		NITY HOSPI			u of Form CMS-2552-10	)
	t is required by law (42 USC 1395g; 42 CFR 413.20( ade since the beginning of the cost reporting perio				FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022	_
	ND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIF MENT SUMMARY	CATI ON Pr	rovider CCN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepared: 11/22/2022 9:20 am	
PART I - CO	OST REPORT STATUS					1
Provi der use only	<ol> <li>[X] Electronically prepared cost report</li> <li>[] Manually prepared cost report</li> <li>[0] If this is an amended report enter the</li> <li>[F] Medicare Utilization. Enter "F" for fu</li> </ol>	number of    or "L" 1	times the provider re for low.	Date: 11/22/2 esubmitted this co		_
Contractor use only	<ul> <li>5. [1] Cost Report Status</li> <li>6. Date Received:</li> <li>(1) As Submitted</li> <li>7. Contractor No.</li> <li>(2) Settled without Audit</li> <li>8. [N] Initial R</li> <li>(3) Settled with Audit</li> <li>9. [N] Final Rep</li> <li>(4) Reopened</li> <li>(5) Amended</li> </ul>	eport for <sup>-</sup> ort for thi	11.C this Provider CCN 12.[		pr Code: 4 Ulumn 1 is 4: Enter Nes reopened = 0-9.	
MI SREPRESEI ADMI NI STRA PROVI DED OI	CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMI NTATION OR FALSIFICATION OF ANY INFORMATION CONTAIN TIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL R PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECT TIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	NED IN THIS _ LAW. FUR	COST REPORT MAY BE F THERMORE, IF SERVICES	IDENTIFIED IN TH	IIS REPORT WERE	J
CE	RTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINIST	RATOR OF PR	ROVI DER(S)			
el St be ar ap re	HEREBY CERTIFY that I have read the above certific ectronically filed or manually submitted cost repo atement of Revenue and Expenses prepared by COMMUN ginning 07/01/2021 and ending 06/30/2022 and to th e true, correct, complete and prepared from the bo plicable instructions, except as noted. I further garding the provision of health care services, and ovided in compliance with such laws and regulation	rt and subr ITY HOSPITA e best of r oks and rec certify tha that the s	hitted cost report and AL (15–0125) for the my knowledge and belie cords of the provider at I am familiar with	d the Balance Shee e cost reporting p ef, this report and in accordance with the laws and regu	et and period nd statement th ulations	
SI GNA	TURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		Ī
	1	2		IATURE STATEMENT		
1	Daniel R. Obrien	Y	I have read and agrees statement. I certify signature on this ce binding equivalent of	/ that I intend my ertification be th	/ electronic ne legally	

			Title	XVI I I			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1 00	llaani tal	0	1 000 704	172 044	0	0	1 00

3

4

1.00	Hospital	0	1,028,724	1/3,864	0	0 1.00
2.00	Subprovider - IPF	0	0	0		0 2.00
3.00	Subprovider - IRF	0	7, 833	0		0 3.00
5.00	Swing Bed - SNF	0	0	0		0 5.00
6.00	Swing Bed - NF	0				0 6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0 9.00
200.00	Total	0	1, 036, 557	173, 864	0	0 200. 00

