REHABI LI TATI ON 12,937 0 3,629 0 0 0UTPATI ENT SERVICE COST CENTERS 0			C	0			0	74.00
76. 97 O7697 CARDI AC REHABILITATION 12,937 0 3,629 0 0 0UTPATI ENT SERVICE COST CENTERS			15, 093				0	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 </td <td></td> <td></td> <td>12 02</td> <td></td> <td></td> <td></td> <td>0</td> <td></td>			12 02				0	
90.00 09000 CLINIC 0	/0.9/		12,937		3, 02	9 0	0	76.97
90.01 04950 DIABETIC CARE CENTER 0	90.00		0	0	(0 0	0	90.00
90.03 04952 PALLI ATI VE CARE 0 <td></td> <td></td> <td> </td> <td></td> <td>(</td> <td>o o</td> <td>0</td> <td>•</td>					(o o	0	•
90. 04 04953 SPI NE CENTER 0 0 780 0 0 91. 00 09100 EMERGENCY 155, 241 644, 636 278, 896 0 132, 656 92. 00 09SERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS			C	0	2, 179	9 0	0	
91.00 09100 EMERGENCY 155,241 644,636 278,896 0 132,656 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECIAL PURPOSE COST CENTERS 1			0	0	(0 0	0	
92.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) Image: special system Special purpose cost centers 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,522,221 3,375,387 1,915,117 2,312,037 1,119,424 190.00 IGFT, FLOWER, COFFEE SHOP & CANTEEN 0 <td></td> <td></td> <td>155 241</td> <td></td> <td></td> <td></td> <td>122 450</td> <td>90.04</td>			155 241				122 450	90.04
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,522,221 3,375,387 1,915,117 2,312,037 1,119,429 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0			100, 24	044, 030	270, 090	5 0	132,039	91.00 92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,522,221 3,375,387 1,915,117 2,312,037 1,119,424 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0	72.00			II				/2.00
190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191.00 19100 RESEARCH 0 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 12,688 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 194.00 07950 HOME OFFICE 0	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 522, 221	3, 375, 387	1, 915, 117	7 2, 312, 037	1, 119, 429	118.00
191.00 19100 RESEARCH 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 12,68 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 194.00 07950 HOME OFFICE 0 0 0 0 0 0 0 194.06 07956 LEASED OFFICE SPACE 0	400.07					-	-	100 0-
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 12,688 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 194.00 07950 HOME OFFICE 0 <td></td> <td></td> <td></td> <td></td> <td>(</td> <td></td> <td></td> <td>190.00 191.00</td>					(190.00 191.00
193.00 193.00 NONPAID WORKERS 0					(
194.00 07950 HOME OFFICE 0 0 0 0 0 194.06 07956 LEASED OFFICE SPACE 0			((192.00
194. 08 07958 MISC NONREI MBURSABLE COST CENTERS 0 0 0 21,750 200. 00 Cross Foot Adjustments 0 0 0 0 21,750	194.00	07950 HOME OFFICE	0		(o o		194.00
200.00 Cross Foot Adjustments 00			0	0	(0 0		194.06
			0	0	(0 0		194.08
			,		(200.00
			1, 522, 221	3, 375, 387	1, 915, 115	2, 312, 037		

Health Financial Systems	COMMUNI TY HOSF	PITAL SOUTH		In Lie	u of Form CMS-255	52-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2021	Worksheet B	
				o 12/31/2021	Part I Date/Time Prepar	
	INTERNS &				<u>5/30/2022 2:34 p</u>	om
	RESIDENTS					
Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total		
	PRGM. COSTS		Residents Cost			
			& Post Stepdown			
			Adjustments			
	22.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						1.00
2. 00 00200 CAP REL COSTS MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPING						9.00
10. 00 01000 DI ETARY					10	0.00
						1.00
13.00 01300 NURSING ADMINISTRATION 16.00 01600 MEDICAL RECORDS & LIBRARY						3.00 6.00
17. 00 01700 SOCIAL SERVICE						7.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD					2	1. 00
22. 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	1, 602, 032				22	2.00
30. 00 03000 ADULTS & PEDIATRICS	1, 154, 660	59, 119, 207	-1, 986, 307	57, 132, 900	3(0. 00
31. 00 03100 I NTENSI VE CARE UNI T	93, 093	9, 225, 460				1.00
43. 00 04300 NURSERY	0	1, 430, 416	0	1, 430, 416	43	3.00
ANCI LLARY SERVI CE COST CENTERS	7(400	15 070 404	101 570	15 700 050		0.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	76, 488	15, 870, 436 6, 688, 204				0.00 1.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	6, 350, 244				2.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 573, 145		4, 573, 145		4.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 909, 947	0			5.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2, 932, 665 1, 176, 790		2, 932, 665 1, 176, 790		7.00 8.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	5, 399, 147		5, 399, 147		9.00
60. 00 06000 LABORATORY	0	10, 766, 518	0			0.00
64.00 06400 I NTRAVENOUS THERAPY	0	0	0	0		4.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 45, 793	4, 385, 808 5, 224, 123		.,,		5.00 6.00
67. 00 06700 0CCUPATI ONAL THERAPY	43, 793	1, 231, 119				7.00
68.00 06800 SPEECH PATHOLOGY	0	266, 211	0			8.00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 773, 475				9.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 514, 442 21, 497, 547	0	1, 514, 442 21, 497, 547		'0. 00 '1. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	12, 324, 032	-			2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	17, 502, 189			7:	3.00
74.00 07400 RENAL DIALYSIS	0	782, 650		782, 650		4.00
76. 00 03950 ENDOSCOPY 76. 06 03330 I MAGI NG CENTER	0	1, 740, 794 2, 552, 853	0			'6. 00 '6. 06
76. 97 07697 CARDI AC REHABI LI TATI ON	0	631, 084				'6. 97
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0	0	0		0.00
90. 01 04950 DI ABETI C CARE CENTER 90. 02 04951 ANTI - COAGULATI ON CLI NI C	0	0 542, 586		542, 586		0. 01 0. 02
90. 03 04952 PALLI ATI VE CARE	0	0,542	0	0 0		0.02
90. 04 04953 SPI NE CENTER	0	502, 852		502, 852		0. 04
91.00 09100 EMERGENCY	184, 184	16, 827, 284	-316, 843	16, 510, 441		1.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) SPECIAL PURPOSE COST CENTERS			0		9.	2.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 554, 218	215, 741, 228	-2, 673, 647	213, 067, 581	118	8.00
NONREI MBURSABLE COST CENTERS			I			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		0.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0 17, 616	0 171, 005	-30, 304	140, 701		1.00 2.00
193. 00 19300 NONPALD WORKERS	0	0	0	0		3.00
194. 00 07950 HOME OFFICE	0	0	0	0	194	4.00
194.06 07956 LEASED OFFICE SPACE	0	1 040 220	0 E1 040			4.06
194.08 07958 MISC NONREIMBURSABLE COST CENTERS 200.00 Cross Foot Adjustments	30, 198	1, 860, 320 0	-51, 948	1, 808, 372 0		4.08 0.00
201.00 Negative Cost Centers	0	0	0	0		1.00
202.00 TOTAL (sum lines 118 through 201)	1, 602, 032	217, 772, 553	-2, 755, 899	215, 016, 654	202	2.00

Cost Center Description Directly Assigned Mer Cost Center Description Directly Cost Center Description Subt Subt Subt Subt Subt Subt Subt Subt		Financial Systems	COMMUNITY HOS				u of Form CMS-	2552-10
Cost Center Description Directly Assigned two related costs Functly BLG 6 F1XT INRUE F201F Subtotal EPP(nyre BBRF1)S DEDRFTENT 0 00000 (AP REL 005T S-BL0 0 \$ F1XT 0.00000 (AP REL 005T S-BL0 0 \$ F1XT 0.00000 (AP REL 005T S-BL0 0 \$ F1XT 0.00000 (APR REL 005T S-BL0 0 \$ F1XT 0.000000 (APR REL 005T S-BL0 0 \$ F1XT 0.00000 (APR REL 005T S-BL0 0 \$ F1XT 0.00000 (APR REL 005T S-BL0 0 \$ F1XT 0.000000 (APR REL 005T S-BL0 0 \$ F1XT 0.000000 (APR REL 005T S-BL0 0 \$ F1XT 0.000000 (APR REL 005T S-BL0 0 \$ F1XT 0.00000 (APR REL 005T S-BL0 0 \$ F1XT 0.000000 (APR REL 005T S-BL0 0 \$ F1XT 0.00000000 (APR REL 005T S-BL0 0 \$ F1XT 0.00000000000000000000000000000000000	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	rom 01/01/2021	Date/Time Pre	
Assigned five Bill clod Costs Assigned five Capital 0 2.00 2A 4.00 1.00 Ditol CAP REL_COST_SHUE C AFTAT 0 1.00 2000 2A 4.00 0.00 Ditol CAP REL_COST_SHUE C AFTAT 0 90.00 27.00 2.00 0.0				CAPI TAL REL	_ATED COSTS		57 507 2022 2. 5	
OWNERS STRVICE COST CHARTERS 0 1.00 2.00 2.00 2.00 2.00 0.00 0.00 0.0		Cost Center Description	Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	BENEFI TS	
1.00 00100[CAP_REL_COSTS=BLOB_S_FLXT 1 0				1.00	2.00	2A	4.00	
2.00 COUDED COUDED <td>1 00</td> <td></td> <td></td> <td></td> <td>[</td> <td></td> <td></td> <td>1 1 00</td>	1 00				[1 1 00
5.00 00500 ADMINI ISTRATIVE & GENERAL 0 393, 149 2, 351, 014 2, 744, 163 0 5, 00 0.00 00500 ADMINI ISTRATIVE & GENERAL 0 1, 400, 592 51, 349 1, 451, 941 0 7, 00 0.00 00500 ADMISEREEPI IN GENERAL 0 1, 400, 592 51, 349 1, 451, 941 0 7, 00 0.00 00500 ADMISEREEPI IN GENERAL 0 1, 60, 000 0 0 0 0 0 0 0 0 1, 60, 000 13, 00 150, 00 11, 60, 000 0 <t< td=""><td>2.00</td><td>00200 CAP REL COSTS-MVBLE EQUIP</td><td></td><td></td><td></td><td></td><td>0</td><td>2.00</td></t<>	2.00	00200 CAP REL COSTS-MVBLE EQUIP					0	2.00
8.00 000000 000000 000000 000000 000000 000000 000000 000000 00000 000000 000000 000000 000000			-	393, 149	2, 351, 014	-		
9.00 000001 000000000000000000000000000000000000	7.00							
10.00 DITODOD IN ETARY 0 87, 137 7, 2, 307 94, 444 0 10.0 11.00 DITODO CAFTERIN 0 159, 052 17, 641 176, 693 0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
11.00 01100 CAFETERIA 0 159, 052 17, 641 176, 693 0	10.00		0				-	
16.00 DETCOL NETWORK 0	11.00		0					
17.00 01700 SCC1 AL. SERVICE. 0 20.01 02.001 1.814 22.,192 0 7.00 <	13.00		0	0	0	0	-	
21 00 02100 1AR SERVICES-SALARY & FRINCES APPRVD 0 10 0 0 0 21.00 100 0011 6.00 0 11.662 0 11.662 0 22.00 100 03000 011.652 0011.16.62 0 21.00 2001.116.8 0 30.00 30.				0	0	0	-	
22.00 022001 RAR SERVICES-OTHER PROM. 0STA 11, 662 0 11, 662 0 22.00 INPART LIN ROUTINE SERVICE COST CENTERS 0 11, 229, 993 199, 243 2, 029, 236 0 31.00 30.00 030001 AULTISAL VE CAST CENTERS 0 49, 289 9, 604 58, 993 0 31.00 43.00 04300 MURESLEW SERVICE COST CENTERS 0 49, 289 9, 604 58, 993 0 43.00 50.00 D05000 OPFRATING ROM 0 775, 638 2, 119, 917 2, 895, 556 650.0				20, 378		22, 192	-	
INPATE INF. ROUTINE. SERVICE COST CENTERS 0 1.829, 993 199, 243 2, 029, 236 0 0.0	22.00			11, 662	, v	11, 662		1
31: 00 002100[INTERSIVE CARE UNIT 0 554, 144 174, 658 728, 802 0 31. 00 ANCILLARY SERVICE COST CENTERS 0 49, 389 9, 604 58, 993 43. 00 ANCILLARY SERVICE COST CENTERS 0 49, 389 9, 604 58, 993 51. 00 50: 00 05000 (DFRATI IG ROM 0 160, 504 45, 60, 45, 60, 565 50. 00 50: 00 05000 (DCV-PI AGNOSTI C 0 246, 590 246, 590 245, 590 25. 00 550. 00 560. 00 550. 00 560. 00 550. 00 560. 00 560. 00 550. 00 560. 00 550. 00 560. 00 560. 00 560. 00 560. 00 560. 00 560. 00 560. 00 560. 00 560. 00 560. 00<								
43. 00 0 04300 NURSERY 0 43. 00 94. 389 9. 604 58. 993 0 43. 00 ANCILLARY SERVICE COST CENTERS 0 775. 638 2. 119, 917 2. 695, 555 0 50. 00 50. 00 05100 0FECNTING ROOM 0 219, 448 42, 676 262, 124 0 52. 00 51. 00 05500 RADI CLOCY - THERAPUTI C 0 246, 590 246, 590 0 55. 00 55. 00 05500 RADI CLOCY - THERAPUTI C 0 34, 842 40, 093 74, 935 057. 00 50. 00 05500 CRAIN ACCENTHERERIZITION 0 246, 590 246, 590 0 55. 00 50. 00 05800 (MAGNETIC RESPNANCE I MAGI NG (MRI) 0 31, 794 15, 347 47, 141 0 56. 00 50. 00 05900 (MIRAVERNORY 0 27, 754 440, 755 650, 505 59. 00 64. 00 64. 00 64. 00 64. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66.								
MACILIARY SERVICE COST CENTRES 1 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>								
50. 00 05000 (DEEATI NG ROOM 0 775.638 2, 119, 917 2, 895, 555 0 50. 00 50. 00 05200 (DELUYERY ROOM 0 160, 504 45, 043 205, 547 0 51. 00 52. 00 05200 (DELUYERY ROOM ALBOR ROOM 0 219, 448 42, 676 262, 174 0 52. 00 550. 00 550. 00 550. 00 550. 00 550. 00 550. 00 550. 00 550. 00 550. 00 550. 00 560. 50 559. 00 560. 50 59. 00 560. 00 560. 00 560. 00 560. 00 560. 50 59. 00 660. 505. 50 59. 00 660. 00 660. 71 57. 00 670. 00 0 0 0 60. 00 660. 00	43.00		0	49, 309	9,004	30, 993	0	43.00
52.00 05200 DELLYERY PROM & LABOR ROOM 0 219,448 42,676 226,2124 0 52.00 55.00 05500 RADIOLOCY-THEARPEUTIC 0 0 246,590 246,590 0 55.00 57.00 57.00 57.00 0 57.00 0 57.00 0 57.00 0 57.00 0 57.00 0 57.00 0 57.00 0 57.00 0 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 50.00 59.00 65.00 50.00 50.00 50.00 50.00 50.00 50.00 60.00 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 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00	50.00		0	775, 638	2, 119, 917	2, 895, 555	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 263.70 2245.955 509.125 0 55.00 55.00 05500 RADIOLOGY-DIREARPEUTIC 0 34.842 40.093 74.935 0 55.00 50.00 05600 CARDIAC CATHETERIZATION 0 31.794 15.347 47.141 0 58.00 50.00 05600 CARDIAC CATHETERIZATION 0 209.750 440.755 650.505 0 69.00 60.00 06000 LABORATORY 0 97.162 11 97.173 0 60.00 64.00 06400 INTRAVENOUS THERAPY 0 48.202 25.461 73.663 0 65.00 06500 RESPI RATURE THERAPY 0 4.317 22.321 26.638 0 67.00 06700 OCCUPATIONAL THERAPY 0 14.282 179.433 223.512 0 69.00 00 0600 SPECH ATHORY THERAPY 0 114.815 575.092 73.378 0 66.00 00 0500 RESPI RATURE THERAPY 0 41.4.815 575.00 70.070 70.00 70.00 70.00 70.00 70.0			-					
55. 00 05500 RADIOLOGY-THERAPEUTIC 0 0 246. 590 246. 590 246. 590 57. 00 57. 00 05700 05700 05700 05700 57. 00			-					
57.0 00 05700 C T. SCAN 0 34.842 40.093 74.935 0 57.00 58.0 0 05800 CARDIAC CATHETERIZATION 0 31.794 15.347 47.141 58.00 59.00 06000 LABORATORY 0 97.162 11 97.173 0 60.00 64.00 064001 INTRAVENOUS THERAPY 0 48.02 25.461 73.663 0 65.00 66.00 60.00			0	263, 170			-	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 31.794 15.347 47.141 0 58. 00 60. 00 CARDIA C CATHETERIZATION 0 209.750 650.055 59. 00 64. 00 66400 INTRAVENUS THERAPY 0 0 97.162 11 97.173 0 60. 00 64. 00 66400 INTRAVENUS THERAPY 0 48. 202 25.461 73.663 65.0 65.0 65.00 65.00 66.00 67.00 22.3512 0 69.0 0 73.378 66.00 60.00 73.00 73.00 73.00 73.01 61.03.08 073.00 73.00 73.00 73.00 73.00			0	34.842				
60.00 660.00 InstructionUS THERAPY 0 97, 162 11 97, 173 0 60.00 64.00 660.00 INSRVENUSUS THERAPY 0 0 0 0 64.00 660.00 06000 PHYSI CAL THERAPY 0 16.286 557, 092 573, 378 0 66.00 06000 OCUPATIONAL THERAPY 0 4, 317 22, 321 26, 638 0 67.00 06000 OCUPATIONAL THERAPY 0 4, 317 22, 3512 0 69.00 06000 DELECTROCARDEPHALOGRAPHY 0 47, 220 105, 804 153, 024 0 70.00 07100 DTOID MEDICAL SUPPLIES CHARGED TO PATIENTS 0 219, 755 1, 195, 505 1, 415, 260 0 71.00 73.00 0200 PROSCOPY 0 0 0 73.00 73.00 0306, 714.386, 174 0 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00			0					
64.00 06400 INTRAVENUUS THERAPY 0 0 0 0 0 0 0 0 0 0 64.00 0 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
65:00 06500 RESPIRATORY THERAPY 0 48.202 25.461 73.663 0 65.00 06:00 06:00 PHYSICAL THERAPY 0 16.286 557.092 573.378 0 66.00 06:00 06:00 SPEECH PATHOLOGY 0 44.317 22.321 26.638 0 67.00 06:00 06:00 ELECTROCARDIOLOGY 0 144.0815 5.756 0 68.00 0.00 MEDICAL SCRIDCEPHALOGRAPHY 0 47.220 105.804 153.024 0 71.00 0.00 00 00 0 0 0 72.00 0 0 0 72.00 0 0 22.014 0 72.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 22.014 0 22.014 0 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.02 74.00 <			0				-	
66.00 06600 PHYSI CAL THERAPY 0 16.286 557.092 573.378 0 66.00 67.00 06700 0CCUPATI (NAL THERAPY 0 4,317 22,321 26,638 0 67.00 68.00 06800 SPECH PATHOLOGY 0 941 4,815 5,756 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 114,082 109,430 223,512 0 69.00 0 071.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 219,755 1,195,505 1,415,260 0 71.00 0 073.00 DRUGS CHARGED TO PATIENTS 0 119,545 481,763 601,308 0 73.00 74.00 07400 RENAL DI ALYSIS 0 22,014 0 22,014 76.07 76.07 70.60 03330 IMAGI NC CENTER 0 0 0 15.285 0 76.97 0.01 04950 DI ALYSIS 0 0 0 0			0	Ŭ	-	0		
67.00 06700 0CCUPATI ONAL THERAPY 0 4,317 22,321 26,638 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 941 4,815 5,756 0 68.00 06900 ELECTROCARDIOLOGY 0 114,082 109,430 223,512 0 69.00 070.00 OTOO DELECTROERCEPHALOGRAPHY 0 47,220 105,804 153,024 0 70.00 71.00 OTOO IDEDICAL SUPPLIES CHARGED TO PATIENTS 0 219,755 1,195,505 1,415,260 0 72.00 72.00 073.00 IMEL DEV. CHARGED TO PATIENTS 0 22,014 0 22,014 0 22,014 0 22,014 0 73.00 74.00 74.00 76.00 386,174 386,174 386,174 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00	66. 00		0				-	1
69.00 06900 ELECTROCARDIOLOGY 0 114,082 199,430 223,512 0 69.00 70.00 07000 ELECTROCENCEPHALOGRAPHY 0 47,220 105,804 153,024 0 70.00 70.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72.00 0 0 0 0 0 0 0 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 22,014 0 22,014 0 74.00 74.00 74.00 74.00 74.00 74.00 74.00 76.00 0 0 20.4,622 0.0 76.00 76.00 76.00 76.00 76.90 76.97 76.97 76.97 76.97 76.97 76.97 76.97 76.97 76.91 76.97 76.91 76.92 76.91 76.92 76.91 76.92 76.91 76.92 90.00	67.00		0				0	67.00
70.00 070.00 ELECTROENCEPHALGGRAPHY 0 47, 220 105, 804 153, 024 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 219, 755 1, 195, 505 1, 415, 260 0 72.00 72.00 072000 INPL. DEV. CHARGED TO PATIENTS 0 119, 545 481, 763 601, 308 0 73.00 74.00 07400 RENAL DI ALYSI S 0 22, 014 0 74.00 76.00 73.00 0.3850 ENDOSCOPY 0 0 204, 622 204, 622 0 76.07 70.07 7070 (CARDIA CREHABILITATION 0 0 386, 174 386, 174 386, 174 0 76.97 70.77 CARDIA CRE CREHABILITATION 0 0 0 0 0 90.00 90.00 0.10 04900 CARDIA CRE CRENTER 0 0 0 0 90.02 90.02 9451 ANTI-COAGULATION CLINIC 90.02 90.02 90.02 90.02 90.02	68.00		0					
71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 219,755 1,195,505 1,415,260 0 71.00 72.00 OT2000 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 OT300 DRUGS CHARGED TO PATIENTS 0 119,545 481,763 601,308 0 73.00 74.00 OT400 RENAL DI ALYSI S 0 22,014 0 22,014 74.00 76.00 O3500 ENDOSCOPY 0 0 204,622 204,622 76.07 76.97 O7697 CARDI AC REHABI LI TATI ON 0 0 386,174 386,174 76.07 70.00 OYGOO CLU NI C 0 0 0 0 90.07 90.07 70.01 OH450 DI ABETI C CARE CENTER 0 0 0 90.07<			0					
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 10 0 0 0 0 72.00 73.00			0				-	
73:00 DRUGS CHARGED TO PATIENTS 0 119,545 481,763 601,308 0 73.00 74:00 O7400 RENAL DIALYSIS 0 22,014 0 22,014 0 74.00 74:00 O3950 ENDOSCOPY 0 0 204,622 204,622 0 76.00 76:07 CARDI AC REHABILITATION 0 0 386,174 386,174 386,174 0 76.00 00 OT407 CARDI AC REHABILITATION 0 0 15,285 0 76.00 00 OP000 CLINIC 0 0 0 0 0 90.00 90.00 O9000 CLINIC 0 0 0 0 90.00 <t< td=""><td>72.00</td><td></td><td>0</td><td>0</td><td>0</td><td>1, 413, 200</td><td>-</td><td>1</td></t<>	72.00		0	0	0	1, 413, 200	-	1
76.00 03950 ENDOSCOPY 0 0 204,622 204,622 0 76.00 76.00 03330 IMAGING CENTER 0 0 386,174 386,174 0 76.00 000797 CARDIA C REHABILITATION 0 0 15,285 15,285 0 76.00 00070 CLINIC 0 </td <td>73.00</td> <td></td> <td>0</td> <td>119, 545</td> <td>481, 763</td> <td>601, 308</td> <td>0</td> <td>73.00</td>	73.00		0	119, 545	481, 763	601, 308	0	73.00
76.06 03330 IMAGING CENTER 0 0 386, 174 386, 174 0 76.06 07697 CARDIAC REHABILITATION 0 0 15, 285 0 76.97 0000 CLINIC 0 0 0 0 0 90.00 0 <td< td=""><td></td><td></td><td>0</td><td>22, 014</td><td></td><td></td><td>-</td><td></td></td<>			0	22, 014			-	
76. 97 07697 CARDIAC REHABILITATION 0 15,285 15,285 0 76. 97 0000 CLINIC COUTPATIENT SERVICE COST CENTERS 0			0	0				
OUTPATI ENT SERVICE COST CENTERS 90.00 00000 CLINIC 0 </td <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>			-	-				
90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 0 90. 01 90. 02 04951 ANTI -COAGULATI ON CLINI C 0 0 710 710 0 90. 02 90. 03 04952 PALLI ATI VE CARE 0 0 0 0 0 90. 02 90. 04 04953 SPI NE CENTER 0 0 69, 086 69, 086 0 90. 02 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 635, 306 107, 140 742, 446 0 91. 00 92.00 OS200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 7589, 961 9, 307, 235 16, 897, 196 0 118. 00 SPECI AL PURPOSE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0								
90. 02 04951 ANTI-COAGULATION CLINIC 0 0 710 710 0 90. 02 90. 03 04952 PALLIATIVE CARE 0				0	0	0		
90.03 04952 PALLI ATI VE CARE 0<			0	0	0	-		
90.04 04953 SPINE CENTER 0 0 69,086 69,086 09.04 90.04 91.00 09100 EMERGENCY 0 635,306 107,140 742,446 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0 0 92.00 0 0 92.00 0 0 92.00 0 92.00 0 0 92.00 0 92.00 0 92.00 0 92.00 0 0 92.00 92.00 92.00 92.00 92.01			0	0	/10	/10		
91.00 09100 EMERGENCY 0 635, 306 107, 140 742, 446 0 91.00 92.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0 92.00 0 92.00 0 0 92.00 0 92.00 0 0 0 92.00 92.00 0 92.00 0 0 92.00 0 92.00 0 92.00 0 92.00 <td></td> <td></td> <td>0</td> <td>0</td> <td>69,086</td> <td>69, 086</td> <td></td> <td>1</td>			0	0	69,086	69, 086		1
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) O 7,589,961 9,307,235 16,897,196 0 NONREI MBURSABLE COST CENTERS 190.00 GIF, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.00 GIF, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.00 GIF, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.00 GIF, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.00 GIF, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 190.00 GIF 190.00 191.00 192.00 192.00 0 0 0 192.00 192.00 192.00	91.00	09100 EMERGENCY	0	635, 306			0	1
SUBTOTALS SUBTOTALS <t< td=""><td>92.00</td><td></td><td></td><td></td><td></td><td>0</td><td></td><td>92.00</td></t<>	92.00					0		92.00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 HOME OFFICE 0 0 0 0 194.00 194.00 07956 LEASED OFFICE SPACE 0 0 0 0 194.00 194.06 07958 MISC NONREI MBURSABLE COST CENTERS 0 11,089 78 11,167 0 194.00 200.00 Cross Foot Adj ustments 0 0 0 0 200.00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7, 589, 961	9, 307, 235	16, 897, 196	0	118.00
191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSICLANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPALD WORKERS 0 0 0 0 193.00 194.00 07950 HOME OFFICE 0 0 0 0 194.00 194.00 07956 LEASED OFFICE SPACE 0 0 0 0 194.00 194.00 07958 MISC NONREIMBURSABLE COST CENTERS 0 11,089 78 11,167 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00	190.00		0	0	0	0	0	190. 00
193.00 19300 NONPAID WORKERS 0 0 0 193.00 194.00 07950 HOME OFFICE 0 0 0 0 194.00 194.06 07956 LEASED OFFICE SPACE 0 0 0 0 194.00 194.08 07958 MISC NONREI MBURSABLE COST CENTERS 0 11,089 78 11,167 0 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	191.00	19100 RESEARCH	0	0	0	0		
194.00 07950 HOME OFFICE 0 0 0 194.00 194.06 07956 LEASED OFFICE SPACE 0 0 0 0 194.00 194.08 07958 MISC NONREI MBURSABLE COST CENTERS 0 11,089 78 11,167 0 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00	192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
194.06 07956 LEASED OFFICE SPACE 0 0 0 194.06 194.08 07958 MISC NONREI MBURSABLE COST CENTERS 0 11,089 78 11,167 0 194.06 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	0	0	0		
194. 08 07958 MI SC NONREI MBURSABLE COST CENTERS 0 11, 089 78 11, 167 0 194. 08 200. 00 Cross Foot Adjustments 0 200. 00 <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>			0	0	0	0		
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0				11 089	ן 0 78	0 11 167		
201.00 Negative Cost Centers 0 0 0 0 201.00				11, 507	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	0	200.00
202.00 TOTAL (sum lines 118 through 201) 0 7,601,050 9,307,313 16,908,363 0 202.00	201.00	Negative Cost Centers		0	0	0		201.00
	202.00	TOTAL (sum lines 118 through 201)	0	7, 601, 050	9, 307, 313	16, 908, 363	0	202.00

