This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1300 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/30/2023 11:59 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2023 Time: 11:59 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF BREMEN, INC. (15-1300) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date				4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	335	-68, 501	0	1, 734, 426	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	282, 122	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	282, 457	-68, 501	0	1, 734, 426	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA

Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems COMMUNITY HOSPITAL OF BREMEN, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1300 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 11:59 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1020 HIGH RD 1.00 PO Box: 8 1.00 2.00 City: BREMEN State: IN Zi p Code: 46506-County: MARSHALL 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPITAL OF 151300 99915 07/01/1966 Ν 0 0 3.00 BREMEN, INC. Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF COMMUNITY HOSPITAL 157300 99915 N 05/01/1984 N 0 7 00 7.00 SWING BED 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital - Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2022 01/01/2022 20.00 21.00 Type of Control (see instructions) 21.00 13 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν N 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22 03 N N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 3 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Heal th	Financial Systems COMMUNITY H	HOSPITAL OF	BREMEN, INC	D		In Lieu	ı of For	m CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		Provider CC			1/2022	Workshop Part I Date/Ti 5/30/20	me Pre	pared:
		In-State Medicaid paid days	unpai d days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Med	ther di cai d days	
24 00	If this provider is an LDDS bestital enter the	1.00	2.00	3. 00	4. 00	5. 00	0	5. 00	24 00
24. 0025. 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 ir column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state	1			0		0	C	25. 00
	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.	9							
					Urban/Ru		Date of 2.		-
26. 00	Enter your standard geographic classification (not v	vage) status	at the beg	ginning of t		2	2.	<u> </u>	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassif	vage) status or "2" for r	rural. If ap		t	2			27. 00
35. 00	If this is a sole community hospital (SCH), enter the			CH status in		0			35. 00
	effect in the cost reporting period.				Begi nn		Endi		
36. 00	Enter applicable beginning and ending dates of SCH s	status. Subs	script line	36 for numb	1.0	00	2.	00	36.00
	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente	tes.				0			37.00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for a accordance with FY 2016 OPPS final rule? Enter "Y" f								37. 01
38. 00	instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/I		Υ/		
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent e requiremer	er in colum nts in	ın		2. I		39.00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ober 1. Ente	er "Y" for y				N	I	40. 00
	ino in corumni 2, for di senarges on or arter october	1. (300 11131	ir de tr oris)			V	XVIII		
	Prospective Payment System (PPS)-Capital					1. 00	2. 00	3.00	
45. 00	Does this facility qualify and receive Capital payme	ent for disp	roporti onat	e share in	accordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00
47. 00 48. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymer Teaching Hospitals					N N	N N	N N	47. 00 48. 00
56.00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to convolved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable	"Y" for yes er 27, 2020, column 1 is rams in the CRs) MA dir	or "N" for under 42 ("Y", or if prior year	no in colu CFR 413.78(b this hospit or penultim	mn 1. For)(2), see al was ate year,	N			56.00
57. 00	"Y" for yes; otherwise, enter "N" for no in column 2 For cost reporting periods beginning prior to Decemb is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete.	per 27, 2020 n residents n column 1. cost report te Worksheet f applicable FR 413.77(e e on duty, i	in approved If column ing period? E-4. If column For cost (1)(iv) ar f the response	d GME progra 1 is "Y", o 2 Enter "Y" Dlumn 2 is " reporting p nd (v), rega onse to line	ms trained lid for yes or N", eriods rdless of 56 is "Y"				57.00
58. 00	If line 56 is yes, did this facility elect cost rein defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	nbursement f	or physicia						58.00

	Financial Systems COMMUNITY HO TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		OF BREMEN, IN Provider Co		Peri od:	worksheet S-2	
					From 01/01/2022 To 12/31/2022		
				,	V	XVIII XIX	
9 00	Are costs claimed on line 100 of Worksheet A? If yes	compl	ata Wkst D-2	, Pt. I.	1. O	0 2.00 3.00	59. (
7. 00	Are costs charmed on time 100 of worksheet A: 11 yes	s, compr	ete wkst. D-2	NAHE 413.85		Pass-Through	37.
				Y/N	Line #	Qualification Criterion Code	
				1. 00	2.00	3. 00	
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent Cadjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHE	ee If column 1	N			60.
	ladjustillent? Enter Y for yes of N for no fin coruli	Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2. 00	3. 00	4.00	5. 00	1
1. 00	Did your hospital receive FTE slots under ACA	N			0.00	0.00	61.
1. 01	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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.
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
. 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.
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the 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 61.04 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.
		Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
10	06 the FTF- in Line /1 0Fi for each many manager		1. 00	2. 00	3.00	4.00	(1
. 10	Of the FTEs in line 61.05, specify each new program 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.				0.00	0.00	01.
. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0.00	61.
						1.00	
	ACA Provisions Affecting the Health Resources and Ser	vi ces A	dmi ni strati on	(HRSA)		1. 00	
. 00	Enter the number of FTE residents that your hospital	trai ned			riod for which	0.00	62.
. 01	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ı Teachi ıram. (s	ee instructio		o your hospital	0.00	62.
. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c			N	63.

which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	"Y" for yes and "N" for no.				
	TEFRA Provi ders				
35. 00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter	r "Y" for yes o	or "N" for no.	N	7 85. 00
	Did this facility establish a new Other subprovider (excluded unit) under				86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				
37. 00	Is this hospital an extended neoplastic disease care hospital classified u	ınder section		N	87.00
77.00	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ander Section		14	07.00
	1 101 yes of W 101 He.		Approved for	Number of	
			Permanent	Approved	
			Adjustment	Permanent	
			(Y/N)	Adjustments	
					-
00.00	Column 1 1 - this bearing to a second of the	24 ++	1. 00	2.00	00.00
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFF amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co			(88. 00
	89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				
	cordiniti 2. Litter the number of approved permanent adjustments.	Wkst Alina	Effective Date	Approved	
		No.	Lirective bate	Permanent	
		INO.		Adjustment	
				Amount Per	
				Di scharge	
		1.00	2.00		-
20.00	Column 1, If Line 99, column 1 is V enter the Werksheet A Line number	1. 00	2.00	3.00	89.00
.9. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.	0.00	'	(J 89. UL
	Column 2: Enter the effective date (i.e., the cost reporting period				
	beginning date) for the permanent adjustment to the TEFRA target amount				
	per di scharge.				
	Column 3: Enter the amount of the approved permanent adjustment to the				
	TEFRA target amount per discharge.		.,	V// V/	
			V	XI X	-
	THE WORLD CO.		1. 00	2. 00	
	Title V and XIX Services	1 111/11 6			
0.00	Does this facility have title V and/or XIX inpatient hospital services? En	nter "Y" for	N	Υ	90.00
	yes or "N" for no in the applicable column.			.,	
1.00	Is this hospital reimbursed for title V and/or XIX through the cost report		N	Υ	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column.				
2.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificati	on)? (see		N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.				
3. 00	Does this facility operate an ICF/IID facility for purposes of title V and	d XIX? Enter	N	N	93.00
	"Y" for yes or "N" for no in the applicable column.				1
4. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	o in the	N	N	94.00
	applicable column.				
5. 00	If line 94 is "Y", enter the reduction percentage in the applicable column		0. 00	0.00	95.00
6. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no	o in the	N	N	96. 00
	applicable column.				
7. 00	If line 96 is "Y", enter the reduction percentage in the applicable column	٦.	0.00	0.00	97.00
			'		

HOSPI T.		D ' I O		In Lie		
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: rom 01/01/2022 o 12/31/2022		
					5/30/2023 11	: 59 am
				V	XIX	
98. 00	Does title V or XIX follow Medicare (title XVIII) for the i	ntorns and ros	i donts post	1. 00 Y	2. 00 Y	98. 00
98.00	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			Y	Y	98.00
	Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t			Y	Y	98. 01
	title XIX. Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			Y	Y	98. 02
	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y	tical access h	ospital (CAH)	N	N	98. 03
98. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH	reimbursed 10	1% of	N	N	98. 04
00.05	outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.		V	00.00		
	Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			Y	Y	98. 05
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	Y	98. 06
	Rural Providers				1	
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all	inclusivo mot	had of navmont	Y N		105. 00 106. 00
	for outpatient services? (see instructions)		. 3			
107. 00	Column 1: If line 105 is Y, is this facility eligible for c training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	n 1. (see ins you train I&R	tructions) s in an	N		107. 00
	Enter "Y" for yes or "N" for no in column 2. (see instruct Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	i ons)	. ,	N		108. 00
	CFR Section 9412.113(C). Enter 1 101 yes of N 101 110.	Physi cal	Occupati onal	Speech	Respi ratory	
		1.00	2.00	3.00	4.00	
109. 00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	+
110. 00	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I1		N	110.00
		TRSHEET L-2, T	ines 200 throug			
		TRSHEET E-2, T	ines 200 throug	gh 215, as	2.00	
111. 00	If this facility qualifies as a CAH, did it participate in				2.00	111.00
	If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	the Frontier C ost reporting olumn 1 is Y, rticipating in	ommunity period? Enter enter the column 2.	gh 215, as	2.00	111.00
	Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds	ommunity period? Enter enter the column 2. ; and/or "C"	gh 215, as	2.00	
112. 00	Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce	the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the	ommunity period? Enter enter the column 2. ; and/or "C"	gh 215, as		
112. 00	Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Did this hospital participate in the Community Health Acces Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.	the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased s and Rural	ommunity period? Enter enter the column 2. ; and/or "C"	gh 215, as		112.00
112. 00	Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Did this hospital participate in the Community Health Acces Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased s and Rural cost r "N" for no B, or E only) 93" percent (includes	ommunity period? Enter enter the column 2. ; and/or "C"	gh 215, as	3.00	111.00
112. 00 113. 00 115. 00	Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Did this hospital participate in the Community Health Acces Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1. Is this facility classified as a referral center? Enter "Y"	the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased s and Rural cost "N" for no B, or E only) 93" percent (includes rs) based on	ommunity period? Enter enter the column 2. ; and/or "C"	gh 215, as	3.00	112. 00 113. 00 0 115. 00
112. 00 113. 00 115. 00	Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Did this hospital participate in the Community Health Acces Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased s and Rural cost r "N" for no B, or E only) 93" percent (includes rs) based on for yes or	ommunity period? Enter enter the column 2. ; and/or "C" 1.00 N	gh 215, as	3.00	112.00

140 00 4 +							
140.00 Are there any related organization o	r home office co	sts as defined in	CMS Pub. 15-1,	Y	HB0683	140. 00	
chapter 10? Enter "Y" for yes or "N"	for no in colum	n 1. If yes, and h	ome office costs				
are claimed, enter in column 2 the h	ome office chain	number. (see inst	ructions)				
1.00		2. 00		3. 00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the							
home office and enter the home office	e contractor nam	ne and contractor r	umber.				
141.00 Name: BEACON HEALTH SYSTEM	Contractor's	Name: WPS	Contractor	's Number: 0800	1	141. 00	
142.00 Street: 615 N. MICHIGAN STREET	PO Box:					142. 00	
143.00 City: SOUTH BEND	State:	I N	Zi p Code:	4660	1	143. 00	
					1.00		
144.00 Are provider based physicians' costs included in Worksheet A?							
				1. 00	2. 00		
145.00 If costs for renal services are clai	med on Wkst. A,	line 74, are the c	osts for			145. 00	
inpatient services only? Enter "Y" f	or yes or "N" fo	r no in column 1.	If column 1 is				
no, does the dialysis facility inclu	de Medicare util	ization for this c	ost reporting				
period? Enter "Y" for yes or "N" fo	r no in column 2						
146.00 Has the cost allocation methodology	changed from the	previously filed	cost report?	N		146. 00	
Enter "Y" for yes or "N" for no in c	olumn 1. (See CM	IS Pub. 15-2, chapt	er 40, §4020) If				
yes, enter the approval date (mm/dd/	yyyy) in column	2.					

Health Financial Systems	COMMUNITY HOS	PITAL O	F BREMEN, INC	C.		In Lie	u of Form CMS	i-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	A	Provi der CC			ri od: om 01/01/2022 12/31/2022	Worksheet S- Part I Date/Time Pr 5/30/2023 1	epared:
							1.00	
147.00 Was there a change in the statisti	cal hasis? Enter "Y"	for ves	s or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order of							N N	148. 00
149.00 Was there a change to the simplifi					for no).	N	149. 00
			Part A	Part	В	Title V	Title XIX	
			1. 00	2. 00		3. 00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '							3. 13)	
155. 00 Hospi tal			N	N		N	N	155. 00
156. 00 Subprovi der - IPF			N	N		N	N	156. 00
157. 00 Subprovi der - IRF			N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF			N	l N		N	N	158. 00 159. 00
160.00 HOME HEALTH AGENCY			N	N N		N N	N N	160.00
161. 00 CMHC			IV	N N		N	N N	161. 00
TOT. GO OWNTO				14			1.00	101.00
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that h	as one o	or more campu	ıses in di	fferer	nt CBSAs?	N	165. 00
	Name		County	State	Zip (Code CBSA	FTE/Campus	
	0		1. 00	2.00	3. 0	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)							0.0	00 166. 00
							1.00	\dashv
Health Information Technology (HI) incentive in the A	meri can	Recovery and	d Reinvest	ment	Act		
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and ís a m	eani ngfu	ul user (line			enter the	N	167. 00 168. 00
168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)?	ot a meaningful user	, does t	this provider			hardshi p	Y	168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction	ser (line 167 is "Y"), enter the	9.	99169. 00
						Begi nni ng	Endi ng	
						1. 00	2. 00	1
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	eginning date and en	ding dat	te for the re	eporting				170. 00
						1. 00	2. 00	
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans re "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3 umn 1. If column 1 is	, Pt. I,	line 2, col	. 6? Ente		N		0 171. 00

	Bad Debts								
12.00	Is the provider seeking reimbursement for bad debts? If yes	, see instruct	i ons.		Υ	12. 00			
13.00	If line 12 is yes, did the provider's bad debt collection p	olicy change d	luring this cos	t reporting	N	13.00			
	period? If yes, submit copy.	3 0	o .						
14.00	If line 12 is yes, were patient deductibles and/or coinsura	ince amounts wa	ived? If yes, s	see	N	14.00			
	instructions.		, .						
	Bed Complement								
15.00	Did total beds available change from the prior cost reporti	ng period? If	yes, see instru	uctions.	N	15. 00			
		Par	t A	Par	t B				
		Y/N	Date	Y/N	Date				
		1. 00	2.00	3. 00	4.00				
	PS&R Data								
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00			
	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)								
17.00	Was the cost report prepared using the PS&R Report for	Υ	05/19/2023	N	05/19/2023	17. 00			
	totals and the provider's records for allocation? If								
	either column 1 or 3 is yes, enter the paid-through date								
	in columns 2 and 4. (see instructions)								
18.00	1	N		N		18. 00			
	Report data for additional claims that have been billed								
	but are not included on the PS&R Report used to file this								
	cost report? If yes, see instructions.								
19.00	' '	N		N		19. 00			
	Report data for corrections of other PS&R Report	· ·							
	information? If yes, see instructions.								
	,		'		1	1			

Heal th	Financial Systems COMMUNITY HOSPITAL	. OF BREMEN, IN	IC.	In Lie	u of Form CMS-	-2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/30/2023 11:	2 epared:	
			i pti on	Y/N	Y/N		
20.00	LE Line 1/ on 17 in one of the DCOD		0	1. 00	3. 00	20.00	
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	
	report data for other. Beserve the other day astmorts.	Y/N	Date	Y/N	Date		
		1.00	2.00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPLTALS)		1.00		
	Capital Related Cost	IT OTH EDITERS II	1001111120)				
22.00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made duri	ng the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost rep	porting period?	N	24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00	
27. 00	instructions. Has the provider's capitalization policy changed during the copy.	cost reportir	ng period? If	yes, submit	N	27. 00	
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	stored into dur	ing the cost	roporting	N	28. 00	
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		Ü		N	29. 00	
	treated as a funded depreciation account? If yes, see instr	,					
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.		-		N	30. 00	
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	N	31.00	
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32. 00	
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	N	33. 00	
	Provi der-Based Physi ci ans						
34. 00	Were services furnished at the provider facility under an a	irrangement wit	h provi der-ba	ased physicians?	Y	34. 00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		nts with the p	provi der-based	Υ	35. 00	
	physicians during the cost reporting period? If yes, see in	istructions.	-	Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
36. 00				Y		36. 00	
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	N		37. 00	
38. 00				N		38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			N		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00	
	instructions.						
	1.00 2.						
44 00	Cost Report Preparer Contact Information						
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.	NATHANI EL		HAMMAR		41.00	
42. 00	'	BEACON HEALTH	SYSTEM			42. 00	
43. 00		574-647-8396		NHAMMAR@BEACONI RG	HEALTHSYSTEM. O	43. 00	

Health Financial Systems	COMMUNITY HOSPITAL	OF BREMEN, I	NC.	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provi der (CCN: 15-1300	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
					5/30/2023 11:	59 am
		3	. 00			
Cost Report Preparer Contact Information	1 .					
41.00 Enter the first name, last name and the	title/position	REI MBURSEMENT	ANALYST			41.00
held by the cost report preparer in col	umns 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the	cost report					42.00
preparer.	•					
43.00 Enter the telephone number and email ad	dress of the cost					43.00
report preparer in columns 1 and 2, res	pecti vel y.					