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

2 Signatory Printed Name Daniel R. Obrien

CFO

(Dated when report is electronica

3 Signatory Title

4 Date

JSP1	FAL AND HOSPITAL HEALTH CARE COMPLEX		Provi d		: 15-0125	Period: From 07/01/ To 06/30/	/2022	Workshe Part I Date/Ti 11/22/2	me Pre	epare
	1.00	2.00		3.00			4.00			
00	Hospital and Hospital Health Care Co Street: 901 MACARTHUR BOULEVARD	PO Box:								1.
00	City: MUNSTER	State: IN	Zip Cod	e <sup>.</sup> 4632	1 Cou	nty: LAKE				2.
00	orey. monoren	Component Name	CCN	CBSA			Pavme	ent Syst	em (P.	2.
			Number	Numbe		Certified		, 0, or		
							V	XVIII		
		1.00	2.00	3.00	0 4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componen		150105			10 (00 (1070				-
00 00	Hospi tal Subprovi der – IPF	COMMUNITY HOSPITAL	150125	2384	4 1	10/03/1973	N	P	Р	3.
00	Subprovider - IRF	THE REHAB CENTER AT	15T125	2384	4 5	06/30/1996	N	P	Р	5.
		COMMUNITY	101120	2001						
00	Subprovider - (Other)									6.
00	Swing Beds - SNF									7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF									9.
00	Hospital - Based NF									10.
00 00	Hospi tal -Based OLTC Hospi tal -Based HHA	COMMUNITY HOME HEALTH	157487	2384	4	01/07/1997	N	P	N	12.
00		SERVICES	13/40/	2304	-	01/01/199/		<sup>г</sup>		'2.
00	Separately Certified ASC									13.
	Hospi tal -Based Hospi ce									14.
	Hospital-Based Health Clinic - RHC									15.
	Hospital-Based Health Clinic - FQHC									16
	Hospital-Based (CMHC) I									17
00	Renal Dialysis Other									18
00	other					From:	<u> </u>	То		17.
						1.00		2.0		
00	Cost Reporting Period (mm/dd/yyyy)					07/01/2	021	06/30/	/2022	20.
00	Type of Control (see instructions)					2				21.
						-				
				-	1 00			2 (	0	-
	Inpatient PPS Information				1.00	2.00		3. (	00	_
00	Inpatient PPS Information Does this facility qualify and is it	currently receiving pa	ments for	-	1.00 Y			3. (	00	22
00	Does this facility qualify and is it disproportionate share hospital adju	stment, in accordance w	th 42 CFR			2.00		3. (	00	22.
00	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo	stment, in accordance w r yes or "N" for no. Is	th 42 CFR this			2.00		3. (	00	22.
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	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	ITAL Provider CC	N: 15-0125		eri od:		Wor	kshee	n CMS-2 et S-2	
					Fr To	rom 07/0 p 06/30	1/2021 0/2022	Dat	e/Tin	me Pre 022 9:	pared: <u>20 am</u>
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Me el	ut-of State dicaid igible npaid	Medica HMO da		Medi	her caid ays	
		1.00	2.00	3.00		4.00	5.00		6.	00	
25. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state	1, 582				0	10,	, 638 88		291	24.00
	Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									_	
						Urban/R 1.C		Date	e of 2.00		-
	Enter your standard geographic classification (not wa		at the beg	inning of t	the	1.0	1	I	2.00	-	26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status ~ "2" for r cation in	ural. If ap column 2.	plicable,			1				27.00
	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	H status ir	٦		C	D			35.00
						Begi nr		E	Endi n	0	
4 00	Enter applicable beginning and ending dates of SCH st	tatus Subs	crint line	24 for numb	or	1.0	00		2.00	0	36.0
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.					C	þ			37.0
7 01	is in effect in the cost reporting period.										
	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for the second										37.0
38. 00		or yes or " s of MDH st	N" for no. atus. If li	(see ne 37 is							
88. 00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	or yes or " s of MDH st	N" for no. atus. If li	(see ne 37 is		Y/			Y/N		37.0 38.0
38. 00 39. 00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	or yes or " s of MDH st periods i payment a ), (ii), or the mileage	N" for no. atus. If li n excess of djustment f (iii)? Ent requiremen	(see ne 37 is one and for low volu ter in column its in	nn	Y/1 1. C N	00		Y/N 2.00 N		38.0
38. 00 39. 00 40. 00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii	pr yes or " s of MDH st periods i payment a d, (ii), or the mileage i)? Enter n adjustmen per 1. Ente	N" for no. atus. If li n excess of djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y	(see ne 37 is fone and for low volu er in colum its in e. "Y" for yes (" for yes o	nn es or	1. C	00		2.00		
38. 00 39. 00 40. 00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 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 a accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	pr yes or " s of MDH st periods i payment a d, (ii), or the mileage i)? Enter n adjustmen per 1. Ente	N" for no. atus. If li n excess of djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y	(see ne 37 is fone and for low volu er in colum its in e. "Y" for yes (" for yes o	nn es or	1. C N	00		2.00 N		38. 0
8.00 9.00 0.00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 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 factor accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital	pr yes or " s of MDH st periods i payment a ), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst	N" for no. atus. If li n excess of (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions)	(see ne 37 is one and for low volu er in colum tts in "Y" for yes "Y" for yes res or "N" f	nn es or for	1. C N N	00 V 1.00	0 2.	2.00 N N (111 .00	0 XI X 3. 00	38. 0 39. 0 40. 0
8.00 9.00 0.00 5.00 6.00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	pr yes or " s of MDH st periods i payment a ), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst	N" for no. atus. If li n excess of djustment f (iii)? Ent requiremen in column 2 t? Enter "Y ructions) roportionat extraordina	(see ne 37 is for low volu er in colum ts in t' 'Y' for yes r'' for yes of res or "N" f e share in try circums1	nn es for acc tanc	1.C N N cordance res	00 V	0 2.	2.00 N N	D XI X	38. C 39. C 40. C
8.00 9.00 0.00 5.00 6.00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 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 to accordance with 42 CFR 412. 101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	pr yes or " s of MDH st periods i payment a ), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst n for disp eption for t. L, Pt. I	N" for no. atus. If li n excess of djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst	(see ne 37 is for low volu er in colum ts in "Y" for yes "Sor "N" f re share in ury circumst - L-1, Pt.	nn es for acc tanc I t	1.0 N N ordance es hrough	DO V 1.00	0 2.	2.00 N N (111 .00 Y	0 XI X 3. 00 N	38. C 39. C 40. C 45. C 46. C
8. 00 9. 00 0. 00 5. 00 6. 00 7. 00 8. 00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	pr yes or " s of MDH st periods i payment a ), (ii), or the mileage i)? Enter n adjustmen ber 1. Ente (see inst t for disp eption for t. L, Pt. I capital? E t? Enter "	N" for no. atus. If li n excess of (iii)? Ent requiremen in column 2 t? Enter "Y r"Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes	(see ne 37 is for low volu er in colum ts in try for yes res or "N" for res or "N" for try circumst L-1, Pt.	nn es for acc tanc I t r fo	1.0 N N cordance es hrough or no.	DO V 1.00 N N N N N	0 2.	2.00 N N 1111 .00 Y N	0 XI X 3. 00 N N	38. C 39. C 40. C 45. C 45. C 46. C
8.00         9.00         0.00         5.00         6.00         7.00         8.00         6.00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 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 factordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pri year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col	pryes or " s of MDH st periods i payment a ), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst t for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to column cable CRs) umn 2.	N" for no. atus. If li n excess of djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for <u>y" for yes</u> 1 is "Y", the programs 1 is "Y",	(see ne 37 is for low volu- er in colum its in "Y" for yes res or "N" for es share in ary circumst . L-1, Pt. yes or "N" or "N" for or "N" for sear or penu- ME payment	nn es for for acc tanc l t fo no. hos ulti red	1.0 N N N ordance es hrough or no. pital mate luction?	DO V 1.00 N N N N N	0 2.	2.00 N N Y N N	0 XI X 3. 00 N N N	38. C 39. C 40. C 45. C 46. C 47. C 48. C 56. C
8.00         9.00         0.00         5.00         6.00         7.00         8.00         6.00         7.00         7.00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 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 faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "V" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N	pryes or " s of MDH st f periods i payment a ), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst seption for t. L, Pt. I capital? E t? Enter " approved G e to column cograms in cable CRs) umn 2. period duri r yes or "N th of this (", complet	N" for no. atus. If Ii n excess of djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct G ng which re " for no in cost report	(see ne 37 is one and for low volution ter in columination ts in "Y" for yes of ter share in try circumstation yes or "N" for yes or "N" for ? Enter "Y" or "N" for ? Enter "Y" or if this year or penu- ME payment sidents in a column 1. ing period?	nn pr for acc tanc I t ' fo hos ul ti red app If ? E	1.0 N N N ordance es hrough or no. or yes or pital mate luction? oroved column 1 inter "Y"	DO V 1. OC N N N N N N	0 2.	2.00 N N Y N N	0 XI X 3. 00 N N N	38. C 39. C 40. C 45. C 45. C 46. C 47. C 48. C 56. C
88.00         89.00         99.00         40.00         45.00         45.00         46.00         46.00         46.00         57.00         56.00         57.00         58.00	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 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 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospitals is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pri year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start training in the first monter is "Y" did residents start trai	pryes or " s of MDH st periods i payment a payment a payment a payment a provestigation period stream of the mileage i)? Enter the mileage i)? Enter (see inst see inst to disp eption for t. L, Pt. I capital? E t? Enter approved G e to column ograms in cable CRs) umn 2. beriod duri ryes or "N th of this (", complet pursement f	N" for no. atus. If li n excess of djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct G ng which re " for no in cost report cable. or physicia	(see ne 37 is <sup>5</sup> one and <sup>7</sup> one and <sup>7</sup> one and <sup>7</sup> er in colum tts in tts in try for yes tres or "N" for <sup>7</sup> e share in try circumst <sup>7</sup> L-1, Pt. <sup>6</sup> yes or "N" or "N" for <sup>7</sup> enter "Y" or if this year or penu ME payment sidents in a column 1. ing period? <sup>5</sup> E-4. If co	nn es for accontance tance tance tance tance to no. ' fo hos ulti red app If ? E blum	1.0 N N N N N N N N N N N N N N N N N N N	DO V 1. OC N N N N N N	0 2.	2.00 N N Y N N	0 XI X 3. 00 N N N	38. 0