Heal th	Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/30/2022 2:3	pared: 4 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	1	L	1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	2, 744, 163					4.00 5.00
7.00	00700 OPERATION OF PLANT	116, 414					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	11,006			5		8.00
9.00	00900 HOUSEKEEPI NG	44, 575			0 113, 271		9.00
10.00	01000 DI ETARY	18, 206	23, 533		0 1, 719	137, 902	10.00
11.00	01100 CAFETERI A	14, 734		1	3, 137	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	42, 288			0 0	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	24, 132			0 0	0	
17.00 21.00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	28, 156 14, 540			0 402 0 0	0	17.00 21.00
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	19, 861	3, 149		230	0	
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	17,001	0,117		200		22.00
30.00	03000 ADULTS & PEDIATRICS	579, 040	494, 221	17, 39	1 36, 095	126, 277	30.00
31.00	03100 I NTENSI VE CARE UNI T	89, 517	149, 655	1, 82	1 10, 930	11, 625	31.00
43.00	04300 NURSERY	13, 832	13, 338	32	1 974	0	43.00
	ANCI LLARY SERVICE COST CENTERS	170.070	000 (70	1	45.000	-	
50.00	05000 OPERATING ROOM	172, 279			0 15, 299	0	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	76, 298 72, 303				0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	48, 576				0	
55.00	05500 RADI OLOGY - THERAPEUTI C	23, 116		1		0	
57.00	05700 CT SCAN	33, 230		1		0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	13, 412	8, 586	, (0 627	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	59, 322			0 4, 137	0	1
60.00	06000 LABORATORY	131, 091	26, 240		0 1, 916	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	1
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	52, 802 63, 777	13, 018 4, 398		0 951 0 321	0	
67.00	06700 OCCUPATI ONAL THERAPY	15, 107			0 85	0	
68.00	06800 SPEECH PATHOLOGY	3, 259			0 19	0	1
69.00	06900 ELECTROCARDI OLOGY	30, 639			2, 250	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	17, 470	12, 753		0 931	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	263, 718			0 4, 334	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	154, 504	0		0 0	0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	214, 833 9, 194			2, 358 0 434	0	
76.00	03950 ENDOSCOPY	21, 502		1	0 0	0	
76.06	03330 I MAGI NG CENTER	31, 761	0		0 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	7,743	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS	1	1	1			
90.00		0	0		0 0	0	
90. 01 90. 02	04950 DI ABETI C CARE CENTER 04951 ANTI - COAGULATI ON CLI NI C	0 6, 810	-			0	
	04952 PALLIATIVE CARE	0,010				0	1
90.04	04953 SPI NE CENTER	6, 327	0		0 0	0	1
	09100 EMERGENCY	174, 539		7,00	4 12, 531	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	I	L	1			
118.00		2, 719, 913	1, 565, 360	37, 22	5 113, 052	137, 902	118.00
100 00	NONREIMBURSABLE COST CENTERS	0	0		0 0	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 773	0		0 0		192.00
	19300 NONPALD WORKERS	0	0) (0 0		193.00
	07950 HOME OFFICE	0	0		0 0		194.00
	07956 LEASED OFFICE SPACE	0	0		0 0		194.06
	07958 MISC NONREI MBURSABLE COST CENTERS	22, 477	2, 995	1	219	0	194.08
200.00 201.00		0	_		0	0	200. 00 201. 00
201.00		2, 744, 163	1, 568, 355	37, 22	0		
	· · · · · · · · · · · · · · · · · · ·		, , , , , , , , , , , , , , , , , , , ,			, /02	

Heal th	Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der C	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/30/2022 2:3	pared: 4 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES	
		11.00	13.00	16.00	17.00	21.00	
4 00	GENERAL SERVICE COST CENTERS	[1		1		1 4 00
16. 00 17. 00 21. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I & SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM. COSTS APPRVD INPATIENT ROUTINE SERVICE COST CENTERS	237, 518 3, 028 0 5, 046 0 0	45, 316 0 0 0	24, 132 0 0 0	61, 299 0 0	14, 540	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 16.\ 00\\ 17.\ 00\\ 22.\ 00\\ \end{array}$
30.00	03000 ADULTS & PEDI ATRI CS	89, 824	32, 094	2, 944	53, 063		30.00
	03100 INTENSIVE CARE UNIT	10, 766					31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2,019	721	92	3, 748		43.00
50.00	05000 OPERATING ROOM	17, 158	0	2, 981	0		50.00
51.00	05100 RECOVERY ROOM	11, 439		830			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 084	0	409	0		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 738	0	881	0		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 691	0	576	0		55.00
57.00	05700 CT SCAN	4, 374		1, 651	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 355		339			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	5,046					59.00
60.00		0		1, 866			60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	-		64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	8,074	, o	465	0		65.00 66.00
67.00	06700 OCCUPATIONAL THERAPY	4, 374 2, 691		69	0		67.00
	06800 SPEECH PATHOLOGY	673	-	15			68.00
69.00	06900 ELECTROCARDI OLOGY	6, 392		606			69.00
	07000 ELECTROENCEPHALOGRAPHY	2,019	-	131	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 364		755	-		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	791	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 766	0	1, 503	0		73.00
	07400 RENAL DI ALYSI S	0	0	52	0		74.00
	03950 ENDOSCOPY	2, 355		244			76.00
	03330 I MAGI NG CENTER	0	-				76.06
76.97	07697 CARDI AC REHABI LI TATI ON	2,019	0	46	0		76.97
00 00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0		90.00
	04950 DI ABETI C CARE CENTER	0	0				90.00
	04951 ANTI-COAGULATION CLINIC	0	0	28			90.01
	04952 PALLI ATI VE CARE	0	0	0			90.03
	04953 SPI NE CENTER	0	0	10			90.04
	09100 EMERGENCY	24, 223	8, 655				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	ſ	r	r	1		
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	237, 518	45, 316	24, 132	61, 299	0	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
	19300 NONPALD WORKERS	0	0	0	0		193.00
	07950 HOME OFFICE		0		0		194.00
	07956 LEASED OFFICE SPACE 07958 MISC NONREIMBURSABLE COST CENTERS				0		194. 06 194. 08
200.00		0				14 540	200.00
200.00		n	0	0	0		200.00
202.00		237, 518	45, 316	24, 132	61, 299		202.00
			, 510			, 510	

Health Financial Systems	COMMUNI TY HOSI	PITAL SOUTH		In Lie	u of Form CMS-2552-1
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0128	Period: From 01/01/2021	Worksheet B
				To 12/31/2021	Part II Date/Time Prepared:
· · · · · · · · · · · · · · · · · · ·	INTERNS &				5/30/2022 2:34 pm
	RESIDENTS				
Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total	
	PRGM. COSTS		Residents Cos	st	
			& Post Stepdown		
			Adjustments		
	22.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT					1.0
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					2.0
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
5. 00 00500 ADMINI STRATI VE & GENERAL					5.0
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.0
9. 00 00900 HOUSEKEEPING					9.0
10. 00 01000 DI ETARY					10.0
11. 00 01100 CAFETERIA					11.0
13. 00 01300 NURSING ADMINISTRATION 16. 00 01600 MEDICAL RECORDS & LIBRARY					13. 0 16. 0
17. 00 01700 SOCIAL SERVICE					17.0
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD					21.0
22. 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	34, 902				22.0
30. 00 03000 ADULTS & PEDIATRICS	1	3, 460, 185	;	0 3, 460, 185	30.0
31. 00 03100 I NTENSI VE CARE UNI T		1, 011, 758	1	0 1, 011, 758	31.0
43. 00 04300 NURSERY		94, 038		0 94, 038	43.0
ANCI LLARY SERVICE COST CENTERS	1 1		1		
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM		3, 312, 745 346, 300		0 3, 312, 745 0 346, 300	50. 0 51. 0
52.00 05200 DELIVERY ROOM & LABOR ROOM		408, 939		0 346, 300 0 408, 939	52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		643, 199		0 643, 199	54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C		273, 494		0 273, 494	55.0
57.00 05700 CT SCAN		126, 740		0 126, 740	57.0
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION		72, 460 778, 105		0 72, 460 0 778, 105	58. 0 59. 0
60. 00 06000 LABORATORY		258, 286	1	0 258, 286	60.0
64. 00 06400 I NTRAVENOUS THERAPY		C		0 0	64.0
65. 00 06500 RESPIRATORY THERAPY		148, 973		0 148, 973	65.0
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI 0NAL THERAPY		646, 499 45, 756	1	0 646, 499 0 45, 756	66. 0 67. 0
68. 00 06800 SPEECH PATHOLOGY		9, 976		0 9, 976	68.0
69. 00 06900 ELECTROCARDI OLOGY		294, 209		0 294, 209	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY		186, 328		0 186, 328	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1, 746, 779 155, 295		0 1, 746, 779 0 155, 295	71.0
73. 00 07300 DRUGS CHARGED TO PATIENTS		863, 053		0 863, 053	73.0
74.00 07400 RENAL DIALYSIS		37, 639		0 37, 639	74.0
76.00 03950 ENDOSCOPY		228, 723		0 228, 723	76.0
76. 06 03330 I MAGI NG CENTER 76. 97 07697 CARDI AC REHABI LI TATI ON		418, 343 25, 093		0 418, 343 0 25, 093	76.0 76.9
OUTPATIENT SERVICE COST CENTERS		20,070	<u>'</u>	23,073	, 0. /
90. 00 09000 CLINIC		C)	0 0	90.0
90. 01 04950 DI ABETI C CARE CENTER		C		0 0	90.0
90. 02 04951 ANTI - COAGULATI ON CLI NI C 90. 03 04952 PALLI ATI VE CARE		7, 548	3	0 7, 548	90. 0 90. 0
90. 04 04953 SPINE CENTER		75, 423	3	0 75, 423	90.0
91. 00 09100 EMERGENCY		1, 144, 404	ŀ	0 1, 144, 404	91.0
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				0	92.0
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	16, 820, 290		0 16, 820, 290	118.0
NONREI MBURSABLE COST CENTERS	<u> </u>	10, 020, 290	<u>/</u>	0 10, 620, 290	110.0
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		C		0 0	190. 0
191.00 19100 RESEARCH		C		0 0	191. 0
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		1, 773	3	0 1, 773	192.0
193. 00 19300 NONPALD WORKERS 194. 00 07950 HOME OFFLCE					193. 0 194. 0
194. 06 07956 LEASED OFFICE SPACE		C		0 0	194.0
194.08 07958 MISC NONREI MBURSABLE COST CENTERS		36, 858	1	0 36, 858	194.0
200.00 Cross Foot Adjustments	34, 902	49, 442	2	0 49, 442	200. 0
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 34, 902	16, 908, 363	3	0 0 0 16, 908, 363	201. 0 202. 0
	1 57,702	.5, 700, 500	.1	- 10, 700, 000	1202.0

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNITY HOS	SPITAL SOUTH Provider CO		eri od:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/30/2022 2:3	
		CAPI TAL RE	LATED COSTS			575072022 2.5	
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	371, 518	8				1.00
	00200 CAP REL COSTS-MVBLE EQUIP	371, 310	9, 432, 778				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	C		72, 293, 887			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	19, 216		4, 466, 277		172, 607, 117	
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	68, 457 1, 009		840, 793 C		7, 322, 526 692, 305	
	00900 HOUSEKEEPI NG	2, 143		1, 561, 606	-	2, 803, 812	
	01000 DI ETARY	4, 259		480, 996		1, 145, 167	
	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	7,774		889, 585		926, 781	
	01600 MEDICAL RECORDS & LIBRARY		-	351, 129		2, 659, 961 1, 517, 927	
	01700 SOCIAL SERVICE	996	1, 838	1, 313, 774	-	1, 771, 053	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	C	0 0	C	-	914, 558	
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD INPATIENT ROUTINE SERVICE COST CENTERS	570	0 0	C	0	1, 249, 265	22.00
	03000 ADULTS & PEDIATRICS	89, 445	201, 929	22, 319, 089	0	36, 418, 802	30.00
	03100 I NTENSI VE CARE UNI T	27, 085			-	5, 630, 718	
	04300 NURSERY	2, 414	9, 733	563, 425	0	870, 041	43.00
	ANCILLARY SERVICE COST CENTERS	37,911	2, 148, 494	3, 878, 122	0	10, 836, 548	50.00
	05100 RECOVERY ROOM	7,845				4, 799, 234	
	05200 DELIVERY ROOM & LABOR ROOM	10, 726		3, 131, 554		4, 547, 948	
	05400 RADI OLOGY-DI AGNOSTI C	12, 863		1, 815, 248		3, 055, 477	
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	1, 703		730, 920 991, 402		1, 454, 006 2, 090, 189	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 703		515, 238		843, 614	
	05900 CARDI AC CATHETERI ZATI ON	10, 252		1, 454, 016		3, 731, 395	
	06000 LABORATORY	4, 749		C		8, 245, 769	
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2,356	° °	C 2, 331, 464	0	0 3, 321, 301	
	06600 PHYSI CAL THERAPY	796		2, 531, 404		4, 011, 651	
	06700 OCCUPATI ONAL THERAPY	211		676, 451		950, 219	
	06800 SPEECH PATHOLOGY	46		145, 930		204, 999	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	5, 576		1, 139, 714 495, 218		1, 927, 196 1, 098, 854	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 741		520, 807		16, 588, 100	
	07200 IMPL. DEV. CHARGED TO PATIENTS	C	-	C		9, 718, 482	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	5,843		3, 216, 707	0	13, 513, 209	
	03950 ENDOSCOPY	1,076	207, 380	708, 952	0	578, 332 1, 352, 508	
76.06	03330 I MAGI NG CENTER	C	391, 380			1, 997, 815	
	07697 CARDI AC REHABI LI TATI ON	C	15, 491	346, 356	0	487, 069	76.97
	OUTPATIENT SERVICE COST CENTERS		0	C	0	0	90.00
	04950 DI ABETI C CARE CENTER	C	0	C	0	0	
90. 02	04951 ANTI-COAGULATION CLINIC	C	720	558, 138	0	428, 328	90.02
	04952 PALLI ATI VE CARE	C	0 70 017	0	0	0	
	04953 SPINE CENTER 09100 EMERGENCY	31, 052	70, 017 108, 584	226, 699 5, 727, 310		397, 944 10, 978, 676	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	01,002	100,001	0, 727, 010	, U	10, 770, 070	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	370, 976	9, 432, 699	71, 619, 426	-45, 165, 436	171, 081, 779	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	C			190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES		0		-	0 111, 520	191.00
	19300 NONPAID WORKERS				0		192.00
194.00	07950 HOME OFFICE	C	0	C	-	0	194.00
	07956 LEASED OFFICE SPACE	0	0	(74.4/1	-		194.06
194.08 200.00	07958 MISC NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	542	79	674, 461	0	1, 413, 818	194.08 200.00
200.00							201.00
202.00	Cost to be allocated (per Wkst. B,	7, 601, 050	9, 307, 313	3, 573, 067		45, 165, 436	
202 00	Part I)	20 450420	0.004400	0 040404		0 2/1///	202 00
203.00		20. 459439	0. 986699	0. 049424		0. 261666 2, 744, 163	
204.00	Cost to be allocated (per Wkst. B,						

Health Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	
				To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
	CAPI TAL RE	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
			DEPARTMENT (GROSS		(ACCUM. COST)	
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 00000	0	0. 015898	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)	ł					206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