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2023 | Health Financial Systems COMMUNITY HORSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1300

					10 12/31/2022	5/30/2023 11:	
						I/P Days / 0/P	07 diii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	·	Line No.		Avai I abl e			
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	24	8, 760	20, 760. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider					0	4. 00 5. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	
7. 00	Total Adults and Peds. (exclude observation		24	8, 76	20, 760. 00		7.00
7.00	beds) (see instructions)		24	0, 70	20, 760.00	U	7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY	43. 00				o	13. 00
14.00	Total (see instructions)		24	8, 76	20, 760. 00	0	14.00
15.00	CAH visits					0	15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	89. 00				0	26. 00 26. 25
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	89.00	24			U	26. 25
28. 00	Total (sum of lines 14-26) Observation Bed Days		24			o	28.00
29. 00	Ambulance Trips					U	29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	1			32.00
32. 01	Total ancillary labor & delivery room		J	·			32. 01
02.01	outpatient days (see instructions)						22.0.
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0			0	34. 00
	'						

34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 15-1300

0

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/30/2023 11:59 am Full Time Equivalents I/P Days / O/P Visits / Trips Component Title XVIII Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 409 138 1, 177 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 350 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 0 0 4.00 Hospital Adults & Peds. Swing Bed SNF 822 1,517 5.00 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 226 6.00 Total Adults and Peds. (exclude observation 2, 920 7.00 1, 231 138 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 146 13.00 Total (see instructions) 138 127. 25 14.00 1, 231 3,066 0.00 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 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 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23 00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 0 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 127. 25 27.00 Observation Bed Days 28.00 0 547 28.00 29 00 Ambul ance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 0 32.00 32.00 38 32.01 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 33.01 33.01

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provi der CCN: 15-1300

					12/31/2022	5/30/2023 11:	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	82	60	305	1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	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			62	0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF 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	0. 00 0. 00 0. 00	0	82	60	305	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00
	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care			0			29. 00 30. 00 31. 00 32. 00 32. 01 33. 00 33. 01 34. 00

Medicaid (see instructions for each line) Net revenue from Medicaid 1,031,975 No Net revenue from Medicaid 1,031,975 No No No No No No No N	leal th	Financial Systems COMMUNITY HOSPITAL OF BREMEN, I	NC.	In Lie	eu of Form CMS-2	2552-10
To 12/31/202 Date/Time Preparts Date/Time Pre	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 15-1300			0
Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) Net revenue from Medicald 1, 1,031,975 Net revenue from Medicald 3, 1,031,975 Did you receive DSI or supplemental payments from Medicald? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? If line 4 is no, then enter DSH and/or supplemental payments from Medicald? In line 4 is no, then enter DSH and/or supplemental payments from Medicald Power and DSH and/or supplemental payments from Medicald Power and DSH and/or supplemental payments from Medicald Power and DSH and/or supplemental payments from Medicald Power and/or supplemental p					Date/Time Pre	
Uncompensated and indigent care cost computation 0. 459961					07 007 2020 111.	, diii
Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.459961					1. 00	
Medical d (see Instructions for each line) Medicaid 1,031,975 N N N N N N N N N						4
Not revenue from Medicaid Not provide the DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? Note that the model of the model of the Medicaid charges and the model of the Medicaid charges and the Medicaid charges and the model of the Medicaid charges and the model of the Medicaid cost (line 1 times line 6) Note that the model of the Medicaid cost (line 1 times line 6) Note revenue from enter zero) Children's Health Insurance Program (CHIP) (see instructions for each line) Note revenue from stand-alone CHIP cost (line 1 times line 10) 10.00 Stand-alone CHIP cost (line 1 times line 10) 10.01 Stand-alone CHIP cost (line 1 times line 10) 10.02 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then only only only only only only only onl			ine 202 colum	in 8)	0. 459961	1.00
Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Olif line 4 is no, then enter DSH and/or supplemental payments from Medicaid? Olif line 4 is no, then enter DSH and/or supplemental payments from Medicaid? Olif line 4 is no, then enter DSH and/or supplemental payments from Medicaid? Olif line 4 is no, then enter DSH and/or supplemental payments from Medicaid? Olif line 4 is no, then enter DSH and/or supplemental payments from Medicaid? 5,986,284 2,753,457 Olif Children's Heal th Insurance Program (CHIP) (see instructions for each line) Olif Children's Heal th Insurance Program (CHIP) (see instructions for each line) Olif Stand-al one CHIP cost (line 1 times line 10) Olif Stand-al one CHIP cost (line 1 times line 10) Olif Grence between net revenue and costs for stand-al one CHIP (line 11 minus line 9; if < zero then enter zero) Olif Children's Heal thinsurance Program (see instructions for each line) Olif Grence between net revenue and costs for stand-al one CHIP (line 11 minus line 9; if < zero then enter zero) Olif Children's Heal thinsurance Program (see instructions for each line) Olif Grence between net revenue and costs for stand-al one CHIP (line 11 minus line 9; if < zero then enter zero) Olif Children's Heal thinsurance Program (see instructions for each line) Olif Grence between ret revenue and costs for state or local indigent care program (Not included in lines 6 or 10) Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0) Difference between net revenue and costs for Medicaid, CHIP and state/local indigent care programs (see Instructions for each line) Olif Charl type grants, donations, or endowment income restricted to funding charity care 0 1 Olif Covernment grants, appropriations or transfers for support of hospital operations 0 1 Olif Charl type grants, donations, or endowment income restricted to funding charity care 1 1.					1 021 075	2.00
If In a 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?					1	3.0
If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 0 0 0 0 0 0 0 0 0			nts from Medic	ai d?	I IV	4. 0
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Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,721,482 2 zero then enter zero) Children's Heal th Insurance Program (CHIP) (see instructions for each line) Net revenue from stand-al one CHIP 0 0 0 0 0 0 0 0 0	. 00					
<pre></pre>	. 00	Medicaid cost (line 1 times line 6)			2, 753, 457	7.0
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Stand-alone CHIP cost (line 1 times line 10) 1 1 1 1 1 1 1 1 1						
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Other state or local government indigent care program (see instructions for each line) 3.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 5.00 State or local indigent care program cost (line 1 times line 14) 6.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 1; if < zero then enter zero) 6.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 7.00 Private grants, donations, or endowment income restricted to funding charity care 8.00 Government grants, appropriations or transfers for support of hospital operations 9.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1, 721, 482 1, 2 and 16) Uninsured patients 1, 721, 482 1, 2 and 16) Uninsured Insured patients 1, 700 2, 00 3, 00 Uncompensated Care (see instructions for each line) 0.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 1.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 2.00 Payments received from patients for amounts previously written off as 0 0 0 0 charity care	2.00		ii iius Titie 7,	II < Zero then	0	12.0
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Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 7.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 0 1 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1,721,482 1) Uninsured patients patients patients 1,721,482 1 Uninsured patients patients 1,00 2,00 3,00 Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see 31,271 45,435 76,706 2 instructions) 2.00 Payments received from patients for amounts previously written off as 0 0 0 0 2					_	
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instructions for each line) Private grants, donations, or endowment income restricted to funding charity care 8.00 Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients Uninsured patients Total (col. 1 + col. 2)			te/Local indi	gent care program	l ms (see	i
Private grants, donations, or endowment income restricted to funding charity care 8.00 Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients 1.00 2.00 3.00 Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) 2.00 Private grants, donations, or endowment income restricted to funding charity care possible in sured patients 1,721,482 1 1,721,482 1 1,721,482 1 1,721,482 1 45,435 113,421 2 1,00 Cost of patients approved for charity care and uninsured discounts (see instructions) 2.00 Prayments received from patients for amounts previously written off as 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			rte/Tocal Thai	gent care program	(300	
7. Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients Total (col. 1 + col. 2) 1.00 2.00 3.00	7. 00		nrity care		0	17.0
8, 12 and 16) Uninsured patients patients patients 1 nsured patients patients 1 nsured patients patients 2 nsured patients 3 nsured 3 nsured patients 3 nsured patients	8. 00				0	18. 0
Uninsured patients Insured patients Total (col. 1 + col. 2)	9. 00		care program	s (sum of lines	1, 721, 482	19. 0
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chari ty care	1. 00	Cost of patients approved for charity care and uninsured discounts (see	31, 2	45, 435	76, 706	21. 0
	2. 00			0 0	0	22. 0
	3. 00		31, 2	271 45, 435	76 <u>,</u> 706	23. 00
1.00					1.00	

24. 00

26.00

27.00

27. 01

28. 00 29. 00

30.00

0 25.00

307, 065

8, 046

12, 379

294, 686

139, 877

216, 583

1, 938, 065 31. 00

24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

imposed on patients covered by Medicaid or other indigent care program?

Total bad debt expense for the entire hospital complex (see instructions)

28.00 Non-Medicare bad debt expense (see instructions)

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

27.00 | Medicare reimbursable bad debts for the entire hospital complex (see instructions)

Medicare allowable bad debts for the entire hospital complex (see instructions)

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)

25.00

26.00

stay limit

Heal th	Financial Systems COMM	IUNI TY HOSPI TAL	OF BREMEN, INC	C.	In Lie	u of Form CMS-2	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der CC	CN: 15-1300 P	eri od:	Worksheet A	
				Т	rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/30/2023 11:	pared: 59 am
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Tri al Bal ance	
						(col. 3 +-	
		1.00	0.00	0.00		col . 4)	
	OFNEDAL CEDIU OF COCT OFNEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS		ام		007.405	007.405	4 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		0	C	837, 425	837, 425	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		0	0	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0		U	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1 007 014	U F 140 F22	. 140 220	007 405	O	4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 027, 816	5, 140, 523			5, 330, 914	5. 00
7.00	00700 OPERATION OF PLANT	198, 401	195, 255			392, 820	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	252 450	205 024	550 202	104, 635	104, 635	8.00
9.00	00900 HOUSEKEEPI NG	253, 458	305, 924	559, 382		428, 647	9.00
10.00	01000 DI ETARY	285, 071	339, 188			304, 715	10.00
11.00	01100 CAFETERI A	107 (05	0	45, 005	311, 182	311, 182	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	127, 695	28, 600	· ·		156, 295	13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	167, 277	81, 258	248, 535	0	248, 535	16. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.047.047	4 (0(047	4 074 0/0	04.004	4 040 000	00.00
30.00	03000 ADULTS & PEDIATRICS	3, 247, 816	1, 626, 247			4, 843, 039	30.00
43. 00	04300 NURSERY	0	0	C	7, 519	7, 519	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	1 101 707	1 071 225	2 1/2 122	(22,021	2 521 101	FO 00
50.00	05000 OPERATING ROOM	1, 191, 797	1, 971, 325	3, 163, 122		2, 531, 101	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	00 040	400 400	0	13, 856	13, 856	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	699, 948	483, 122	1, 183, 070	-11, 301	1, 171, 769	54.00
57. 00	05700 CT SCAN	0	0	C	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	0 744 744	0	0	59. 00
60.00	06000 LABORATORY	1, 120, 313	1, 621, 433	2, 741, 746	0	2, 741, 746	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	145 500	0	044 003	0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	145, 528	66, 369			211, 897	65. 00
66.00	06600 PHYSI CAL THERAPY	392, 952	101, 318	494, 270	-2, 272	491, 998	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	U	107 020	10/ 020	U	107 020	69. 00
69. 02	06902 SLEEP LAB	U	106, 030	106, 030	U	106, 030	69. 02
70.00	07000 ELECTROENCEPHALOGRAPHY	U	0		00.020	0	70.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	U	0	C	98, 030	98, 030	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	405 021	(20.7(2	1 025 503	557, 213	557, 213	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	405, 821	629, 762	1, 035, 583	0	1, 035, 583	73. 00
90. 00	09000 CLINIC	0	0		O	0	90. 00
91. 00	09100 EMERGENCY	1, 402, 672	2, 047, 111	3, 449, 783		3, 449, 783	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 402, 072	2,047,111	3, 449, 703	l o	3, 449, 703	91.00
72.00	SPECIAL PURPOSE COST CENTERS						92.00
118. 00		10, 666, 565	14, 743, 465	25, 410, 030	-35, 298	25, 374, 732	112 00
110.00	NONREI MBURSABLE COST CENTERS	10, 000, 303	14, 743, 403	25, 410, 030	-33, 270	25, 514, 132	1110.00
190, 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12, 559	12, 559	0	12, 559	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	32, 642	42, 081	74, 723		101, 659	
	07950 MOW	0	0	0	8, 362		194. 00
200.00		10, 699, 207	14, 798, 105	25, 497, 312		25, 497, 312	
	, , ,				,	•	

Health FinancialSystemsCOMMUNITY HOSPRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Health Financial Systems COM	MUNITY HOSPITAL	OF BREMEN, INC.	In Lieu	of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CCN: 15-		Worksheet A
			From 01/01/2022	D-+- /T: D
				Date/Time Prepared: 5/30/2023 11:59 am
Cost Center Description	Adjustments	Net Expenses		07 007 2020 11. 07 dill
		For Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS	'			
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	-29, 600	807, 825		1.00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP	191, 740	191, 740		2. 00
3.00 00300 OTHER CAPITAL RELATED COSTS	0	O		3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	O		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-922, 259	4, 408, 655		5. 00
7.00 00700 OPERATION OF PLANT	0	392, 820		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	104, 635		8. 00
9. 00 00900 HOUSEKEEPI NG	0	428, 647		9. 00
10. 00 01000 DI ETARY	0	304, 715		10.00
11. 00 01100 CAFETERI A	-106, 033	205, 149		11. 00
13. 00 01300 NURSING ADMINISTRATION	o	156, 295		13. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	248, 535		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-923, 483	3, 919, 556		30.00
43. 00 04300 NURSERY	0	7, 519		43. 00
ANCILLARY SERVICE COST CENTERS		, ,		
50. 00 05000 OPERATI NG ROOM	-73, 035	2, 458, 066		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	13, 856		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	1, 171, 769		54.00
57. 00 05700 CT SCAN	o	o		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	o		59. 00
60. 00 06000 LABORATORY	0	2, 741, 746		60.00
60. 01 06001 BLOOD LABORATORY	0	_, ,		60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	o		64.00
65. 00 06500 RESPI RATORY THERAPY	0	211, 897		65. 00
66. 00 06600 PHYSI CAL THERAPY	o	491, 998		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68. 00 06800 SPEECH PATHOLOGY	o	o o		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	Ö		69. 00
69. 02 06902 SLEEP LAB	0	106, 030		69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	98, 030		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	557, 213		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	1, 035, 583		73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	1, 000, 000		70.00
90. 00 09000 CLINIC	O	0		90.00
91. 00 09100 EMERGENCY		3, 449, 783		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ĭ	3, 117, 733		92.00
SPECIAL PURPOSE COST CENTERS				72. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 862, 670	23, 512, 062		118. 00
NONREI MBURSABLE COST CENTERS	1, 002, 070	25, 512, 552		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	O	12, 559		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		101, 659		192. 00
194. 00 07950 MOW	0	8, 362		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-1, 862, 670	23, 634, 642		200. 00
	., 552, 570	20,00.,012		1200.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1300

| Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

					10 12/3	172022	5/30/2023	
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4. 00	5. 00				
	- IMPLANTABLE DEVICES							
	IPL. DEV. CHARGED TO	72. 00	0	557, 213				1. 00
	ATI ENTS							
2. 00		0.00	0	0				2. 00
0			0	557, 213				
	- MEDICAL SUPPLIES CHARGED							
	DICAL SUPPLIES CHARGED TO	71. 00	0	113, 085				1. 00
	ATI ENTS							
2. 00		0.00	0	0				2. 00
3. 00		0.00	0	0				3. 00
4. 00		0.00	0	0				4. 00
0			0	113, 085				
	- OB RECLASS							
1.00 NU	IRSERY	43.00	6, 183	1, 336				1. 00
2. 00 DE	LIVERY ROOM & LABOR ROOM	52.00	11, 394	2, 462				2. 00
0			17, 577	3, 798				
D	- CAFETERIA RECLASS							
1.00 CA	FETERI A	11. 00	199, 243	111, 939				1. 00
0			199, 243	111, 939				
E	- HOUSEKEEPING RECLASS							
1.00 PH	IYSICIANS' PRIVATE OFFICES	192. 00	26, 100	0				1. 00
0			26, 100	0				
	- MAINTENANCE RECLASS							
1.00 PH	IYSICIANS' PRIVATE OFFICES	192. 00	836	0				1. 00
0			836	0				
G	- MOW RECLASS							
1.00 MO)W	194. 00	0	8, 362				1. 00
0			0	8, 362				
Н	- LAUNDRY RECLASS							
1.00 LA	UNDRY & LINEN SERVICE	8. 00	0	104, 635				1. 00
T0	TALS		0	104, 635				
CD	- MOVE DEPRECIATION TO LIN	IE 1						
1. 00 NE	W CAP REL COSTS-BLDG &	1.00	0	837, 425				1. 00
FI	XT	L L						
0			0	837, 425				
	and Total: Increases		243, 756	1, 736, 457				500.00