OSPI TAL AND	HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	FI	eriod: rom 07/01/2021 p 06/30/2022	Worksheet S-2 Part I Date/Time Pre 11/22/2022 9:	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
any pro instruc is "Y", adjuste 0.01  f line instruc	claiming nursing and allied health education grams that meet the criteria under 42 CFR 413. tions) Enter "Y" for yes or "N" for no in col are you impacted by CR 11642 (or subsequent C ment? Enter "Y" for yes or "N" for no in colu e 60 is yes, complete columns 2 and 3 for each tions) e 60 is yes, complete columns 2 and 3 for each	85? (s umn 1. CR) NAHE umn 2. progran	see If column 1 E MA payment n. (see	Y	Y 23. 00 23. 01		60. 00 60. 0 60. 0
i nstruc		Y/N	I ME	Direct GME	I ME	Direct GME	00.02
		1.00	2.00	2.00	4.00	F 00	
	ur bospital roccivo FTE slots updor ACA	1.00 N	2.00	3.00	4.00	5.00	61.00
section column 1.01 Enter t FTEs fr	r hospital receive FTE slots under ACA 5503? Enter "Y" for yes or "N" for no in 1. (see instructions) he average number of unweighted primary care om the hospital's 3 most recent cost reports and submitted before March 23, 2010. (see	N			0.00		61. 01
FTE cou and pri	tions) he current year total unweighted primary care nt (excluding OB/GYN, general surgery FTEs, mary care FTEs added under section 5503 of see instructions)						61.02
and/or determi i nstruc	he base line FTE count for primary care general surgery residents, which is used for ning compliance with the 75% test. (see tions) he number of unweighted primary care/or						61. 0 61. 0
surgery current 1.05 Enter t and/or	allopathic and/or osteopathic FTEs in the cost reporting period. (see instructions). he difference between the baseline primary general surgery FTEs and the current year's care and/or general surgery FTE counts (line						61. 0
61.04 m 1.06 Enter t used fo	inus line 61.03). (see instructions) he amount of ACA §5503 award that is being r cap relief and/or FTEs that are nonprimary general surgery. (see instructions)	Pr	ogram Name	Program Codo	Unweighted IME	Unweighted	61. 0
			Jgi alli Malle			Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
special for eac column program unweigh FTE unw	FTEs in line 61.05, specify each new program ty, if any, and the number of FTE residents h new program. (see instructions) Enter in 1, the program name. Enter in column 2, the code. Enter in column 3, the IME FTE ted count. Enter in column 4, the direct GME eighted count. FTEs in line 61.05, specify each expanded				0.00		61. 10
program resider instruc Enter i 3, the	i specialty, if any, and the number of FTE is for each expanded program. (see stions) Enter in column 1, the program name. In column 2, the program code. Enter in column IME FTE unweighted count. Enter in column 4, sect GME FTE unweighted count.				0.00	0.00	01.20
						1.00	
	visions Affecting the Health Resources and Ser he number of FTE residents that your hospital				od for which	0.00	62.00
your ho 2.01 Enter t	spital received HRSA PCRE funding (see instruc he number of FTE residents that rotated from a	ctions) a Teachi	ng Health Cen	ter (THC) into			62. 01
Teachi r	in this cost reporting period of HRSA THC proc g Hospitals that Claim Residents in Nonprovide r facility trained residents in nonprovider se r yes or "N" for no in column 1. If yes, comple	er Setti	ngs		eriod? Enter	N	63.00

Ith Financial Systems PITAL AND HOSPITAL HEALTH CARE COMPL		MUNITY HOSPITAL	CCN: 15-0125 P	eri od:	u of Form CMS- Worksheet S-2	
THE ARE NOT THE HEALTH OAKE COMPL	EXTREMITION DF		F	rom 07/01/2021 o 06/30/2022	Part I	pared:
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Site	nospi tai	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year			-This base year	is your cost n	reporting	
period that begins on or after Ju 00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you	yes, or your facili er of unweighted nor ations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	0 64. C
of (column 1 divided by (column 1	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
	ri ogram Name		FTEs	FTEs in	(col . 3 + col .	
			Nonprovi der	Hospi tal	(4))	
_			Site			4
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unweighted	Ratio (col. 1/	
			FTEs Nonprovider Site 1.00	FTEs in Hospital	(col. 1 + col. 2)) 3.00	_
Section 5504 of the ACA Current	'ear FTE Residents i	n Nonprovider Settin				
beginning on or after July 1, 20 00 Enter in column 1 the number of u	0					
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonpu nweighted non-prima I. Enter in column (	rovider settings. ry care resident 3 the ratio of	0.00	0.00	, 0.00000	, 00.0
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
-	1.00	2.00	3. 00	4.00	5.00	1
00 Enter in column 1, the program		2.00	0.00			67.0
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						