0001 /1	LLOCATION - STATISTICAL BASIS		Provider C				
					Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre 5/30/2022 2:3	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	1		1			1
2.00 4.00 5.00 7.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	283, 845 1, 009	147, 086				1.00 2.00 4.00 5.00 7.00 8.00
9.00 10.00 11.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	2, 143 4, 259 7, 774	0	280, 69 4, 25 7, 77	9 36, 894	706 9	9.00 10.00
	01600 MEDICAL RECORDS & LIBRARY		0		0 0	9	16.00
	01700 SOCIAL SERVICE	996	0	99	6 0	15	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0 0	0	
	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD I NPATI ENT ROUTI NE SERVI CE COST CENTERS	570	0	57	0 0	0	22.00
30, 00	03000 ADULTS & PEDIATRICS	89, 445	68, 719	89, 44	5 33, 784	267	30,00
	03100 I NTENSI VE CARE UNI T	27, 085	7, 197			32	31.00
	04300 NURSERY	2, 414	1, 268	2, 41	4 0	6	43.00
	ANCI LLARY SERVI CE COST CENTERS	37, 911	0	37, 91	1 0	51	50.00
	05100 RECOVERY ROOM	7,845	22, 414			34	
	05200 DELIVERY ROOM & LABOR ROOM	10, 726	5, 636			27	52.00
	05400 RADI OLOGY-DI AGNOSTI C	12, 863	2, 430			23	
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	2, 057 9, 692		0 0	8	55.00 57.00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 703 1, 554	9,092	1, 70 1, 55		13 7	58.00
	05900 CARDI AC CATHETERI ZATI ON	10, 252	0			15	
	06000 LABORATORY	4, 749	0			0	60.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 2, 356	0		0 0 6 0	0 24	64.00 65.00
	06600 PHYSI CAL THERAPY	796	0	2, 35		13	66.00
	06700 OCCUPATI ONAL THERAPY	211	0	21		8	67.00
	06800 SPEECH PATHOLOGY	46	0	4		2	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	5, 576 2, 308		5, 57 2, 30		19 6	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 741	0	10, 74		10	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	5,843	0	5, 84		32	73.00
	07400 RENAL DI ALYSI S 03950 ENDOSCOPY	1,076		1, 07		0 7	74.00 76.00
	03330 I MAGI NG CENTER	0	0		0 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	6	76.97
	OUTPATIENT SERVICE COST CENTERS	0	0			0	90.00
	04950 DI ABETI C CARE CENTER	0	0			0	
	04951 ANTI-COAGULATION CLINIC	0	0		0 0	0	
	04952 PALLI ATI VE CARE	0	0		0 0	0	90.03
	04953 SPINE CENTER 09100 EMERGENCY	0 31, 052	0 27, 673	31, 05	0 0	0 72	90.04 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	51,052	27,073	31,05	2 0	12	92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	283, 303	147, 086	280, 15	1 36, 894	706	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		ol ol	0	190.00
191.00	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19300 NONPALD WORKERS 07950 HOME OFFICE	0	0				193.00 194.00
	07956 LEASED OFFICE SPACE	0	0		0 0		194.06
	07958 MI SC NONREI MBURSABLE COST CENTERS	542	0	54	2 0	0	194. 08
200.00	Cross Foot Adjustments						200. 00 201. 00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	9, 238, 582	906, 299	3, 607, 22	4 1, 638, 173	1, 522, 221	
203.00	Part I)	22 647000	6 14140F	10 05110	6 11 100150	2 156 120207	202 00
203.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	32. 547982 1, 568, 355	6. 161695 37, 225			2, 156. 120397 237, 518	
205.00	Part II) Unit cost multiplier (Wkst. B, Part	5. 525392	0. 253083	0. 40354	1 3. 737789	336. 427762	205. 00
206.00	II) NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						

Health Financial Systems	COMMUNI TY HOS	PITAL SOUTH		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2021	Worksheet B-1	
				To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET) (PATIENT DAYS)	(MEALS SERVED)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems	COMMUNITY HOS				u of Form CMS-	
COST ALL	LOCATION - STATISTICAL BASIS		Provider C	CN: 15-0128 P F	eriod: rom 01/01/2021	Worksheet B-1	
				T	o 12/31/2021	Date/Time Pre 5/30/2022 2:3	
					INTERNS &	RESI DENTS	
	Cost Center Description	NURSI NG		SOCIAL SERVICE	SERVI CES-SALAR		
		ADMI NI STRATI ON	RECORDS & LI BRARY	(TOTAL PATIENT	Y & FRI NGES (ASSI GNED	PRGM. COSTS (ASSI GNED	
		(DI RECT NURS.	(GROSS	DAYS)	TIME)	TI ME)	
		HRS.)	CHARGES)	,		·	
		13.00	16.00	17.00	21.00	22.00	
	ENERAL SERVICE COST CENTERS						1.00
	0200 CAP REL COSTS-BEDG & FIXT						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINI STRATI VE & GENERAL						5.00
7.00 0	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
	01100 CAFETERIA						11.00
	1300 NURSI NG ADMI NI STRATI ON	377					13.00
16.00 0	01600 MEDICAL RECORDS & LIBRARY	0	1, 053, 504, 688				16.00
	01700 SOCIAL SERVICE	0	0	42, 473			17.00
	02100 I & R SERVICES-SALARY & FRINGES APPRVD	0	0	C		07.045	21.00
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD NPATIENT ROUTINE SERVICE COST CENTERS	0	0	C		87, 215	22.00
	03000 ADULTS & PEDIATRICS	267	127, 995, 917	36, 766	62, 860	62, 860	30.00
	03100 I NTENSI VE CARE UNI T	32	13, 402, 256			5, 068	1
	04300 NURSERY	6	4, 005, 628			0	1
	NCI LLARY SERVI CE COST CENTERS			1			
	05000 OPERATING ROOM	0	129, 628, 996			4, 164	
	05100 RECOVERY ROOM	0	36, 084, 472			0	
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	17, 799, 989 38, 295, 639		-	0	
	05500 RADI OLOGY-THERAPEUTI C	0	25, 056, 734		-	0	1
	05700 CT SCAN	0	71, 772, 096		0	0	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	14, 734, 080	C	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	106, 490, 228		-	0	
	06000 LABORATORY	0	81, 139, 501	0	-	0	60.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	20, 202, 674		-	0	
	06600 PHYSI CAL THERAPY	0	10, 899, 364		-	2, 493	1
	06700 OCCUPATI ONAL THERAPY	0	2, 987, 298			0	1
	06800 SPEECH PATHOLOGY	0	644, 167	c	0	0	68.00
	06900 ELECTROCARDI OLOGY	0	26, 339, 549		-	0	
	07000 ELECTROENCEPHALOGRAPHY	0	5, 685, 767			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	32, 845, 066 34, 408, 037		-	0	
	07300 DRUGS CHARGED TO PATIENTS	0	65, 329, 833			0	
	07400 RENAL DIALYSIS	0	2, 276, 264		0		74.00
	3950 ENDOSCOPY	0	10, 609, 532		0	0	
	03330 I MAGI NG CENTER	0	17, 754, 504			0	
		0	1, 995, 908	C	0	0	76.97
	DUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
	04950 DI ABETI C CARE CENTER	0	0	0	-	0	
90. 02 0	04951 ANTI-COAGULATION CLINIC	0	1, 198, 742	C C	0	0	90. 02
90.03 0	04952 PALLIATIVE CARE	0	0	C	0	0	
	04953 SPI NE CENTER	0	429, 317		-	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	72	153, 493, 130	C	10, 027	10, 027	
	PECIAL PURPOSE COST CENTERS		L				92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	377	1,053,504,688	42, 473	84, 612	84, 612	118.00
	IONREI MBURSABLE COST CENTERS	0.11	1,000,001,000	12, 170	01/012	01/012	
190.001	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
	9100 RESEARCH	0	0	C	-		191.00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	C	959		192.00
	9300 NONPALD WORKERS 07950 HOME OFFLCE	0			0		193.00 194.00
	07950 HOME OFFICE 07956 LEASED OFFICE SPACE						194.00
	07958 MISC NONREI MBURSABLE COST CENTERS	0	0		1, 644		194.08
200.00	Cross Foot Adjustments		-				200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	3, 375, 387	1, 915, 117	2, 312, 037	1, 153, 867	1, 602, 032	202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	8, 953. 281167	0. 001818	54.435453	13. 230144	18. 368767	203 00
203.00	Cost to be allocated (per Wkst. B,	45, 316					203.00
	Part II)	,	, .52		,	21,752	

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	
				To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
				INTERNS &	RESI DENTS	
Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVIC	ESERVI CES-SALAR	SERVI CES-OTHER	
	ADMI NI STRATI ON	RECORDS &		Y & FRINGES	PRGM. COSTS	
		LI BRARY	(TOTAL PATIEN	T (ASSI GNED	(ASSI GNED	
	(DI RECT NURS.	(GROSS	DAYS)	TIME)	TIME)	
	HRS.)	CHARGES)				
	13.00	16.00	17.00	21.00	22.00	
205.00 Unit cost multiplier (Wkst. B, Part	120. 201592	0.000023	1. 44324	6 0. 166714	0. 400183	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	I I		1	I	1	I

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CON: 15-0128 Period: To 12/3/2021 Worksheet C Part I To 12/3/2021 Worksheet C Part I Date/ Date/ To 12/3/2021 Worksheet C Part I Date/ D	Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-:	2552-10
Cost Center Description Total Cost (rrom Ws.tb, Rpert 1, col.) 26) Total Cost (rrom Ws.tb, Rpert 1, col.) 2.00 Total Costs (rrom Ws.tb, Rpert 1, col.) 2.00 <thtps: 2.00 Total Costs 1, rrom Stal 2.00</thtps: 	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0128	From 01/01/2021	Part I Date/Time Pre	pared:
Cost Center Description Total Cost (from Wkst. B, Part I,, 26) Therapy Limit Adj. Total Costs Total Costs Total Costs 1.00 2.00 3.00 4.00 5.00 3.00 003000 ADULTS & PEDIATRICS 57, 132, 900 0, 57, 132, 900 0, 57, 132, 900 0, 65, 317 0, 9, 065, 317 0, 0, 05, 05, 00, 05,			Title	XVIII	Hosni tal		
Cost Center Description Total Cost (from Wist) Data Total Cost (part 1, col. 2) Total Cost (part 1, col. 2) RCE (part 1, col. 2) Total Costs (part 1, col. 2) Total Costs (part 1, col. 2) RCE (part 1, col. 2) Total Costs (part 1, co						115	
Impart Learn Routh Less Revice Cost Centrers Adj . Disal Lowance 0.00 03000 ADULTS & PEDIATRI CS 5.00 0.01 03000 ADULTS & PEDIATRI CS 57, 132, 900 57, 132, 900 0, 57, 132, 900 0, 00, 03000 ADULTS & PEDIATRI CS 50, 00 0.01 03000 INTERSIVE CARE UNIT 9, 065, 317 0, 9, 065, 317 0, 9, 065, 317 0, 9, 065, 317 0, 0, 0, 00, 00, 00, 00, 00, 00, 00, 00	Cost Center Description	Total Cost	Therapy limit	Total Costs		Total Costs	
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ANCI LLARY SERVICE COST CENTERS 1 ANCI LLARY SERVICE COST CENTERS 15,738,858 0 15,738,858 0 15,738,858 0 15,738,858 0 15,738,858 0 15,738,858 0 15,738,858 0 15,738,858 0 0 50,00 0 0 0 0 6,688,204 6,688,204 6,688,204 6,688,204 0 6,688,204 0 6,350,244 0 6,350,244 0 53,00 0 50,00 0 1,909,947 1,066,518 10,766,518 10,766,518 10,766,518 10,766,518 10,766,518 0 10,766,518 0 0,760,00 0 600 0 0 0 0 0 0<	31. 00 03100 INTENSIVE CARE UNIT	9,065,317		9,065,3	17 0	9, 065, 317	31.00
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51 00 DISOD RECOVERY ROM 6, 688, 204 6, 688, 204 6, 688, 204 51, 00 52.00 05200 DELIVERY ROM & LABOR ROM 6, 350, 244 6, 350, 244 0 6, 350, 244 52, 00 54.00 DS400 RADI OLOGY - JLAGNOSTI C 4, 573, 145 4, 573, 145 0 4, 573, 145 0 4, 573, 145 0 4, 573, 145 0 2, 932, 665 0 2, 932, 665 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 53. 99, 147 0 5, 399, 147 0 5, 399, 147 0 53. 99, 147 5 399, 147 0 64. 00 66. 00 60. 00	ANCILLARY SERVICE COST CENTERS						1
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57.00 05700 CT SCAN 2,932,665 2,932,665 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,176,790 1,176,790 1,176,790 1,176,790 1,176,790 1,176,790 1,176,790 1,176,790 1,176,790 1,176,790 5,399,147 5,399,147 5,399,147 0 5,399,147 0 5,399,147 0 5,399,147 0 0<0	55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 909, 947		1, 909, 9	47 0	1, 909, 947	55.00
59.00 CARDIAC CATHETERIZATION 5, 399, 147 5, 399, 147 5, 399, 147 50.00 60.00 06000 LABORATORY 10, 766, 518 0 10, 766, 518 0 10, 766, 518 0 0 60.00 64.00 O6400 INTRAVENOUS THERAPY 0 0 64.00 0 64.00 0 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 0.00 0 5.145.347 0 5.145.347 0 5.145.347 0 1.231,119 0 1.231,119 0 1.231,119 0 1.231,119 0 2.773,475 0 2.773,474 0 2.14.97,547 1.514.442 0 1.514.442 0 1.514.442 0 1.514.442 0 1.514.442 0 1.514.442 0 1.2324.032 0 12.324.032 0 12.324.032		2, 932, 665		2, 932, 6	65 0	2, 932, 665	57.00
60.00 06000 LABORATORY 10, 766, 518 0 10, 766, 518 0 <td>58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)</td> <td>1, 176, 790</td> <td></td> <td>1, 176, 7</td> <td>90 0</td> <td>1, 176, 790</td> <td>58.00</td>	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 176, 790		1, 176, 7	90 0	1, 176, 790	58.00
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69.00 06900 ELECTROCARDIOLOGY 2,773,475 2,773,475 0 2,773,475 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,514,442 1,514,442 0 1,514,442 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 21,497,547 21,497,547 0 21,497,547 0 21,497,547 0 1,514,442 70.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 12,324,032 12,324,032 0 12,324,032 72.00 73.00 74.00 17,502,189 0 17,502,189 0 17,502,189 73.00 74.00 75.25.853	67.00 06700 OCCUPATI ONAL THERAPY	1, 231, 119	0	1, 231, 1	19 0	1, 231, 119	67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 1, 514, 442 1, 514, 442 0 1, 514, 442 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 21, 497, 547 21, 497, 547 0 21, 497, 547 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 12, 324, 032 12, 324, 032 0 12, 324, 032 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 17, 502, 189 17, 502, 189 17, 502, 189 17, 502, 189 73.00 74.00 07400 RENAL DI ALYSI S 782, 650 782, 650 782, 650 74.00 76.00 03305 ENDOSCOPY 1, 740, 794 1, 740, 794 0 1, 740, 794 76.00 76.01 03305 INAGI NG CENTER 2, 552, 853 2, 552, 853 0 2, 552, 853 76.06 76.97 CARDI AC REHABI LI TATI ON 631, 084 631, 084 0 631, 084 0 631, 084 0 90.00 90.00 09000 CLI NI C 542, 586 542, 586 0 90.01 90.01 90.01 90.02 90.01 90.02 <td>68.00 06800 SPEECH PATHOLOGY</td> <td>266, 211</td> <td>0</td> <td>266, 2</td> <td>11 0</td> <td>266, 211</td> <td>68.00</td>	68.00 06800 SPEECH PATHOLOGY	266, 211	0	266, 2	11 0	266, 211	68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 21, 497, 547 21, 497, 547 0 21, 497, 547 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 12, 324, 032 12, 324, 032 0 12, 324, 032 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 17, 502, 189 0 17, 502, 189 0 17, 502, 189 73.00 74.00 07400 RENAL DIALYSIS 782, 650 782, 650 0 782, 650 782, 650 0 782, 650 74.00 76.00 03950 ENDOSCOPY 1, 740, 794 1, 740, 794 1, 740, 794 0 1, 740, 794 76.00 76.06 03300 IMAGI NG CENTER 2, 552, 853 2, 552, 853 0 2, 552, 853 0 2, 552, 853 76.06 70.07697 CARDI AC REHABILI TATI ON 631, 084 631, 084 0 631, 084 76.97 90.00 09000 CLI NI C 0 0 0 0 90.01 90.01 04950 DI ABETI C CARE CENTER 0 0 0 90.02 90.02	69. 00 06900 ELECTROCARDI OLOGY	2, 773, 475		2, 773, 4	75 0	2, 773, 475	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 12, 324, 032 12, 324, 032 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 17, 502, 189 17, 502, 189 0 17, 502, 189 73.00 74.00 07400 RENAL DI ALYSI S 782, 650 782, 650 0 782, 650 74.00 76.00 03950 ENDOSCOPY 1, 740, 794 1, 740, 794 0 1, 740, 794 74.00 76.00 03330 IMAGI NG CENTER 2, 552, 853 0 2, 552, 853 0 2, 552, 853 76.06 76.97 07697 CARDI AC REHABILITATION 631, 084 0 631, 084 0 631, 084 76.97 90.00 09000 CLINIC 0 0 0 90.00 90.01 90.01 90.00 90.00 90.01 90.00 90.00 90.01 90.00 90.00 90.00 90.01 90.01 90.02 04951 ANTI -COAGULATI ON CLINIC 542, 586 0 542, 586 90.02 90.03 90.04 952 PALLI ATI VE CARE 0 0 0 00.03	70.00 07000 ELECTROENCEPHALOGRAPHY	1, 514, 442		1, 514, 4	42 0	1, 514, 442	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 17, 502, 189 17, 502, 189 0 17, 502, 189 73.00 74.00 07400 RENAL DI ALYSI S 782, 650 782, 650 782, 650 782, 650 74.00 76.00 03950 ENDOSCOPY 1, 740, 794 1, 740, 794 0 1, 740, 794 76.00 76.00 03330 IMAGI NG CENTER 2, 552, 853 2, 552, 853 0 2, 552, 853 0 631, 084 0 631, 084 631, 084 76.00 76.07 OT697 CARDI AC REHABILITATION 631, 084 0 631, 084 0 631, 084 76.97 77.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 90.00 90.00 90.01 90.00 90.01 90.01 90.00 90.01 90.02 90.03 04952 PALLI ATI VE CARE 0 0 0 0 90.02 90.03 90.92 90.92 502, 852 0 502, 852 90.04 90.03 90.04 91.00 90.02 502, 852 0 502, 852 90.04 90.03 </td <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>21, 497, 547</td> <td></td> <td>21, 497, 5</td> <td>47 0</td> <td>21, 497, 547</td> <td>71.00</td>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 497, 547		21, 497, 5	47 0	21, 497, 547	71.00
74.00 07400 RENAL DIALYSIS 782,650 782,650 74.00 76.00 03950 ENDOSCOPY 1,740,794 1,740,794 0 1,740,794 76.00 76.06 03330 IMAGING CENTER 2,552,853 2,552,853 0 2,552,853 76.06 76.07 OT697 CARDIA C REHABILITATION 631,084 631,084 0 631,084 76.97 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 90.00 09000 CLINIC 90.00 90.01 90.01 90.00 0 0 90.00 90.01 90.01 90.01 90.00 0 0 0 90.00 90.01 90.01 90.01 90.01 90.02 94951 ANTI-COAGULATION CLINIC 542,586 542,586 0 542,586 90.02 90.03 94952 PALLIATIVE CARE 0 0 0 90.04 91.00 90.02 91.00 90.04 91.00 90.02 502,852 0 502,852 90.04 91.00 92.00 90.9200 085ERVATION BEDS (NON-DISTINCT PART) 7,365,155 <td></td> <td>12, 324, 032</td> <td></td> <td>12, 324, 0</td> <td>32 0</td> <td>12, 324, 032</td> <td>72.00</td>		12, 324, 032		12, 324, 0	32 0	12, 324, 032	72.00
76.00 03950 ENDOSCOPY 1,740,794 1,740,794 0 1,740,794 76.00 76.06 03330 IMAGING CENTER 2,552,853 2,552,853 0 2,552,853 76.06 76.07 OZ697 CARDIAC REHABILITATION 631,084 0 631,084 0 631,084 76.97 0UTPATIENT SERVICE COST CENTER 0 0 0 0 0 90.00 09000 CLINIC 0 0 0 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.02 90.01 0 0 0 90.02 90.01 90.01 90.02 90.01 90.02 90.01 0 0 0 90.02 90.01 90.02 90.02 90.01 90.02 90.01 90.03 90.02 90.03 94952 PALLIATIVE CARE 0 0 0 0 90.02 90.03 90.03 90.04 91.03 91.00 90.03 90.04 91.00 90.03 90.04 91.00 90.03 90.04 91.00 90.03 <	73.00 07300 DRUGS CHARGED TO PATIENTS	17, 502, 189		17, 502, 1	89 0	17, 502, 189	73.00
76. 06 03330 IMAGI NG CENTER 2, 552, 853 2, 552, 853 0 2, 552, 853 76. 06 76. 97 07697 CARDI AC REHABI LI TATI ON 631, 084 0 631, 084 0 631, 084 76. 97 000 09000 CLI NI C 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 01 04950 DI ABETI C CARE CENTER 0 0 0 90. 02 90. 01 90. 02 04951 ANTI - COAGULATI ON CLI NI C 542, 586 542, 586 0 542, 586 90. 02 90. 03 90. 04 91. 00 90. 02 90. 03 90. 04 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.0432, 736 <td>74. 00 07400 RENAL DI ALYSI S</td> <td>782, 650</td> <td></td> <td>782, 6</td> <td>50 0</td> <td>782, 650</td> <td>74.00</td>	74. 00 07400 RENAL DI ALYSI S	782, 650		782, 6	50 0	782, 650	74.00
76. 97 07697 CARDI AC REHABILITATION 631,084 631,084 0 631,084 76. 97 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 90.00 90.00 CLINIC 0 0 0 90.00 90.00 90.00 0 0 0 0 90.00 90.01 90.01 94950 DI ABETI C CARE CENTER 0 0 0 0 90.01 90.02 94951 ANTI-COAGULATION CLINIC 542,586 542,586 0 542,586 90.02 90.03 94952 PALLI ATIVE CARE 0 0 0 0 90.03 90.04 91.00 91.00 CENTER 502,852 502,852 0 502,852 0 404953 SPI NE CENTER 502,852 0 502,852 0 404953 91.00 91.00 ERGENCY 16,510,441 16,510,441 91.00 91.00 16,510,441 91.00 92.00 92.00 0 92.00	76. 00 03950 ENDOSCOPY	1, 740, 794		1, 740, 7	94 0	1, 740, 794	76.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 90.00 90.01 04950 DLABETIC CARE CENTER 0 0 0 0 90.01 90.02 04951 ANTI-COAGULATION CLINIC 542,586 542,586 0 542,586 90.02 90.03 04952 PALLIATIVE CARE 0 0 0 0 90.03 90.04 04953 SPINE CENTER 502,852 502,852 0 502,852 0 90.04 91.00 09100 EMERGENCY 16,510,441 16,510,441 0 16,510,441 91.00 16,510,441 91.00 16,510,441 91.00 16,510,441 91.00 16,510,441 91.00 16,510,441 91.00 16,510,441 91.00 16,510,441 91.00 16,510,441 91.00 16,510,441 91.00 16,510,441 91.00 220,432,736 220,432,736 220,432,736 220,432,736 220,432,736 200.00 200.00 Subtotal (s		2, 552, 853		2, 552, 8	53 0	2, 552, 853	76.06
90. 00 09000 CLINIC 0 0 0 90. 00 90. 01 04950 DIABETIC CARE CENTER 0 0 0 90. 01 90. 02 04951 ANTI-COAGULATION CLINIC 542, 586 542, 586 0 542, 586 90. 02 90. 03 04952 PALLIATIVE CARE 0 0 0 0 90. 03 90. 04 04953 SPINE CENTER 502, 852 502, 852 0 502, 852 0 90. 04 91. 00 09100 EMERGENCY 16, 510, 441 16, 510, 441 0 16, 510, 441 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 365, 155 7, 365, 155 7, 365, 155 20. 00 200. 00 Subtotal (see instructions) 220, 432, 736 0 220, 432, 736 0 220, 432, 736 200. 00 201. 00 Less Observation Beds 7, 365, 155 7, 365, 155 7, 365, 155 201. 00		631, 084		631, 0	84 0	631, 084	76.97
90. 01 04950 DI ABETI C CARE CENTER 0 0 0 90. 01 90. 02 04951 ANTI-COAGULATI ON CLINIC 542, 586 542, 586 0 542, 586 90. 02 90. 03 04952 PALLI ATI VE CARE 0 0 0 90. 03 90. 04 04953 SPI NE CENTER 502, 852 0 502, 852 0 502, 852 0 90. 04 91. 00 09100 EMERGENCY 16, 510, 441 16, 510, 441 0 16, 510, 441 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 7, 365, 155 7, 365, 155 7, 365, 155 92. 00 200. 00 Less Observation Beds 7, 365, 155 7, 365, 155 7, 365, 155 201. 00		1		1	-		
90. 02 04951 ANTI-COAGULATION CLINIC 542, 586 0 542, 586 0 90. 02 90. 02 90. 02 90. 02 90. 02 90. 02 90. 02 90. 03 90. 02 90. 03 90. 02 90. 03 90. 02 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 <							
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90. 04 04953 SPI NE CENTER 502, 852 502, 852 0 502, 852 90. 04 91. 00 09100 EMERGENCY 16, 510, 441 0 16, 510, 441 0 16, 510, 441 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 7, 365, 155 7, 365, 155 7, 365, 155 92. 00 200. 00 Subtotal (see instructions) 220, 432, 736 0 220, 432, 736 0 220, 432, 736 200. 00 201. 00 Less Observation Beds 7, 365, 155 7, 365, 155 7, 365, 155 201. 00				542, 5			
91. 00 09100 EMERGENCY 16, 510, 441 0 16, 510, 441 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 7, 365, 155 7, 365, 155 7, 365, 155 92. 00 200. 00 Subtotal (see instructions) 220, 432, 736 0 220, 432, 736 0 220, 432, 736 0 220, 432, 736 200. 00 201. 00 Less Observation Beds 7, 365, 155 7, 365, 155 7, 365, 155 201. 00							
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 7, 365, 155 7, 365, 155 7, 365, 155 92. 00 200. 00 Subtotal (see instructions) 220, 432, 736 0 220, 432, 736 0 220, 432, 736 0 220, 432, 736 200. 00 201. 00 Less Observation Beds 7, 365, 155 7, 365, 155 7, 365, 155 201. 00							
200.00 Subtotal (see instructions) 220, 432, 736 0 220, 432, 736 0 220, 432, 736 200.00 201.00 Less Observation Beds 7, 365, 155 7, 365, 155 7, 365, 155 201.00							
201.00 Less Observation Beds 7, 365, 155 7, 365, 155 7, 365, 155 201.00							
202.00 10tal (see instructions) 213,067,581 0 213,067,581 0 213,067,581 202.00							
	202.00 IOTAL (see instructions)	213,067,581	0	213,067,5	51 O	213, 067, 581	202.00