Provider CCN: 15-1300

						o 12/31/2022 Date/lime F 5/30/2023 1	repared: I1:59 am
		Decreases		<u>'</u>			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	15, 055	0		1. 00
	PATI ENTS						
2.00	OPERATING ROOM	5000		54 <u>2, 1</u> 58			2. 00
	0		0	557, 213			_
	B - MEDICAL SUPPLIES CHARGED						
1.00	ADULTS & PEDIATRICS	30.00	0	9, 649			1. 00
2.00	OPERATING ROOM	50.00	0	89, 863			2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	11, 301			3. 00
4.00	PHYSICAL THERAPY	6600	•	<u>2, 2</u> 72			4. 00
	0		0	113, 085			
	C - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	17, 577	3, 798	1		1. 00
2.00		0.00	•	0			2. 00
	0		17, 577	3, 798			
	D - CAFETERIA RECLASS						
1.00	DI ETARY	10. 00	19 <u>9, 2</u> 43	11 <u>11, 9</u> 39			1. 00
	0		199, 243	111, 939			
	E - HOUSEKEEPING RECLASS				,		
1.00	HOUSEKEEPI NG	9.00	<u>26, 1</u> 00	0			1. 00
	0		26, 100	0			
	F - MAINTENANCE RECLASS				,		
1.00	OPERATION OF PLANT			0	0		1. 00
	0		836	0			
	G - MOW RECLASS				1		
1.00	DI ETARY	10.00	0				1. 00
	0		0	8, 362			_
	H - LAUNDRY RECLASS						
1.00	HOUSEKEEPI NG	<u> </u>	0	104, 635			1. 00
	TOTALS		0	104, 635			_
	CD - MOVE DEPRECIATION TO LIN						
1. 00	ADMI NI STRATI VE & GENERAL			837, 425			1. 00
	0		0	837, 425			500.5
500.00	Grand Total: Decreases		243, 756	1, 736, 457	1		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1300

| Period: | Worksheet A-7 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				T	12/31/2022	Date/Time Prep 5/30/2023 11:	
				Acqui si ti ons		1 37 307 2023 11.	J7 alli
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	779, 000	0	0	0	0	1. 00
2.00	Land Improvements	12, 900	0	0	0	0	2. 00
3.00	Buildings and Fixtures	9, 581, 431	396, 451	0	396, 451	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fi xed Equi pment	3, 442, 543	858, 428	0	858, 428	0	5. 00
6.00	Movable Equipment	327, 204	52, 787	0	52, 787	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	14, 143, 078	1, 307, 666	0	1, 307, 666		8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	14, 143, 078	1, 307, 666	0	1, 307, 666	0	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
		6.00	Assets 7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		7.00				
1. 00	Land	779,000	0				1. 00
2.00	Land Improvements	12, 900	0				2. 00
3.00	Buildings and Fixtures	9, 977, 882	0				3. 00
4. 00	Building Improvements	0	0				4. 00
5. 00	Fi xed Equipment	4, 300, 971	0				5. 00
6.00	Movable Equipment	379, 991	o				6. 00
7. 00	HIT designated Assets	0	ol				7. 00
8.00	Subtotal (sum of lines 1-7)	15, 450, 744	ol				8. 00
9.00	Reconciling Items	0	o				9. 00
10.00	Total (line 8 minus line 9)	15, 450, 744	o				10. 00

| Peri od: | Worksheet A-7 | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/202 Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS COMMUNITY HOSPITAL OF BREMEN, INC. Provider CCN: 15-1300

				· ·	0 12/01/2022	5/30/2023 11:	
			SL	IMMARY OF CAPIT	AL		
						T (
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				12.00	10.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	C	0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	o	0	C	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	C	0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0				1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	o	0				3. 00

Health Financial Systems C	OMMUNITY HOSPITAL	OF BREMEN, IN	C.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 01/01/2022 To 12/31/2022		pared: 59 am
	COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	instructions)	Insurance	
	1.00	2. 00	2) 3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	9, 977, 882	O	9, 977, 882	0. 680673	0	1.0
2 OO NEW CAP REL COSTS_MVRIE FOLLE	4 680 962	0	4 680 963	0 319327	0	2 0

	COM	PUTATION OF RATIOS A		ALLOCATION OF OTHER CAPITAL		
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
'		Leases	for Ratio	instructions)		
			(col. 1 - col.	,		
			2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	9, 977, 882	0	9, 977, 882	0. 680673	0	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	4, 680, 962	0	4, 680, 962	0. 319327	0	2. 00
3.00 Total (sum of lines 1-2)	14, 658, 844		14, 658, 844		0	3. 00
	ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)	0.00	10.00	
DART III DECONOLILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NIERS			070 457	0	1 00
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0	0	878, 457	0	1.00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	191, 740	0	2.00
3.00 Total (sum of lines 1-2)	0		<u>U</u> JMMARY OF CAPIT	1, 070, 197	0	3. 00
		St	JIMIMARY OF CAPIT	AL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Relate	of cols. 9	
		,	,	d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	-70, 632	0	0	0	807, 825	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	191, 740	
3.00 Total (sum of lines 1-2)	-70, 632	0	0	0	999, 565	3. 00

Health Financial Systems

COMMUNITY HOSPITAL OF BREMEN, INC.

In Lieu of Form CMS-2552-10

Provider CCN: 15-1300

Period: From 01/01/2022 To 12/31/2022

Provider CCN: 15-1300

Period: From 01/01/2022 To 12/31/2022

Pate/Time Prepared: 5/30/2023 11: 59 am

				T	o 12/31/2022	Date/Time Prep 5/30/2023 11:5	
	,			Expense Classification on			J7 dili
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1. 00 B	2. 00 -70, 632	3.00 NEW CAP REL COSTS-BLDG &	4. 00 1. 00	5. 00 11	1. 00
	REL COSTS-BLDG & FLXT (chapter			FIXT			
2. 00	2) Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2. 00	0	2. 00
2.00	REL COSTS-MVBLE EQUIP (chapter		· ·	EQUI P	2.00		2.00
3. 00	2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		· ·				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of	В	-11, 903	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
	suppliers (chapter 8)		· ·				
7. 00	Tel ephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-996, 518			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	71, 957			0	12. 00
12.00	transactions (chapter 10)	A-0-1	71, 737				
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-106 033	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee		0	SALETERIA.	0.00	o	15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
10.00	supplies to other than		O		0.00		10.00
17. 00	patients Sale of drugs to other than	В	0	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
	pati ents					Ĭ	
18. 00	Sale of medical records and abstracts	В	0	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		0		0. 00	О	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)		_				
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
05.00	limitation (chapter 14)				444.00		05 00
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
2/ 22	(chapter 21)		-	NEW CAR REL COOTS RUSS S	4 00		2/ 22
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT			NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26. 00
27. 00	Depreciation - NEW CAP REL			NEW CAP REL COSTS-MVBLE	2. 00	o	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist			EQUIP *** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
20.00	limitation (chapter 14)		-	ADULTO O DEDLATRICO	20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
	,	,				'	

From 01/01/2022

				Т	o 12/31/2022	Date/Time Prep 5/30/2023 11:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2.00	3.00	4. 00	5. 00	
32.00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	HAF PROVIDER ASSESSMENT	A	-551, 116	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
33. 01	REFUNDS AND REBATES - PHARMACY	В	0	DRUGS CHARGED TO PATIENTS	73.00	0	33. 01
33. 02	PLYMOUTH ST DEPRECIATION	A	0	NEW CAP REL COSTS-BLDG &	1.00	9	33. 02
				FLXT			
33. 03	WATERFORD FAMILY MEDICINE	A	0	NEW CAP REL COSTS-BLDG &	1.00	9	33. 03
				FI XT			
33. 04	MISC INCOME - ADMIN	В	-54, 400	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	AFFILIATE RENT REVENUE	В	-144, 025	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	MISC INCOME - PLANT OPS	В	0	OPERATION OF PLANT	7. 00	10	33. 06
33. 07	MISC INCOME - LAB	В	0	LABORATORY	60.00	0	33. 07
33. 08	MISC INCOME - NSG ADMIN	В	0	NURSING ADMINISTRATION	13.00	0	33. 08
33.09	PHYSICIAN RECRUITMENT	A	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 10
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-1, 862, 670				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

OFFICE COSTS

From 01/01/2022 To 12/31/2022 Date/Time Prepared:

				10 12/31/2022	5/30/2023 11:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE ALLOCATION	41, 032	0	1. 00
2.00	2. 00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE ALLOCATION	191, 740	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	2, 461, 877	2, 622, 692	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			2, 694, 649	2, 622, 692	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

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

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- 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	HOSPITAL OF	BREMEN, I	NC.	In Lie	u of Form CMS	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN: 15-1300	Peri od:	Worksheet A-	-8-1
OFFICE	COSTS							From 01/01/2022		
								To 12/31/2022	Date/Time Pr	
							-1		5/30/2023 11	l: <u>59 am</u>
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REC	QUIRED AS A RE	SULT OF TRA	NSACTI ONS	WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:								
1.00	41, 032	9								1. 00
2.00	191, 740	9								2. 00
3.00	-160, 815	0								3.00

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

4.00

5.00

nas not	been posted to worksheet A,	cordinate and the amount arrowable should be murcated in cordinate and this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

4.00

5.00

0

71, 957

0

| Period: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1300

					-	Γο 12/31/2022	Date/Time Pre 5/30/2023 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		OPERATING ROOM	73, 035			_		
2.00		EMERGENCY	1, 655, 000		.,,	0	0	2. 00
3.00		ADULTS & PEDIATRICS	923, 483	923, 483	0	0	0	
4.00	0.00		0	0	0	0	0	
5.00	0. 00		0	ľ	0	0	0	0.00
6.00	0.00		0	0	0	0	0	0.00
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	
9.00	0. 00		0	0	0	0	0	7.00
10.00	0. 00		0	0	0	0	0	10.00
200.00			2, 651, 518				0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE		Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00		OPERATING ROOM	8.00				14.00	1.00
2. 00		EMERGENCY	0	-	-	1		1
3. 00		ADULTS & PEDIATRICS	0	1	-			1
4. 00	0.00	ADULIS & FEDIATRICS	0	0	0			1
5. 00	0.00		0	0	0			1
6. 00	0.00		0	0			0	1
7. 00	0.00		0	0	0		0	1
8. 00	0.00		0	0	0	0	0	1
9. 00	0.00		0	0	0	0	0	1
10. 00	0.00		0	0	0	0	0	1
200.00			0	0	0	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		OPERATING ROOM	0		-		•	1. 00
2.00		EMERGENCY	0		-	_		2. 00
3.00		ADULTS & PEDIATRICS	0	0	0	923, 483	•	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	996, 518		200. 00

Provider CCN: 15-1300

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 11:59 am CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE **EMPLOYEE** Subtotal for Cost FIXT **FOULP BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 807 825 807 825 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 191, 740 191, 740 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3,022 717 3, 739 4.00 00500 ADMINISTRATIVE & GENERAL 4. 408. 655 16, 001 4, 492, 430 5 00 67, 415 359 5 00 7.00 00700 OPERATION OF PLANT 392, 820 145, 858 34,620 69 573, 367 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 104, 635 2,878 683 108, 196 8.00 9.00 00900 HOUSEKEEPI NG 428, 647 4, 945 1, 174 79 434, 845 9.00 01000 DI ETARY 10.00 16, 523 325, 190 304, 715 3.922 30 10 00 11.00 01100 CAFETERI A 205, 149 16, 432 3, 900 70 225, 551 11.00 01300 NURSING ADMINISTRATION 156, 295 5, 220 1, 239 162, 799 13.00 45 13.00 01600 MEDICAL RECORDS & LIBRARY 2,056 16, 00 248, 535 259, 310 16, 00 8.661 58 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 919, 556 147, 689 35, 054 1, 131 4, 103, 430 30.00 04300 NURSERY 43.00 7,519 3,820 907 12, 248 43.00 ANCILLARY SERVICE COST CENTERS 2, 594, 800 50 00 05000 OPERATING ROOM 2, 458, 066 110, 169 26, 149 416 50 00 13, 856 05200 DELIVERY ROOM & LABOR ROOM 15, 882 3, 770 33, 512 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 171, 769 52, 108 12, 368 244 1, 236, 489 54.00 57.00 05700 CT SCAN 57.00 C 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 C 60.00 06000 LABORATORY 2, 741, 746 31, 529 7, 484 391 2, 781, 150 60.00 60. N1 06001 BLOOD LABORATORY 0 0 0 60.01 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 Λ 06500 RESPIRATORY THERAPY 211, 948 65.00 211, 897 51 65.00 66.00 06600 PHYSI CAL THERAPY 491, 998 36, 841 8.744 137 537, 720 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 0 Ω 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY C Ω 69.00 06902 SLEEP LAB 0 69 02 106, 030 5, 874 1, 394 113, 298 69 02 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 Λ 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 98,030 27, 814 6,602 132, 446 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 557, 213 0 557, 213 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 048, 659 73.00 1,035,583 10, 453 2, 481 142 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 09100 EMERGENCY 3, 449, 783 89, 197 490 3, 560, 641 91.00 91 00 21 171 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 23, 512, 062 802, 330 190, 436 3, 718 23, 505, 242 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 12,559 5, 495 1, 304 19, 358 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 101, 659 21 101, 680 192. 00 C 194. 00 07950 MOW 8.362 0 8, 362 194. 00 0 0 200.00 200 00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 23, 634, 642 807.825 191, 740 3.739 23, 634, 642 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1300

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: 5/30/2023 11: 59 am

						5/30/2023 11:	59 am_
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 492, 430					5. 00
7. 00	00700 OPERATION OF PLANT	134, 562	l				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	25, 392					8.00
9. 00	00900 HOUSEKEEPI NG	102, 052			553, 532		9. 00
10. 00	01000 DI ETARY	76, 318	l		·	437, 311	1
11. 00	01100 CAFETERI A	52, 934			15, 582	437, 311	
13. 00							
	01300 NURSI NG ADMI NI STRATI ON	38, 207	1		4, 950	0	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	60, 857	10, 365	0	8, 213	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	963, 023			140, 056	437, 311	30. 00
43.00	04300 NURSERY	2, 874	4, 572	211	3, 623	0	43. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	608, 966	131, 847	42, 421	104, 473	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 865	19, 008	276	15, 061	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	290, 188	62, 362	13, 603	49, 414	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	652, 700	37, 733	l o	29, 899	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	49, 741	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	126, 196	1	_	34, 936	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	120, 170	11,070	0, 1, 7	01,700	0	67. 00
68. 00	06800 SPEECH PATHOLOGY				0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY				0	0	1
69. 00	06900 SLEEP LAB	26, 590	7 020	301	5, 570	0	69.00
		20, 590	7, 030	301	5, 570	_	
70.00	07000 ELECTROENCEPHALOGRAPHY	04 000	00.007	0	0 07 07 (0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 083	1		26, 376	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	130, 771		_	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	246, 107	12, 510	0	9, 913	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0	0	90. 00
91.00	09100 EMERGENCY	835, 636	106, 749	20, 767	84, 586	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 462, 062	701, 353	137, 033	548, 321	437, 311	118. 00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4, 543	6, 576	0	5, 211	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	23, 863			0,		192. 00
	07950 MOW	1, 962			0		194. 00
200.00	1	1, 702	ĺ		Ĭ		200.00
201.00	1 1	0	_	_	U	n	201.00
201.00		4, 492, 430	707, 929	137, 033	553, 532	437, 311	
202.00	TOTAL (Sum Times The through 201)	1 7,472,430	101, 323	1 137,033	555, 552	437, 311	1202.00

Provider CCN: 15-1300

				10	12/31/2022	5/30/2023 11:	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	
	·		ADMI NI STRATI ON	RECORDS &		Residents Cost	
				LI BRARY		& Post	
						Stepdown	
						Adjustments	
	I	11. 00	13. 00	16. 00	24. 00	25. 00	
	GENERAL SERVI CE COST CENTERS	T		T			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	044 440					10.00
11. 00	01100 CAFETERI A	314, 143					11.00
13.00	01300 NURSING ADMINISTRATION	0	212, 203	054 400			13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	12, 355	0	351, 100			16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00.772	04 475	4/ 150	/ 000 4/4		20.00
30.00	03000 ADULTS & PEDI ATRI CS	99, 773	84, 475	46, 158	6, 090, 464	0	30.00
43. 00	04300 NURSERY	0	0	1, 126	24, 654	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	36, 674	31, 051	71, 115	3, 621, 347	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	30, 674	31,031	2, 855	3, 621, 347 78, 577		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	31, 040		68, 056	1, 751, 152		54. 00
57. 00	05700 CT SCAN	31,040		00, 030	1, 751, 152 O	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0	0	58.00
59. 00	05900 CARDIAC CATHETERIZATION	0		0	0		59.00
60.00	06000 LABORATORY	66, 296	56, 131	74, 064	3, 697, 973	0	60.00
60. 01	06001 BLOOD LABORATORY	00, 270	30, 131	74,004	3, 077, 773 N		60. 01
64. 00	06400 NTRAVENOUS THERAPY	0	0	0	0		64. 00
65. 00	06500 RESPIRATORY THERAPY	0		3, 427	265, 116	- 1	65. 00
66. 00	06600 PHYSI CAL THERAPY	18, 004		14, 220	783, 645	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	10,001	o o	11, 220	700,010	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	o o	0	0		68.00
69. 00	06900 ELECTROCARDI OLOGY	0		0	0	0	69. 00
69. 02	06902 SLEEP LAB	0	o o	4, 085	156, 874	0	69. 02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	o o	., 555	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4, 707	227, 899	l o	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	9, 980	697, 964	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 514	9, 748	24, 987	1, 363, 438	Ö	73. 00
	OUTPATIENT SERVICE COST CENTERS		,		,	_	
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	36, 376	30, 798	26, 320	4, 701, 873	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	312, 032	212, 203	351, 100	23, 460, 976	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	35, 688		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	2, 111	0	0	127, 654		192. 00
	07950 MOW	0	0	0	10, 324		194. 00
200.00	1 1				0		200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	314, 143	212, 203	351, 100	23, 634, 642	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1300