Heal th	Financial Systems COMMUNITY HOSPITAL	L	n Lieu	of For	m CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0125	Period: From 07/01/ Fo 06/30/	/2021 /2022	Workshe Part I Date/Ti	et S-2 me Pre	pared:
				11/22/2		20 am
	Inpatient Psychiatric Facility PPS		1.00	2.00	3.00	
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub Enter "Y" for yes or "N" for no.	provi der?	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in				0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac	no. (see hing				
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportir					
	(see instructions)					
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		Y			75.00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in	the most	N	N	0	76.00
78.00	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes c	r "N" for		N		78.00
	no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y					
	indicate which program year began during this cost reporting period. (see instructions)				<u> </u>	
				1.0	00	
80 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
	Is this a LTCH co-located within another hospital for part or all of the cost reporting	period? E	nter	N		81.00
	"Y" for yes and "N" for no. TEFRA Providers					
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes		no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectic §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	n				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.00
		V 1.00		XI 2		
	Title V and XIX Services					00.00
	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			Ν		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N		Ν		93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N		Ν		94.00
	applicable column.					
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N		0. 0 N		95.00 96.00
97 00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.0	0	97.00
	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post	N		N N		98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.	N		Y		98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	N		Y		98.02
00.00	for title V, and in column 2 for title XIX.					
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N		N		98.03
08 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N		Ν		98.04
70. 04	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and			i i i		70.04
98.05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	N		Y		98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in					
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	N		Ν		98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
405 -	Rural Providers					105
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N				105.00 106.00
	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R					107.00
107.00	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)					107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?					
	Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems COMMUNITY H	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C			Worksheet S-2 Part I Date/Time Pro 11/22/2022 93	epared:
			V 1.00	XI X 2.00	-
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N	2.00	108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respi ratory 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.	1.00	2.00	3.00		109.00
110.00 Did this hospital participate in the Rural Community Hospita	al Demonstrati	on project (841	04	1.00 N	110.00
Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. If	f yes,	IV.	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	4
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in th demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? s "Y", enter ne	1.00 N	2.00	3.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider	3, or E only) 93" percent (includes	N			0115.00
the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"		N			116.00
"N" for no. 117.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00  s the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr	5	1 Premiums	Losses	Insurance	118.00
		1.00	2.00	3.00	-
118.01 List amounts of malpractice premiums and paid losses:		1	0		0118.01
			1.00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.			N		118.02
119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment Extension and Ward for your on "N" for non.	n column 1, "Y ualifies for t	" for yes or he Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	antable device	s charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or ves and "N"	for no lf	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 lf this is a Medicare certified kidney transplant center, er	-				126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent	2.				127.00
in column 1 and termination date, if applicable, in column 2	2.				
128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	2.				128.00
<ul><li>129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li><li>130.00 If this is a Medicare certified pancreas transplant center,</li></ul>					129.00 130.00
date in column 1 and termination date, if applicable, in col		ti i Cati Ull			130.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CCI	N: 15-0125	From 07	7/01/2021 5/30/2022	Worksheet S-2 Part I Date/Time Pre 11/22/2022 9:	epared:
					1.00	2.00	-
31.00 If this is a Medicare certified in date in column 1 and termination of	•		rtificati	on			131. 0
32.00 If this is a Medicare certified is in column 1 and termination date,	slet transplant center,	enter the certific	cation da	te			132. 0
33.00 Removed and reserved 34.00 If this is an organ procurement or <u>and termination date, if applicabl</u> All Providers		r the OPO number in	n column	1			133. 0 134. 0
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	'N" for no in column 1.	If yes, and home o ber. (see instruction	office co		Y	15H054	140. 0
<u> </u>	in organization enter	2.00 on lines 141 throu	  ah 143 th	e name and	3.00 address	of the	
home office and enter the home of 1.00Name: COMMUNITY FOUNDATION OF NW	<u>fice contractor name an</u>	d contractor numbe	er.	actor's Nur			141.0
INC. 42.00Street: 10010 DONALD S POWERS DRIV 201	E STE PO Box:						142.0
13.00 City: MUNSTER	State:	IN	Zip C	ode:	4632	1	143.0
						1.00	
14.00 Are provider based physicians' cos	sts included in Workshe	et A?				Y	144.0
					1.00	2.00	_
<ul> <li>15.00 If costs for renal services are clipatient services only? Enter "Y" no, does the dialysis facility inception period? Enter "Y" for yes or "N"</li> <li>16.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d)</li> </ul>	' for yes or "N" for no clude Medicare utilizat for no in column 2. gy changed from the pre n column 1. (See CMS Pu	in column 1. If co ion for this cost viously filed cost	olumn 1 i reporting report?		Y		145. 0
	dd/vvvv) in column 2						
yes, enter the approval date (min/t	dd/yyyy) in column 2.					1.00	-
17.00 Was there a change in the statisti		or yes or "N" for i	no.			1.00 N	147. (
17.00Was there a change in the statisti 18.00Was there a change in the order of	ical basis? Enter "Y" f f allocation? Enter "Y"	for yes or "N" for	r no.	for po		N N	148. (
17.00 Was there a change in the statisti	ical basis? Enter "Y" f f allocation? Enter "Y"	for yes or "N" for ? Enter "Y" for yes Part A	r no. s or "N" Part	B Ti	tle V	N	148. (
7.00Was there a change in the statisti 8.00Was there a change in the order of 9.00Was there a change to the simplifi	cal basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method	for yes or "N" for ? Enter "Y" for yes Part A 1.00	r no. <u>s or "N"</u> <u>Part</u> 2.00	B Ti	3.00	N N Title XIX 4.00	148.
7.00Was there a change in the statisti 8.00Was there a change in the order of 9.00Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or	ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for	for yes or "N" for <u>Part A</u> 1.00 an exemption from	r no. s or "N" Part 2.00 n the appl	B Ti ication of	3.00 the lowe	N N Title XIX 4.00 r of costs .13)	148. ( 149. (
7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or 55.00 Hospital	ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N	r no. s or "N" Part 2.00 a the appl and Part N	B Ti ication of	3.00 the lowe CFR §413 N	N N Title XIX 4.00 r of costs .13) N	148. ( 149. ( 
<ul> <li>7.00 Was there a change in the statisti</li> <li>8.00 Was there a change in the order of</li> <li>9.00 Was there a change to the simplifi</li> <li>Does this facility contain a provior charges? Enter "Y" for yes or 55.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> </ul>	ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A	r no. <u>s or "N"</u> <u>Part</u> 2.00 the appl and Part	B Ti ication of	3.00 the lowe CFR §413	N N Title XIX 4.00 r of costs .13)	148. ( 149. ( 155. ( 156. ( 157. (
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<ul> <li>7.00 Was there a change in the statisti</li> <li>8.00 Was there a change in the order of 19.00 Was there a change to the simplifi</li> <li>Does this facility contain a provior charges? Enter "Y" for yes or 55.00 Hospital</li> <li>66.00 Subprovider - IPF</li> <li>77.00 Subprovider - IRF</li> <li>88.00 SUBPROVIDER</li> <li>99.00 SNF</li> <li>90.00 HOME HEALTH AGENCY</li> </ul>	ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N	r no. s or "N" Part 2.00 h the appl and Part N N	B Ti ication of	3.00 the lowe CFR §413 N N	N N Title XIX 4.00 r of costs .13) N N	148. ( 149. ( 155. ( 156. ( 157. ( 158. ( 159. (
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<ul> <li>17.00 Was there a change in the statisti</li> <li>18.00 Was there a change in the order of</li> <li>19.00 Was there a change to the simplifi</li> <li>Does this facility contain a provior charges? Enter "Y" for yes or 55.00 Hospital</li> <li>56.00 Subprovider - IPF</li> <li>57.00 Subprovider - IRF</li> <li>58.00 SUBPROVIDER</li> <li>59.00 SNF</li> <li>50.00 HOME HEALTH AGENCY</li> <li>51.00 CMHC</li> </ul>	ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N N N	r no. s or "N" Part 2.00 h the appl and Part N N N N N	B Ti ication of	3.00 the Iowe CFR §413 N N N N	N N Title XIX 4.00 r of costs .13) N N N N	148. ( 149. ( 149. ( 155. ( 156. ( 157. ( 158. ( 159. ( 160. (
17.00 Was there a change in the statisti 18.00 Was there a change in the order of 19.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica	cal basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each com	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N N N	r no. s or "N" Part 2.00 h the appl and Part N N N N N N	B Ti ication of B. (See 42	3.00 the Iowe <u>CFR \$413</u> N N N N N N	N N Title XIX 4.00 r of costs .13) N N N N N N N N	148. ( 149. ( 155. ( 156. ( 156. ( 157. ( 158. ( 159. ( 160. ( 161. (
17.00 Was there a change in the statisti 18.00 Was there a change in the order of 19.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IPF 58.00 SUBPROVIDER 59.00 SNF 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus	cal basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each com	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N N N	r no. s or "N" Part 2.00 h the appl and Part N N N N N N	B Ti ication of B. (See 42	3.00 the Iowe <u>CFR \$413</u> N N N N N N	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N	148. ( 149. ( 155. ( 156. ( 156. ( 157. ( 158. ( 159. ( 160. ( 161. (
7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provior or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each com	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N	r no. <u>s or "N"</u> <u>Part</u> 2.00 1 the appl and Part N N N N N N Ses in di	B Ti ication of B. (See 42	3.00 the Iowe <u>CFR \$413</u> N N N N N SAS?	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N FTE/Campus 5.00	148.0 149.0 155.0 155.0 157.0 158.0 157.0 158.0 160.0 161.0 165.0
17.00 Was there a change in the statisti 18.00 Was there a change in the order of 19.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica	ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each com ampus hospital that has Name	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. <u>s or "N"</u> <u>Part</u> 2.00 n the appl and Part N N N N N N N Ses in di <u>State</u>	B Ti ication of B. (See 42 fferent CB Zip Code	3.00 the Iowe <u>CFR \$413</u> N N N N SAs? <u>CBSA</u>	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N FTE/Campus 5.00	147. ( 148. ( 149. ( 149. ( 155. ( 156. ( 157. ( 158. ( 157. ( 158. ( 160. ( 161. ( 165. ( 165. ( 0 166. (
7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provior charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.           Multicampus           6.00 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	ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each com ampus hospital that has Name	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. <u>s or "N"</u> <u>Part</u> 2.00 n the appl and Part N N N N N N N Ses in di <u>State</u>	B Ti ication of B. (See 42 fferent CB Zip Code	3.00 the Iowe <u>CFR \$413</u> N N N N SAs? <u>CBSA</u>	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N FTE/Campus 5.00	148. ( 149. ( 149. ( 155. ( 156. ( 157. ( 158. ( 157. ( 158. ( 160. ( 161. ( 161. ( 165. ( 165. (
7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provious or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 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) Heal th Information Technology (HI 7.00 Is this provider a meaningful user	ical basis? Enter "Y" f f allocation? Enter "Y" ed cost finding method ider that qualifies for "N" for no for each com "N" for no for each com	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. <u>s or "N"</u> <u>Part</u> 2.00 n the appl and Part N N N N N N N Ses in di <u>State</u> 2.00 <u>State</u> 2.00 <u>State</u> 2.00	B Ti ication of B. (See 42 fferent CB Zip Code 3.00	3.00 the Iowe <u>CFR \$413</u> N N N N SAS? <u>CBSA</u> 4.00	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	148. ( 149. ( 149. ( 155. ( 156. ( 157. ( 157. ( 159. ( 167. ( 160. ( 161. ( 161. ( 165. ( 165. ( 165. ( 166. ( 16
17. 00 Was there a change in the statisti     18. 00 Was there a change in the order of     19. 00 Was there a change to the simplifi     Does this facility contain a provior charges? Enter "Y" for yes or     15. 00 Hospital     56. 00 Subprovider - IPF     77. 00 Subprovider - IRF     100 SUBPROVIDER     59. 00 SNF     00 SNF     00 OHOME HEALTH AGENCY     100 CMHC     Multicampus     55. 00 Is this hospital part of a Multica     Enter "Y" for yes or "N" for no.     100 CMHC     66. 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)	ical basis? Enter "Y" f f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each com "N" for no for each com	for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. <u>s or "N"</u> <u>Part</u> 2.00 n the appl and Part N N N N N N N N N N N N N	B Ti ication of B. (See 42 fferent CB Zip Code 3.00 ment Act Y"), enter	3.00 the Iowe CFR \$413 N N N N SAS? CBSA 4.00 the	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	148. ( 149. ( 155. ( 156. ( 157. ( 158. ( 157. ( 158. ( 160. ( 161. ( 165. ( 165. (