Health Financial Systems	COMMUNITY HOSE	PLTAL SOUTH		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/30/2022 2:3	epared: 4 pm
		Title	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	118, 861, 764		118, 861, 76			30.00
31.00 03100 INTENSIVE CARE UNIT	13, 402, 256		13, 402, 25			31.00
43. 00 04300 NURSERY	4, 005, 628		4,005,62	28		43.00
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 05000 OPERATING ROOM	59, 033, 064	70, 595, 932				
51.00 05100 RECOVERY ROOM	11, 615, 827	24, 468, 645				
52.00 05200 DELIVERY ROOM & LABOR ROOM	17, 799, 989	0			0. 000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	7, 404, 056	30, 891, 583			0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	8, 625, 413	16, 431, 321			0.00000	•
57.00 05700 CT SCAN	19, 248, 384	52, 523, 712			0. 000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 379, 279	11, 354, 801			0.00000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	38, 858, 987	67, 631, 241			0. 000000	
60. 00 06000 LABORATORY	48, 093, 647	33, 045, 854			0.00000	•
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0. 000000		•
65. 00 06500 RESPI RATORY THERAPY	18, 367, 743	1, 834, 931				
66. 00 06600 PHYSI CAL THERAPY	2, 781, 845	8, 117, 519				
67.00 06700 OCCUPATI ONAL THERAPY	2, 048, 827	938, 471				
68.00 06800 SPEECH PATHOLOGY	478, 776	165, 391			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	6, 508, 148	19, 831, 401			0.00000	
70.00 07000 ELECTROENCEPHALOGRAPHY	454, 164	5, 231, 603			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 729, 594	17, 115, 472			0.00000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	18, 289, 174	16, 118, 863			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	48, 527, 232	16, 802, 601			0. 000000	
74. 00 07400 RENAL DI ALYSI S	2, 276, 264	0			0.00000	
76. 00 03950 ENDOSCOPY	2, 267, 409	8, 342, 123				
76.06 03330 I MAGI NG CENTER	157, 833	17, 596, 671				
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 896	1, 994, 012	1, 995, 90	0. 316189	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS	1 1		1			-
90. 00 09000 CLINIC	0	0		0 0. 000000		
90. 01 04950 DIABETIC CARE CENTER	0	0		0 0.00000		
90. 02 04951 ANTI - COAGULATION CLINIC	6, 412	1, 192, 330				
90. 03 04952 PALLI ATI VE CARE	0	0		0 0.00000	0.00000	
90. 04 04953 SPI NE CENTER	0	429, 317			0.00000	
91.00 09100 EMERGENCY	34, 752, 161	118, 740, 969				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 678, 777	6, 455, 376			0. 000000	
200.00 Subtotal (see instructions)	505, 654, 549	547, 850, 139	1, 053, 504, 68	88		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	505, 654, 549	547,850,139	1, 053, 504, 68	58		202.00

Health Financial Systems		COMMUNITY HOSPI		In Lieu of Form CMS-25			
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/30/2022 2:3	epared: 34 pm	
			Title XVIII	Hospi tal	PPS		
	Cost Center Description	PPS Inpatient Ratio 11.00					
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00					
30.00	03000 ADULTS & PEDIATRICS					T 30. 0	
31.00	03100 I NTENSI VE CARE UNI T					31.0	
43.00	04300 NURSERY					43.0	
	ANCI LLARY SERVICE COST CENTERS					-	
50.00	05000 OPERATI NG ROOM	0. 121415				T 50. 0	
51.00	05100 RECOVERY ROOM	0. 185349				51.0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 356756				52.0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 119417				54.0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0.076225				55.0	
57.00	05700 CT SCAN	0. 040861				57.0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 079869				58.0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 050701				59.0	
60.00	06000 LABORATORY	0. 132691				60.0	
64.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.0	
65.00	06500 RESPI RATORY THERAPY	0. 217090				65.0	
66.00	06600 PHYSI CAL THERAPY	0. 472078				66.0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 412118				67.0	
68.00	06800 SPEECH PATHOLOGY	0. 413264				68.0	
69.00	06900 ELECTROCARDI OLOGY	0. 105297				69.0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 266357				70.0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 654514				71.0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 358173				72.0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 267905				73.0	
	07400 RENAL DI ALYSI S	0, 343831				74.0	
76.00	03950 ENDOSCOPY	0. 164078				76.0	
76.06	03330 I MAGI NG CENTER	0. 143786				76.0	
76.97	07697 CARDI AC REHABI LI TATI ON	0. 316189				76.9	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0. 000000				90.0	
	04950 DI ABETI C CARE CENTER	0. 000000				90.0	
90.02	04951 ANTI - COAGULATI ON CLINIC	0. 452630				90.0	
90.03	04952 PALLI ATI VE CARE	0. 000000				90.0	
90.04	04953 SPINE CENTER	1. 171284				90.0	
	09100 EMERGENCY	0. 107565				91.0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 806331				92.0	
200.00		0.000001				200. 0	
200.00						200.0	
		1				1-01.0	

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0128 Period: From 01/01/2021 To 12/31/2021 Worksheet C Part I Date/Time Prepared: 5/30/2022 2: 34 pm Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Total Costs Adj. Total Costs Total Costs Total Costs Disal Iowance Total Costs Disal Iowance Total Costs Disal Iowance Total Costs Disal Iowance 0:00 03000 ADULTS & PEDIATRI CS 59, 119, 207 0 59, 119, 207 0 59, 119, 207 0 9, 225, 460 30. 00 1:00 03000 INTENSI VE CARE UNI T 9, 225, 460 9, 225, 460 0 9, 225, 460 31. 00 30:00 05000 OPERATI NG ROOM 15, 870, 436 15, 870, 436 0 14, 30, 416 43. 00 4ANCILLARY SERVICE COST CENTERS 0 0, 5, 244 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 50. 00 0 50. 00 0 50. 00 2, 932, 665 0 2, 932, 665 0 0 2, 932, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 </th
International condition Title XIX Hospital PPS Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Total Costs Total Costs Total Costs Total Costs Total Costs Disal Iowance Disal Iowance Disal Iowance Total Costs Disal
Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Adj. Total Costs Disal I owance Total Costs 0.00 30.00 AULTS & PEDIATRICS 59, 119, 207 59, 119, 207 0 59, 119, 207 30.00 31.00 03000 ADULTS & PEDIATRICS 59, 119, 207 9, 225, 460 0 9, 225, 460 1, 430, 416 1, 430, 416 1, 430, 416 43.00 ANCILLARY SERVICE COST CENTERS 5000 05000 OPERATING ROOM 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 50.00 6, 688, 204 50.00 6, 688, 204 6, 688, 204 6, 688, 204 51.00 6, 500 REOVERY ROOM 6, 580, 244 6, 500, 244 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 500, 244 52.00 0 55.00 2, 932, 665 0 2, 932, 665 0 2, 932, 665 0 2, 932, 665 0 2, 932, 665 0 2, 932, 665 0 2, 932, 665 0 2, 932, 665 0 2, 932, 665 0 2, 932, 665
Cost Center Description Total Cost (from Wkst.) 26) Therapy Limit Adj. Total Costs Adj. RCE Disal Iowance Total Costs RCE Disal Iowance 30.00 03000 ADULTS & PEDI ATRI CS 59, 119, 207 0 59, 119, 207 0 59, 119, 207 30.00 03000 ADULTS & PEDI ATRI CS 59, 119, 207 0 59, 119, 207 0 59, 119, 207 31.00 03100 INTENSI VE CARE UNI T 9, 225, 460 9, 225, 460 0 9, 225, 460 1, 430, 416 1, 450, 416 1, 450, 416 1, 450, 416 1, 500, 900 1, 909, 947 1, 909, 947 1, 909, 947 1, 909, 947
Image: Instruct of the service cost centers Adj. Disal I owance 30.00 ADULTS & PEDIATRICS 59, 119, 207 0 3.00 4.00 5.00 30.00 03000 ADULTS & PEDIATRICS 59, 119, 207 0 59, 119, 207 0 9, 225, 460 9, 225, 460 0 9, 225, 460 1.00 1.430, 416 0 0
Part I, col. 26 1 1 1 260 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDI ATRICS 59,119,207 59,119,207 0 59,119,207 30.00 31.00 03001 NITENSIVE CARE UNIT 9,225,460 9,225,460 9,225,460 9,225,460 1,430,416 1,430,416 43.00 43.00 04300 NURSERY 1,430,416 1,430,416 0 1,430,416 43.00 50.00 05000 OPERATING ROOM 15,870,436 15,870,436 50.00<
26) 26) 0 4.00 5.00 30.00 ADULTS & PEDIATRICS 1.00 2.00 3.00 4.00 5.00 31.00 03000 ADULTS & PEDIATRICS 59, 119, 207 59, 119, 207 0 59, 119, 207 30.00 31.00 03100 INTENSIVE CARE UNIT 9, 225, 460 9, 225, 460 9, 225, 460 1, 430, 416 1, 430, 416 1, 430, 416 43.00 AMOLILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 15, 870, 436 15, 870, 436 0 15, 870, 436 50.00 51.00 05100 RECOVERY ROOM 6, 888, 204 6, 688, 204 0 6, 580, 244 52.00 05200 PELIVERY ROOM 4, 573, 145 4, 573, 145 0 4, 573, 145 0 4, 573, 145 0 4, 573, 145 0 4, 573, 145 0 1, 909, 947 0 1, 909, 947 0 1, 909, 947 0 1, 909, 947 0 1, 909, 947 0 1, 76, 790 0 1, 76, 790 0 1, 76, 790 0
1.00 2.00 3.00 4.00 5.00 INPATI ENT ROUTI NE SERVICE COST CENTERS 59, 119, 207 59, 119, 207 0 59, 119, 207 30.00 30.00 59, 119, 207 0 59, 119, 207 30.00 30.00 1.100 2.25, 460 9, 225, 460 0 9, 225, 460 0 9, 225, 460 9, 225, 460 0 9, 225, 460 0 9, 225, 460 1, 430, 416 43.00 43.00 0.0000 NURSERY 1, 430, 416 1, 430, 416 1, 430, 416 43.00 43.00 50.00 05000 PERATI NG ROOM 6, 688, 204 6, 688, 204 0 6, 688, 204 50.00 50.00 50.00 50.00 50.00 50.00 15, 870, 436 50.00 50.00 50.00 6, 688, 204 6, 688, 204 6, 688, 204 50.00 50.00 50.00 50.00 50.00 6.688, 204 6, 688, 204 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 <
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 59, 119, 207 0 59, 119, 207 30. 00 31. 00 03100 INTENSI VE CARE UNI T 9, 225, 460 9, 225, 460 0 9, 225, 460 31. 00 43. 00 04300 NURSERY 1, 430, 416 0 1, 430, 416 0 1, 430, 416 43. 00 ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 [OPERATI NG ROOM 6, 688, 204 6, 688, 204 0 6, 688, 204 50. 00 51. 00 50.00 5000 RECOVERY ROOM 6, 350, 244 6, 350, 244 52. 00 05200 DELI VERY ROOM & LABOR ROOM 6, 350, 244 6, 350, 244 52. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 1, 909, 947 1, 909, 947 1, 909, 947 1, 909, 947 51. 00 54. 00 05500 RADI OLOGY-THERAPEUTI C 1, 909, 947 1, 909, 947 0 1, 909, 947 53. 00 50. 00 1, 176, 790 1, 176, 790 1, 176, 790 1, 176, 790 1, 176, 790 1, 176, 790 1, 176, 790 1, 176, 790 1, 176, 790 0 7, 3399, 147 59, 39
30. 00 O3000 ADULTS & PEDIATRICS 59, 119, 207 59, 119, 207 0 59, 119, 207 30. 00 31. 00 O3100 INTENSIVE CARE UNIT 9, 225, 460 9, 225, 460 0 9, 225, 460 31. 00 43. 00 O4300 NURSERY 1, 430, 416 1, 430, 416 0 1, 430, 416 10 1, 130, 416 10 1, 100 1, 100 1, 100 1, 130, 116 10, 00 10, 00 1, 100 1, 100 1, 100 1, 100, 947 1, 909, 947 1, 909, 947 1, 909, 947 1, 909, 947 1
31.00 03100 INTENSIVE CARE UNIT 9,225,460 9,225,460 0 9,225,460 31.00 43.00 04300 NURSERY 1,430,416 1,430,416 0 1,430,416 43.00 ANCILLARY SERVICE COST CENTERS
43. 00 04300 NURSERY 1, 430, 416 1, 430, 416 0 1, 430, 416 43. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 15, 870, 436 0 15, 870, 436 50. 00 50. 00 50. 00 50. 00 DECOVERY ROOM 6, 688, 204 6, 688, 204 6, 688, 204 50. 00 6, 688, 204 50. 00 6, 688, 204 6, 688, 204 6, 688, 204 50. 00 6, 688, 204 50. 00 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 6, 688, 204 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 6, 350, 244 6, 350, 244 6, 350, 244 52. 00 53. 00 73. 145 4, 573, 145 4, 573, 145 4, 573, 145 54. 00 75. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 1, 909, 947 55. 00 2, 932, 665 0 2, 932, 665 57. 00 57. 00 58. 00 0, 5900
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 15, 870, 436 0 15, 870, 436 50.00 51.00 05100 RECOVERY ROOM 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 688, 204 0 6, 350, 244 0 6, 350, 244 52.00 0 50.00 9500 RADI OLOGY-DI AGNOSTI C 4, 573, 145 4, 573, 145 0 4, 573, 145 54.00 55.00 0 57.00 05700 CT SCAN 2, 932, 665 0 2, 932, 665 57.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 5, 399, 147 0 5, 399, 147 5 399, 147 5 399, 147 5 399, 147 0 5, 399, 147 5 399, 147 0 5, 399, 147
50.00 05000 0PERATING ROOM 15, 870, 436 15, 870, 436 0 15, 870, 436 50.00 51.00 05100 RECOVERY ROOM 6, 688, 204 6, 688, 204 0 6, 688, 204 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 6, 350, 244 6, 350, 244 0 6, 688, 204 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 573, 145 4, 573, 145 0 4, 573, 145 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 909, 947 1, 909, 947 0 1, 909, 947 55.00 57.00 05700 CT SCAN 2, 932, 665 2, 932, 665 2, 932, 665 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 1, 176, 790 1, 176, 790 0 1, 766, 518 0 10, 766, 518 60.00 60.00 64.00 64.00 64.00 10, 766, 518 0 10, 766, 518 60.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 65.00 65.00 65.00 66.00 66.00 66.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 6, 350, 244 0 6, 350, 244 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 573, 145 4, 573, 145 0 4, 573, 145 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 909, 947 1, 909, 947 0 1, 909, 947 55.00 57.00 05700 CT SCAN 2, 932, 665 2, 932, 665 0 2, 932, 665 0 2, 932, 665 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 1, 176, 790 1, 176, 790 0 1, 176, 790 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 5, 399, 147 5, 399, 147 5, 399, 147 59.00 60.00 06000 LABORATORY 10, 766, 518 0 10, 766, 518 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 4, 385, 808 4, 385, 808 4, 385, 808 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 1, 231, 119 0 1, 231, 119 67.00 67.00 67.00 67
54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 573, 145 4, 573, 145 0 4, 573, 145 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 909, 947 1, 909, 947 0 1, 909, 947 55.00 57.00 05700 CT SCAN 2, 932, 665 2, 932, 665 0 2, 932, 665 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 1, 176, 790 1, 176, 790 0 1, 176, 790 5, 399, 147 5, 399, 147 5, 399, 147 59.00 59.00 CARDI AC CATHETERI ZATI ON 5, 399, 147 0 5, 399, 147 59.00 60.00 64.00 10, 766, 518 0 10, 766, 518 60.00 64.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 4, 385, 808 0 4, 385, 808 0 4, 385, 808 64.00 64.00 66.00 06600 PHYSI CAL THERAPY 5, 224, 123 0 5, 224, 123 65.00 62.00 66.00 66.00 66.00 66.00 66.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 573, 145 4, 573, 145 0 4, 573, 145 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 909, 947 1, 909, 947 0 1, 909, 947 55.00 57.00 05700 CT SCAN 2, 932, 665 2, 932, 665 0 2, 932, 665 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 1, 176, 790 1, 176, 790 0 1, 176, 790 53.99, 147 53.99, 147 53.99, 147 59.00 59.00 06000 LABORATORY 10, 766, 518 0 10, 766, 518 0 10, 766, 518 0 64.00 64.00 06400 INTRAVENOUS THERAPY 0 4, 385, 808 0 4, 385, 808 0 4, 385, 808 64.00 65.00 06500 RESPI RATORY THERAPY 4, 385, 808 0 4, 385, 808 0 4, 385, 808 0 5, 224, 123 0 5, 224, 123 66.00 66.00 06600 PHYSI CAL THERAPY 5, 224, 123 0 5, 224, 123 0 5, 224, 123 67.00 67.00 67.00 <t< td=""></t<>
55.00 05500 RADI OLOGY-THERAPEUTI C 1,909,947 1,909,947 0 1,909,947 55.00 57.00 05700 CT SCAN 2,932,665 2,932,665 0 2,932,665 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 1,176,790 1,176,790 0 1,176,790 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 5,399,147 5,399,147 0 5,399,147 59.00 60.00 06000 LABORATORY 10,766,518 0 10,766,518 00 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 0 4,385,808 0 4,385,808 0 4,385,808 64.00 65.00 06600 PHYSI CAL THERAPY 4,385,808 0 5,224,123 0 5,224,123 66.00 66.00 06600 PHYSI CAL THERAPY 1,231,119 0 1,231,119 67.00 67.00 06700 0CUPATI IONAL THERAPY 1,231,119 0 1,231,119 67.00 68.00 06800 SPEECH PATHOLOGY 266,211 0<
57.00 05700 CT SCAN 2,932,665 2,932,665 0 2,932,665 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 1,176,790 1,176,790 1,176,790 1,176,790 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 5,399,147 5,399,147 0 5,399,147 59.00 60.00 06000 LABORATORY 10,766,518 10,766,518 0 10,766,518 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 4,385,808 0 4,385,808 0 4,385,808 66.00 66.00 06600 PHYSI CAL THERAPY 5,224,123 0 5,224,123 66.00 67.00 0 0 1,231,119 0 1,231,119 0 1,231,119 67.00 68.00 06800 SPECH PATHOLOGY 266,211 0 266,211 0 266,211 68.00 69.00 06900 ELECTROCARDI OLOGY 2,773,475 2,773,475 0 2,773,475
59.00 05900 CARDI AC_CATHETERI ZATI ON 5, 399, 147 0 5, 399, 147 59.00 60.00 06000 LABORATORY 10, 766, 518 10, 766, 518 0 10, 766, 518 0 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 4, 385, 808 0 4, 385, 808 0 4, 385, 808 65.00 66.00 06600 PHYSI CAL THERAPY 5, 224, 123 0 5, 224, 123 0 5, 224, 123 0 5, 224, 123 0 6, 200 67.00 06700 0CCUPATI ONAL THERAPY 1, 231, 119 0 1, 231, 119 67.00 68.00 06800 SPECH PATHOLOGY 266, 211 0 266, 211 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 773, 475 2, 773, 475 0 2, 773, 475 69.00
59.00 05900 CARDI AC_CATHETERI ZATI ON 5, 399, 147 5, 399, 147 0 5, 399, 147 59.00 60.00 06000 LABORATORY 10, 766, 518 10, 766, 518 0 10, 766, 518 0 0 60.00 64.00 64.00 0 0 0 0 64.00 66.00
60.00 06000 LABORATORY 10, 766, 518 0 10, 766, 518 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 4, 385, 808 0 4, 385, 808 0 4, 385, 808 65.00 66.00 06600 PHYSI CAL THERAPY 5, 224, 123 0 5, 224, 123 0 5, 224, 123 0 5, 224, 123 0 5, 224, 123 0 1, 231, 119 67.00 67.00 06700 0CCUPATI ONAL THERAPY 1, 231, 119 0 1, 231, 119 67.00 68.00 9EECH PATHOLOGY 266, 211 0 266, 211 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 773, 475 2, 773, 475 0 2, 773, 475 69.00
64.0006400INTRAVENOUS THERAPY00064.0065.0006500RESPI RATORY THERAPY4, 385, 80804, 385, 80804, 385, 80865.0066.0006600PHYSI CAL THERAPY5, 224, 12305, 224, 12305, 224, 12305, 224, 12366.0067.00067000CCUPATI ONAL THERAPY1, 231, 11901, 231, 11901, 231, 11967.0068.0006800SPEECH PATHOLOGY266, 2110266, 2110266, 21168.0069.0006900ELECTROCARDI OLOGY2, 773, 4752, 773, 47502, 773, 47569.00
65. 0006500RESPI RATORY THERAPY4, 385, 80804, 385, 80804, 385, 80865. 0066. 0006600PHYSI CAL THERAPY5, 224, 12305, 224, 12305, 224, 12366. 0067. 00067000CCUPATI ONAL THERAPY1, 231, 11901, 231, 11901, 231, 11967. 0068. 0006800SPEECH PATHOLOGY266, 2110266, 2110266, 21168. 0069. 0006900ELECTROCARDI OLOGY2, 773, 4752, 773, 47502, 773, 47569. 00
67. 00067000CCUPATI ONAL THERAPY1, 231, 11901, 231, 11901, 231, 11967. 0068. 0006800SPEECH PATHOLOGY266, 2110266, 2110266, 21168. 0069. 0006900ELECTROCARDI OLOGY2, 773, 47502, 773, 47502, 773, 47569. 00
68. 00 06800 SPEECH PATHOLOGY 266, 211 0 266, 211 68. 00 69. 00 06900 ELECTROCARDI OLOGY 2, 773, 475 0 2, 773, 475 69. 00
68. 00 06800 SPEECH PATHOLOGY 266, 211 0 266, 211 68. 00 69. 00 06900 ELECTROCARDI OLOGY 2, 773, 475 0 2, 773, 475 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 514, 442 1, 514, 442 0 1, 514, 442 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 21, 497, 547 21, 497, 547 0 21, 497, 547 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 12, 324, 032 12, 324, 032 0 12, 324, 032 72. 00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 17, 502, 189 17, 502, 189 0 17, 502, 189 73. 00
74. 00 07400 RENAL DI ALYSI S 782, 650 782, 650 0 782, 650 74. 00
76. 00 03950 ENDOSCOPY 1, 740, 794 1, 740, 794 0 1, 740, 794 76. 00
76. 06 03330 I MAGI NG CENTER 2, 552, 853 0 2, 552, 853 0 2, 552, 853 76. 06
76. 97 07697 CARDI AC REHABI LI TATI ON 631, 084 631, 084 0 631, 084 76. 97
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC 0 0 0 90. 00
90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 90. 01
90. 02 04951 ANTI -COAGULATION CLINIC 542, 586 542, 586 0 542, 586 90. 02
90. 03 04952 PALLIATIVE CARE 0 0 0 90. 03
90. 04 04953 SPINE CENTER 502, 852 0 502, 852 90. 04
91. 00 09100 EMERGENCY 16, 827, 284 0 16, 827, 284 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 7, 365, 155 7, 365, 155 7, 365, 155 92. 00
200.00 Subtotal (see instructions) 223, 106, 383 0 223, 106, 383 0 223, 106, 383 200.00
201.00 Less Observation Beds 7, 365, 155 7, 365, 155 7, 365, 155 201.00 202.00 Total (see instructions) 215.744, 239 215.744, 239 215.744, 239 215.744, 239
202. 00 Total (see instructions) 215, 741, 228 0 215, 741, 228 0 215, 741, 228 202. 00