			5/30/2023 12	
	Cost Center Description	Total	0,00,2020	
	,	26. 00		
	GENERAL SERVICE COST CENTERS	·		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON			13. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		
30.00	03000 ADULTS & PEDI ATRI CS	6, 090, 464		30.00
43.00	04300 NURSERY	24, 654		43.00
	ANCILLARY SERVICE COST CENTERS	.,		
50.00	05000 OPERATING ROOM	3, 621, 347		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	78, 577		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 751, 152		54.00
57. 00	05700 CT SCAN	0		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o		59. 00
60.00	06000 LABORATORY	3, 697, 973		60.00
60. 01	06001 BLOOD LABORATORY	o		60, 01
64. 00	06400 I NTRAVENOUS THERAPY	ō		64. 00
65.00	06500 RESPI RATORY THERAPY	265, 116		65. 00
66. 00	06600 PHYSI CAL THERAPY	783, 645		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	ō		68. 00
69. 00	06900 ELECTROCARDI OLOGY	ō		69. 00
69. 02	06902 SLEEP LAB	156, 874		69. 02
70.00	07000 ELECTROENCEPHALOGRAPHY	0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	227, 899		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	697, 964		72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 363, 438		73. 00
	OUTPATIENT SERVICE COST CENTERS	,		
90.00	09000 CLI NI C	0		90.00
91.00	09100 EMERGENCY	4, 701, 873		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	23, 460, 976		118. 00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	35, 688		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	127, 654		192. 00
	07950 MOW	10, 324		194. 00
200.00		0		200.00
201.00	,	o		201.00
202.00		23, 634, 642		202. 00
		1		•

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF BREMEN, INC. Provider CCN: 15-1300

				То	12/31/2022	Date/Time Pre 5/30/2023 11:	
			CAPI TAL REI	ATED COSTS		373072023 11.	J7 dili
	Cost Center Description	Di rectl y	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FLXT	EQUI P		BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 022	717	3, 739	3, 739	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	67, 415	16, 001	83, 416	359	5. 00
7.00	00700 OPERATION OF PLANT	0	145, 858	34, 620	180, 478	69	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	2, 878	683	3, 561	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	4, 945		6, 119	79	9. 00
10.00	01000 DI ETARY	0	16, 523		20, 445	30	10. 00
11. 00	01100 CAFETERI A	0	16, 432		20, 332	70	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	5, 220		6, 459	45	13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	8, 661	2, 056	10, 717	58	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		147 (00	25 054	100 740	1 101	20.00
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS	0	147, 689		182, 743 4, 727	1, 131	30.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	U	3, 820	907	4, 727	2	43. 00
50. 00	05000 OPERATING ROOM	0	110, 169	26, 149	136, 318	416	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	15, 882		19, 652	410	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	52, 108		64, 476	244	54.00
57. 00	05700 CT SCAN	0	02, 100		01, 170	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		o	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	Ö	o	0	59. 00
60.00	06000 LABORATORY	0	31, 529	7, 484	39, 013	391	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	O	0	0	o	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	51	65. 00
66.00	06600 PHYSI CAL THERAPY	O	36, 841	8, 744	45, 585	137	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	O	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
69. 02	06902 SLEEP LAB	0	5, 874	1, 394	7, 268	0	69. 02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27, 814	6, 602	34, 416	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	10, 453	2, 481	12, 934	142	73. 00
	OUTPATIENT SERVICE COST CENTERS				-		
90.00	09000 CLI NI C	0	0		0	0	90.00
91. 00	09100 EMERGENCY	0	89, 197	21, 171	110, 368	490	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS				0		92.00
118. 00		0	802, 330	190, 436	992, 766	2 710	118. 00
110.00	NONREI MBURSABLE COST CENTERS	ı o	002, 330	170, 430	772, 700	3, 710] 110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5, 495	1, 304	6, 799	n	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		0, 479		0, 777		192. 00
	07950 MOW	l ol	0		o O		194. 00
200.00			· ·		o	ŭ	200. 00
201.00	,		0	o	ol	0	201. 00
202.00	1 1 9	0	807, 825	191, 740	999, 565		202. 00
				. '	'		•

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 | 11: 59 am

						5/30/2023 11:	<u>59 am</u>
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	83, 775					5. 00
7. 00	00700 OPERATION OF PLANT	2, 509	183, 056	,			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	473	891				8.00
9. 00	00900 HOUSEKEEPI NG	1, 903	1, 530				9.00
10. 00	01000 DI ETARY	1, 423	5, 113			27, 308	10.00
11. 00	01100 CAFETERI A	987	5, 085			27, 300	11.00
	01300 NURSI NG ADMI NI STRATI ON	712			90	0	13.00
13. 00	I I	1	1, 615				1
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 135	2, 680	0	149	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	17, 965	45, 706			27, 308	30.00
43.00		54	1, 182	. 8	66	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00		11, 355	34, 093			0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	147	4, 915	10	273	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 411	16, 125	489	894	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0	o o	o	0	59.00
60.00	06000 LABORATORY	12, 170	9, 757	· 0	541	0	60.00
60. 01	06001 BLOOD LABORATORY		. 0	ol o	o	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	l	0	ol o	o	0	64.00
65. 00	06500 RESPI RATORY THERAPY	927	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 353	11, 401	305	632	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2,000	,		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
69. 02	06902 SLEEP LAB	496	1, 818	1	101	0	69. 02
70. 00	07000 ELECTROENCEPHALOGRAPHY	470	1,010		101	0	70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	580	8. 607	, 0	477	0	71.00
			8, 607	1	4//	-	
72.00	I I	2, 438	0.005	0	470	0	72.00
73. 00		4, 589	3, 235	0	179	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0	1		0	90. 00
91. 00	09100 EMERGENCY	15, 581	27, 603	746	1, 531	0	91. 00
92.00							92. 00
	SPECIAL PURPOSE COST CENTERS						
118. 0		83, 208	181, 356	4, 925	9, 922	27, 308	118. 00
	NONREI MBURSABLE COST CENTERS						
190.0	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	85	1, 700	0	94	0	190. 00
192.0	19200 PHYSICIANS' PRIVATE OFFICES	445	0	o o	O	0	192. 00
	07950 MOW	37	0	0	o	0	194. 00
200.0	1 1						200. 00
201. 0	1 1	0	0	0	o	0	201. 00
202. 0	1 1 0	83, 775	183, 056	4, 925	10, 016		202. 00
			, ,			,	

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1300

				То	12/31/2022	Date/Time Prep 5/30/2023 11:5	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	J7 alli
	555 55mtor 5555rrptron		ADMI NI STRATI ON	RECORDS &		Residents Cost	
				LI BRARY		& Post	
						Stepdown	
						Adjustments	
		11.00	13.00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A	26, 771					11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	8, 921				13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 053	0	15, 792			16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.500	0 554	0.070	202 222		00.00
30.00	03000 ADULTS & PEDI ATRI CS	8, 503	3, 551	2, 079	292, 938	0	30. 00
43. 00	04300 NURSERY	0	0	51	6, 090	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	3, 125	1, 305	3, 203	193, 229	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 123	1, 303	129	25, 130	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 645	0	3, 065	93, 349	0	54. 00
57. 00	05700 CT SCAN	2,043	0	3,005	73, 347	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDIAC CATHETERIZATION	0	0	0	ol	0	59. 00
60.00	06000 LABORATORY	5, 650	2, 360	3, 316	73, 198	0	60.00
60. 01	06001 BLOOD LABORATORY	3,030	2, 300	3, 310	73, 170	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö	Ö	ő	ő	64. 00
65. 00	06500 RESPIRATORY THERAPY	0	0	154	1, 132	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 534	0	640	62, 587	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1,001	Ö	0.0	02, 007	ő	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	Ö	Ö	Ö	ő	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	Ö	Ö	ol	ő	69. 00
69. 02	06902 SLEEP LAB	0	Ö	184	9, 878	ő	69. 02
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	Ö	0	7, 0, 0	ő	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	212	44, 292	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	o	449	2, 887	ő	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	981	410	1, 125	23, 595	ő	73. 00
70.00	OUTPATIENT SERVICE COST CENTERS	701	110	1, 120	20,070		70.00
90.00	09000 CLI NI C	0	ol	0	ol	0	90.00
91.00	09100 EMERGENCY	3, 100	1, 295	1, 185	161, 899	ol	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			,	,	0	92.00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	26, 591	8, 921	15, 792	990, 204	0	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0		0	8, 678		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	180	0	0	646		192. 00
	07950 MOW	0	0	0	37		194. 00
200.00	1 1				0		200. 00
201.00	1 1 3	0	0	0	o		201. 00
202.00	TOTAL (sum lines 118 through 201)	26, 771	8, 921	15, 792	999, 565	0	202. 00

118.00

190.00

192. 00

194.00

200.00

201. 00

202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1300 Peri od: Worksheet B From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 5/30/2023 11:59 am Cost Center Description Total 26. 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 292, 938 30.00 43.00 04300 NURSERY 6,090 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 193, 229 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 25, 130 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 93, 349 54.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 60.00 60.00 73.198 60.01 06001 BLOOD LABORATORY 0 60.01 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 1.132 06600 PHYSI CAL THERAPY 66.00 62, 587 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 69 02 06902 SLEEP LAB 9.878 69 02 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 44, 292 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,887 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 23, 595 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 161, 899 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS

990, 204

999, 565

8,678

646

37

0

0

118.00

200.00

201.00

202.00

194. 00 07950 MOW

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

NONREI MBURSABLE COST CENTERS

190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN

Cross Foot Adjustments

Negative Cost Centers

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1300

Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Ti me Prepared:

5/30/2023 11:59 am CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE FLXT **FOULP** BENEFITS & GENERAL (SOLIARE (SOUARE DEPARTMENT (ACCUM. FOOTAGE) FOOTAGE) (GROSS COST) SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 61.748 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 61, 748 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 231 231 10, 699, 207 4.00 00500 ADMINISTRATIVE & GENERAL 1, 027, 816 5 00 5 153 -4, 492, 430 19, 142, 212 5 00 5 153 7.00 00700 OPERATION OF PLANT 11, 149 11, 149 197, 565 573, 367 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 220 220 108, 196 8.00 00900 HOUSEKEEPI NG 378 378 227, 358 0 434, 845 9.00 9.00 01000 DI ETARY 0 325, 190 10 00 10.00 1.263 1, 263 85, 828 11.00 01100 CAFETERI A 1, 256 1, 256 199, 243 0 225, 551 11.00 01300 NURSING ADMINISTRATION 399 0 162, 799 13.00 399 127, 695 13.00 01600 MEDICAL RECORDS & LIBRARY 167. 277 259, 310 16,00 662 16,00 662 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 289 11, 289 3, 230, 239 0 4, 103, 430 30.00 04300 NURSERY 43.00 292 292 6, 183 0 12, 248 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 8.421 8, 421 1, 191, 797 2, 594, 800 50 00 05200 DELIVERY ROOM & LABOR ROOM 1, 214 1, 214 11, 394 52.00 33, 512 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 983 3, 983 699, 948 0 1, 236, 489 54.00 0 57.00 05700 CT SCAN 57.00 0 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 0 0 60.00 06000 LABORATORY 1, 120, 313 2, 781, 150 2.410 2.410 60.00 06001 BLOOD LABORATORY 60.01 0 0 0 60.01 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 Λ 06500 RESPIRATORY THERAPY 211, 948 65.00 145, 528 0 65.00 66.00 06600 PHYSI CAL THERAPY 2,816 2, 816 392, 952 537, 720 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 0 0 06800 SPEECH PATHOLOGY 0 68.00 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 Ω 69.00 06902 SLEEP LAB 69 02 449 449 0 113, 298 69 02 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 Λ 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 2, 126 2, 126 0 132, 446 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 557, 213 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 799 799 73.00 405, 821 1, 048, 659 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 09100 EMERGENCY 6 818 1, 402, 672 ol 91 00 6 818 3 560 641 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 61, 328 61, 328 10, 639, 629 -4, 492, 430 19, 012, 812 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 420 420 19, 358 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 59, 578 0 101, 680 192. 00 0 194.00 07950 MOW 0 0 8, 362 194. 00 Cross Foot Adjustments 200 00 200 00 201.00 Negative Cost Centers 201.00 4, 492, 430 202. 00 202.00 Cost to be allocated (per Wkst. B, 807.825 191, 740 3.739 Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 13.082610 3.105202 0.000349 0. 234687 203. 00 204.00 Cost to be allocated (per Wkst. B, 3, 739 83, 775 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000349 0.004376 205.00 II)NAHE adjustment amount to be allocated 206.00 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207. 00 Parts III and IV)

Heal th Financial Systems COMMUNITY HOSPITAL OF BREMEN, INC.

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1300 | Period: From 01/01/2022 To 12/31/2022 | Date/Time Prepared: 5/30/2023 11: 59 am

Cost Center Description | OPERATION OF PLANT | LINEN SERVICE | (SQUARE (MEALS (FTE HRS))

				To	12/31/2022	Date/Time Pre 5/30/2023 11:	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	J9 alli
	, , , , , , , , , , , , , , , , , , ,	PLANT	LINEN SERVICE	(SQUARE	(MEALS	(FTE HRS)	
		(SQUARE	(POUNDS	FOOTAGE)	SERVED)		
		FOOTAGE)	OF LAUNDRY)				
	CENEDAL CEDIUCE COCT CENTEDO	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	45, 215					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	220	125, 123				8. 00
9.00	00900 HOUSEKEEPI NG	378	9, 786	44, 617			9. 00
10.00	01000 DI ETARY	1, 263	ł		9, 698		10.00
11. 00	01100 CAFETERI A	1, 256			0	187, 360	1
13.00	01300 NURSI NG ADMINI STRATI ON	399	ł		0	7 0/0	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	662	0	662	0	7, 369	16. 00
30. 00	03000 ADULTS & PEDIATRICS	11, 289	36, 056	11, 289	9, 698	59, 506	30. 00
43. 00	04300 NURSERY	292	193		0,070	07,000	43. 00
	ANCILLARY SERVICE COST CENTERS	: -			-,	-	1
50.00	05000 OPERATING ROOM	8, 421	38, 733	8, 421	0	21, 873	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 214	252		0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 983	12, 421		0	18, 513	1
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	2, 410	0	2, 410	0	39, 540	1
60. 01 64. 00	06001 BLOOD LABORATORY 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	60. 01 64. 00
65. 00	06500 RESPIRATORY THERAPY	0		0	0	0	1
66. 00	06600 PHYSI CAL THERAPY	2, 816	7, 742	-	Ö	10, 738	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	ō	0	1
68.00	06800 SPEECH PATHOLOGY	0	0	0	o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 02	06902 SLEEP LAB	449	275	1	0	0	69. 02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 126	0	-,	0	0	•
	07300 DRUGS CHARGED TO PATIENTS	799	1		o	6, 867	
73.00	OUTPATIENT SERVICE COST CENTERS	, , , ,		777	<u></u>	0,007	73.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	6, 818	18, 962	6, 818	o	21, 695	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
440.00	SPECIAL PURPOSE COST CENTERS	14 705	105.400	I	0 (00	10/ 10/	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	44, 795	125, 123	44, 197	9, 698	186, 101	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	420	0	420	ol	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1	1	ő		192. 00
	07950 MOW	0	0	0	Ö		194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00		707, 929	137, 033	553, 532	437, 311	314, 143	202. 00
000 00	Part I)	45 (5(050	4 005407	40.40/000	45 000001	4 (7//04	000 00
203.00		15. 656950	l e		45. 092906	1. 676681	203.00
204.00	Part II)	183, 056	4, 925	10, 016	27, 308	20, 771	204.00
205.00		4. 048568	0. 039361	0. 224488	2. 815838	0. 142885	205. 00
					2.2200		
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	1 1 1						207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1300

Peri od: Worksheet B-1 From 01/01/2022

12/31/2022 Date/Time Prepared: 5/30/2023 11:59 am Cost Center Description NURSI NG MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY (DI RECT (GROSS NRSING HRS) CHARGES) 13.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 149, 481 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 51, 006, 429 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 6, 706, 031 30.00 59, 506 43.00 04300 NURSERY 163, 520 43.00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 10, 331, 992 21,873 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 414, 850 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 9, 887, 552 54.00 57. 00 | 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58 00 58 00 0 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 39, 540 10, 757, 069 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06400 I NTRAVENOUS THERAPY 0 64 00 64.00 0 65.00 06500 RESPIRATORY THERAPY 497, 933 65.00 06600 PHYSI CAL THERAPY 0 66.00 2,066,032 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 69.00 C 06902 SLEEP LAB 69.02 593, 455 69.02 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 683, 796 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 449, 916 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 6,867 3, 630, 301 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 21, 695 3, 823, 982 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 149, 481 51, 006, 429 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 194. 00 07950 MOW 0 194. 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 212, 203 351, 100 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 1. 419598 0.006883 203.00 Cost to be allocated (per Wkst. B, 204.00 15, 792 204.00 8, 921 Part II) 205.00 0.000310 205.00 Unit cost multiplier (Wkst. B, Part 0.059680 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems COMMUNITY HOSPITAL OF BREMEN, INC. In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1300 Peri od: Worksheet C From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/30/2023 11:59 am Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 2.00 4. 00 5. 00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 6, 090, 464 30 00 6, 090, 464 Ω 43.00 04300 NURSERY 24,654 24,654 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 3, 621, 347 0 50.00 3, 621, 347 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 78, 577 78, 577 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 751, 152 1, 751, 152 0 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 57.00 05700 CT SCAN 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 O 58.00 Λ 05900 CARDIAC CATHETERIZATION 59.00 0 59.00 60.00 06000 LABORATORY 3, 697, 973 3, 697, 973 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 0 0 06400 I NTRAVENOUS THERAPY 64.00 0 Ω 0 64.00 65.00 06500 RESPIRATORY THERAPY 265, 116 265, 116 0 65.00 06600 PHYSI CAL THERAPY 66.00 783, 645 783, 645 0 66.00 06700 OCCUPATIONAL THERAPY 67 00 0 0 0 67 00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 06902 SLEEP LAB 69.02 156, 874 156, 874 0 69.02 07000 ELECTROENCEPHALOGRAPHY 70 00 Ω 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 227, 899 227, 899 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 697, 964 697, 964 0 72.00 0 72.00 0 73 00 07300 DRUGS CHARGED TO PATIENTS 1, 363, 438 1, 363, 438 Ω 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 09100 EMERGENCY 4, 701, 873 4, 701, 873 ol 91.00 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 018, 366 1, 018, 366 Ω