Health Financial Systems	COMMUNI TY HO	SPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Period:	Worksheet S-2	
			From 07/01/2021	Part I	
			To 06/30/2022	Date/Time Pre 11/22/2022 9:	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	inning date and ending da	te for the reporting			170.00
			1.00	2.00	1
171.00 If line 167 is "Y", does this provid	ler have any days for indi	viduals enrolled in	N	0	171.00
section 1876 Medicare cost plans rep	orted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in columr	ı1. lf column 1 is yes, e	nter the number of section	ו		
1876 Medicare days in column 2. (see	instructions)				

	Financial Systems COMMUNITY				u of Form CMS-	
OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Pro 11/22/2022 93	eparec
		· I		Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	l for all NO re	esponses. Ente	er all dates in t	the	
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation	boginning of	the cost	N		1 1
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	column 2 (see	instructions			1.
	reperting periodi in yes, enter the date of the endinge in e	010111121 (000	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug ler or its of the board	Y			3.
			Y/N	Туре	Date	
	Financial Data and Danasta		1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, Milable in	Y	A		4.
00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		IN			5.
				Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If yos in	the provide	r N		6.
00	is the legal operator of the program?	2. Triyes, Ts	s the provide	IN		0.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during the	e N		7. 8.
00	Are costs claimed for Interns and Residents in an approved	graduate medio	cal education	Ν		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.		the current	N		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 13.
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		*		Ν	14.
. 00	Did total beds available change from the prior cost reporti		yes, see ins rt A		t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16
. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	09/27/2022	Y	09/27/2022	17
. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are pat included on the PS&P Report used to file this	Ν		Ν		18.
. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19

PITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE 00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	Descr	CCN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Pre 11/22/2022 9:		
		intion			:20 a	
		iption	Y/N	Y/N		
		0	1.00	3.00		
			N	N	20.	
	Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00		
00 Was the cost report prepared only using the provider's	N	2.00	N N	4.00	21.	
records? If yes, see instructions.				1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)		1.00		
Capital Related Cost					-	
<ul> <li>Have assets been relifed for Medicare purposes? If yes, see</li> <li>Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.</li> </ul>			ing the cost		22 23	
00 Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost rep	porting period?		24	
00 Have there been new capitalized leases entered into during instructions.		25				
00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.			-		26	
00 Has the provider's capitalization policy changed during the copy.		27				
Interest Expense Were new Loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into du	ring the cost	reporting		28	
Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	eserve Fund)		29	
Has existing debt been replaced prior to its scheduled mate instructions.		debt? If yes,	, see		30	
Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	, see		31	
Purchased Services 00 Have changes or new agreements occurred in patient care services		ed through co	ntractual		32	
arrangements with suppliers of services? If yes, see instru- 1f line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi <sup>.</sup>	tive bidding? If		33	
Provi der-Based Physi ci ans					-	
20 Are services furnished at the provider facility under an ar If yes, see instructions.	irrangement with	h provider-bas	sed physi ci ans?		34	
20 If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the p	provi der-based		35	
			Y/N	Date		
Home Office Costs			1.00	2.00	-	
Were home office costs claimed on the cost report?					36	
00 If line 36 is yes, has a home office cost statement been pu If yes, see instructions.	repared by the	home office?			37	
0 If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end					38	
00 If line 36 is yes, did the provider render services to othe see instructions.			,		39	
00 If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see			40	
	1	. 00	2.	00	-	
Cost Report Preparer Contact Information					<b>.</b>	
00 Enter the first name, last name and the title/position	CATHERI NE WOERNER				41	
held by the cost report preparer in columns 1, 2, and 3,		COMMUNITY FOUNDATION OF NW				
	COMMUNITY FOUN	NDATION OF NW			42	