COMPLITATI	nancial Systems		Provider C	N· 15-0128	Peri od:	Worksheet C	2552-10
COMI OTATI			TTOVIGET O	SN. 15 0120	From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre	epared:
						5/30/2022 2:3	34 pm
		-		e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other		
				+ col. 7)	Rati o	Inpati ent	
		(Ratio	
		6.00	7.00	8.00	9.00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS	440 0/4 7/4		110 0/4 7	<i>(</i>)	1	0.00
	000 ADULTS & PEDIATRICS	118, 861, 764		118, 861, 7			30.00
	100 INTENSIVE CARE UNIT	13, 402, 256		13, 402, 2			31.00
	300 NURSERY	4,005,628		4, 005, 6	28		43.00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	59, 033, 064	70, 595, 932				
	100 RECOVERY ROOM	11, 615, 827	24, 468, 645				
	200 DELIVERY ROOM & LABOR ROOM	17, 799, 989	0				
	400 RADI OLOGY-DI AGNOSTI C	7, 404, 056	30, 891, 583				
	500 RADI OLOGY-THERAPEUTI C	8, 625, 413	16, 431, 321				
	700 CT SCAN	19, 248, 384	52, 523, 712				
	800 MAGNETIC RESONANCE IMAGING (MRI)	3, 379, 279	11, 354, 801	14, 734, 08			
	900 CARDI AC CATHETERI ZATI ON	38, 858, 987	67, 631, 241	106, 490, 22	28 0. 050701	0. 000000	59.00
60.00 06	000 LABORATORY	48, 093, 647	33, 045, 854	81, 139, 50	0. 132691	0. 000000	60.00
64.00 06	400 INTRAVENOUS THERAPY	0	0		0 0.00000	0. 000000	64.00
65.00 06	500 RESPI RATORY THERAPY	18, 367, 743	1, 834, 931	20, 202, 6	0. 217090	0. 000000	65.00
66.00 06	600 PHYSI CAL THERAPY	2, 781, 845	8, 117, 519	10, 899, 3	64 0. 479305	0. 000000	66.00
	700 OCCUPATI ONAL THERAPY	2, 048, 827	938, 471	2, 987, 2	98 0. 412118	0. 000000	67.00
68.00 06	800 SPEECH PATHOLOGY	478, 776	165, 391	644, 10	67 0. 413264	0. 000000	68.00
69.00 06	900 ELECTROCARDI OLOGY	6, 508, 148	19, 831, 401	26, 339, 54	49 0. 105297	0. 000000	69.00
70.00 07	000 ELECTROENCEPHALOGRAPHY	454, 164	5, 231, 603	5, 685, 7	67 0. 266357	0. 000000	70.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 729, 594	17, 115, 472	32, 845, 0	66 0. 654514	0. 000000	71.00
72.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	18, 289, 174	16, 118, 863	34, 408, 03	0. 358173	0. 000000	72.00
73.00 07	300 DRUGS CHARGED TO PATIENTS	48, 527, 232	16, 802, 601	65, 329, 8	0. 267905	0. 000000	73.00
74.00 07	400 RENAL DIALYSIS	2, 276, 264	0	2, 276, 20	64 0. 343831	0. 000000	74.00
76.00 03	950 ENDOSCOPY	2, 267, 409	8, 342, 123	10, 609, 5	0. 164078	0. 000000	76.00
76.06 03	330 I MAGI NG CENTER	157, 833	17, 596, 671	17, 754, 50	0. 143786	0. 000000	76.06
76.97 07	697 CARDI AC REHABI LI TATI ON	1, 896	1, 994, 012	1, 995, 90	0. 316189	0. 000000	76.97
	TPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			!		
	000 CLINIC	0	0		0 0.00000	0. 000000	90.00
90.01 04	950 DIABETIC CARE CENTER	0	0		0 0.00000	0. 000000	90.01
90.02 04	951 ANTI-COAGULATION CLINIC	6, 412	1, 192, 330	1, 198, 7	42 0. 452630	0. 000000	90.02
90.03 04	952 PALLIATIVE CARE	0	0		0 0.000000	0. 000000	90.03
	953 SPI NE CENTER	0	429, 317	429, 3			
	100 EMERGENCY	34, 752, 161	118, 740, 969				
	200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 678, 777	6, 455, 376				
200.00	Subtotal (see instructions)	505, 654, 549		1,053,504,6			200.00
201.00	Less Observation Beds						201.00

	Financial Systems	COMMUNITY HOSPI			u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/30/2022 2:3	epared: 34 pm
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30, 00	03000 ADULTS & PEDI ATRI CS					30, 00
31.00	03100 I NTENSI VE CARE UNI T					31.00
43.00	04300 NURSERY					43.00
	ANCI LLARY SERVICE COST CENTERS	1				
50.00	05000 OPERATI NG ROOM	0. 122430				50.00
51.00	05100 RECOVERY ROOM	0. 185349				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 356756				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 119417				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0.076225				55.00
57.00	05700 CT SCAN	0. 040861				57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 079869				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 050701				59.00
60.00	06000 LABORATORY	0. 132691				60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65.00	06500 RESPI RATORY THERAPY	0. 217090				65.00
66.00	06600 PHYSI CAL THERAPY	0. 479305				66.00
67.00	06700 OCCUPATIONAL THERAPY	0. 412118				67.00
68.00	06800 SPEECH PATHOLOGY	0. 413264				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 105297				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 266357				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 654514				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 358173				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 267905				73.00
74.00	07400 RENAL DIALYSIS	0. 343831				74.00
76.00	03950 ENDOSCOPY	0. 164078				76.00
76.06	03330 I MAGI NG CENTER	0. 143786				76.06
76.97	07697 CARDI AC REHABI LI TATI ON	0. 316189				76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 000000				90.00
90.01	04950 DIABETIC CARE CENTER	0. 000000				90.01
90.02	04951 ANTI-COAGULATION CLINIC	0. 452630				90.02
90.03	04952 PALLI ATI VE CARE	0. 000000				90.03
90.04	04953 SPINE CENTER	1. 171284				90.04
91.00	09100 EMERGENCY	0. 109629				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 806331				92.00
200.00	Subtotal (see instructions)					200.00
201.00						201.00
202.00	Total (see instructions)					202.00

Heal th	Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
	ATION OF OUTPATIENT SERVICE COST TO CHARGE RA IONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part II Date/Time Pre 5/30/2022 2:3	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
			(Wkst. B, Part			Reduction	
		I, col. 26)	II col. 26)		-	Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS		1	1			
	05000 OPERATING ROOM	15, 870, 436					
	05100 RECOVERY ROOM	6, 688, 204					
	05200 DELIVERY ROOM & LABOR ROOM	6, 350, 244				0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	4, 573, 145					1
	05500 RADI OLOGY-THERAPEUTI C	1, 909, 947				0	55.00
	05700 CT SCAN	2, 932, 665			25 0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 176, 790				0	58.00
	05900 CARDI AC CATHETERI ZATI ON	5, 399, 147	778, 105	4, 621, 04	42 0	0	59.00
60.00	06000 LABORATORY	10, 766, 518	258, 286	10, 508, 2	32 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	4, 385, 808	148, 973	4, 236, 8	35 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	5, 224, 123	646, 499	4, 577, 6	24 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 231, 119	45, 756	1, 185, 3	53 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	266, 211	9, 976	256, 23	35 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 773, 475	294, 209	2, 479, 20	66 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 514, 442	186, 328	1, 328, 1	14 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 497, 547	1, 746, 779	19, 750, 7	68 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 324, 032	155, 295	12, 168, 7	37 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 502, 189				0	73.00
74.00	07400 RENAL DI ALYSI S	782,650				0	74.00
	03950 ENDOSCOPY	1, 740, 794				0	76.00
	03330 I MAGI NG CENTER	2, 552, 853				0	76.06
	07697 CARDI AC REHABI LI TATI ON	631,084					
	OUTPATIENT SERVICE COST CENTERS						1
	09000 CLINIC	0	C		0 0	0	90.00
	04950 DIABETIC CARE CENTER	0			0 0		
	04951 ANTI -COAGULATI ON CLI NI C	542, 586	7, 548	535, 0		0	90.02
	04952 PALLIATIVE CARE	0 12, 000		220, 0	0 0	0	
	04953 SPI NE CENTER	502, 852	75, 423	427, 42	-	0	90.04
	09100 EMERGENCY	16, 827, 284				0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 365, 155				0	
200.00		153, 331, 300				-	200.00
200.00		7, 365, 155					200.00
201.00		145, 966, 145					201.00
202.00		1 145, 700, 145	12,234,307	155,711,0	0	0	202.00

Health Financial Systems CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F	COMMUNITY HOSI	Provider C	ON: 15 0120	Peri od:	u of Form CMS Worksheet C	-2002-
REDUCTIONS FOR MEDICALD ONLY	ATTUS NET OF	Provider C	UN. 13-0120	From 01/01/2021 To 12/31/2021	Part II Date/Time Pr 5/30/2022 2:	epared
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
·	Capital and	(Worksheet C,	Cost to Char	ge		
	Operating Cost	Part I, column		6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	15, 870, 436					50. C
51.00 05100 RECOVERY ROOM	6, 688, 204	36, 084, 472	0. 1853	49		51. C
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 350, 244	17, 799, 989		56		52. C
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 573, 145	38, 295, 639				54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 909, 947	25, 056, 734				55. C
7. 00 05700 CT SCAN	2, 932, 665	71, 772, 096				57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 176, 790	14, 734, 080	0. 0798	69		58. (
9. 00 05900 CARDI AC CATHETERI ZATI ON	5, 399, 147	106, 490, 228	0. 0507	01		59.0
0. 00 06000 LABORATORY	10, 766, 518	81, 139, 501	0. 1326	91		60.0
4.00 06400 INTRAVENOUS THERAPY	0	0	0.0000	00		64.
5. 00 06500 RESPI RATORY THERAPY	4, 385, 808	20, 202, 674	0. 2170	90		65.0
6. 00 06600 PHYSI CAL THERAPY	5, 224, 123	10, 899, 364	0. 4793	05		66.0
7.00 06700 OCCUPATI ONAL THERAPY	1, 231, 119	2, 987, 298		18		67.0
8.00 06800 SPEECH PATHOLOGY	266, 211	644, 167		64		68.
9. 00 06900 ELECTROCARDI OLOGY	2, 773, 475	26, 339, 549	0. 1052	97		69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	1, 514, 442	5, 685, 767	0. 2663	57		70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 497, 547	32, 845, 066	0. 6545	14		71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 324, 032	34, 408, 037	0. 3581	73		72.
3.00 07300 DRUGS CHARGED TO PATIENTS	17, 502, 189	65, 329, 833				73.
4. 00 07400 RENAL DI ALYSI S	782, 650	2, 276, 264				74.
6. 00 03950 ENDOSCOPY	1, 740, 794	10, 609, 532				76.
6. 06 03330 I MAGI NG CENTER	2, 552, 853	17, 754, 504				76.
6. 97 07697 CARDI AC REHABI LI TATI ON	631,084	1, 995, 908				76.
OUTPATIENT SERVICE COST CENTERS	001,001	1, 770, 700	0.0101	57		- /0.
0. 00 09000 CLINIC	0	0	0.0000	20		90.
0. 01 04950 DIABETIC CARE CENTER	0	0	0.0000			90.
0. 02 04951 ANTI-COAGULATION CLINIC	542, 586	1, 198, 742				90.
0. 03 04952 PALLIATIVE CARE	0,2,000	۲, ۲, ۵, 7, 42 ۵	0.0000			90.
0. 04 04953 SPINE CENTER	502, 852	429, 317				90.
1. 00 09100 EMERGENCY	16, 827, 284	153, 493, 130				91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 365, 155	9, 134, 153				92.
00.00 Subtotal (sum of lines 50 thru 199)	153, 331, 300	917, 235, 040		51		200.
01.00 Less Observation Beds	7, 365, 155	917, 235, 040				200.
202.00 Total (line 200 minus line 201)	145, 966, 145	0				201.0
	145, 700, 145	717,230,040	1	1		1202.

Health Financial Systems	COMMUNITETIOS	COMMUNITY HOSPITAL SOUTH			In Lieu of Form CMS-2		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAR	PLTAL COSTS	Provider CO		Peri od:	Worksheet D		
				From 01/01/2021	Part I		
				To 12/31/2021	Date/Time Pre	pared:	
					5/30/2022 2:3	4 pm	
			XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient			
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)		
	(from Wkst. B,		Related Cost				
	Part II, col.		(col. 1 - col				
	26)		2)				
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS			•				
30. 00 ADULTS & PEDIATRICS	3, 460, 185	0	3, 460, 18	5 42, 207	81.98	30.00	
31.00 INTENSIVE CARE UNIT	1,011,758		1, 011, 75		325.32	31.00	
43.00 NURSERY	94, 038		94, 03				
200.00 Total (lines 30 through 199)	4, 565, 981		4, 565, 98			200.00	
Cost Center Description	I npati ent	Inpati ent					
	Program days	Program					
	3 5	Capital Cost					
		(col. 5 x col.					
		6)					
	6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	10, 289	843, 492				30.00	
31.00 INTENSIVE CARE UNIT	935	304, 174				31.00	
43. 00 NURSERY	,	001,171				43.00	
200.00 Total (lines 30 through 199)	11, 224	1, 147, 666				200.00	

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/30/2022 2:3	pared: 4 pm
		Title	× XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	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)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 312, 745	129, 628, 996	0. 0255	56 17, 139, 862	438, 026	50.00
51.00 05100 RECOVERY ROOM	346, 300	36, 084, 472	0.0095	2, 557, 616	24, 545	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	408, 939	17, 799, 989	0. 0229	74 16, 943	389	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	643, 199	38, 295, 639	0. 01679	2, 490, 075	41, 823	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	273, 494	25, 056, 734	0. 0109	15 2, 740, 590	29, 914	55.00
57.00 05700 CT SCAN	126, 740	71, 772, 096	0.0017	6, 174, 770	10, 905	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	72,460					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	778, 105					59.00
60. 00 06000 LABORATORY	258, 286					60.00
64.00 06400 INTRAVENOUS THERAPY	0					64.00
65. 00 06500 RESPI RATORY THERAPY	148, 973	20, 202, 674	0.0073	4, 758, 520	35, 089	65.00
66. 00 06600 PHYSI CAL THERAPY	646, 499					66.00
67.00 06700 OCCUPATI ONAL THERAPY	45, 756					67.00
68. 00 06800 SPEECH PATHOLOGY	9, 976					68.00
69. 00 06900 ELECTROCARDI OLOGY	294, 209					
70. 00 07000 ELECTROENCEPHALOGRAPHY	186, 328					70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 746, 779					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	155, 295					
73.00 07300 DRUGS CHARGED TO PATIENTS	863, 053					73.00
74. 00 07400 RENAL DI ALYSI S	37,639					74.00
76. 00 03950 ENDOSCOPY	228, 723				1, 294	76.00
76. 06 03330 I MAGI NG CENTER	418, 343					76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	25, 093					76.97
OUTPATIENT SERVICE COST CENTERS	23,073	1,773,700	0.0123	0		/0. //
90. 00 09000 CLINIC	0	0	0,0000	0 00	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	-				90.01
90. 02 04951 ANTI - COAGULATI ON CLINIC	7, 548	-			-	90.02
90. 03 04952 PALLI ATI VE_CARE	,, 340				-	90.02
90. 04 04953 SPINE CENTER	75, 423	-			-	90.03
91. 00 09100 EMERGENCY	1, 144, 404				u u	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	446, 063					
200.00 Total (lines 50 through 199)	12, 700, 372			103, 020, 123		
	1 12,700,372	1 717, 200, 040	I	100,020,120	1, 577, 427	200.00

Health Financial Systems	COMMUNI TY HOS	PITAL SOUTH		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COST			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/30/2022 2:3	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	n Cost	Medi cal	
	Post-Stepdown	0	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		o o	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	$5 \div col, 6)$	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	42, 20	7 0.00	10, 289	30.00
31.00 03100 INTENSIVE CARE UNIT		0	3, 11		935	31.00
43. 00 04300 NURSERY		0	2, 59			
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	I npati ent				, 22 1	200100
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	I O					1200.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	S Provider C	CN: 15-0128		eriod: com 01/01/2021 o 12/31/2021	Worksheet D Part IV Date/Time Pre 5/30/2022 2:3	pared: 4 pm
	-		XVIII		Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	Allied Health	
	Anestheti st	Program	Program		Post-Stepdown		
	Cost	Post-Stepdown			Adjustments		
	1.00	Adjustments	0.00				
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0		0	0	0	50.00
51. 00 05100 PERATING ROOM	0	-		0	0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0	0	0	52.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0	0	0	54.00
57. 00 05700 CT SCAN	0			0	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	0	0	59.00
60. 00 06000 LABORATORY	0			0	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0			0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74. 00 07400 RENAL DIALYSIS	0	0		0	0	0	74.OC
76. 00 03950 ENDOSCOPY	0	0		0	0	0	76.00
76.06 03330 I MAGI NG CENTER	0	0		0	0	0	76.06
76. 97 07697 CARDIAC REHABILITATION	0	0	I	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1		1				
90. 00 09000 CLINIC	0	-		0	0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	, s		0	0	0	90.01
90. 02 04951 ANTI - COAGULATI ON CLINIC	0	0		0	0	0	90.02
90. 03 04952 PALLI ATI VE CARE	0	0		0	0	0	90.03
90. 04 04953 SPI NE CENTER	0	0		0	0	0	90.04
91.00 09100 EMERGENCY	0	0		0	0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0			0	_	0	92.00
200.00 Total (lines 50 through 199)	0	0	1	0	0	0	200.00