24, 479, 342

1, 018, 366

23, 460, 976

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24, 479, 342

1, 018, 366

23, 460, 976

0

0

0 200. 00

0 201.00

0 202. 00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1300 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 11:59 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 733, 977 4, 733, 977 30.00 30.00 43.00 04300 NURSERY 163, 520 163, 520 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 143, 075 9, 188, 917 10, 331, 992 0.350498 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 403, 706 0.189411 52.00 11. 144 414, 850 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 425, 515 9, 462, 037 9, 887, 552 0.177107 0.000000 54.00 57.00 05700 CT SCAN 0 C 0 0.000000 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0.000000 58.00 0 0 58.00 C 05900 CARDIAC CATHETERIZATION 59 00 0.000000 0.000000 59 00 60.00 06000 LABORATORY 1, 128, 407 9, 628, 662 10, 757, 069 0.343771 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06400 INTRAVENOUS THERAPY 64.00 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 497, 933 65.00 335, 557 162, 376 0.532433 0.000000 65.00 06600 PHYSI CAL THERAPY 864, 735 1, 201, 297 0.379300 0.000000 66.00 2,066,032 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 68.00 0 0 0.000000 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 06902 SLEEP LAB 0. 264340 0.000000 69.02 3,812 589, 643 593, 455 69.02 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 32, 987 650, 809 683, 796 0.333285 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 118, 982 1, 330, 934 1, 449, 916 0.481382 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 403, 352 2, 226, 949 3, 630, 301 0.375572 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 89, 246 3, 734, 736 3, 823, 982 1. 229575 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 494 1, 965, 560 1, 972, 054 0.516399 0.000000 92.00 200.00 Subtotal (see instructions) 10, 853, 365 40, 153, 064 51, 006, 429 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 10, 853, 365 40, 153, 064 51, 006, 429 202.00

NPATI ENT ROUTINE SERVICE COST CENTERS 30.00 300.00 ADULTS & PEDIATRICS 43.00					To 12/31/2022	Date/Time Prepared: 5/30/2023 11:59 am
NPATI ENT ROUTINE SERVICE COST CENTERS 11.00 11.00 13.00 03900 ADULTS & PEDI ATRICS 43.00 43.00 ADULTS & PEDI ATRICS & 43.00 43.00 ADULTS & PEDI ATRICS & 43.00 43.00 ADULTS & PEDI ATRICS & 43.00 43.00				Title XVIII	Hospi tal	Cost
INPATI ENT ROUTINE SERVICE COST CENTERS 30. 00 33000 ADULTS & PEDI ATRI CS 30. 00 A3000 ADULTS & PEDI ATRI CS 30. 00 A3000 NURSERY 30. 00 A3000 A30000 A3000 A30000 A300000 A300000 A300000 A300000 A300000 A300000 A300000 A3000000 A3000000 A3000000 A3000000 A3000000 A3000000 A3000000 A3000000 A3000000 A30000000 A3000000 A30000000 A300000000 A3000000000 A3000000000 A3000000000 A3000000000 A30000000000		Cost Center Description				
IMPATLENT ROUTINE SERVICE COST CENTERS 30.00						
30. 00 03000 ADULTS & PEDIATRICS 30. 00 43. 00 ADULTS & PEDIATRICS 43. 00 ADULTS & SERVICE COST CENTERS			11. 00			
43.00						
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM 0.000000 052. 00 05200 DELI VERY ROOM & LABOR ROOM 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.00000000						43. 00
52.00						
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 00 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.000000 60. 00 64. 00 06400 I INTRAVENOUS THERAPY 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 66. 00 69. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 66900 ELECTROCARDI OLOGY 0.000000 69. 00 69. 02 0.0000 ELECTROCARDI OLOGY 0.000000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70. 00 71. 00 07000 IRDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72. 00 70. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73. 00 001000 IRBIN ENGLISH STRUCT CONTERS 0.0000						
57. 00 05700 CT SCAN 0.0000000 57. 00 58. 00 058000 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.000000 60. 01 64. 00 06400 INTRAVENOUS THERAPY 0.000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 68. 00 69. 02 06900 ELECTROCARDI OLOGY 0.000000 69. 00 69. 02 06902 SLEEP LAB 0.000000 69. 02 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 71. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 09000 CLI NI C 0.000000 90. 00 90. 00 09000 OBSERVATI ON BEDS (NON						
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0.00000 0.00000 0.000000 0.000000						
59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.000000 60. 00 61. 00 06400 I NTRAVENOUS THERAPY 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 08800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 69. 02 06902 SLEEP LAB 0.000000 69. 02 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 09000 CLI NI C 0.000000 91. 00 91. 00 09100 EMERGENCY 0.000000 91. 00 90. 00						
60. 00						
60. 01	59. 00 05900	CARDI AC CATHETERI ZATI ON	0. 000000			59.00
64. 00	60.00 06000	LABORATORY	0. 000000			60.00
65. 00			0. 000000			60. 01
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68. 00	66. 00 06600	PHYSI CAL THERAPY	0. 000000			66. 00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 02 06902 SLEEP LAB 0.000000 69. 02 70. 00 70. 00 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 000000 73. 00 000000 000000 000000 000000 000000	67. 00 06700	OCCUPATIONAL THERAPY	0. 000000			67. 00
69. 02	68. 00 06800	SPEECH PATHOLOGY	0. 000000			68. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 000000 000000 000000 000000 000000	69. 00 06900	ELECTROCARDI OLOGY	0. 000000			69. 00
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72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 09100 EMERGENCY 0.000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 9200.00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	70.00 07000	ELECTROENCEPHALOGRAPHY	0. 000000			70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.000000 91. 00 91. 00 91. 00 92. 00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 09200 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 91.00 09100 EMERGENCY 0.000000 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
90. 00 90. 00 90. 00 91. 00 91. 00 92. 00 92. 00 92. 00 92. 00 Subtotal (see instructions) Less Observation Beds 90. 0000000 90. 0000000 90. 0000000000	73.00 07300	DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
91. 00 09100 EMERGENCY 0.000000 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	OUTPA	ATIENT SERVICE COST CENTERS	•			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	90.00 09000	CLI NI C	0. 000000			90.00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	91.00 09100	EMERGENCY	0. 000000			91.00
201.00 Less Observation Beds 201.00	92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
201.00 Less Observation Beds 201.00	200. 00	Subtotal (see instructions)				200. 00
	201. 00					201. 00
		Total (see instructions)				

Health Financial Systems In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1300 Peri od: Worksheet C From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/30/2023 11:59 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 2.00 4. 00 1.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 30 00 6, 090, 464 6, 090, 464 6, 090, 464 43.00 24, 654 04300 NURSERY 43.00 24,654 24,654 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 3, 621, 347 3, 621, 347 3, 621, 347 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 78, 577 78, 577 0 78, 577 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 751, 152 1, 751, 152 0 0 0 0 0 0 0 1, 751, 152 54.00 57.00 05700 CT SCAN 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 O 58.00 Λ 59.00 05900 CARDIAC CATHETERIZATION Ω 59.00 60.00 06000 LABORATORY 3, 697, 973 3, 697, 973 3, 697, 973 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 0 06400 I NTRAVENOUS THERAPY 64.00 0 Ω Λ 64.00 65.00 06500 RESPIRATORY THERAPY 265, 116 265, 116 265, 116 65.00 06600 PHYSI CAL THERAPY 66.00 783, 645 783, 645 0 0 0 0 0 783, 645 66.00 06700 OCCUPATIONAL THERAPY 67 00 0 Ω 0 67 00 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 06902 SLEEP LAB 69.02 156, 874 156, 874 156, 874 69.02 07000 ELECTROENCEPHALOGRAPHY 70 00 70 00 C 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 227, 899 227, 899 227, 899 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 697, 964 0 72.00 697, 964 697, 964 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 1, 363, 438 1, 363, 438 1, 363, 438 73 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 n 90.00 09100 EMERGENCY 4, 701, 873 4, 701, 873 4, 701, 873 91.00 o 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 018, 366 1, 018, 366 1, 018, 366 92 00 200.00 Subtotal (see instructions) 24, 479, 342 0 24, 479, 342 0 24, 479, 342 200. 00

1, 018, 366

23, 460, 976

1, 018, 366

23, 460, 976

1, 018, 366 201. 00

23, 460, 976 202. 00

o

201.00

202.00

Less Observation Beds

Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1300 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 11:59 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 733, 977 4, 733, 977 30.00 30.00 43.00 04300 NURSERY 163, 520 163, 520 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 143, 075 9, 188, 917 10, 331, 992 0.350498 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 403, 706 0.189411 52.00 11. 144 414, 850 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 425, 515 9, 462, 037 9, 887, 552 0.177107 0.000000 54.00 57.00 05700 CT SCAN 0 C 0 0.000000 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0.000000 58.00 0 0 58.00 C 05900 CARDIAC CATHETERIZATION 59 00 0.000000 0.000000 59 00 60.00 06000 LABORATORY 1, 128, 407 9, 628, 662 10, 757, 069 0.343771 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06400 INTRAVENOUS THERAPY 64.00 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 497, 933 65.00 335, 557 162, 376 0.532433 0.000000 65.00 06600 PHYSI CAL THERAPY 864, 735 1, 201, 297 0.379300 0.000000 66.00 2,066,032 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 68.00 0 0 0.000000 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 06902 SLEEP LAB 0. 264340 0.000000 69.02 3,812 589, 643 593, 455 69.02 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 32, 987 650, 809 683, 796 0.333285 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 118, 982 1, 330, 934 1, 449, 916 0.481382 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 403, 352 2, 226, 949 3, 630, 301 0.375572 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 91. 00 09100 EMERGENCY 89, 246 3, 734, 736 3, 823, 982 1. 229575 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 494 1, 965, 560 1, 972, 054 0.516399 0.000000 92.00 200.00 Subtotal (see instructions) 10, 853, 365 40, 153, 064 51, 006, 429 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 10, 853, 365 40, 153, 064 51, 006, 429 202.00

NPATI ENT ROUTINE SERVICE COST CENTERS 30.00 300.00 ADULTS & PEDIATRICS 43.00 ANOLIL SERVICE COST CENTERS 52.00 62.0					To 12/31/2022	Date/Time Prepared: 5/30/2023 11:59 am
NPATI ENT ROUTINE SERVICE COST CENTERS 11.00				Title XIX	Hospi tal	Cost
INPATI ENT ROUTINE SERVICE COST CENTERS 30. 00 33000 ADULTS & PEDI ATRICS 30. 00 43. 00 04300 NURSERY 43. 00 ADULTS & PEDI ATRICS 43. 00	C	ost Center Description				
IMPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00						
30. 00 03000 ADULTS & PEDIATRICS 30. 00 43. 00 ADULTS & PEDIATRICS 43. 00 ADULTS & SERVICE COST CENTERS			11.00			
43.00 04300 NURSERY						
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM 0.000000 0.000000 52. 00 0520 0.00 DELI VERY ROOM & LABOR ROOM 0.000000 0.000000 55. 00 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000						43. 00
52. 00 05200 DELI VERY ROM & LABOR ROOM 0.000000 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 00 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58. 00 59. 00 05900 CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.000000 60. 00 64. 00 06400 I NTRAVENDUS THERAPY 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 PHYSI CAL THERAPY 0.000000 65. 00 67. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 69. 02 06900 ELECTROCARDI OLOGY 0.000000 69. 00 70. 00 O7000 ELECTROCARDI OLOGY 0.000000 71. 00 72. 00 07						
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 00 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58. 00 60. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 01 06000 LABORATORY 0.000000 60. 00 64. 00 06400 I NTRAVENOUS THERAPY 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 02 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 69. 02 71. 00 0710 OMEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72. 00 70. 00 07200 I MPL DEV. CHARGED TO PATI ENTS 0.000000 73. 00 001000 LINIC 09100 EMERGENCY 0.000000 90. 00 0						
57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.000000 60. 01 64. 00 06400 INTRAVENOUS THERAPY 0.000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 68. 00 69. 02 06900 ELECTROCARDI OLOGY 0.000000 69. 00 69. 02 06902 SLEEP LAB 0.000000 69. 02 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 09000 CLI NI C 0.000000 90. 00 91. 00 09000 OSERVATI ON BEDS (NON-DI						
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0.00000 0.00000 0.00000 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 0.00000 60. 00 60. 00 06000 LABORATORY 0.000000 0.00000 60. 01 64. 00 06400 I INTRAVENOUS THERAPY 0.000000 0.00000 64. 00 65. 00 06500 R RESPI RATORY THERAPY 0.000000 0.00000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 0.00000 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 0.00000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 0.00000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0.0000 69. 00 69. 02 06902 SLEEP LAB 0.000000 0.00000 69. 02 71. 00 071000 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.00000 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 0.00000 72. 00 73. 00 09000 CLI NI C 0.000000 0.00000 90. 00 91. 00 09100 EMERGENCY 0.000000 0.00000 90. 00 90. 00 090000 CLI NI C 0.000000 0.00000 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 64.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 67.00 06600 PHYSI CAL THERAPY 0.000000 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 08800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.01 06900 ELECTROCARDI OLOGY 0.000000 69.00 70.00 07000 ELECTROCEPHALOGRAPHY 0.000000 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 90.00 91.00						
60. 00						
60. 01			0. 000000			59. 00
64. 00	60. 00 06000 L	ABORATORY	0. 000000			60.00
65. 00			0. 000000			60. 01
66. 00	64. 00 06400 I	NTRAVENOUS THERAPY	0. 000000			64.00
67. 00	65. 00 06500 R	ESPI RATORY THERAPY	0. 000000			65. 00
68. 00	66. 00 06600 P	HYSI CAL THERAPY	0. 000000			66. 00
69. 00	67. 00 06700 0	CCUPATI ONAL THERAPY	0. 000000			67. 00
69. 02	68. 00 06800 S	PEECH PATHOLOGY	0. 000000			68. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07400 0	69. 00 06900 E	LECTROCARDI OLOGY	0. 000000			69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 72.00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 000000 000000 000000 000000 000000	69. 02 06902 S	LEEP LAB	0. 000000			69. 02
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 000000 000000 000000 000000 000000	70. 00 07000 E	LECTROENCEPHALOGRAPHY	0. 000000			70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.000000 91. 00 09100 EMERGENCY 0.000000 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 920. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	71.00 07100 M	EDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
OUTPATIENT SERVICE COST CENTERS 90.00 90.00 CLINIC 90.00 91.00 91.00 92.00 92.00 92.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 90.00 91.00 92.00 201.00 00.00000 92.00 00.000000 92.00 00.000000 92.00 00.000000 92.00 00.000000 00.000000 00.000000 00.000000 00.000000 00.000000 00.000000 00.0000000 00.0000000 00.0000000 00.00000000	72. 00 07200 I	MPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
90. 00 90. 00 90. 00 90. 00 90. 00 91. 00 92. 00 92. 00 92. 00 92. 00 Subtotal (see instructions) Less Observation Beds 90. 000000 90. 000000 90. 000000 90. 0000000 90. 0000000 90. 0000000 90. 0000000 90. 0000000000	73. 00 07300 D	RUGS CHARGED TO PATIENTS	0. 000000			73.00
91. 00 09100 EMERGENCY 0.000000 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	OUTPATI	ENT SERVICE COST CENTERS				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	90. 00 09000 C	LINIC	0. 000000			90.00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	91. 00 09100 E	MERGENCY	0. 000000			91.00
201.00 Less Observation Beds 201.00	92. 00 09200 0	BSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
	200.00 S	ubtotal (see instructions)				200. 00
202.00 Total (see instructions) 202.00	201. 00 L	ess Observation Beds				201. 00
	202. 00 T	otal (see instructions)				202. 00