Heal th	Financial Systems COMMUNITY	HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10			
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0125	Period: From 07/01/2021	Worksheet S-2 Part II			
			To 06/30/2022		pared: 20 am		
		3.00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	REIMBURSEMENT MANAGER			41.00		
	held by the cost report preparer in columns 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 address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						

	Financial Systems	COMMUNI TY				u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0125	Period: From 07/01/2021	Worksheet S-3 Part I	
					To 06/30/2022	Date/Time Pre	
						11/22/2022 9: 2	
						I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Visits / Trips Title V	
	component	Line Number	NO. OT DEUS	Avai I abl e	CAIT HOURS	intro v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	324	115, 6	34 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)						0.00
2.00 3.00	HMO and other (see instructions)						2.00 3.00
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider						4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		324	115, 6	0.00	-	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	43	15, 69	95 0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE	31.01	32	11, 6	30 0.00	0	8. 01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	10.00					12.00
13.00	NURSERY	43.00	399	142.0		0	
14.00 15.00	Total (see instructions) CAH visits		399	143, 0	59 0.00	0	14.00 15.00
16.00	SUBPROVIDER - IPF					0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	2, 5	76	0	17.00
18.00	SUBPROVI DER	111 00	0	2,0			18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						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 Total (sum of lines 14-26)	89.00	399			0	20.25
28.00	Observation Bed Days		577			0	28.00
29.00	Ambul ance Trips					0	29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33. 01

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	:N: 15-0125	Period: From 07/01/2021 To 06/30/2022		pared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	Ι
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	27, 436	670	67, 53	31		1. (
00 00	HMO and other (see instructions) HMO IPF Subprovider	21, 949	13, 276 0				2.0
00	HMO I RF Subprovi der	378	88				4.0
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.0
00	Hospital Adults & Peds. Swing Bed NF	Ŭ	0		0		6.
00	Total Adults and Peds. (exclude observation beds) (see instructions)	27, 436	670	67, 53			7.0
00	INTENSI VE CARE UNI T	3, 500	681	11, 22	21		8.
01	NEONATAL INTENSIVE CARE	0	112	3, 49			8.
00	CORONARY CARE UNI T	-		-,			9.
. 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGICAL INTENSIVE CARE UNIT						11.
. 00	OTHER SPECIAL CARE (SPECIFY)						12.
. 00	NURSERY		119	2, 86	53		13.
. 00	Total (see instructions)	30, 936	1, 582	85, 10	0. 00	2, 472. 40	14.
. 00	CAH visits	0	0		0		15.
00	SUBPROVIDER - IPF						16
00	SUBPROVIDER - IRF	1, 552	0	2, 18	37 0.00	15.50	17
00	SUBPROVI DER						18
00	SKILLED NURSING FACILITY						19
00	NURSING FACILITY						20
00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY	24, 286	0	49,60	0. 00	48.45	
00	AMBULATORY SURGICAL CENTER (D. P.)						23
00	HOSPI CE						24
10	HOSPICE (non-distinct part)				0		24
00	CMHC - CMHC						25
00	RURAL HEALTH CLINIC	0	0		0 0 00	0.00	26
25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
00 00	Total (sum of lines 14-26)		0	16, 80	0.00	2, 536. 35	27
00	Observation Bed Days Ambulance Trips	o	0	10, 80			28
00	Employee discount days (see instruction)	0			0		30
00	Employee discount days (see fisting for the second se				0		31
00	Labor & delivery days (see instructions)	o	291	68	-		32
00	Total ancillary labor & delivery room	0	291	00	0		32
01	outpatient days (see instructions)				Ŭ.		32.
. 00	LTCH non-covered days	0					33.
	LTCH site neutral days and discharges	0					33.

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der (	CCN: 15-0125		riod: om 07/01/2021 06/30/2022	Worksheet S-3 Part I Date/Time Prep 11/22/2022 9:2	
		Full Time		D	i scha	rges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVI	11	Title XIX	Total All Patients	
		11.00	12.00	13.00		14.00	15.00	
. 00 . 00 . 00 . 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider				676 186	229 2, 474 0 7	15, 599	1. 2. 3. 4.
. 00 . 00 . 00 . 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT					,		5. 6. 7. 8.
. 00 . 01 . 00 0. 00 1. 00 2. 00 3. 00	NEONATAL INTENSIVE CARE CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY							8. 9. 10. 11. 12. 13.
4.00 5.00 5.00	Total (see instructions) CAH visits SUBPROVIDER - IPF	0.00		0 5,	676	229	15, 599	14. 15. 16.
5.00 7.00 3.00 9.00 0.00 1.00	SUBPROVIDER - IFF SUBPROVIDER - IFF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0. 00		0	129	O	178	10. 17. 18. 19. 20. 21.
2.00 3.00 4.00 4.10 5.00 6.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00						22. 23. 24. 24. 25. 26.
<ol> <li>25</li> <li>00</li> </ol>	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)	0. 00 0. 00						26. 27. 28. 29. 30. 31. 32.
. 01 . 00 . 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0			32 33 33