	Financial Systems	COMMUNITY HOS				u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Period: From 01/01/2021	Worksheet D Part IV	
THROUG	GH COSTS				To 12/31/2021	Date/Time Pre	nared
					10 12/01/2021	5/30/2022 2:3	4 pm
			Title	e XVIII	Hospi tal	PPS	•
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	T	4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS	_					
50.00	05000 OPERATING ROOM	0			0 129, 628, 996		
51.00	05100 RECOVERY ROOM	0	0		0 36, 084, 472		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 17, 799, 989		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 38, 295, 639		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 25, 056, 734		
57.00	05700 CT SCAN	0	0		0 71, 772, 096		
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 14, 734, 080		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 106, 490, 228	0.000000	59.00
60.00	06000 LABORATORY	0	0		0 81, 139, 501	0.000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0		
65.00	06500 RESPI RATORY THERAPY	0	0		0 20, 202, 674	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 10, 899, 364	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 987, 298	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 644, 167		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 26, 339, 549		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 685, 767	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 32, 845, 066	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 34, 408, 037		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 65, 329, 833		
74.00	07400 RENAL DI ALYSI S	0	0		0 2, 276, 264		
76.00	03950 ENDOSCOPY	0	0		0 10, 609, 532		
76.06	03330 I MAGI NG CENTER	0			0 17, 754, 504		76.06
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 1, 995, 908	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			0 0		
90.01	04950 DI ABETI C CARE CENTER	0	0		0 0	0.000000	
90.02	04951 ANTI-COAGULATION CLINIC	0	0		0 1, 198, 742		
90.03	04952 PALLI ATI VE CARE	0	0		0 0	0.000000	
90.04	04953 SPINE CENTER	0	0		0 429, 317		
91.00	09100 EMERGENCY	0	0		0 153, 493, 130		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 9, 134, 153	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	1	0 917, 235, 040	1	200.00

Health Financial Systems	COMMUNITY HOSP				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/30/2022 2:3	
		Title	XVIII	Hospi tal	PPS	4 pili
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	J	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATI NG ROOM	0. 000000	17, 139, 862		0 11, 209, 856	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	2, 557, 616	1	0 4, 806, 124	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	16, 943	1	0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 490, 075		0 5, 648, 466	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	2, 740, 590		0 6, 952, 451	0	55.00
57.00 05700 CT SCAN	0. 000000	6, 174, 770		0 8, 547, 485	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	1, 130, 306		0 2, 386, 727		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	11, 781, 363		0 21, 192, 729		59.00
60. 00 06000 LABORATORY	0. 000000	14, 724, 114		0 4, 875, 207	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0, 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0, 000000	4, 758, 520		0 288, 070	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	962, 897		0 43, 132	Ŭ	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	779, 279		0 7,675		67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	168, 723		0 4, 543		68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 432, 127		0 5, 150, 398		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	156, 451		0 816, 065		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 672, 879		0 3, 931, 252		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 990, 137				72.00
73. 00 07200 DRUGS CHARGED TO PATIENTS	0.000000	13, 192, 306		0 5, 645, 465 0 4, 295, 459		73.00
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	0.000000	13, 192, 306				74.00
		•			0	
76. 00 03950 ENDOSCOPY	0. 000000	60, 011		0 1, 628, 647	0	76.00
76. 06 03330 I MAGI NG CENTER	0. 000000	0		0 2, 995, 888		76.06
76. 97 O7697 CARDIAC REHABILITATION	0. 000000	0		0 625, 118	0	76.97
	0,000000	0		0	0	
90. 00 09000 CLINIC	0. 000000 0. 000000	0		0 0		90.00
90. 01 04950 DIABETIC CARE CENTER		0			-	90.01
90. 02 04951 ANTI - COAGULATI ON CLINIC	0.00000	0		0 453, 110		90.02
90. 03 04952 PALLI ATI VE CARE	0. 000000	0		0 0		90.03
90. 04 04953 SPI NE CENTER	0. 000000	0		0 0	0	90.04
91.00 09100 EMERGENCY	0. 000000	11,031,353		0 12, 191, 024		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2,059,801		0 2, 567, 821	0	
200.00 Total (lines 50 through 199)		103, 020, 123		0 106, 262, 712	0	200.00

APPORTIONMENT OF MEDICAL, OT	HER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0128	Peri od:	worksheet D	
					From 01/01/2021 To 12/31/2021		epared: 34 pm
			Title	e XVIII	Hospi tal	PPS	
				Charges		Costs	
Cost Center Desc	ription	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	0.00	(see inst.)	(see inst.)	5.00	
		1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COS 50.00 05000 OPERATI NG ROOM	I CENTERS	0. 121415	11, 209, 856		0 0	1 2/1 0/5	50,00
51.00 05100 RECOVERY ROOM		0. 121415			0 0		
52.00 05200 DELIVERY ROOM &		0. 356756			0 0		
54. 00 05400 RADI OLOGY-DI AGNO		0. 358758			0 0	-	
55. 00 05500 RADI OLOGY-THERAF		0. 076225			0 0	529, 951	
57. 00 05700 CT SCAN	EUTIC	0. 040861			0 0		
58. 00 05800 MAGNETIC RESONAN	ICE LMACING (MDL)	0. 079869			0 0		
59. 00 05900 CARDI AC CATHETER	. ,	0. 050701			0 0		
60. 00 06000 LABORATORY	AT ZATTON	0. 132691			0 0	646, 896	
64. 00 06400 I NTRAVENOUS THEF		0. 000000		1	0 0	040,090	
65. 00 06500 RESPI RATORY THEF		0. 217090			0 0	62, 537	
66. 00 06600 PHYSI CAL THERAPY		0. 472078			0 0	20, 362	
67.00 06700 OCCUPATIONAL THE		0. 412118			0 0	3, 163	
68.00 06800 SPEECH PATHOLOGY		0. 413264			0 0	1, 877	
69. 00 06900 ELECTROCARDI OLOC		0. 105297			0 0	542, 321	
70.00 07000 ELECTROENCEPHAL		0. 266357			0 0	217, 365	
71.00 07100 MEDI CAL SUPPLIES		0. 654514			0 0		
72.00 07200 I MPL. DEV. CHARC		0. 358173			0 0		
73.00 07300 DRUGS CHARGED TO) PATI ENTS	0. 267905			0 31, 239		
74.00 07400 RENAL DIALYSIS		0. 343831	0)	0 0	0	74.00
76.00 03950 ENDOSCOPY		0. 164078	1, 628, 647		0 0	267, 225	76.00
76.06 03330 I MAGI NG CENTER		0. 143786			0 0	430, 767	76.06
76. 97 07697 CARDI AC REHABI LI	TATION	0. 316189	625, 118		0 0	197, 655	76.97
OUTPATIENT SERVICE COS	ST CENTERS					-	
90. 00 09000 CLINIC		0. 000000			0 0	0	90.00
90. 01 04950 DI ABETI C CARE CE		0. 000000			0 0		
90. 02 04951 ANTI - COAGULATI ON	I CLINIC	0. 452630			0 0	205, 091	
90. 03 04952 PALLI ATI VE CARE		0. 000000			0 0	0	
90. 04 04953 SPI NE CENTER		1. 171284			0 0	-	
91.00 09100 EMERGENCY		0. 107565			0 0	.,	
92.00 09200 OBSERVATI ON BEDS		0. 806331			0 0	_,	
200.00 Subtotal (see in			106, 262, 712	1	0 31, 239		
	Lab. Services-Program				0 0		201.00
Only Charges			10/ 0/0 710		0 01 000	1/ 700 /00	000 00
202.00 Net Charges (lir	ne 200 - line 201)	1	106, 262, 712		0 31, 239	16, 793, 693	202.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pro 5/30/2022 2:3	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts			1	
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	8, 369				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76. 00 03950 ENDOSCOPY	0	0				76.00
76.06 03330 I MAGI NG CENTER	0	0				76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0					90.00
90. 01 04950 DI ABETI C CARE CENTER	0	-				90.01
90. 02 04951 ANTI - COAGULATI ON CLINIC	0	0				90.02
90. 03 04952 PALLI ATI VE CARE	0	0				90.03
90. 04 04953 SPI NE CENTER	0	0				90.04
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	8, 369				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	_	0.2/0				202.00
202.00 Net Charges (line 200 - line 201)	0	8, 369	l			202.00

Health Financial Systems	COMMUNI TY HOSE	PITAL SOUTH		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OF	CAPITAL COSTS	Provider CO		Period:	Worksheet D	
				rom 01/01/2021	Part I	
			[]	To 12/31/2021		
			NI N		5/30/2022 2:3	4 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 ADULTS & PEDIATRICS	3, 460, 185	0	3, 460, 185	42, 207	81.98	30.00
31. 00 INTENSIVE CARE UNIT	1,011,758		1, 011, 758	3, 110	325.32	31.00
43.00 NURSERY	94, 038		94, 038	2, 597	36.21	43.00
200.00 Total (lines 30 through 199)	4, 565, 981		4, 565, 981	47, 914		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
	0 9	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 ADULTS & PEDIATRICS	1, 465	120, 101				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
43.00 NURSERY	1, 455	52, 686				43.00
200.00 Total (lines 30 through 199)	2, 920	172, 787				200.00

Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	COMMUNITY HOS	Provider C	CN. 15 0120	Period:	u of Form CMS-: Worksheet D	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL CUSIS	Provider C	CN: 15-0128	From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre	pared:
					5/30/2022 2:3	4 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	-	r	1	1	r	
50. 00 05000 OPERATI NG ROOM	3, 312, 745					
51.00 05100 RECOVERY ROOM	346, 300					
52.00 05200 DELIVERY ROOM & LABOR ROOM	408, 939					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	643, 199	38, 295, 639	0. 01679	226, 668	3, 807	54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	273, 494	25, 056, 734	0. 0109	15 212, 911	2, 324	55.00
57.00 05700 CT SCAN	126, 740	71, 772, 096	0.00176	66 683, 389	1, 207	57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	72, 460	14, 734, 080	0.0049	18 87, 922	432	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	778, 105	106, 490, 228	0.00730	07 866, 925	6, 335	59.0
50. 00 06000 LABORATORY	258, 286	81, 139, 501	0.00318	1, 667, 286		
54.00 06400 INTRAVENOUS THERAPY	0					64.00
65. 00 06500 RESPI RATORY THERAPY	148, 973	20, 202, 674			7, 172	65.00
56. 00 06600 PHYSI CAL THERAPY	646, 499					
57.00 06700 OCCUPATIONAL THERAPY	45, 756					•
58.00 06800 SPEECH PATHOLOGY	9, 976					
59. 00 06900 ELECTROCARDI OLOGY	294, 209					
70. 00 07000 ELECTROENCEPHALOGRAPHY	186, 328					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 746, 779					
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	155, 295					
73. 00 07300 DRUGS CHARGED TO PATIENTS	863, 053					1
74. 00 07400 RENAL DIALYSIS	37,639					
76. 00 03950 ENDOSCOPY	228, 723					
76. 06 03330 I MAGI NG CENTER	418, 343					
76. 97 07697 CARDI AC REHABI LI TATI ON	25, 093				-	
OUTPATIENT SERVICE COST CENTERS	25,075	1, 993, 900	0.0125	0	0	70.9
20. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.0
20. 01 04950 DI ABETI C CARE CENTER	0	-	0.0000		0	
20. 01 04950 DTABETTC CARE CENTER 20. 02 04951 ANTI-COAGULATION CLINIC	7, 548	, s			0	
20. 02 04951 ANTI-COAGOLATTON CLINIC 20. 03 04952 PALLIATIVE CARE	7, 548				0	
20. 03 04952 PALLIATIVE CARE 20. 04 04953 SPINE CENTER	0	, s				
	75, 423				-	
91.00 09100 EMERGENCY	1, 144, 404					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	446,063					
200.00 Total (lines 50 through 199)	12, 700, 372	917, 235, 040	1	10, 107, 024	123, 962	1200.00

Health Financial Systems	COMMUNI TY HOS	PITAL SOUTH		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COST			Period: From 01/01/2021 To 12/31/2021	5/30/2022 2:3	pared: 4 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
·	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	5	Adjustments		Education Cost	
	Adjustments					
	1A	1,00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	20	2.00	0.00	
30, 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	1 30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
43. 00 04300 NURSERY	0	0			0	
200.00 Total (lines 30 through 199)	0	0			, o	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
oust center beschiption	Adjustment	(sum of cols.	Days	$5 \div col.$ (col.	Program Days	
	Amount (see	1 through 3,	Days	5 . cor. o)		
		minus col. 4)				
	4,00	5.00	6,00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS		0	42, 20	7 0.00	1, 465	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	3, 11			
43. 00 04300 NURSERY		0	2, 59			43.00
		0				200.00
	Long the set	0	47,91	4	2, 920	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 I NTENSI VE CARE UNI T	0					31.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS					Worksheet D Part IV Date/Time Pre 5/30/2022 2:3	pared: 4 pm
	-		e XIX		Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown	Nursing Program		Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	Adjustments 2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00		3A	3.00	
50. 00 05000 OPERATING ROOM	0	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
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
57. 00 05700 CT SCAN	0			0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0)	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76.00 03950 ENDOSCOPY	0	0		0	0	0	76.00
76.06 03330 I MAGI NG CENTER	0	-		0	0	0	76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
	0	0	1	0	0	0	
90. 00 09000 CLINIC 90. 01 04950 DIABETIC CARE CENTER	0	-		0	0	0	90.00 90.01
90. 01 04950 DTABETTC CARE CENTER 90. 02 04951 ANTI - COAGULATI ON CLINIC	0			0	0	0	90.01
90. 02 04951 ANTI-COAGOLATION CLINIC 90. 03 04952 PALLI ATI VE CARE	0			0	0	0	90.02
90. 04 04952 PALLIATIVE CARE 90. 04 04953 SPINE CENTER	0			0	0	0	90.03
91. 00 09100 EMERGENCY	0			0	0	0	90.04
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0	0	-	200.00
······································			1	-1	9	Ŭ	

APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0128	Peri od:	Worksheet D	2552-1
THROUG	H COSTS				From 01/01/2021	Part IV	
					To 12/31/2021	Date/Time Pre	pared:
			T; +1	e XIX	Hospi tal	5/30/2022 2:3 PPS	4 pm
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost	•	Cost (sum of		$(col. 5 \div col.$	
		Education cost	4)	col s. 2, 3,	8)	7)	
			''	and 4)	0)	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 129, 628, 996	0.000000	1 50. O
51.00	05100 RECOVERY ROOM	0	0		0 36, 084, 472	0. 000000	51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 17, 799, 989		52.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 38, 295, 639	0. 000000	54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 25, 056, 734		
57.00	05700 CT SCAN	0	0		0 71, 772, 096		
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 14, 734, 080		
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 106, 490, 228		
	06000 LABORATORY	0	0		0 81, 139, 501	0, 000000	
64.00	06400 INTRAVENOUS THERAPY	0	0		0 0		
5.00	06500 RESPI RATORY THERAPY	0	0		0 20, 202, 674		
6.00	06600 PHYSI CAL THERAPY	0	0		0 10, 899, 364		
	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 987, 298		
58.00	06800 SPEECH PATHOLOGY	0	0		0 644, 167		
59.00	06900 ELECTROCARDI OLOGY	0	0		0 26, 339, 549		
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 685, 767		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 32, 845, 066		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 34, 408, 037		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 65, 329, 833		
	07400 RENAL DI ALYSI S	0	0		0 2, 276, 264		
	03950 ENDOSCOPY	0	0		0 10, 609, 532		
	03330 I MAGI NG CENTER	0	0		0 17, 754, 504		
	07697 CARDI AC REHABI LI TATI ON	0	0		0 1, 995, 908		
	OUTPATIENT SERVICE COST CENTERS			I			
0.00	09000 CLI NI C	0	0		0 0	0.000000	1 90.0
0. 01	04950 DIABETIC CARE CENTER	0			0 0	0.000000	
	04951 ANTI-COAGULATION CLINIC	0	0		0 1, 198, 742		
	04952 PALLIATIVE CARE	0	0		0 0		
	04953 SPI NE CENTER	0	0		0 429, 317		
	09100 EMERGENCY	0	0		0 153, 493, 130		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 9, 134, 153		
200.00		0	0		0 917, 235, 040		200. 0

Heal th Financial Systems	COMMUNITY HOSPI		01 45 0400		u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	JN: 15-0128	Period: From 01/01/2021	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2021	Date/Time Pre	nared
				10 12/31/2021	5/30/2022 2:3	4 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0.000000	841, 567		0 0		50.00
51.00 05100 RECOVERY ROOM	0. 000000	201, 553		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	155, 551		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	226, 668		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	212, 911		0 0	0	55. OC
57.00 05700 CT SCAN	0. 000000	683, 389	1	0 0	0	57. OC
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	87, 922		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	866, 925		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	1, 667, 286		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0.000000	972, 583		0 0	0	65. OC
66.00 06600 PHYSI CAL THERAPY	0.000000	75, 877		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	43, 849		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	16, 028		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	181, 468		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	27, 943		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	454, 737		0 0	-	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	200, 479		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 863, 974		0 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	28, 014		0 0	0	74.00
74. 00 107400 KEINAL DI ALI SI S 76. 00 103950 ENDOSCOPY	0. 000000	60, 083		0 0	0	76.00
76. 06 03330 I MAGI NG CENTER	0. 000000	00,083		0 0	-	76.06
76. 97 07697 CARDIAC REHABILITATION	0.000000	0		0 0		76.97
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	10.91
90. 00 09000 CLINIC	0. 000000	0	1	0 0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0. 000000	0		0 0		90.00
90. 02 04951 ANTI-COAGULATION CLINIC	0. 000000	0		0 0		90.02
90. 03 04952 PALLI ATI VE CARE	0. 000000	0		0 0		90.02
90. 03 04952 PALLIATIVE CARE 90. 04 04953 SPI NE CENTER	0.000000	0		0 0	-	90.03
90. 04 04953 SPINE CENTER 91. 00 09100 EMERGENCY	0.000000	0				90.02
	0.000000	1, 206, 921		-	-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.00000	31, 296		0 0		•
200.00 Total (lines 50 through 199)		10, 107, 024	I	0 0	0	200.00

APPORTI ONMI	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/30/2022 2:3	
			Titl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	. ,	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	0. 122430	0			0	50.00
51.00 0510	DO RECOVERY ROOM	0. 185349	0	299, 74	40 0	0	51.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0. 356756	0		0 0	0	52.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	0. 119417	0	717, 40	69 0	0	54.00
55.00 0550	00 RADI OLOGY-THERAPEUTI C	0. 076225	0	275, 42	24 0	0	55.00
57.00 0570	DO CT SCAN	0. 040861	0	1, 767, 60	62 0	0	57.00
58.00 0580	DO MAGNETIC RESONANCE IMAGING (MRI)	0. 079869	0	124, 18	84 0	0	58.00
	O CARDI AC CATHETERI ZATI ON	0. 050701	0	311, 55	56 0	0	59.00
60.00 0600	DO LABORATORY	0. 132691	0	1, 181, 9	71 0	0	60.00
64.00 0640	00 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65.00 0650	00 RESPI RATORY THERAPY	0. 217090	0	40, 70	0 07	0	65.00
66.00 0660	0 PHYSI CAL THERAPY	0. 479305	0	57, 35	55 0	0	66.00
67.00 0670	OCCUPATIONAL THERAPY	0. 412118	0	11, 99	99 0	0	67.00
68.00 0680	OO SPEECH PATHOLOGY	0. 413264	0	4, 54	48 0	0	68.00
69.00 0690	00 ELECTROCARDI OLOGY	0. 105297	0	166, 60	0 80	0	69.00
70.00 0700	00 ELECTROENCEPHALOGRAPHY	0. 266357	0	42, 81	13 0	0	70.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 654514	0	195, 82	23 0	0	71.00
72.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	0. 358173	0	44, 24	41 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 267905	0	219, 04	44 0	0	73.00
74.00 0740	DO RENAL DIALYSIS	0. 343831	0		0 0	0	74.00
76.00 0395	O ENDOSCOPY	0. 164078	0	69, 08	39 0	0	76.00
	BO I MAGI NG CENTER	0. 143786	0	145, 94	42 0	0	76.06
76.97 0769	7 CARDI AC REHABILI TATI ON	0. 316189	0		0 0	0	76.97
OUTP	ATIENT SERVICE COST CENTERS						
	DO CLINIC	0. 000000	0		0 0	0	90.00
90.01 0495	O DIABETIC CARE CENTER	0. 000000	0		0 0	0	90.01
90. 02 0495	51 ANTI-COAGULATION CLINIC	0. 452630	0	10, 52	20 0	0	90.02
90.03 0495	2 PALLIATIVE CARE	0. 000000	0		0 0	0	90.03
90.04 0495	3 SPINE CENTER	1. 171284	0		0 0	0	90.04
91.00 0910	DO EMERGENCY	0. 109629	0	6, 017, 6 ⁻	13 0	0	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 806331	0	1, 92	21 0	0	92.00
200.00	Subtotal (see instructions)		0			0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1	0	12, 476, 62	23 0	<u>م</u>	202.00

Health Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pr 5/30/2022 2:	
		Titl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	94, 319	0				50.00
51. 00 05100 RECOVERY ROOM	55, 557					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	85, 678					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	20, 994					55.00
57. 00 05700 CT SCAN	72, 228					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	9, 918					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	15, 796					59.00
60. 00 06000 LABORATORY	156, 837					60.00
64. 00 06400 I NTRAVENOUS THERAPY	0					64.00
65. 00 06500 RESPI RATORY THERAPY	8, 837					65.00
66. 00 06600 PHYSI CAL THERAPY	27, 491					66.00
67.00 06700 OCCUPATI ONAL THERAPY	4, 945	0				67.00
68.00 06800 SPEECH PATHOLOGY	1, 880	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	17, 543					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	11, 404					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	128, 169					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 846					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 683					73.00
74.00 07400 RENAL DI ALYSI S	0	, o				74.00
76. 00 03950 ENDOSCOPY	11, 336					76.00
76.06 03330 I MAGI NG CENTER	20, 984					76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
	0	0				
90. 00 09000 CLINIC 90. 01 04950 DIABETIC CARE CENTER	0					90.00 90.01
90. 02 04951 ANTI-COAGULATION CLINIC	4, 762					90.01
90. 03 04952 PALLI ATI VE CARE	4,702					90.02
90. 04 04953 SPI NE CENTER	0					90.03
91. 00 09100 EMERGENCY	659, 705					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 549					92.00
200.00 Subtotal (see instructions)	1, 484, 461					200.00
201.00 Less PBP Clinic Lab. Services-Program	0					200.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1, 484, 461	0				202.00

	Financial Systems COMMUNITY HOSPI ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0128	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 2:3	pare
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s excluding newborn)		42, 207	1 1
00	Inpatient days (including private room days, excluding swing-			42, 207	
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed dave)		36, 766	4
00	Total swing-bed SNF type inpatient days (including private ro	5 7	er 31 of the cost	0	
	reporting period			-	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	r 31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	o the Program (excluding	a swina-bed and	10, 289	9
	newborn days) (see instructions)	0 1	5 6		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room davs) after	0	11
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	J		
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lin	ne)		
. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 o	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruction		ting pariod (line	57, 132, 900	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	er 31 of the cost repor	ting period (inne	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 21 of the cost reporti	ing pariod (line	0	24
. 00	7 x line 19)		ng period (inne	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		57, 132, 900	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			· · ·	
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x li	, ,	56 0137	0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	-		0	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	57, 132, 900	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
. 00	Adjusted general inpatient routine service cost per diem (see	-		1, 353. 64	
. 00 . 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		13, 927, 602 0	
	Incar carry necessary private room cost appricable to the riogr			0	1 70