Health Financial Systems COM	IMUNITY HOSPITAL	OF BREMEN, IN	C.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/30/2023 11:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	193, 229	10, 331, 992			4, 090	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	25, 130				0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	93, 349	9, 887, 552	0.00944	1 124, 297	1, 173	54.00
57.00 05700 CT SCAN	0	0	0. 00000	0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.00000	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59. 00
60. 00 06000 LABORATORY	73, 198	10, 757, 069	0. 00680	5 244, 595	1, 664	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	0	0	0. 00000	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	1, 132	497, 933	0. 00227	3 64, 542	147	65. 00
66. 00 06600 PHYSI CAL THERAPY	62, 587	2, 066, 032	0. 03029	3 59, 023	1, 788	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 00000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	ol o	0. 00000	0 0	0	69. 00
69. 02 06902 SLEEP LAB	9, 878	593, 455	0. 01664	5 0	0	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	44, 292	683, 796	0. 06477	4 10, 143	657	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 887	1, 449, 916	0. 00199	1 107, 753	215	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	23, 595	3, 630, 301	0.00649	9 253, 608	1, 648	73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	•			
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY	161, 899	3, 823, 982	0. 04233	8, 886	376	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	48, 981		1	·	0	92.00
200.00 Total (lines 50 through 199)	740, 157		1	1, 091, 537	11, 758	200. 00
	•	•	•			•

| Period: | Worksheet D | From 01/01/2022 | Part IV | To | 12/31/2022 | Date/Time | Prepared: Provider CCN: 15-1300 THROUGH COSTS

					lo 12/31/2022	Date/lime Pre 5/30/2023 11:	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (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
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
69. 02	06902 SLEEP LAB	0	0		0	0	69. 02
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	_	_		_	_	
90.00	09000 CLI NI C	0	0		0	0	90.00
	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			ט	0	92.00
200.00	Total (lines 50 through 199)	0	0) O	1 0	200. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	BREMEN, INC.	In Lieu (of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT (OUTDATIENT	ANCILLARY CERVICE OTHER DACC	D: -I CON 1E 1200	Davet and W	

Peri od: From 01/01/2022 To 12/31/2022 Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1300 THROUGH COSTS Date/Time Prepared: 5/30/2023 11:59 am Title XVIII Hospi tal Cost All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 7. 00 5.00 6.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10, 331, 992 0.00000050.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 414, 850 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 9, 887, 552 0.000000 54.00 05700 CT SCAN 0 0 57 00 0.000000 57 00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 0 0.000000 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 59.00 60.00 06000 LABORATORY 0 0 10, 757, 069 0.000000 60.00 06001 BLOOD LABORATORY 0 0 60.01 0.000000 60.01 64.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 06500 RESPIRATORY THERAPY 0 497, 933 65.00 0 0.000000 65.00 06600 PHYSI CAL THERAPY Ω 0 66.00 2, 066, 032 0.000000 66 00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0.000000 69.00 06902 SLEEP LAB 593, 455 69 02 Ω 0.000000 69 02 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 683, 796 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 1, 449, 916 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 3, 630, 301 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 0 0.000000 90.00 09000 CLI NI C 0 90.00 0 0 91. 00 09100 EMERGENCY 0 3, 823, 982 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 972, 054 0.000000 92.00

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0

0

46, 108, 932

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	COMMUNITY HOSPITAL OF	F BREMEN, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1300	Peri od:	Worksheet D
			From 01/01/2022	Dow+ IV

THROUGH COSTS From 01/01/2022 To 12/31/2022 Part IV Date/Time Prepared: 5/30/2023 11:59 am Title XVIII Hospi tal Cost Cost Center Description Outpati ent I npati ent Inpati ent Outpati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. Costs (col. (col. 6 ÷ col x col. 10) 11.00 x col . 12) 13.00 7) 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 0.000000 218, 690 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 124, 297 0 0 54.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0 59.00 60.00 06000 LABORATORY 0.000000 244, 595 0 0 60.00 0 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 0 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 64, 542 0 65.00 06600 PHYSI CAL THERAPY 0.000000 0 66.00 59,023 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 0 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 69.00 0 06902 SLEEP LAB 0 0.000000 69.02 69 02 Ω 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0.000000 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 10, 143 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0.000000 107, 753 0 07300 DRUGS CHARGED TO PATIENTS 0. 000000 253<u>,</u> 608 0 ol 73.00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.000000 0 90.00 0 0 0 0 0 91.00 91. 00 09100 EMERGENCY 0.000000 8,886 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 0 200.00 Total (lines 50 through 199) 1, 091, 537 0 200. 00 Health Financial Systems COMMUNITY HOSPITAL OF BREMEN, INC. In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1300 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/30/2023 11:59 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 350498 1, 190, 400 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.189411 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 177107 0 1, 810, 096 54 00 0 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 59.00 06000 LABORATORY 0 60.00 0.343771 2, 804, 063 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 71, 081 65 00 0.532433 0 65 00 06600 PHYSI CAL THERAPY 66.00 0.379300 336, 095 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 69.02 06902 SLEEP LAB 0. 264340 0 26, 440 0 69.02 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 333285 0 64, 489 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 228.572 72.00 72.00 0.481382 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 375572 642, 170 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 90.00 09000 CLINIC 0.000000 0 09100 EMERGENCY 647, 090 91.00 1. 229575 Ω 91.00

0.516399

478, 112

0

8, 298, 608

8, 298, 608

0

0

0 92.00

200.00

201.00

0 202.00

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net Charges (line 200 - line 201)

Less PBP Clinic Lab. Services-Program

Subtotal (see instructions)

Only Charges

| Period: | Worksheet D | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time Prepared:
 Heal th Financial
 Systems
 COMMUNITY HOSPITAL

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-1300

				To 12/31/2022	Date/Time Prep. 5/30/2023 11:5	
		Titl∈	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	417, 233	0)			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	320, 581	0)			54.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	963, 956	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPIRATORY THERAPY	37, 846	0				65.00
66. 00 06600 PHYSI CAL THERAPY	127, 481	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
69. 02 06902 SLEEP LAB	6, 989	Ö				69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 493	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	110, 030	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	241, 181	0				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	795, 646	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	246, 897	0				92.00
200.00 Subtotal (see instructions)	3, 289, 333	0			2	200.00
201.00 Less PBP Clinic Lab. Services-Program	0				2	201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	3, 289, 333	O)		2	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF BREMEN, INC. APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1300 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/30/2023 11:59 am Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 350498 1, 274, 934 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.189411 6, 192 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 177107 0 1, 315, 816 0 57.00 05700 CT SCAN 0.000000 0 0 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 0 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 0 06000 LABORATORY 0 60.00 0.343771 1, 072, 386 0 60.01 06001 BLOOD LABORATORY 0.000000 0

| Peri od: | Worksheet D | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time Prepared:
 Heal th Financial
 Systems
 COMMUNITY HOSPITAL

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-1300

				10 12/31/2022	5/30/2023 11:5	pared: 59 am
		Titl	e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	446, 862	l .				50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	1, 173	l .				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	233, 040	0				54. 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	368, 655	0				60.00
60. 01 06001 BL00D LABORATORY	0	0				60. 01
64.00 06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPI RATORY THERAPY	6, 182					65. 00
66. 00 06600 PHYSI CAL THERAPY	30, 236	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
69. 02 06902 SLEEP LAB	3, 326	0				69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 339	l e				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 906					72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	138, 911	0				73.00
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLI NI C	0	1				90. 00
91. 00 09100 EMERGENCY	975, 196	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	2, 283, 826	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	2, 283, 826	0				202. 00

Health Financial Systems	COMMUNITY HOSPITAL OF B	BREMEN, INC.	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Pı	rovider CCN: 15-1300	Peri od: From 01/01/2022	Worksheet D-1
			To 12/31/2022	Date/Time Prepared: 5/30/2023 11:59 am
		Ti +Lo V/////	Uocni tal	Cost

		T: +1 o V/// 1 1	Heeni tel	5/30/2023 11:	59 am_
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	oost ochter beschiptron			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-be			3, 467	1.00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed day	3 /	ivate room days	1, 724 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pri	i vate i oom days,	ا	3.00
4.00	Semi-private room days (excluding swing-bed and observation be			1, 177	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	1, 517	5. 00
6. 00	reporting period	om days) after December	21 of the cost	0	6. 00
6.00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	olli days) at tel becellbel .	of the cost) 	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	226	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_hed and	409	9. 00
7. 00	newborn days) (see instructions)	The fregram (exertaining	Swifing Dear and	107	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	822	10.00
44.00	through December 31 of the cost reporting period (see instruct				44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period		•		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	diii (exciddring swriig-bed i	uays)	l 0	15. 00
16. 00	Nursery days (title V or XIX only)			0	•
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period	arter becomber or or	the cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	250. 44	19. 00
20.00	reporting period	£t D 21 -£ tl	L 1	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	sarter becember 31 or th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		6, 090, 464	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	21 of the east reporting	a nominal (line (22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	56, 599	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			2, 880, 843	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		3, 209, 621	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	1
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	ı
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line)	ne 31)		0.00	•
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 209, 621	36. 00 37. 00
57.00	27 minus line 36)			3, 20 , 02 1	000
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY				
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 0/4 ==	00.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 861. 73	1
40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		761, 448 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			761, 448	1
		•			•

COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-1300	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre	
			T: +1 a	× V// 1 1		5/30/2023 11:	
	Cost Center Description	Total	Total	Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
40.00	NURSER VIVI	1.00	2.00	3.00	4.00	5. 00	10.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0. (00 0	0	42.00
	INTENSIVE CARE UNIT						43. 00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					4.00	
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	3 Line 200)			1. 00 400, 925	48. 00
48. 01	Program inpatient cellular therapy acquisition	on cost (Worksh	neet D-6, Part		column 1)	0	1
	Total Program inpatient costs (sum of lines	11 through 48.0	01)(see instruc	ctions)		1, 162, 373	49. 00
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D. sur	n of Parts I and	0	50.00
	III) Pass through costs applicable to Program inpa		·			0	51.00
	and IV) Total Program excludable cost (sum of lines 5		<i>y</i> (0	
	Total Program inpatient operating cost exclude		lated, non-phy	sician anestl	netist, and	0	
	medical education costs (line 49 minus line 5	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	55. 00
	Permanent adjustment amount per discharge					l e	55. 01
	Adjustment amount per discharge (contractor of Target amount (line 54 x sum of lines 55, 55.					0.00	55. 02 56. 00
	Difference between adjusted inpatient operati			ine 56 minus	line 53)	Ö	1
	Bonus payment (see instructions)					0	58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, of updated and compounded by the market basket)	or line 55 from	n the cost repo	orting period	endi ng 1996,	0.00	59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year o	cost report, u	updated by the	0.00	60.00
(1 00	market basket)	. 50 1: 54	:- ! #6		1: 55 -1		(1.00
61. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61. 00
	53) are less than expected costs (lines 54 x						
, , , , ,	enter zero. (see instructions)						
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instri	ıctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	311 (300 111311)	1011 0113)				00.00
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost reporti	ng period (See	1, 530, 342	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	ts after Decemb	per 31 of the d	cost reporting	g period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH, see instructions	ne costs (line	64 plus line 6	ob)(title XVII	ı only); for	1, 530, 342	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after [ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-hed NF innatient of	coutine costs /	line 67 ± line	, 68)		_	69. 00
	<u>Total title V or XIX swing-bed NF inpatient r</u> PART III – SKILLED NURSING FACILITY, OTHER NU					<u> </u>	J U7. UU
70. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	itine service d	cost (line 37))		70. 00
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.00
1	Program routine service cost (line 9 x line 7 Medically necessary private room cost applications)	•	n (line 14 x li	ne 35)			72. 00 73. 00
1	Total Program general inpatient routine servi		•				74. 00
75. 00	Capital-related cost allocated to inpatient r	routine service	costs (from V	Vorksheet B, I	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					76. 00
- 1	Program capital -related costs (line 9 x line						77. 00
	Inpatient routine service cost (line 74 minus						78. 00
79. 00	Aggregate charges to beneficiaries for excess	coctc (from r	rovi der record	1c)		1	79. 00

Health Financial Systems COM	MUNITY HOSPITAL	OF BREMEN, IN	C.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 11:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	292, 938	6, 090, 464	0. 04809	1, 018, 366	48, 981	90. 00
91.00 Nursing Program cost	0	6, 090, 464	0. 000000	1, 018, 366	0	91. 00
92.00 Allied health cost	0	6, 090, 464	0. 000000	1, 018, 366	0	92. 00
93.00 All other Medical Education	0	6, 090, 464	0. 000000	1, 018, 366	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	BREMEN, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-1300	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/30/2023 11:59 am
		Ti +Lo VIV	⊎osni tal	Cost

District All Profession Consensation 1.00 Position All Profession Consensation			Title XIX	Hospi tal	5/30/2023 11: Cost	59 am
INPATIENT DAY INPATIENT DAY INPATIENT DAY INPATIENT DAY INPATIENT DAY Inpatient days (Including private room days, and saing-bed days, excluding aning-bad and modern days) Inpatient days (Including private room days, excluding aning-bad and broadern days) Inpatient days (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of t		Cost Center Description		·	1 00	
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21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 26.00 Total general inpatient routine service cost net of swing-bed cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average perivate room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 29 + line 3) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
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23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 56,599 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 31.00 Average per diem private room cost differential (line 34 x line 31) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 34 x line 35) 34.00 Average per diem private room cost differential (line 34 x line 35) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 x line 38) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 23.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		Swing-bed cost applicable to SNF type services through December		ng period (line		
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 2, 880, 843 26.00 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3, 209, 621 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 Pri vate room charges (excluding swing-bed charges) 0 29.00 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 20	22.00	· · · · · · · · · · · · · · · · · · ·	21 of the east reporting	nominal (line (0	22.00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8		x line 18)		, , ,		
x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 31.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 209, 621) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 209, 621) 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		7 x line 19)	·			
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32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 209, 621) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 36.00 0.00			: line 28)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 209, 621) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
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36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 209, 621 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 37.00	34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	tions)	0.00	34. 00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 27.0		9 ' '	ne 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,861.73 38.00 Program general inpatient routine service cost (line 9 x line 38) 256,919 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 256,919 40.00	37.00	27 minus line 36)	and private room cost di	fferential (line	3, 209, 621	37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,861.73 38.00 Program general inpatient routine service cost (line 9 x line 38) 256,919 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 256, 919 39.00 40.00	20 00				1 041 72	20 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			•			
		, , ,	•			
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		MUNITY HOSPITAL				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Co	CN: 15-1300	Peri od: From 01/01/2022 To 12/31/2022		
			T: +1	. VIV	Hooni tol	5/30/2023 11:	59 am_
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	5557 55.115.1 55551 7 51.1 51.	Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1. 00 24, 654	2. 00 146	3. 00 168. 8	4. 00 36 0	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units		140	100.	50 0	0	42.00
	INTENSIVE CARE UNIT						43. 00
44.00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
48 00	Program inpatient ancillary service cost (Wk	et D-3 col 3	! Line 200)			1. 00 146. 120	48.00
48. 01	Program inpatient cellular therapy acquisiti			III, line 10,	column 1)	0	
49. 00	PASS THROUGH COST ADJUSTMENTS	J	, ,	,	,	403, 039	
50. 00	Pass through costs applicable to Program inp	oatient routine	services (from	ı Wkst. D, sur	n of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpand IV)		y services (fr	om Wkst. D, s	sum of Parts II	0	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non nhy	rcician anacth	actict and	0	
33.00	medical education costs (line 49 minus line		rated, non-pny	Si Ci ali allesti	letist, and	0	33.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge						55.00
55. 01	Permanent adjustment amount per discharge						55. 01
55. 02	Adjustment amount per discharge (contractor					0.00	1
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			ine 56 minus	line 53)	0 0	
58. 00	Bonus payment (see instructions)	ing cost and ta	irget amount (i	THE 50 III HUS	111le 33)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost repo	rting period	endi ng 1996,	0.00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		m prior year o	ost report i	indated by the	0.00	60.00
	market basket)			•			
61. 00	Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les					0	61. 00
	53) are less than expected costs (lines 54)						
	enter zero. (see instructions)		-			_	
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ment (see instru	ıctions)			0 0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Dece	ember 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only): for	0	66. 00
	CAH, see instructions	•	•		3,		
67. 00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ne costs through	December 31 o	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	itine service c	ost (line 37))		70. 00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		ı (line 14 v li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv		•	,			74.00
75. 00	Capital-related cost allocated to inpatient	•			Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
	Program capital related costs (line 9 x line						77. 00

Health Financial Systems COMM	MUNITY HOSPITAL	OF BREMEN, INC	3.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2022	Worksheet D-1	
				Γο 12/31/2022	Date/Time Pre 5/30/2023 11:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	292, 938	6, 090, 464	0. 04809	1, 018, 366	48, 981	90. 00
91.00 Nursing Program cost	0	6, 090, 464	0.00000	1, 018, 366	0	91.00
92.00 Allied health cost	0	6, 090, 464	0.00000	1, 018, 366	0	92. 00
93.00 All other Medical Education	0	6, 090, 464	0. 000000	1, 018, 366	0	93. 00

Health Financial Systems COMMUNITY HOSPITAL	_ OF BREMEN, IN	C.	In Li€	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
			From 01/01/2022 Fo 12/31/2022		pared: 59 am
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cost To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			843, 496		30.00
43. 00 O4300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 350498	218, 690	76, 650	50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 350490			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17710		1	54. 00
57. 00 05700 CT SCAN		0. 000000		22,014	57. 00
58. 00 05700		0.000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 000000		0	59. 00
60. 00 06000 LABORATORY		0. 34377		84, 085	60.00
60. 01 06001 BLOOD LABORATORY		0. 000000		0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY		0. 000000	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 532433	64, 542	34, 364	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 379300	59, 023	22, 387	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 000000	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 000000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 000000	0	0	69. 00
69. 02 06902 SLEEP LAB		0. 264340	0	0	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.000000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 33328!	10, 143	3, 381	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 481382			
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 375572	253, 608	95, 248	73. 00
OUTPATIENT SERVICE COST CENTERS					
90 00 09000 01 NC		0 00000	nl n	nl nl	l an nn

0. 000000 1. 229575

0. 516399

8, 886

1, 091, 537

1, 091, 537

90.00

91.00

201. 00

202. 00

10, 926

0 92.00

400, 925 200. 00

90. 00 09000 CLI NI C

202.00

91. 00 09100 EMERGENCY

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

Net charges (line 200 minus line 201)