PI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 07/01/2021 To 06/30/2022		par
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200, 00	204, 152, 724	0	204, 152, 72	4 5, 275, 616. 37	38.70	1
0	instructions)	2001.00	2011102112		201,102,72			
0	Non-physician anesthetist Part		C	0	(	0.00	0.00	
0	A Non-physician anesthetist Part		4, 879, 925	0	4, 879, 92	5 44, 748. 93	109. 05	3
0	B Physician-Part A -		C	0	(	0.00	0.00	4
1	Administrative Physicians - Part A - Teaching		C	0	(	0.00	0.00	
0	Physician and Non		10, 399, 866	0	10, 399, 86			
	Physician-Part B							
0	Non-physician-Part B for hospital-based RHC and FQHC		C	0	(	0.00	0.00	0
0	services Interns & residents (in an	21.00	C	0	(	0.00	0.00	-
1	approved program) Contracted interns and		C	0	(	0.00	0.00	-
0	residents (in an approved programs)		c.			0.00	0.00	
0	Home office and/or related organization personnel	44.00	(	0		0.00		
0 00	SNF Excluded area salaries (see instructions)	44.00	8, 607, 652	479, 301	9, 086, 95	0 0.00 3 249, 888.25		
	OTHER WAGES & RELATED COSTS			1 1				
00	Contract Labor: Direct Patient		3, 992, 859	0	3, 992, 85	9 40, 196. 04	99.33	1
00	Care Contract Labor: Top Level		C	0	(	0.00	0.00	1:
	management and other management and administrative services							
00	Contract Labor: Physician-Part A - Administrative		652, 703	0	652, 703	3 3, 776. 76	172. 82	1
00	Home office and/or related organization salaries and		C	0	(	0.00	0. 00	1.
	wage-related costs							
	Home office salaries		22, 893, 582	0	22, 893, 58			
02 00	Related organization salaries Home office: Physician Part A		(			0.00 0.00		
0	- Administrative		C C		·			'
00	Home office and Contract Physicians Part A - Teaching		C	0	(	0.00	0.00	1
01	Home office Physicians Part A - Teaching		C	0	(	0.00	0. 00	1
02	Home office contract		C	0	(	0.00	0.00	1
	Physicians Part A - Teaching WAGE-RELATED COSTS							
00	Wage-related costs (core) (see instructions)		45, 777, 675	0	45, 777, 67	5		1
00	Wage-related costs (other) (see instructions)							1
00	Excluded areas		2, 329, 296	0	2, 329, 29	6		1
00	Non-physician anesthetist Part A Non physician anosthetist Part		E04 E44	0	E04 F4	6		2
	Non-physician anesthetist Part B Physician Part A -		584, 546		584, 54			2
	Admi ni strati ve		( ,					2
)1 )0	Physician Part A - Teaching Physician Part B		1, 117, 986		1, 117, 98	6		2
)0 )0	Wage-related costs (RHC/FQHC)		1, 117, 980		1, 117, 98	D D		2
00	Interns & residents (in an		C	0	(	C		2
50	approved program) Home office wage-related		5, 861, 170	0	5, 861, 17	D		2
51	(core) Related organization		C	0	(	c		2
52	wage-related (core) Home office: Physician Part A		C	0	(	D		2
	- Administrative - wage-related (core)		_					

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C	CN: 15-0125	Period: From 07/01/2021 To 06/30/2022		
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4.00		0	988, 83	31, 534. 00	31.36	
27.00	Administrative & General	5.00	18, 320, 187	0	18, 320, 18	554, 498. 00	33.04	27.00
28.00	Administrative & General under		2, 833, 277	0	2, 833, 27	28, 442. 32	99.61	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	4, 000, 192	0	4, 000, 19	2 113, 212. 00	35.33	30.00
31.00	Laundry & Linen Service	8.00	147, 971	0	147, 97	1 8, 225. 00	17.99	31.00
32.00	Housekeepi ng	9.00	4, 226, 402	0	4, 226, 40	221, 545. 00	19.08	32.00
33.00	Housekeeping under contract		0	0		0 0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	4, 049, 676	-1, 267, 790	2, 781, 88	127, 021. 00	21.90	34.00
35.00	Dietary under contract (see		0	0		0 0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	1, 267, 790	1, 267, 79	0 57, 887. 00	21.90	
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	7, 081, 830	-319, 111	6, 762, 71	9 163, 543.00	41.35	38.00
39.00	Central Services and Supply	14.00	0	0		0 0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0		0 0.00	0.00	40.00
41.00	Medical Records & Medical	16.00	0	0		0 0.00	0.00	41.00
	Records Library							
42.00	Social Service	17.00	981, 939	0	981, 93	31, 531. 00	31.14	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 07/01/2021	Worksheet S-3 Part III	
						Foil 07/01/2021		pared:
							11/22/2022 9:	20 am
		Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-i		
1.00	Net salaries (see		191, 706, 210	0	191, 706, 210	5, 181, 094. 31	37.00	1.00
	instructions)							
2.00	Excluded area salaries (see		8, 607, 652	479, 301	9, 086, 953	3 249, 888. 25	36.36	2.00
	instructions)							
3.00	Subtotal salaries (line 1		183, 098, 558	-479, 301	182, 619, 25	7 4, 931, 206. 06	37.03	3.00
	minus line 2)							
4.00	Subtotal other wages & related		27, 539, 144	0	27, 539, 144	4 660, 536. 80	41.69	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		51, 638, 845	0	51, 638, 84	5 0.00	28. 28	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		262, 276, 547	-479, 301	261, 797, 240	5, 591, 742. 86	46. 82	6.00
7.00	Total overhead cost (see		42, 630, 305	-319, 111	42, 311, 194	4 1, 337, 438. 32	31.64	7.00
	instructions)							

Heal th	Financial Systems	COMMUNI TY HOS	SPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL WAGE RELATED COSTS		Provider CCN:	15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part IV	pared:
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						-
	Part A - Core List RETIREMENT COST						-
1 00						0	1.00
1.00 2.00	401K Employer Contributions Tax Sheltered Annuity (TSA) Employer Contribu	tion				6, 508, 240	
2.00						0, 508, 240	
3.00 4.00							
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External Or					0	4.00
5.00	401K/TSA Plan Administration fees	yanı zatron)				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan					0	
7.00	Employee Managed Care Program Administration I	005				0	0.00
7.00	HEALTH AND INSURANCE COST	663				0	7.00
8.00	Heal th Insurance (Purchased or Self Funded)					0	8.00
8.01	Heal th Insurance (Sel f Funded wi thout a Third	Party Administry	ator)			0	
8.02	Heal th Insurance (Self Funded without a Third Par					26, 092, 535	
8.03	Heal th Insurance (Purchased)	ty Administrato				0	
9.00	Prescription Drug Plan					0	
10.00	Dental, Hearing and Vision Plan					1, 418, 652	
11.00	Life Insurance (If employee is owner or benefi	ci arv)				133, 047	
12.00	Accident Insurance (If employee is owner or be					0	•
13.00	Disability Insurance (If employee is owner or					99, 731	
14.00	Long-Term Care Insurance (If employee is owned		)			0	
15.00	'Workers' Compensation Insurance	or somerrorary				1, 182, 159	
16.00	Retirement Health Care Cost (Only current year	. not the extra	ordi narvi accru	al require	ed by FASB 106.	0	
	Non cumulative portion)	,				-	
	TAXES						1
17.00	FICA-Employers Portion Only					11, 789, 921	17.00
18.00	Medicare Taxes - Employers Portion Only					2, 858, 762	18.00
19.00	Unemployment Insurance					-273, 543	19.00
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER					•	1
21.00	Executive Deferred Compensation (Other Than Reinstructions))	etirement Cost R	eported on lin	es 1 throu	igh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)					49, 809, 504	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00

Heal th	Financial Systems	COMMUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0125	Peri od:	Worksheet S-3	
			From 07/01/2021	Part V	
			To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description		Contract Labor		20 411
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identifi	cati on:			
1.00	Total facility's contract labor and benefit co	st	3, 992, 859	49, 809, 504	1.00
2.00	Hospi tal		3, 992, 859	49, 809, 504	2.00
3.00	SUBPROVIDER - IPF				3.00
4.00	SUBPROVIDER - IRF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	SKILLED NURSING FACILITY				8.00
9.00	NURSING FACILITY				9.00
10.00	OTHER LONG TERM CARE I				10.00
11.00	Hospital-Based HHA		0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I				12.00
13.00	Hospital-Based Hospice				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00	RENAL DIALYSIS I		0	0	17.00
18.00	Other		0	0	18.00