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0128	Period:	Worksheet D-1	1
					From 01/01/2021 To 12/31/2021		epare
				× XVIII	Hospi tal	5/30/2022 2:3 PPS	34 pm
	Cost Center Description	Total	Total	Average Per			
		Inpatient Costl	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	0	0) 42.
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT	9, 065, 317	3, 110	2, 914.	89 935	2, 725, 422	
. 00 . 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
	SURGI CAL I NTENSI VE CARE UNI T						40.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						_
. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1.00 18,720,179	9 48
	Total Program inpatient costs (sum of lines			ns)		35, 373, 203	
	PASS THROUGH COST ADJUSTMENTS			- /		1	
. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	ı Wkst. D, sur	m of Parts I and	1, 147, 666	5 50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	ationt ancillary	, sorvicos (fr	om What D	cum of Parts II	1, 399, 429	51
. 00	and IV)	attent and trais	Services (II	UIII WKSL. D, S	Sum OF Faits II	1, 377, 425	7 51
. 00	Total Program excludable cost (sum of lines !	50 and 51)				2, 547, 095	5 52
8.00	Total Program inpatient operating cost exclud		ated, non-phy	sician anestl	netist, and	32, 826, 108	3 53
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
. 00	Program di scharges					0	54
. 00	Target amount per discharge						55
. 00	Target amount (line 54 x line 55)					(c	
. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting poriod a	nding 1006 u	undated and c	ampounded by the	0.00	
. 00	market basket	bor tring period e	inding 1990, u		Silipounded by the	0.00	5 57
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	60 60
. 00	If line 53/54 is less than the lower of lines					C	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		G (TINES 54 X	60), or 1% of	r the target		
2. 00	Relief payment (see instructions)	1311 4011 0113)				0	62.
. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			c	63
	PROGRAM INPATIENT ROUTINE SWING BED COST					1	
1.00	Medicare swing-bed SNF inpatient routine cosi instructions)(title XVIII only)	ts through Decem	nder 31 of the	e cost report	ng period (See	C	64.
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reportin	a period (See	0	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line 6	5)(title XVI	ll only). For	C	66 0
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	a costs through	December 31 c	of the cost r	porting period	0	67
	(line 12 x line 19)	0					07.
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	(c	68.
	(line 13 x line 20)	autina aaata (l	ing (7 , ling	(0)			
. 00	Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU					<u> </u>) 69.
. 00	Skilled nursing facility/other nursing facili)		70
. 00	Adjusted general inpatient routine service co	ost per diem (li					71
. 00	Program routine service cost (line 9 x line		(1)	25)			72
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73
. 00	Capital -related cost allocated to inpatient	•			Part II. column		75
	26, line 45)		、· ·				
. 00	Per diem capital-related costs (line 75 ÷ lin						76
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus	,					77
00	Aggregate charges to beneficiaries for excess	· ·	ovider record	ls)			79
00	Total Program routine service costs for compa	• •			nus line 79)		80
. 00	Inpatient routine service cost per diem limi	tation		-	<i>,</i>		81
. 00	Inpatient routine service cost limitation (li						82
. 00	Reasonable inpatient routine service costs (s		5)				83
. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		s)				84
. 00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
7.00	Total observation bed days (see instructions)					5, 441	
3.00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•	line 2)			1, 353. 64 7, 365, 155	
00							

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	3, 460, 185	57, 132, 900	0. 06056	4 7, 365, 155	446, 063	90.00
91.00 Nursing Program cost	0	57, 132, 900	0.00000	0 7, 365, 155	0	91.00
92.00 Allied health cost	0	57, 132, 900	0.00000	0 7, 365, 155	0	92.00
93.00 All other Medical Education	0	57, 132, 900	0.00000			93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre	pare
		Title XIX	Hospi tal	5/30/2022 2: 3 PPS	4 pr
	Cost Center Description				
	PART I – ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed day: Inpatient days (including private room days, excluding swing-			42, 207 42, 207	
	Private room days (excluding private room days, excluding swing-		ivate room days,	42,207	
	do not complete this line.		5	o	
00	Semi-private room days (excluding swing-bed and observation by Total swing-bed SNF type inpatient days (including private roo	5 /	r 31 of the cost	36, 766 0	
	reporting period	om days) thi ough becombe		Ũ	
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) Total swing-bed NF type inpatient days (including private roo	m davs) through December	31 of the cost	0	-
	reporting period	5.			
00	Total swing-bed NF type inpatient days (including private room separating period (if colondar year optor 0 op this line)	m days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 465	9
	newborn days) (see instructions)		U U		
00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc	nly (including private r tions)	oom days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, en				
00	Swing-bed NF type inpatient days applicable to titles V or XL through December 31 of the cost reporting period	X only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	e room days)	0	13
~~	after December 31 of the cost reporting period (if calendar y			0	
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 2, 597	14
	Nursery days (title V or XIX only)			1, 455	
	SWING BED ADJUSTMENT	through December 21	6 +1+	0.00	1 1-
00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	T THE COST	0.00	
00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to service:	s through December 31 of	the cost	0.00	10
00	reporting period	s through becember 51 of	the cost	0.00	1 1 2
00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instruction:	s)		59, 119, 207	21
	Swing-bed cost applicable to SNF type services through Decemb	2	ing period (line	0	22
00	5 x line 17) Swing had east applies to SNE type convises often December	21 of the east reporting	a pariad (line (0	1 22
00	Swing-bed cost applicable to SNF type services after December x line 18)	31 OF the cost reportin	g period (inne o	0	23
00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24
00	7 x line 19) 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)	of the cost reporting	period (inne o	0	
	Total swing-bed cost (see instructions)	(1) 01 1 11 0()		0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		59, 119, 207	27
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		-	0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	÷ THE 20)		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mil	, ,	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	59, 119, 207	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	USTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			1, 400. 70	38
	Program general inpatient routine service cost (line 9 x line			2, 052, 026	
00	Medically necessary private room cost applicable to the Progra	om (1, po 14 v lipo 2E)		0	40

OMPUTA	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNITY HOSE	Provider C	CN: 15-0128	Peri od:	u of Form CMS- Worksheet D-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	epare
			T: +1	o. VI.V.		5/30/2022 2:3	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
		Inpatient Costl		Diem (col. 1	5	(col. 3 x col.	
		1.00	2 00	col. 2)	4.00	4)	
2.00	NURSERY (title V & XIX only)	1.00 1,430,416	2.00	3.00 550.8		5.00 801,414	42
I	Intensive Care Type Inpatient Hospital Units	1, 100, 110	2,077	00010	1,100	0017111	1.2.
	INTENSIVE CARE UNIT	9, 225, 460	3, 110	2, 966. 3	39 0	C	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
	SURGICAL INTENSIVE CARE UNIT						45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
. 00	Program inpatient ancillary service cost (Wk	at D-3 col 3	Line 200)			1.00 1,883,913	48.
	Total Program inpatient costs (sum of lines 4			ns)		4, 737, 353	
	PASS THROUGH COST ADJUSTMENTS	··· ··· ··· ··· ··· ··· ··· ··· ··· ··					
	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sum	of Parts I and	172, 787	50.
	III) Pass through costs applicable to Program inpa	atient ancillary	v services (fr	om Wkst D s	um of Parts II	123, 962	51.
	and IV)		y services (II	UNI WKSt. D, S		123, 702	. 51
	Total Program excludable cost (sum of lines !					296, 749	52.
	Total Program inpatient operating cost exclud		ated, non-phy	sician anesth	etist, and	4, 440, 604	53.
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	oZ)					
	Program di scharges					C	54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)	ng post and tax	aget employet (1	ing E(minug	Line E2)	0	
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and tar	rget amount (i	ine 56 minus	Tine 53)		
	Lesser of lines 53/54 or 55 from the cost rep	orting period e	ending 1996, u	pdated and co	mpounded by the		
	market basket						
	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see i				the target		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	ctions)			0	63
	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	cost reporti	ng period (See	C	64
	instructions) (title XVIII only)	5		•	5 T X		
	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65
	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line /	64 nlus line 6	5)(title XVII	lonly) For	C	66.
	CAH (see instructions)				1 011 3). 101		
	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	porting period	C	67.
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	o costs after D	combor 21 of	the cost room	rting poriod		68.
	(line 13 x line 20)		ecember 31 01	the cost repo	n tring period		00
1	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		C	69.
-	PART III - SKILLED NURSING FACILITY, OTHER NU					[1 70
	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	5					70
	Program routine service cost (line 9 x line			<i>-</i>)			72
8. 00	Medically necessary private room cost application	able to Program		ne 35)			73
	Total Program general inpatient routine servi			lunk i D			74
	Capital-related cost allocated to inpatient 26, line 45)	outine service	COSTS (Trom W	orksneet B, F	αrτιι, column		75
	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital-related costs (line 9 x line	76)					77
	Inpatient routine service cost (line 74 minus	,					78
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				us line 70)		79 80
	Inpatient routine service cost per diem limi				103 TITE /7)		81
1	Inpatient routine service cost limitation (li)				82
	Reasonable inpatient routine service costs (5)				83
	Program inpatient ancillary services (see ins						84
1	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	
7.00	Total observation bed days (see instructions))				5, 441	
	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		line 2)			1,400.70	
	vuse valuul ueu cust ulle a/ x lle 88) (See	= INSLIUCTIONS)				7, 621, 209	יו מש

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	3, 460, 185	59, 119, 207	0. 05852	9 7, 621, 209	446, 062	90.00
91.00 Nursing Program cost	0	59, 119, 207	0.00000	0 7, 621, 209	0	91.00
92.00 Allied health cost	0	59, 119, 207	0. 00000	0 7, 621, 209	0	92.00
93.00 All other Medical Education	0	59, 119, 207	0. 00000	0 7, 621, 209	0	93.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0128	Peri od:	Worksheet D-3	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre	
	Ti +1 c	e XVIII	Hospi tal	5/30/2022 2:3 PPS	4 pm
Cost Center Description		Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		To charges	Charges	(col. 1 x col.	
			charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			2100	0100	
0. 00 03000 ADULTS & PEDIATRICS			22, 737, 403		30. 0
1.00 03100 I NTENSI VE CARE UNI T			3, 703, 079		31.0
3. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					1
0. 00 05000 OPERATI NG ROOM		0. 1214	15 17, 139, 862	2, 081, 036	50.0
1.00 05100 RECOVERY ROOM		0. 1853			
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3567			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1194		297, 357	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 0762			
7. 00 05700 CT SCAN		0.0408			
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0798		90, 276	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0507		597, 327	59.0
0. 00 06000 LABORATORY		0. 1326		1, 953, 757	60.0
4.00 06400 I NTRAVENOUS THERAPY		0.0000		0	64.0
5. 00 06500 RESPI RATORY THERAPY		0. 2170		1, 033, 027	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 4720		454, 562	
7.00 06700 OCCUPATI ONAL THERAPY		0. 4121		321, 155	
8.00 06800 SPEECH PATHOLOGY		0. 4132		69, 727	68.0
9. 00 06900 ELECTROCARDI OLOGY		0. 1052		256, 096	
0.00 07000 ELECTROENCEPHALOGRAPHY		0. 2663		41, 672	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.6545			
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3581		1, 787, 332	
3.00 07300 DRUGS CHARGED TO PATIENTS		0.2679		3, 534, 285	
4.00 07400 RENAL DIALYSIS		0.3438		0	74.0
6. 00 03950 ENDOSCOPY		0. 1640		9, 846	
6.06 03330 I MAGI NG CENTER		0. 1437		0	
6. 97 07697 CARDI AC REHABI LI TATI ON		0. 3161		0	
OUTPATIENT SERVICE COST CENTERS			· ·		
0. 00 09000 CLINIC		0.0000	0 00	0	90.0
0. 01 04950 DI ABETI C CARE CENTER		0.0000	0 00	0	90.0
0. 02 04951 ANTI-COAGULATION CLINIC		0. 4526		0	90.0
0. 03 04952 PALLIATIVE CARE		0.0000		0	90.0
0. 04 04953 SPI NE CENTER		1. 1712		0	90.0
1.00 09100 EMERGENCY		0. 1075			
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.8063		1, 660, 881	
00.00 Total (sum of lines 50 through 94 and 96 through 98)			103, 020, 123		
01.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)	1	0		201.0
02.00 Net charges (line 200 minus line 201)	5		103, 020, 123		202.0

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0128	Peri od:	Worksheet D-3	
			From 01/01/2021	Data (Tima Daa	
			To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
	Ti †I	e XIX	Hospi tal	PPS	- piii
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
		j ů	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
0. 00 03000 ADULTS & PEDIATRICS			4, 408, 339		30.0
. 00 03100 INTENSIVE CARE UNIT			869, 611		31.0
. 00 04300 NURSERY			902, 666		43.0
ANCI LLARY SERVI CE COST CENTERS					
00 05000 OPERATI NG ROOM		0. 12243		103, 033	
. 00 05100 RECOVERY ROOM		0. 18534			
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 35675		55, 494	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1194			
. 00 05500 RADI OLOGY-THERAPEUTI C		0.07622		16, 229	
. 00 05700 CT SCAN		0.04086		27, 924	
. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.07986		7,022	
. 00 05900 CARDI AC CATHETERI ZATI ON		0.05070		43, 954	
00 06000 LABORATORY		0. 13269		221, 234	
. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	
		0. 2170		211, 138	
00 06600 PHYSI CAL THERAPY		0. 47930		36, 368	
. 00 06700 OCCUPATI ONAL THERAPY		0. 4121		18, 071	
. 00 06800 SPEECH PATHOLOGY . 00 06900 ELECTROCARDI OLOGY		0.41320		6, 624 19, 108	
00 07000 ELECTROCARD OLOGY		0. 10529		7, 443	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6545		297, 632	
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3581		71, 806	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 26790		499, 368	
. 00 07400 RENAL DIALYSIS		0. 34383		9, 632	
. 00 03950 ENDOSCOPY		0. 1640			
. 06 03330 MAGI NG CENTER		0. 14378		9,030	
. 97 07697 CARDIAC REHABILITATION		0. 31618		0	
OUTPATIENT SERVICE COST CENTERS		0.01010	57	0	/0.
00 09000 CLINIC		0.0000	0 00	0	90.0
01 04950 DI ABETI C CARE CENTER		0.00000		0	
02 04951 ANTI -COAGULATI ON CLI NI C		0. 45263		0	
03 04952 PALLI ATI VE CARE		0. 00000		0	
04 04953 SPINE CENTER		1. 17128		0	90.
. 00 09100 EMERGENCY		0. 10962		132, 314	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 80633		25, 235	
0.00 Total (sum of lines 50 through 94 and 96 through	98)		10, 107, 024	1, 883, 913	
1.00 Less PBP Clinic Laboratory Services-Program only			0	.,,	201.
2.00 Net charges (line 200 minus line 201)			10, 107, 024		202.

ALCUL	Financial Systems COMMUNITY HOSPI ATION OF REIMBURSEMENT SETTLEMENT	TAL SOUTH Provider CCN: 15-0128	Period: From 01/01/2021	u of Form CMS-: Worksheet E Part A Date (Time Dre	
			To 12/31/2021	Date/Time Pre 5/30/2022 2:3	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	(see	0 19, 238, 384	
. 02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	6, 398, 761	1. (
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	prior to October	0	1. (
. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	on or after	0	1. (
. 00 . 01	October 1 (see instructions) Outlier payments for discharges. (see instructions)			0	2.0
. 01 . 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	
. 03	Outlier payments for discharges occurring prior to October 1	-		293, 593	1
. 04	Outlier payments for discharges occurring on or after October			49, 772	
. 00	Managed Care Simulated Payments			21, 692, 040	3.0
. 00	Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	153.83	4. (
. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.0
. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet t	he criteria for an add-o	on to the cap for	0.00	6. (
00	new programs in accordance with 42 CFR 413.79(e)			0.00	_
. 00 . 01	MMA Section 422 reduction amount to the IME cap as specified ACA \S 5503 reduction amount to the IME cap as specified under			0.00 0.00	
. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa	athic and osteopathic pro	ograms for	7.27	8.
	affiliated programs in accordance with 42 CFR 413.75(b), 413.				
. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sI $$	ots under § 5503 of the	ACA. If the cost	0.00	8.
. 02	report straddles July 1, 2011, see instructions.				8.
. 00	under § 5506 of ACA. (see instructions)				9.
0. 00	instructions) FTE count for allopathic and osteopathic programs in the curr	ent vear from vour recom	~ds	7. 12	10.
1.00	FTE count for residents in dental and podiatric programs.			1.51	
2.00	Current year allowable FTE (see instructions)			8.63	12.
3.00	Total allowable FTE count for the prior year.			8.39	13.
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Sep	otember 30, 1997,	7.57	14.
5.00	Sum of lines 12 through 14 divided by 3.			8.20	15.
6.00	Adjustment for residents in initial years of the program			0.00	16.
7.00	Adjustment for residents displaced by program or hospital clo	osure		0.00	17.
8.00	Adjusted rolling average FTE count			8.20	
	Current year resident to bed ratio (line 18 divided by line 4	ł).		0.053306	
	Prior year resident to bed ratio (see instructions)			0.053334	
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.053306	
2.00 2.01	IME payment adjustment (see instructions)			735, 684	
	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional elementics and ectoapathics LME Efficiency		CED 412 105	622, 475]
3.00	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C).	ient cap sints under 42 (5114 412, IUD	0.00	
4.00 5.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or line	e 24 (see	-0. 15 0. 00	
6. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0.00000	26.
7.00	IME payments adjustment factor. (see instructions)			0. 000000	
7.00 3.00	IME add-on adjustment amount (see instructions)			0.000000	
3. 00 3. 01	IME add on adjustment amount - Managed Care (see instructions)	5)		0	
9.00	Total IME payment (sum of lines 22 and 28)	·		735, 684	
9. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment)1)		622, 475	
0. 00	Percentage of SSI recipient patient days to Medicare Part A p	patient days (see instruc	ctions)	3. 07	30.
1.00	Percentage of Medicaid patient days (see instructions)			25.25	
2.00	Sum of lines 30 and 31			28.32	
3.00	Allowable disproportionate share percentage (see instructions	5)		12.58	
	Disproportionate share adjustment (see instructions)			806, 288	1 24

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0128	Period: From 01/01/2021	Worksheet E Part A	
			To 12/31/2021	Date/Time Prep 5/30/2022 2:34	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1.00	2.00	
- 00	Uncompensated Care Adjustment		0.000.014.504	7 400 000 740	0.5
5.00	Total uncompensated care amount (see instructions)			7, 192, 008, 710	
5.01	Factor 3 (see instructions)	antan zana an thia lina) (aa	0. 000397191	0.000173193	35
5. 02	Hospital uncompensated care payment (If line 34 is zero, instructions)	enter zero on this rine) (se	e 3, 292, 717	1, 245, 606	35
5. 03	Pro rata share of the hospital uncompensated care payment	amount (see instructions)	2, 462, 771	313, 961	35
5.00	Total uncompensated care (sum of columns 1 and 2 on line	. ,	2, 776, 732		36
	Additional payment for high percentage of ESRD beneficiary				
0. 00	Total Medicare discharges (see instructions)		0		40
. 00	Total ESRD Medicare discharges (see instructions)		0		41
. 01	Total ESRD Medicare covered and paid discharges (see inst	ructions)	0		41
2. 00	Divide line 41 by line 40 (if less than 10%, you do not q	ualify for adjustment)	0.00		42
. 00	Total Medicare ESRD inpatient days (see instructions)		0		43
. 00	Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by 7	0. 000000		44
	days)				
. 00	Average weekly cost for dialysis treatments (see instruct		0.00		45
. 00	Total additional payment (line 45 times line 44 times lin	ie 41.01)	0		46
. 00	Subtotal (see instructions)	ll amall susal bassitals	30, 299, 214		47
8. 00	Hospital specific payments (to be completed by SCH and MD only. (see instructions)	H, SMALL FULAL NOSPILAIS	0		48
				Amount	
				1.00	
. 00	Total payment for inpatient operating costs (see instruct	ions)		30, 921, 689	49
. 00	Payment for inpatient program capital (from Wkst. L, Pt.	I and Pt. II, as applicable)		2, 051, 697	50
. 00	Exception payment for inpatient program capital (Wkst. L,	Pt. III, see instructions)		0	51
2.00	Direct graduate medical education payment (from Wkst. E-4	, line 49 see instructions).		276, 807	
3. 00	Nursing and Allied Health Managed Care payment			0	53
1.00	Special add-on payments for new technologies			442, 300	54
. 01	Islet isolation add-on payment	(0)		0	54
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li			0	55
5.00 7.00	Cost of physicians' services in a teaching hospital (see Routine service other pass through costs (from Wkst. D, P		brough 2E)	0	56 57
3.00	Ancillary service other pass through costs from Wkst. D,		ni ougir 35).	0	58
9.00	Total (sum of amounts on lines 49 through 58)	11. IV, col. II IIIe 200)		33, 692, 493	
. 00	Primary payer payments			9, 534	6
. 00	Total amount payable for program beneficiaries (line 59 m	ninus line 60)		33, 682, 959	6
2.00	Deductibles billed to program beneficiaries	<i>,</i>		2, 505, 452	
8. 00	Coinsurance billed to program beneficiaries			58, 618	63
. 00	Allowable bad debts (see instructions)			82, 955	64
6. 00	Adjusted reimbursable bad debts (see instructions)			53, 921	6!
6.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		11, 960	66
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			31, 172, 810	67
. 00	Credits received from manufacturers for replaced devices			0	68
. 00	Outlier payments reconciliation (sum of lines 93, 95 and	96). (For SCH see instruction	S)	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	enstration) adjustment (instruct:>	0	70
. 50	Rural Community Hospital Demonstration Project (§410A Dem	, ,	instructions)	0	70
). 87). 88	Demonstration payment adjustment amount before sequestrat SCH or MDH volume decrease adjustment (contractor use onl			0	70
). 88	Pioneer ACO demonstration payment adjustment amount (see			0	70
0. 89 0. 90	HSP bonus payment HVBP adjustment amount (see instruction			0	70
. 90 . 91	HSP bonus payment HRR adjustment amount (see instructions			0	70
. 92	Bundled Model 1 discount amount (see instructions)	· /		0	70
). 93	HVBP payment adjustment amount (see instructions)			-83, 573	
1. 7.1					
). 93	HRR adjustment amount (see instructions)			-93, 055	70