	Financial Systems COMMUNITY HOSENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1300	Peri od:	Worksheet D-3	
		Component	CCN: 15-Z300	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 11:	
		Title	XVIII	Swing Beds - SNF		<u> </u>
	Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00	03000 ADULTS & PEDIATRICS					30. (
	04300 NURSERY					43.
	ANCI LLARY SERVI CE COST CENTERS		1			
0. 00	05000 OPERATI NG ROOM		0. 3504	98 0	0	50.
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 1894	11 0	0	52.
1. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1771	07 36, 201	6, 411	54.
7. 00	05700 CT SCAN		0.0000	00 0	0	57.
3. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	00 0	0	58.
9. 00	05900 CARDI AC CATHETERI ZATI ON		0.0000	00 0	0	59.
0. 00	06000 LABORATORY		0. 3437		66, 930	60.
0. 01	06001 BLOOD LABORATORY		0.0000		0	60.
4. 00	06400 I NTRAVENOUS THERAPY		0.0000		0	64.
5. 00	06500 RESPI RATORY THERAPY		0. 5324			
5. 00	06600 PHYSI CAL THERAPY		0. 3793		130, 278	
7. 00	06700 OCCUPATI ONAL THERAPY		0.0000		0	67.
3. 00	06800 SPEECH PATHOLOGY		0.0000		0	68.
9. 00	06900 ELECTROCARDI OLOGY		0.0000		0	69.
9. 02	06902 SLEEP LAB		0. 2643		0	69.
0. 00	07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3332	· ·	615	
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4813		0	72.
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 3755	72 265, 852	99, 847	73.
	OUTPATIENT SERVICE COST CENTERS			-	_	
	09000 CLI NI C		0.0000		_	
	09100 EMERGENCY		1. 2295		0	

0 92.00 338, 710 200.00 201.00 202.00

0. 516399

907, 100 0 907, 100

92.00 | 09200 | SERVATION BEDS (NON-DISTINCT PART)
200.00 | Total (sum of lines 50 through 94 and 96 through 98)
201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 | Net charges (line 200 minus line 201)

Heal th	Financial Systems	COMMUNITY HOSPITAL OF	BREMEN, IN	IC.	In Lie	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od:	Worksheet D-3	
					From 01/01/2022	D 1 (T' D	
					To 12/31/2022	Date/Time Prep 5/30/2023 11:	parea: 50 am
			Ti +I	e XIX	Hospi tal	Cost	39 alli
	Cost Center Description		11 (.	Ratio of Cos		Inpati ent	
	oost denter beschiptron			To Charges	Program	Program Costs	
				l o onar goo		(col. 1 x col.	
					3	2)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS				184, 103		30. 00
43.00	04300 NURSERY				54, 289		43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM			0. 35049	8 160, 802	56, 361	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM			0. 18941	1 67, 696	12, 822	52. 00
	05400 RADI OLOGY-DI AGNOSTI C			0. 17710		4, 671	
	05700 CT SCAN			0.00000		0	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)			0.00000		0	58. 00
	05900 CARDI AC CATHETERI ZATI ON			0.00000		0	
	06000 LABORATORY			0. 34377		22, 508	
	06001 BLOOD LABORATORY			0.00000		0	60. 01
	06400 I NTRAVENOUS THERAPY			0.00000		0	64. 00
	06500 RESPI RATORY THERAPY			0. 53243			
	06600 PHYSI CAL THERAPY			0. 37930		36	
	06700 OCCUPATI ONAL THERAPY			0.00000		0	
	06800 SPEECH PATHOLOGY			0.00000		0	68. 00
40 00	04000 ELECTROCARRIOLOCV			0 00000	0	Λ .	40 00

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0. 333285

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57, 794

15, 611

2, 180

411, 059

411, 059

0 69.00

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19, 195

1, 126

70. 00

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72.00

73.00

90.00 0

91.00

92.00 146, 120 200. 00

201. 00

202. 00

69.00

72.00

73.00 90.00

200.00

201.00

202.00

06900 ELECTROCARDI OLOGY

70.00 07000 ELECTROENCEPHALOGRAPHY
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 IMPL. DEV. CHARGED TO PATIENTS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

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

07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS

06902 SLEEP LAB

09000 CLI NI C

91. 00 09100 EMERGENCY

Health Financial Systems	COMMUNITY HOSPITAL OF	BREMEN, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1300	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 11:59 am
		T: +1 - \/\/I I I	11: 4-1	C+

PART B MEDICAL /ND OTHER HEALTH SERVICES 1.00		7.11		5/30/2023 11:	59 am
Medical and other services (see instructions)		Title XVIII	Hospi tal	Cost	
Medical and other services (see instructions)				1. 00	
Medical and other services reinforcement of the page		PART B - MEDICAL AND OTHER HEALTH SERVICES		11.00	
OPES payments	1.00	Medical and other services (see instructions)		3, 289, 333	1. 00
0.00 1.00 0.01 1.00 0.01 1.00 0.00		· · · · · · · · · · · · · · · · · · ·			•
Duthler reconcilitation arount (see instructions)					•
Internation 1.00					1
Line 2 Times Line 5		· · · · · · · · · · · · · · · · · · ·			
Sum of Times 3. 4, and 4.01, divided by line 6 0.00 7.00 0.00 7.00 0.00					1
Ancil Flary service other pass through costs from West. D. Pt. IV, col. 13, line 200 0,00 0,00 10,00 10,00 00				0.00	
10.00 Organ acquist inos 10.00 10.00 10.00 10.00 13.289, 338 11.00 10.00 10.00 15.587		Transitional corridor payment (see instructions)			8. 00
1.00					ł
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable entry clear Reasonable Reasonable entry clear Reasonable Reasona					ł
Reasonable charges	11.00			3, 289, 333	11.00
12.00					
14.00 Iotal reasonable charges (sum of lines 12 and 13) 14.00 Iotal reasonable charge harges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00	12.00			0	12. 00
Customary_charges	13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	
15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0 15.00	14. 00			0	14. 00
16.00 Amounts that would have been realized from patients I lable for payment for services on a chargebasis 0 16.00 Nature payment been made in accordance with 42 CFR §413. 13(e) 0.000000 17.00 0.00000 17.00 0.00000 17.00 0.00000 17.00 0.00000 17.00 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000	15.00			0	1 1 00
had such payment been made in accordance with 42 CFR \$413.13(e)		1 00 0	•		ı
17.00 Ratio of line 15 to line 16 (not to exceed 1.0000000) 17.00 18.00 19.00 19.00 18.00 19.0	10.00	· · · · · · · · · · · · · · · · · · ·	i a ciiai yebasi s	0	10.00
18.00 Total customary charges (see instructions) 0 18.00 19.	17. 00			0. 000000	17. 00
instructions					1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line	ne 11) (see	0	19. 00
Instructions					
1.00 Lesser of cost or charges (see instructions) 3, 322, 226 2.00 2.00 Cost of physicians' services in a teaching hospital (see instructions) 0, 23.00 2.00 Cost of physicians' services in a teaching hospital (see instructions) 0, 24.00 2.00 Cost of physicians' services in a teaching hospital (see instructions) 0, 25.00 2.00 Cost of physicians' services in a teaching hospital (see instructions) 0, 25.00 2.00 Cost of physicians' services in a teaching hospital (see instructions) 0, 25.00 2.00 Cost of physicians' services in a teaching hospital (see instructions) 0, 25.00 2.00 Cost of physicians' services in a teaching hospital (see instructions) 0, 25.00 2.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 1, 087, 829 26.00 2.00 Cost of physicians' services in a teaching hospital (see instructions) 0, 28.00 2.01 Cost of control [(lines 21 house services from Wast. E-4, line 50) 0, 28.00 2.02 Subtract (see instruction costs (from Wast. E-4, line 36) 0, 29.00 2.00 Sibb direct medical education costs (from Wast. E-4, line 36) 0, 29.00 2.00 Sibb direct medical education services (from Wast. E-4, line 36) 0, 29.00 2.00 Subtract (see instructions) 0, 23.40 2.00 Subtract (see instructions) 0, 33.00 2.00 Subtract (see instructions) 0, 33.00 2.00 Subtract (see instructions) 0, 33.00 3.00 Costotal (line 30 an inus line 31) 0, 33.00 3.00 Costotal (line 30 an inus line 31) 0, 33.00 3.00 Costotal (see instructions) 0, 36.00 3.00 Allowable bad debts (see instructions) 0, 36.00 3.00 Allowable bad debts (see instructions) 0, 36.00 3.00 Subtract (see from Authority (see instructions) 0, 36.00 3.00 MSP-LCC reconciliation amount from PSRR 0, 36.00 3.00 Subtract (see frabulation payment adjustment amount see instructions) 0, 39.90 3.00 France (see frabulation payment adjustm	20. 00		ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0.22.00	21 00			3 322 226	21 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.23.00 24.00 Total prospective payment (sum of lines 3.4, 4.01, 8 and 9) 0.24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 25.00 26.00 2					
Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		·			
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0.80,802 26.00 27.00 20.00	24.00			0	24. 00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 1.087,829 26.00 27.00 28.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00		COMPUTATION OF REIMBURSEMENT SETTLEMENT			
27.00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see 2,234,397 27.00 instructions)					ı
Instructions			,		
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 28.00 0	27.00	1	and 23] (see	2, 234, 397	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.00 30.00 Subtotal (sum of lines 27 through 29) 30.00 31.00 70.0	28 00			n	28 00
Subtotal (sum of lines 27 through 29) 2, 234, 397 30, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 32, 00 34, 00 3					
31.00 Primary payer payments					
ALLOWABLE ADD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 33.00 All owable bad debts (see instructions) 12, 379 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 8, 046 35.00 37.00 Subtotal (see instructions) 0 36.00 38.00 All owable bad debts for dual eligible beneficiaries (see instructions) 2, 242, 443 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACD demonstration payment adjustment (see instructions) 39.50 39.75 N95 respirator payment adjustment amount (see instructions) 0 39.75 39.97 Pemonstration payment adjustment amount before sequestration 0 39.97 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2, 242, 443 40.00 40.01 Sequestration adjustment (see instructions) 2, 242, 443 40.00 40.02 Demonstration payment adjustment amount after sequestration 2, 282, 689 41.00 41.01 Interim payments 2, 282, 689 41.00 41.01 Interim payments 2, 282, 689 41.00 42.01 Tentative settlement (for contractors use only) 41.01 42.00 Tentative settlement (for contractors use only) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 45.01 Balance due provider/programPARHM or CHART (for contractor use only) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 45.01 Tentative settlement (for contractors) 0 90.00 47.00 Ottier reconciliation adjustment amount (see instructions) 0 91.00 48.00 Ottier reconciliation adjustment amount (see instructions) 0 91.00 49.00 Ottier reconciliation adjustment amount (see instructions) 0 93.00 49.00 Ottier reconciliation adjustment amount (see instructions) 0 93.00 49.00 Ottie	31.00				
33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 All owable bad debts (see instructions) 12, 379 34.00 34.00 All lowable bad debts (see instructions) 8,046 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 2, 242, 443 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.75 N95 respirator payment adjustment amount (see instructions) 0 39.97 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 40.01 Sequestration adjustment (see instructions) 2.242,443 40.00 40.02 Demonstration payment adjustment amount after sequestration 2.282,689 40.02 40.02 Equestration adjustment (see instructions) 2.282,689 41.00	32. 00			2, 234, 397	32. 00
34.00	00.00				
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36. 00		· · · · · · · · · · · · · · · · · · ·			
37.00 Subtotal (see instructions) 2,242,443 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 39.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.50 39.50 39.50 MSP-cepi rator payment adjustment amount (see instructions) 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 MECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.99 MSP (see instructions) 22,242,443 40.00 40.00 MSP (see instructions) 22,242,443 40.00 40.01 MSP (see instructions) 22,242,443 40.00 40.02 MSP (see instructions) 22,242,443 40.00 40.03 MSP (see instructions) 22,242,443 40.00 40.03 MSP (see instructions) 22,242,443 40.00 40.03 MSP (see instructions) 22,242,443 40.00 40.01 MSP (see instructions) 22,242,443 40.00 40.01 MSP (see instructions) 22,282,689 41.00 41.01 MSP (see instructions) 42.01 MSP (see instructions) 43.01 MSP (see instructions) 44.00 MSP (see instructions) 44.		· · · · · · · · · · · · · · · · · · ·			ł
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 39.50 39.50 39.55 39.75 39.75 39.75 39.75 39.75 39.97 Demonstration payment adjustment amount (see instructions) 0 39.75 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 39.99 40.00 40.					
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50 39.75 39.75 39.75 39.75 39.77 39.77 39.77 39.77 39.77 39.78 39.88 39.89 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0.39.99 39.99 39.90					
39. 75 N95 respirator payment adjustment amount (see instructions) 0 39. 75 39. 97 Demonstration payment adjustment amount before sequestration 0 39. 98 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 2, 242, 443 40. 00 40. 01 Sequestration adjustment (see instructions) 28. 255 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM or CHART pass-throughs 40. 03 41. 00 Interim payments-PARHM or CHART 41. 00 42. 01 Tentative settlement (for contractors use only) 0 42. 00 42. 01 Tentative settlement-PARHM or CHART (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) -68,501 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 0 44. 00 §115. 2 To BE COMPLETED BY CONTRACTOR 0 <td< td=""><td>39. 00</td><td>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</td><td></td><td>0</td><td>39. 00</td></td<>	39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 97 39. 98 39. 98 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 99 30. 00 30. 00 30. 99 30. 99 30. 00 30. 00 30. 99 30. 99 30. 99 30. 90 30. 99 30. 99 30. 90 30. 99 30. 99 30. 90 30. 99 30. 99 30. 90 30. 99 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 99 30. 90 30. 90 30. 99 30. 90 30. 99 30. 99 30. 90 30. 99 30. 99 30. 99 30. 99 30. 90 30. 99 30. 99 30. 99 30. 90 30. 99 30. 90 30. 90 30. 99 30. 90 30					1
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 2, 242, 443 40. 00 40. 01 Demonstration adjustment (see instructions) 28, 255 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM or CHART pass-throughs 40. 03 41. 01 Interim payments 2, 282, 689 41. 00 41. 01 Interim payments-PARHM or CHART 41. 01 41. 01 42. 01 Tentative settlement (for contractors use only) 0 42. 00 43. 00 Bal ance due provider/program (see instructions) -68, 501 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 44. 00 Fotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 The rate used to calculate the Time Value of Money (see instructions) 0 <t< td=""><td></td><td></td><td></td><td></td><td>•</td></t<>					•
39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment—PARHM or CHART pass-throughs 41. 00 Interim payments Interim payments-PARHM or CHART pass-throughs 41. 01 Interim payments-PARHM or CHART 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement—PARHM or CHART (for contractor use only) 43. 00 Bal ance due provider/program (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Original outlier amount (see instructions) 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions) 93. 00 93. 00 94. 00 Time Value of Money (see instructions) 94. 00 97. 00 9			ti ana)		•
40.00 Subtotal (see instructions) 2, 242, 443 40.00 40.01 Sequestration adj ustment (see instructions) 28, 255 40.01 40.02 Demonstration payment adj ustment amount after sequestration 0 40.02 40.03 Sequestration adj ustment-PARHM or CHART pass-throughs 2, 282, 689 41.00 41.01 Interim payments 2, 282, 689 41.00 41.01 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) -68,501 43.01 Balance due provider/program-PARHM (see instructions) -68,501 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 80.00 Si15.2 0 70 70 BE COMPLETED BY CONTRACTOR 0 90.00 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00			tions)		•
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM or CHART pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM or CHART 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 40.02 94.00 Time Value of Money (see instructions) 95.00 Og 40.01 Og 40.02 96.00 Og 40.01 Og 40.02 97.00 Og 40.02 97.00 Og 40.01 Og 40.02 97.00 Og 40.02 97.0					•
40.02 Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs 1. Interim payments 1. Interim payments 2, 282, 689 41.00 1. Interim payments-PARHM or CHART 1. Interim payments 1. Interim					1
40. 03 Sequestration adjustment-PARHM or CHART pass-throughs 40. 03 41. 00 Interim payments 42. 00 Interim payments 41. 01 Interim payments-PARHM or CHART 41. 01 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement (for contractor use only) 42. 01 Tentative settlement-PARHM or CHART (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 4					•
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42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 O 93.00	41.00	Interim payments		2, 282, 689	41. 00
42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 96.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions)					1
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 943.00 Advance with CMS Pub. 15-2, chapter 1, 0 44.00 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Time Value of Money (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)		• • • • • • • • • • • • • • • • • • • •		0	1
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00				40 E01	1
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00				-08, 501	1
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0 10 93.00 Time Value of Money (see instructions) 0 93.00			chapter 1	n	ł
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	1 7. 00		aptor 1,		11.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00					
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0 93.00	90.00			0	90. 00
93.00 Time Value of Money (see instructions) 0 93.00					
74. 00 10tai (Suiii 01 111ieS 71 aliu 73)					
	74. UU	TIOTAL (Sum of TITIES 71 and 73)		ı	74.00

Health Financial Systems	COMMUNITY HOSPITAL OF	BREMEN, INC.	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1300	Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pr	epared:
				5/30/2023 11	:59 am_
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF BREMEN, INC. ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1300 Peri od: Worksheet E-1 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 11:59 am Title XVIII Hospi tal Cost Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 1, 070, 599 2, 282, 689 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 1,070,599 2, 282, 689 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1)