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0128	Period:	Worksheet E	
				From 01/01/2021 To 12/31/2021	Part A Date/Time Pre 5/30/2022 2:3	
		Title	e XVIII	Hospi tal	PPS	94 pili
				(уууу)	Amount	
				0	1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column O		0	0	70.
0. 97	the corresponding federal year for the period prior to 10/1)			0	0	1 70
J. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or aft			0	0	70.
), 98	Low Volume Payment-3				0	70.
	HAC adjustment amount (see instructions)				238, 880	
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			30, 757, 302	
1.01	Sequestration adjustment (see instructions)	,			0	
1. 02	Demonstration payment adjustment amount after sequestration				0	71.
1.03	Sequestration adjustment-PARHM pass-throughs					71.
	Interim payments				29, 676, 302	
	Interim payments-PARHM					72.
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)	72 and			1, 081, 000	73.
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.02 73)	, <i>i</i> z, anu			1, 081, 000	' ⁷⁴
4. 01	Balance due provider/program-PARHM (see instructions)					74.
	Protested amounts (nonallowable cost report items) in accordan	ce with			608, 820	
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	f 2.03			0	90
. 00	plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2				0	91
	Operating outlier reconciliation adjustment amount (see instru	ctions)			0	
	Capital outlier reconciliation adjustment amount (see instruct				0	
	The rate used to calculate the time value of money (see instru				0.00	94
5.00	Time value of money for operating expenses (see instructions)				0	95
5.00	Time value of money for capital related expenses (see instruct	ions)			0	96
				Prior to 10/1		
	HSP Bonus Payment Amount			1.00	2.00	
	HSP bonus amount (see instructions)			0	0	100
	HVBP Adjustment for HSP Bonus Payment			-	-	
	HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101
2.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	
	HRR adjustment amount for HSP bonus payment (see instructions)		- + +	0	0	104
	Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per					200
	Century Cures Act? Enter "Y" for yes or "N" for no.		The 21st			200
	Cost Reimbursement					
1.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201
	Medicare discharges (see instructions)					202
	Case-mix adjustment factor (see instructions)					203
	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the curre	nt 5-year demonst	ration	
	period) Medicare target amount					204
	Case-mix adjusted target amount (line 203 times line 204)					204
1	Medicare inpatient routine cost cap (line 202 times line 205)					206
1	Adjustment to Medicare Part A Inpatient Reimbursement			· · · · · · · · · · · · · · · · · · ·		
7.00	Program reimbursement under the §410A Demonstration (see instr					207
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	line 59)				208
	Adjustment to Medicare IPPS payments (see instructions)					209
9.00	Reserved for future use					210
9. 00 0. 00						211
9. 00 0. 00 1. 00	Total adjustment to Medicare IPPS payments (see instructions)					
9.00 0.00 1.00	Total adjustment to Medicare LPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	11)				212
9.00 0.00 1.00 2.00	Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	11)				212
9.00 0.00 1.00 2.00 3.00	Total adjustment to Medicare LPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement		nbursement)			212 213 218

CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Pre 5/30/2022 2:3	
		Title XVIII	Hospi tal	PPS	, b
				1.00	
_	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
0	Medical and other services (see instructions)			8, 369	1.
0	Medical and other services reimbursed under OPPS (see instruc	tions)		16, 793, 693	
0	OPPS payments			15, 821, 412	
0 1	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			76, 839 0	
0	Enter the hospital specific payment to cost ratio (see instru	ictions)		0.000	
0	Line 2 times line 5	<i>,</i>		0	6.
0	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
0	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 12 lino 200		0	-
00	Organ acquisitions	TV, COL. 13, TTHE 200		0	10.
00	Total cost (sum of lines 1 and 10) (see instructions)			8, 369	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			01.000	
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ino (40)		31, 239 0	
	Total reasonable charges (sum of lines 12 and 13)	The 09)		31, 239	
	Customary charges			.,	
	Aggregate amount actually collected from patients liable for		0	0	
00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16.
00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17
	Total customary charges (see instructions)			31, 239	
	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	22, 870	
	instructions)			_	
00	Excess of reasonable cost over customary charges (complete on instructions)	ly if line 11 exceeds li	ne 18) (see	0	20.
00	Lesser of cost or charges (see instructions)			8, 369	21.
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			15, 898, 251	24.
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction			0	25.
	Deductibles and Coinsurance amounts relating to amount on lin		ructions)	2, 573, 816	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•	,	13, 332, 804	
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)			131, 469 0	
	Subtotal (sum of lines 27 through 29)			13, 464, 273	
	Primary payer payments			6, 200	
	Subtotal (line 30 minus line 31)			13, 458, 073	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		0	1 22
	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			184, 626	33. 34.
	Adjusted reimbursable bad debts (see instructions)			120, 007	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		161, 497	36
	Subtotal (see instructions)			13, 578, 080	
	MSP-LCC reconciliation amount from PS&R			157	38 39
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	(a)		0	39
	Demonstration payment adjustment amount before sequestration	-,		0	
	Partial or full credits received from manufacturers for repla	ced devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			13, 577, 923	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	40 40
-	Sequestration adjustment-PARHM pass-throughs			0	40
	Interim payments			13, 723, 964	
01	Interim payments-PARHM				41
1	Tentative settlement (for contractors use only)			0	
1	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-146, 041	42
-	Balance due provider/program-PARHM (see instructions)			- 140, 041	43.
	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	5, 495	
	§115. 2		· ·		
	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
-	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	:N: 15-0128	Period: From 01/01/2021 To 12/31/2021		
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		29, 676, 30)2	13, 723, 964	1.00
2.00	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,			0	0	2.00
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			-	-	
3.01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3.02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
3.05	Provider to Program			0	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
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
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		29, 676, 30)2	13, 723, 964	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as 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			T		
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03	Dura da la tal Dura man			0	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50	TENTATIVE TO PROGRAM			0	0	5.5
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		1, 081, 00	00	0	6.0
6.02	SETTLEMENT TO PROGRAM			0	146, 041	6. 02
7.00	Total Medicare program liability (see instructions)		30, 757, 30		13, 577, 923	7.00
				Contractor	NPR Date	
		C)	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
		0		1.00	2.00	

Heal th	Financial Systems COMMUNITY HOS	PITAL SOUTH	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0128	Peri od:	Worksheet E-1	
			From 01/01/2021	Part II	
			To 12/31/2021	Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2022 2:3 PPS	4 pili
			Tiospi tai	ГГЗ	
				1,00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI	ON			1
1.00	Total hospital discharges as defined in AARA §4102 from Wks	st. S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	nd 8 through 12, and plus f	or cost		2.00
	reporting periods beginning on or after 10/01/2013, line 33	2)			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of line	es 1, and 8 through 12, and	l plus for cost		4.00
	reporting periods beginning on or after 10/01/2013, line 32	2)			
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	Bline 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	<pre>certified HIT technology</pre>	Wkst. S-2, Pt. I		7.00
0.00	line 168				0.00
	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	on (see instructions)			10.00
00.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1 00 00
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)		``````````````````````````````````````		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	i line 31) (see instruction	IS)		32.00

RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CC	N: 15-0128	Peri od:	Worksheet E-4	
DICA	L EDUCATION COSTS			From 01/01/2021 To 12/31/2021	Date/Time Prep 5/30/2022 2:34	
		Ti tl e	XVIII	Hospi tal	PPS	
					1.00	
00	COMPUTATION OF TOTAL DIRECT GME AMOUNT	6		n n n n n i n d n	0.00	1
00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	0.00	1.
00	Unweighted FTE resident cap add-on for new programs per 42 CF		I) (see instr	ructions)	0.00	
)0)1	Amount of reduction to Direct GME cap under section 422 of MM. Direct GME cap reduction amount under ACA §5503 in accordance		8/12 70 (m)	(500	0.00 0.00	
51	instructions for cost reporting periods straddling 7/1/2011)	WITH 42 CIK	9413.74 (III).	(366	0.00	3.
00	Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	7.27	4.
01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	0.00	4.
)2	ACA Section 5506 number of additional direct GME FTE cap slot	s (see instr	ructions for	cost reporting	0.00	4.
00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus l	ine 4 plus l	ines 4.01 and	7.27	5.
00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	7.12	6.
00	Enter the lesser of line 5 or line 6				7.12	7.
		-	Primary Care		Total	
00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1.00	2.00 15 0.67	3.00	8.
	program for the current year.					
0	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		6.4	.67	7.12	9.
00	Weighted dental and podiatric resident FTE count for the curr	ent year		1.51		10
01	Unweighted dental and podiatric resident FTE count for the cu	rrent year		1.51		10
00 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportin	a vear (see	6.4 6.3			11. 12.
00	instructions)	g your (see	0.0	2.00		
00	Total weighted resident FTE count for the penultimate cost re year (see instructions)		5.5	2.01		13.
	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	6. 1			14
00	Adjustment for residents in initial years of new programs	rograme	0.0			15 15
01 00	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo		0. (0. (15
00	Unweighted adjustment for residents displaced by program of h		0.0			16
-	closure					
00	Adjusted rolling average FTE count		6. 1			17
00 00	Per resident amount Approved amount for resident costs		97, 638. 7 598, 52		799, 662	18
00			570, 32	201, 130	777,002	
00	Additional unwaighted all anothic and actempthic direct CNE E	TE magidant (an alata ras	aired under 12	1.00	20
00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)		ap sints rec	erveu under 42	0.00	20
00	Direct GME FTE unweighted resident count over cap (see instru	ctions)			0.00	21
00	Allowable additional direct GME FTE Resident Count (see instr	uctions)			0.00	
00	Enter the locality adjustment national average per resident a	mount (see ir	nstructions)		0.00	
	Multiply line 22 time line 23				0	
00	Total direct GME amount (sum of lines 19 and 24)		npatient Par	t Managed Care	799, 662 Total	25.
			A	Ũ		
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
	Inpatient Days (see instructions) (Title XIX - see S-2 Part I. 3.02, column 2)	X, line	11, 22	9, 850		26.
00	Total Inpatient Days (see instructions)		40, 49			27
00	Ratio of inpatient days to total inpatient days		0.27719			28.
00	Program direct GME amount		221, 66		416, 193	
. 01 . 00	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage			4. 07 7, 917	7, 917	29. 30.
	INCOMPANY IN THE WITCH AND DAVID THE TOT WELL AT E AUVAILLAUE			1,71/	1,71/	1 30.

Heal th	Financial Systems	COMMUNITY HOSPIT	AL SOUTH	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUT	PATIENT DIRECT	Provider CCN: 15-0128	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
				10 12/31/2021	5/30/2022 2: 3	
			Title XVIII	Hospi tal	PPS	
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMP	POSITE RATE - TITLE	E XVIII ONLY (NURSING PR	OGRAM AND PARAMED	I CAL	
	EDUCATION COSTS)					
32.00	Renal dialysis direct medical education cos and 94)	ts (from Wkst. B, F	Pt. I, sum of col. 20 an	d 23, lines /4	0	32.00
33.00	Renal dialysis and home dialysis total char	aes (Wkst. C. Pt. I	. col. 8. sum of lines	74 and 94)	2, 276, 264	33.00
34.00	Ratio of direct medical education costs to				0.000000	
35.00	Medicare outpatient ESRD charges (see instru	uctions)	,		0	35.00
36.00	Medicare outpatient ESRD direct medical edu	cation costs (line	34 x line 35)		0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE (COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)				35, 373, 203	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III,				0	38.00
39.00	Cost of physicians' services in a teaching l	hospital (see insti	ructions)		0	39.00
40.00	Primary payer payments (see instructions)				9, 534	
41.00	Total Part A reasonable cost (sum of lines :	37 through 39 minus	s line 40)		35, 363, 669	41.00
10.00	Part B Reasonable Cost				14 000 040	10.00
42.00	Reasonable cost (see instructions) Primary payer payments (see instructions)				16, 802, 062 6, 200	
43.00 44.00	Total Part B reasonable cost (line 42 minus	line (2)			6, 200 16, 795, 862	
44.00	Total reasonable cost (sum of lines 41 and	,			52, 159, 531	
45.00	Ratio of Part A reasonable cost to total reasonable		$A1 \div \text{line} 45$		0. 677991	
47.00			,		0. 322009	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BET				01022007	
48.00					408, 276	48.00
	Part A Medicare GME payment (line 46 x 48)	(title XVIII only)	(see instructions)		276, 807	
	Part B Medicare GME payment (line 47 x 48)				131, 469	50.00
		÷ ·				-

	Financial Systems COMMUNITY HOS SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet G Date/Time Pre 5/30/2022 2:3	pare 4 pm
		General Fund	Specific Purpose Fund		Plant Fund	
C	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	5, 849		0 0	0	1 1.
	Temporary investments	0		0 0	0	2.
1 00	Notes recei vabl e	0		0 0	0	3
00 /	Accounts receivable	206, 260, 073		0 0	0	4
00 0	Other receivable	-164, 146, 653		0 0	0	5
	Allowances for uncollectible notes and accounts receivable	726, 418		0 0	0	6
	Inventory	4, 309, 153		0 0	0	
	Prepaid expenses	0		0 0	0	8
	Other current assets	11, 828		0 0	0	9
	Due from other funds			0 0	0	10
	Total current assets (sum of lines 1-10)	47, 166, 668		0 0	0	11
	Land	1, 821, 632		0 0	0	12
	Land improvements	3, 022, 362		0 0	0	13
	Accumul ated depreciation	0,022,002		0 0	0	14
	Buildings	190, 935, 678		0 0	0	15
	Accumulated depreciation	0		0 0	0	16
	Leasehold improvements	1, 737, 035		0 0	0	17
. 00 /	Accumulated depreciation	0		0 0	0	18
. 00 I	Fixed equipment	86, 150, 931		0 0	0	19
	Accumul ated depreciation	0		0 0	0	20
	Automobiles and trucks	24, 819		0 0	0	21
	Accumulated depreciation	0		0 0	0	22
	Major movable equipment	0		0 0	0	23
	Accumulated depreciation	-154, 078, 025		0 0	0	24
	Minor equipment depreciable	0		0 0	0	25
	Accumulated depreciation	0			0	26
	HIT designated Assets Accumulated depreciation	0			0	27
	Mi nor equi pment-nondepreci abl e	115, 657		0 0	0	
	Total fixed assets (sum of lines 12-29)	129, 730, 089		0 0	0	
	THER ASSETS	127, 100, 007	<u> </u>	0	0	
	Investments	0		0 0	0	31
	Deposits on leases	0		0 0	0	32
. 00 [Due from owners/officers	0		0 0	0	33
. 00 0	Other assets	602, 295, 341		0 0	0	34
. 00	Total other assets (sum of lines 31-34)	602, 295, 341		0 0	0	35
	Total assets (sum of lines 11, 30, and 35)	779, 192, 098		0 0	0	36
	CURRENT LIABILITIES					
	Accounts payable	416, 146		0 0	0	37
	Salaries, wages, and fees payable	0		0 0	0	38
	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term)	0		0 0	0	
	Deferred income	0		0 0	0	
	Accelerated payments Due to other funds	0		0 0	0	42
	Other current liabilities	21, 023, 163		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	21, 023, 103		0 0	0	
	LONG TERM LIABILITIES	21,437,307		0 0	0	1 70
	Mortgage payable	0		0 0	0	46
	Notes payable	0		0 0	0	47
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	3, 572, 984		0 0	0	49
. 00	Total long term liabilities (sum of lines 46 thru 49)	3, 572, 984		0 0	0	50
. 00 [Total liabilities (sum of lines 45 and 50)	25, 012, 293		0 0	0	51
	CAPI TAL ACCOUNTS					
	General fund balance	754, 179, 805				52
	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	-	56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	754, 179, 805		0 0	0	59
	Total liabilities and fund balances (sum of lines 51 and	779, 192, 098		0 0	0	

Heal th	Financial Systems	COMMUNITY HOSE	PITAL SOUTH			In Lie	eu of Form CMS	-2552-10	0
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0128		eriod: com 01/01/2021	Worksheet G- Date/Time Pr 5/30/2022 2:	1 epared:	_
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fun	ł	
1.00	Fund balances at beginning of period	1.00	2.00	3.00		4.00	5.00	1.00	_
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0 0	85, 487, 370 754, 179, 805		0 0 0 0	0		2. 00 3. 00 0 4. 00 0 5. 00 0 6. 00 0 7. 00 0 8. 00 0 9. 00	0 0 0 0 0 0
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0 0 0 0 0	0 754, 179, 805 0		0 0 0 0 0	0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	0 0 0 0 0 0 0 0
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		754, 179, 805			0		19.00	С
		Endowment Fund	Pl ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	0 0 0 0 0 0
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	000	0 0 0 0 0 0		0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)								

STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CO	CN: 15-0128	Peri od:	Worksheet G-2	2552-1
				From 01/01/2021 To 12/31/2021		
	Cost Center Description		I npati ent	Outpati ent	Total	
	1		1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1 00	General Inpatient Routine Services		101.010.0	50	104 040 050	1
1.00	Hospi tal		124, 919, 3	59	124, 919, 359	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER					3.00
4.00 5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	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)		124, 919, 3	59	124, 919, 359	
	Intensive Care Type Inpatient Hospital Services			1		
11.00	INTENSIVE CARE UNIT		13, 368, 1	51	13, 368, 151	11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum	n of lines	13, 368, 1	51	13, 368, 151	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and	16)	138, 287, 5		138, 287, 510	
18.00	Ancillary services		352, 405, 0			18.00
19.00	Outpatient services			0 0		
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY					22.00
23.00 24.00	AMBULANCE SERVI CES					23.00
24.00	AMBULATORY SURGI CAL CENTER (D. P.)					24.00
26.00	HOSPICE					26.0
27.00	OTHER (SPECIFY)			0	0	27.0
28.00	Total patient revenues (sum of lines 17-27)(transfer colum	nn 3 to Wkst	490, 692, 5	0	1,069,715,771	28.00
20.00	G-3, line 1)	III J LO WKSL.	490,092,3	75 577, 025, 170	1,007,713,771	20.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			250, 762, 903		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.0
38.00				0		38.00
39.00				0		39.0
40.00				0		40.0
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)	(1) (+				42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus lin	ie 42)(transfer		250, 762, 903		43.00

Heal th	Financial Systems	COMMUNI TY HOSPI TA	AL SOUTH	In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prep	
					5/30/2022 2: 3	1 pm
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	t L column 2 line	20)		1.00	1.00
2.00	Less contractual allowances and discounts or				1, 069, 715, 771 745, 748, 214	2.00
2.00	Net patient revenues (line 1 minus line 2)	in patrents accounts	5		323, 967, 557	2.00
4.00	Less total operating expenses (from Wkst. G-	-2 Part II line A	3)		250, 762, 903	4.00
4.00 5.00	Net income from service to patients (line 3		5)		73, 204, 654	5.00
5.00	OTHER I NCOME				73, 204, 034	5.00
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				1, 174	7.00
8.00	Revenues from telephone and other miscellane	eous communication :	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gue	ests			1, 119, 305	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical su		an patients		0	16.00
17.00	Revenue from sale of drugs to other than pat				0	17.00
18.00	Revenue from sale of medical records and abs				0	18.00
	Tuition (fees, sale of textbooks, uniforms,	,			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				748, 509	22.00
23.00	Governmental appropriations				0	23.00
24.00	MI SC REVENUE				1, 158, 694	24.00
24.50	COVI D-19 PHE Fundi ng				9, 255, 034	
25.00	Total other income (sum of lines 6-24)				12, 282, 716	
26.00	Total (line 5 plus line 25)				85, 487, 370	
27.00	OTHER EXPENSES (SPECIFY)	hoorinto)			0	27.00 28.00
28.00	Total other expenses (sum of line 27 and sub Not income (or loss) for the period (line 24				0 85, 487, 370	
29.00	Net income (or loss) for the period (line 26	o minus inne 28)		l	85, 487, 370	29.00

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0128	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prep 5/30/2022 2:34	
	Title XVIII	Hospi tal	PPS	4 piii
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
00 Capital DRG other than outlier			1, 964, 696	1.
01 Model 4 BPCI Capital DRG other than outlier			0	1
00 Capital DRG outlier payments			46, 135	
01 Model 4 BPCI Capital DRG outlier payments			0	
00 Total inpatient days divided by number of days in the cost	st reporting period (see inst	ructions)	112.21	
00 Number of interns & residents (see instructions)			8. 20	
00 Indirect medical education percentage (see instructions)			2.08	
00 Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)			40, 866	
00 Percentage of SSI recipient patient days to Medicare Par 30) (see instructions)		, part A line	0.00	
00 Percentage of Medicaid patient days to total days (see in	nstructions)		0.00	
00 Sum of lines 7 and 8			0.00	
.00 Allowable disproportionate share percentage (see instruc	tions)		0.00	
.00 Disproportionate share adjustment (see instructions)			0	1
.00 Total prospective capital payments (see instructions)			2, 051, 697	12
			1.00	
PART II – PAYMENT UNDER REASONABLE COST			1.00	-
00 Program inpatient routine capital cost (see instructions			0	1 1
00 Program inpatient ancillary capital cost (see instructions)			0	
00 Total inpatient program capital cost (line 1 plus line 2			0	
00 Capital cost payment factor (see instructions))		0	-
00 Total inpatient program capital cost (line 3 x line 4)			0	
00 [10tal_filpatient program capital cost (file 5_x file 4)			0	5
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS		1		1 .
00 Program inpatient capital costs (see instructions)	stances (see instruction-)		0	
00 Program inpatient capital costs for extraordinary circum			0	
00 Net program inpatient capital costs (line 1 minus line 2) 00 Applicable exception percentage (see instructions))		0.00	
00 Applicable exception percentage (see instructions) 00 Capital cost for comparison to payments (line 3 x line 4	<u>۱</u>		0.00	
00 Percentage adjustment for extraordinary circumstances (si			0.00	
00 Adjustment to capital minimum payment level for extraord		(line 6)	0.00	
00 Capital minimum payment level (line 5 plus line 7)	That y circumstances (TTHE 2 X		0	
00 Current year capital payments (from Part I, line 12, as a	annl i cabl e)		0	
0.00 Current year comparison of capital minimum payment level		Less line 0)	0	
.00 Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14)			0	
	al navments (line 10 plus lir	11)	0	12
00 Net comparison of capital minimum payment lovel to capit			0	
	ontor the amount on this line	- /		
0.00 Current year exception payment (if line 12 is positive,		following poriod		
 00 Current year exception payment (if line 12 is positive, or Carryover of accumulated capital minimum payment level or		ollowing period	0	14
 B. 00 Current year exception payment (if line 12 is positive, of Carryover of accumulated capital minimum payment level or (if line 12 is negative, enter the amount on this line) 	ver capital payment for the f	ollowing period	_	
8.00 Current year exception payment (if line 12 is positive, of Carryover of accumulated capital minimum payment level or	ver capital payment for the f e instructions)	ollowing period	0 0	15