335

1,070,934

0

C

Contractor

Number

1 00

0

68, 501

2, 214, 188

NPR Date (Mo/Day/Yr)

2 00

6.01

6.02

7.00

8.00

SETTLEMENT TO PROVIDER

Total Medicare program liability (see instructions)

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

6.01

6 02

7.00

 BREMEN, INC.
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-1300
 Period: From 01/01/2022 Part I To 12/31/2022 Part I Date/Time Prepared: 5/30/2023 11: 59 am
 Health Financial Systems COMMUNITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		'			5/30/2023 11:	59 am
				wing Beds - SNF		
		Inpatier	it 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		1, 562, 245		0	1. 00
2.00	Interim payments payable on individual bills, either		C)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	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		1			
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02			C		0	3. 02
3.03			C		0	3. 03
3.04			C		0	3. 04
3. 05	Describer to Describe		C		0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM			ı	0	3. 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51						3.51
3. 52					0	3. 52
3. 54					0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
J. 77	3. 50-3. 98)					J. 77
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 562, 245		0	4.00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		1,002,210			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		•		•	ĺ
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03			C		0	5. 03
	Provi der to Program		1 -		T -	
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52	Cultural (Lines F 01 F 40 minus Lines		C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		282, 122		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		202, 122		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 844, 367	,	0	7. 00
7.00	1.0ta. moa. oa. o program rrubirity (300 riisti detrolla)		1,011,007	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	· ·	•		•	•	•

Health Financial Systems	COMMUNITY HOSPITAL OF	BREMEN, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1300	Peri od: From 01/01/2022	Worksheet E-2

Component CCN: 15-Z300 To 12/31/2022 Date/Time Prepared: 5/30/2023 11: 59 am

	·			5/30/2023 11:	59 am
		Title XVIII	Swing Beds - SNF	Cost	
			Part A 1.00	<u>Part B</u> 2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		1, 545, 645	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)		1,010,010	_	2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, a	nd sum of Wkst. D,	342, 097	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed	pass-through, see			
	instructions)				
3. 01	Nursing and allied health payment-PARHM or CHART (see instructions)			0.00	3. 01
4. 00	Per diem cost for interns and residents not in approved teaching pr	ogram (see		0. 00	4. 00
5. 00	instructions) Program days		822	0	5. 00
6. 00	Interns and residents not in approved teaching program (see instruc	tions)	022	0	6. 00
7. 00	Utilization review - physician compensation - SNF optional method o		o	_	7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	,	1, 887, 742	0	8. 00
9.00	Primary payer payments (see instructions)		O	0	9. 00
10.00	Subtotal (line 8 minus line 9)		1, 887, 742	0	10. 00
11. 00	Deductibles billed to program patients (exclude amounts applicable	to physician	0	0	11. 00
40.00	professi onal servi ces)		4 007 740	0	40.00
12.00	Subtotal (line 10 minus line 11)	Luda aal nauranaa	1, 887, 742	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (exc for physician professional services)	rude cornsurance	19, 839	0	13. 00
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (see instructions)		1, 867, 903	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstration) payment	O		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)	ma)	0	0	17. 01
18. 00 19. 00	Allowable bad debts for dual eligible beneficiaries (see instruction	ns)	1 0/7 003	0	18. 00 19. 00
19. 00	Total (see instructions) Sequestration adjustment (see instructions)		1, 867, 903 23, 536	0	19.00
19. 01	Demonstration payment adjustment amount after sequestration)		23, 330	0	19. 01
19. 02	Sequestration adjustment-PARHM or CHART pass-throughs		ď	O	19. 02
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20. 00	Interim payments		1, 562, 245	0	20. 00
20. 01	Interim payments-PARHM or CHART		1, 222, 213	_	20. 01
21. 00	Tentative settlement (for contractor use only)		o	0	21.00
21. 01	Tentative settlement-PARHM or CHART (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.	25, 20, and 21)	282, 122	0	22. 00
22. 01	Balance due provider/program-PARHM or CHART (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			
200.00	Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration period u				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	nder the 21st			200.00
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst.	D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst	. D-3, col. 3, line	е		202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)	6 11			204. 00
	Computation of Demonstration Target Amount Limitation (N/A in first	year of the curren	nt 5-year demonst	ration	
205.00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times I	ine 204)			206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				200.00
207.00	Program reimbursement under the §410A Demonstration (see instruction				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col		1		208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209. 00
210.00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 pl	us line 210) (see			215. 00
	instructions)				I

Health Financial Systems	COMMUNITY HOSPITAL OF	BREMEN, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1300	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/30/2023 11:59 am
•				_

				5/30/2023 11: 8	59 am_
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE P	ART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpati ent servi ces			1, 162, 373	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ıs)		0	2. 00
3.00	Organ acquisition	/		0	
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			1, 162, 373	
5. 00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 173, 997	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 173, 777	0.00
	Reasonable charges				
7 00				0	7 00
7.00	Routine service charges				7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	10. 00
44.00	Customary charges				44 00
11. 00	Aggregate amount actually collected from patients liable for pa			0	
12. 00	Amounts that would have been realized from patients liable for	payment for services or	n a charge basis	0	12. 00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	10.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14.00	Total customary charges (see instructions)		() (0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds lir	ne 6) (see	0	15. 00
1/ 00	instructions)	. ! & ! /	14) (0	1/ 00
16. 00	Excess of reasonable cost over customary charges (complete only	TI TIME 6 exceeds TIME	e 14) (See	0	16. 00
17 00	instructions)	anti ana)		0	17. 00
17. 00	Cost of physicians' services in a teaching hospital (see instru COMPUTATION OF REIMBURSEMENT SETTLEMENT	icti ons)		U	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4,	Line 40)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	111le 49)		1, 173, 997	
20. 00	Deductibles (exclude professional component)			88, 620	
21. 00	Excess reasonable cost (from line 16)			08, 020	
	, ,			1, 085, 377	22. 00
22. 00 23. 00	Subtotal (line 19 minus line 20 and 21) Coinsurance			778	
				1, 084, 599	
24. 00	Subtotal (line 22 minus line 23)	a) (ass instructions)		1, 064, 599	
25. 00	Allowable bad debts (exclude bad debts for professional service	(See Instructions)			25. 00
26. 00	Adjusted reimbursable bad debts (see instructions)			0	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		0	27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 084, 599	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 084, 599	30.00
30. 01	Sequestration adjustment (see instructions)			13, 665	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM or CHART				30. 03
31.00	Interim payments			1, 070, 599	31.00
31. 01	Interim payments-PARHM or CHART				31. 01
32.00	Tentative settlement (for contractor use only)			0	32. 00
32. 01	Tentative settlement-PARHM or CHART (for contractor use only)				32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02,	31. and 32)		335	
33. 01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, an		3. 31.01. and		33. 01
	32.01)	3,	,,		
34.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2. o	chapter 1,	0	34.00
	§115. 2	•	•		
				•	

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1300	Peri od: From 01/01/2022	Worksheet E-3 Part VII

To 12/31/2022 Date/Time Prepared: 5/30/2023 11:59 am Title XIX Hospi tal Cost Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 403, 039 1.00 Inpatient hospital/SNF/NF services Medical and other services 2.00 2, 283, 826 2 00 3.00 Organ acquisition (certified transplant programs only) 3.00 4.00 Subtotal (sum of lines 1, 2 and 3) 403, 039 2, 283, 826 4.00 5.00 Inpatient primary payer payments 5.00 186, 471 6.00 Outpatient primary payer payments 719, 299 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 216, 568 1, 564, 527 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 8.00 Ancillary service charges 411, 059 5, 140, 152 9.00 9.00 10.00 Organ acquisition charges, net of revenue 10.00 Incentive from target amount computation 11 00 11 00 12.00 Total reasonable charges (sum of lines 8 through 11) 411, 059 5, 140, 152 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 13.00 basi s 14.00 Amounts that would have been realized from patients liable for payment for services on 0 Ω 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 411, 059 5, 140, 152 16.00 8. 020 2, 856, 326 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 17 00 17.00 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 18.00 0 (see instructions) 19.00 Interns and Residents (see instructions) 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 403, 039 2, 283, 826 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 0 0 22.00 Other than outlier payments 0 23.00 Outlier payments 0 23.00 24.00 Program capital payments 0 24.00 0 25.00 Capital exception payments (see instructions) 25.00 o 26 00 Routine and Ancillary service other pass through costs 0 26 00 0 27.00 Subtotal (sum of lines 22 through 26) Λ 27.00 Customary charges (title V or XIX PPS covered services only) 28.00 28.00 0 29.00 Titles V or XIX (sum of lines 21 and 27) 403, 039 2, 283, 826 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 216, 568 1, 564, 527 31.00 23, 351 32.00 Deducti bl es 0 32.00 33 00 Coi nsurance 0 23, 318 33 00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36, 00 216, 568 1, 517, 858 36, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 37.00 38.00 Subtotal (line 36 ± line 37) 216, 568 1, 517, 858 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 216, 568 1, 517, 858 40.00 41.00 Interim payments 41.00 0

216, 568

1, 517, 858

0 43.00

42.00

42.00

43.00

chapter 1, §115.2

Balance due provider/program (line 40 minus line 41)

Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,

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

Provider CCN: 15-1300

Peri od: From 01/01/2022 To 12/31/2022 Worksheet G Date/Time Prepared: 5/30/2023 11:59 am

			0 16		5/30/2023 11:	59 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	2, 112, 636		0	0	1.00
2.00	Temporary investments	0	· C	0	0	2. 00
3.00	Notes receivable	0	(0	0	3. 00
4.00	Accounts receivable	4, 179, 313	C	0	0	
5.00	Other receivable	166, 208	C	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	0	(0	0	
7. 00	Inventory	368, 049	l .	0	0	1
8. 00	Prepai d expenses	19, 826		0	0	
9.00	Other current assets	99, 018		0	0	
10.00	Due from other funds	0		<u> </u>	0	1
11. 00	Total current assets (sum of lines 1-10)	6, 945, 050)[0	11. 00
12. 00	FI XED ASSETS Land	779, 000) 0	0	12. 00
13. 00	Land improvements	179,000			0	1
14. 00	Accumulated depreciation				0	1
15. 00	Buildings	9, 990, 782	1		0	
16. 00	Accumulated depreciation	7, 770, 702			0	1
17. 00	Leasehold improvements				0	
18. 00	Accumulated depreciation	0		o o	0	1
19. 00	Fi xed equipment	4, 687, 762	1		0	1
20. 00	Accumulated depreciation	-4, 631, 781		0	0	1
21. 00	Automobiles and trucks	0			0	1
22. 00	Accumulated depreciation	0			0	
23. 00	Major movable equipment	Ö		o o	0	1
24. 00	Accumul ated depreciation	0		0	0	1
25. 00	Mi nor equi pment depreci abl e	0	1 0	0	0	25. 00
26.00	Accumulated depreciation	0	ıl c	0	0	26. 00
27.00	HIT designated Assets	0	· C	0	0	27. 00
28. 00	Accumulated depreciation	0	(0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0	(0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	10, 825, 763	C	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	0	(0	
32. 00	Deposits on Leases	0	(0	0	1
33. 00	Due from owners/officers	0	(0	0	1
34.00	Other assets	2, 039, 674	1	0	0	
35. 00	Total other assets (sum of lines 31-34)	2, 039, 674	1	_	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	19, 810, 487		0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	787, 717) 0	0	37. 00
38. 00	Salaries, wages, and fees payable	767,717		_	0	1
39. 00	Payroll taxes payable				0	1
40. 00	Notes and Loans payable (short term)	1, 077, 021	1		0	
41. 00	Deferred income	1,077,021			0	1
42. 00	Accel erated payments	0			Ü	42. 00
43. 00	Due to other funds	-44, 032	1 (0	0	1
44. 00	Other current liabilities	150, 822	1	0	0	1
45.00	Total current liabilities (sum of lines 37 thru 44)	1, 971, 528		0		
	LONG TERM LIABILITIES					1
46.00	Mortgage payable	0	(0	0	46. 00
47.00	Notes payable	0	(0	0	47. 00
48.00	Unsecured Loans	0	(0	0	48. 00
49.00	Other long term liabilities	9, 182, 408	c c	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 182, 408	c c	0	0	50. 00
51.00	Total liabilities (sum of lines 45 and 50)	11, 153, 936	(0	0	51. 00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	8, 656, 551	1			52. 00
53. 00	Specific purpose fund		()		53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
F0 00	replacement, and expansion	0 /5/ 551		,	_	F0 00
59. 00	Total fund balances (sum of lines 52 thru 58)	8, 656, 551	l .	-	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	19, 810, 487		ار ا	0	60.00
	1~'/	I	I	1	l	I .

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1300

				'	10 12/31/2022	5/30/2023 11:	
		General	Fund	Speci al Pu	urpose Fund	Endowment Fund	37 diii
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		1, 639, 560		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1, 900, 136				2.00
3.00	Total (sum of line 1 and line 2)		-260, 576		0		3. 00
4.00	CAPITAL CONTRIBUTIONS	3, 308		(1	0	4. 00
5.00	TRANSFERRED FROM BEACON HEALTH SYSTE	8, 913, 819		(0	5. 00
6.00		0		(1	0	6. 00
7.00		0		(0	7. 00
8.00		0		1		0	8. 00
9.00		0		·)	0	9. 00
10. 00	Total additions (sum of line 4-9)		8, 917, 127		0		10. 00
11. 00	Subtotal (line 3 plus line 10)	_	8, 656, 551		0	_	11. 00
12.00	Deductions (debit adjustments) (specify)	0		(1	0	12.00
13.00		0				0	13.00
14.00		0				0	14.00
15. 00 16. 00		0				0	15. 00 16. 00
17. 00		0				0	17. 00
18. 00	Total deductions (sum of lines 12-17)	١	0			0	18.00
19. 00	Fund balance at end of period per balance		8, 656, 551				19. 00
17.00	sheet (line 11 minus line 18)		0, 030, 331				17.00
	Terres (Trine Tr III The Trine Te	Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		(O .		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0		(3. 00
4.00	CAPITAL CONTRIBUTIONS		0				4. 00
5.00	TRANSFERRED FROM BEACON HEALTH SYSTE		0				5. 00
6. 00 7. 00			0				6. 00 7. 00
8.00			0				7. 00 8. 00
9. 00			0				9. 00
10.00	Total additions (sum of line 4-9)		U	(10. 00
11. 00	Subtotal (line 3 plus line 10)						11. 00
12. 00	Deductions (debit adjustments) (specify)	١	0				12. 00
13. 00	Specify		0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			O.				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	J				18. 00
19. 00	Fund balance at end of period per balance	o					19. 00
	sheet (line 11 minus line 18)						
				•	•		

Health Financial Systems STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES In Lieu of Form CMS-2552-10 Worksheet G-2

From 01/01/2022 Parts I & II Date/Time Prepared: 12/31/2022 5/30/2023 11:59 am Cost Center Description Outpati ent Inpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 4, 897, 497 4, 897, 497 1.00 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 5.00 6.00 0 6.00 SKILLED NURSING FACILITY 7.00 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) 4, 897, 497 4, 897, 497 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16, 00 0 16, 00 11 - 15) 4, 897, 497 17.00 4, 897, 497 17.00 Total inpatient routine care services (sum of lines 10 and 16) 18.00 Ancillary services 6, 141, 671 6, 141, 671 18.00 40, 245, 500 40, 245, 500 19.00 Outpatient services 0 19.00 RURAL HEALTH CLINIC 20.00 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 23.00 CMHC 24.00 24.00 25.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 26.00 HOSPI CE 26.00 27.00 OTHER (SPECIFY) 27.00 0 11, 039, 168 40, 245, 500 51, 284, 668 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 28.00 G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 29.00 25, 497, 312 29.00 0 30.00 ADD (SPECIFY) 30.00 0 31.00 31.00 32.00 32.00 0 33.00 33.00 0 34.00 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) 0 36.00 0 DEDUCT (SPECIFY) 37.00 37.00 0 38.00 38.00 39.00 0 39.00 40.00 0 40.00 0 41.00 41.00 Total deductions (sum of lines 37-41) 42.00 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 25, 497, 312 43.00

Provider CCN: 15-1300

Peri od:

to Wkst. G-3, line 4)

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN, INC.	In Lie	u of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1300	Peri od: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/30/2023 11:59 am

STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1300	Peri od: From 01/01/2022	Worksheet G-3	
			To 12/31/2022	Date/Time Pre	pared:
				5/30/2023 11:	59 am_
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			51, 284, 668	1. 00
2.00	Less contractual allowances and discounts on patients' account	ts		28, 637, 140	2. 00
3. 00	Net patient revenues (line 1 minus line 2)			22, 647, 528	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	13)		25, 497, 312	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)			-2, 849, 784	5. 00
,	OTHER I NCOME		1		
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			70, 632	7. 00
8. 00	Revenues from telephone and other miscellaneous 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	11, 903	11. 00		
12. 00	Parking lot receipts			0	12. 00
13. 00	Revenue from Laundry and Linen service			0 106, 033	13. 00 14. 00
	4.00 Revenue from meals sold to employees and guests				
15. 00	3 1			0	15. 00
16. 00	1	nan patients		0	16. 00
17. 00				0	17. 00
18. 00				0	18. 00
19. 00				0	19. 00
20. 00	3			0	20.00
21. 00				0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER REVENUE			761, 080	24.00
24. 50	0 COVI D-19 PHE Funding				24. 50
25. 00	00 Total other income (sum of lines 6-24)			949, 648	25.00
26. 00	Total (line 5 plus line 25)			-1, 900, 136	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-1, 900, 136	29. 00