Heal th	Financial Systems	COMMUNI TY F	IOSPI TAL		In Lie	eu of Form CMS-:	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA		Provider C	CN: 15-0125 CCN: 15-7487	Period: From 07/01/2021 To 06/30/2022	Worksheet S-4 Date/Time Pre	
			component	CCN. 15-7487		11/22/2022 9:	
					Home Health Agency I	PPS	
			4			00	-
0.00	County				LAKE	00	0.00
		Title V	Title XVIII	Title XIX	Other	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00	Home Health Aide Hours	0	1, 201		3 707	1, 911	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1, 151.00	0.0			2.00
				NUMBER OT EM	ployees (Full Ti	me Equivalent)	
		Enter the number		Staff	Contract	Total	
		your normal	work week				
		0		1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		40.00	0.9			
5.00	Other Administrative Personnel			18.9			1
6.00	Direct Nursing Service Nursing Supervisor			14.3			6.00 7.00
7.00 8.00	Physical Therapy Service			0.0			
9.00	Physical Therapy Supervisor			1.4			1
10.00	Occupational Therapy Service			2.6			
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.4			
13.00	Speech Pathology Supervisor			0.6			1
14.00	Medical Social Service			0.0			
15.00	Medical Social Service Supervisor Home Health Aide			0.0			1
16.00 17.00	Home Health Aide Supervisor			1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1			
18.00	Other (specify)			0.0		0.00	
						CBSA Data 1.00	
	HOME HEALTH AGENCY CBSA CODES					1	
19. 00 20. 00	Enter in column 1 the number of CBSAs where List those CBSA code(s) in column 1 serviced first code).					1 23844	19.00 20.00
		Full Ep					
		Without Outliers	With Outliers	LUPA Epi sode	s PEP Only Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
01 00	PPS ACTIVITY DATA	0.452	0.011			40.7/2	01.00
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	9, 613 2, 011, 075	2, 811 588, 805	1			
23.00	Physical Therapy Visits	4, 991	1, 858		35 81		
24.00	Physical Therapy Visit Charges	1, 222, 656	457, 128	19, 24		1, 719, 108	24.00
25.00 26.00	Occupational Therapy Visits Occupational Therapy Visit Charges	1, 563 382, 728	1, 364 335, 376		17 32 24 7, 932		
28.00	Speech Pathology Visits	124	335, 376		2 5	304	1
28.00	Speech Pathology Visit Charges	30, 000	42, 324	49		74, 052	28.00
29.00 30.00	Medical Social Service Visits Medical Social Service Visit Charges	3 839	0			3 839	29.00 30.00
30.00	Home Health Aide Visits	770	448		3 4	1, 225	1
32.00	Home Health Aide Visit Charges	122, 129	71, 499	48	652	194, 761	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 20, and 21)	17, 064	6, 654	32	26 242	24, 286	33.00
34.00	29, and 31) Other Charges	0	C		0 0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28,	3, 769, 427	1, 495, 132				
36.00	30, 32, and 34) Total Number of Episodes (standard/non	1, 663		18	30 24	1, 867	36.00
37.00	outlier) Total Number of Outlier Episodes		300		6	306	37.00
	Total Non-Routine Medical Supply Charges	279, 998	115, 224	3, 19	1, 967		

Heal th	Financial Systems COMMUNITY HOS	SPI TAL		In Li€	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-0125	Peri od:	Worksheet S-1	0
				From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
					11/22/2022 9:	20 am
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by li	ne 202 column	18)	0. 215530	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				33, 613, 087	2.00
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid?	ntal novmant	o from Modios	40	N	3.00 4.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or suppleme If line 4 is no, then enter DSH and/or supplemental payments			11 U ?	0	4.00 5.00
6.00	Medi cai d charges		284, 802, 189	6.00		
7.00	Medicaid cost (line 1 times line 6)				61, 383, 416	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of lir	nes 2 and 5; if	27, 770, 329	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions	for each lin	e)		-	
9.00	Net revenue from stand-al one CHIP				0	9.00
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00 11.00
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9 <sup>,</sup> i	f < zero then	0	12.00
12.00	enter zero)				, v	12.00
	Other state or local government indigent care program (see in	structions f	or each line)			
13.00	Net revenue from state or local indigent care program (Not in				625	
14.00	Charges for patients covered under state or local indigent ca	re program (	Not included	in lines 6 or	4, 287	14.00
15.00	10) State or local indigent care program cast (line 1 times line	14)			924	15.00
16.00	State or local indigent care program cost (line 1 times line Difference between net revenue and costs for state or local i		nrogram (lir	ne 15 minus line		16.00
10.00	13; if < zero then enter zero)	nurgent eare			2//	10.00
	Grants, donations and total unreimbursed cost for Medicaid, Cl	HIP and stat	e∕local indig	jent care prograi	ms (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to	funding char	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support of	5	5		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loc			s (sum of lines	27, 770, 628	19.00
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	1		1.00	2.00	3.00	
~~ ~~	Uncompensated Care (see instructions for each line)		15 0 ( 1 0 )	(00.(57	15 070 740	
20.00	Charity care charges and uninsured discounts for the entire factor (see instructions)	асниту	15, 264, 06	608, 657	15, 872, 718	20.00
21.00	Cost of patients approved for charity care and uninsured disc	ounts (see	3, 289, 86	608, 657	3, 898, 520	21.00
	instructions)					
22.00	Payments received from patients for amounts previously writte	n off as		0 0	0	22.00
23.00	charity care Cost of charity care (line 21 minus line 22)		3, 289, 86	608, 657	3, 898, 520	23 00
20100			0,20,,00		0,0,0,020	20100
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pati-		ond a length	of stay limit	N	24.00
25.00						
26.00	stay limit Total bad debt expense for the entire hospital complex (see i	nstructions)			15, 718, 661	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see in				1, 084, 380	
27.01	Medicare allowable bad debts for the entire hospital complex				1, 668, 278	
28.00						
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (see	instructions)		3, 612, 177	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				7, 510, 697	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	iine 30)			35, 281, 325	31.00

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CC		eriod: rom 07/01/2021	Worksheet A	
					06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	20 8
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
	-	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	-
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	-
	00100 CAP REL COSTS-BLDG & FIXT		13, 996, 923	13, 996, 923	315, 640	14, 312, 563	] 1
00	00200 CAP REL COSTS-MVBLE EQUIP		13, 985, 222	13, 985, 222	21, 916		
00	00300 OTHER CAP REL COSTS	000.001	0	0	0	0	3
)0 )1	00400 EMPLOYEE BENEFITS DEPARTMENT 00505 PURCHASING & RECEIVING STORES	988, 831 752, 263	25, 060, 865 -145, 037	26, 049, 696 607, 226		26, 049, 696 607, 226	4
)2	00506 ADMITTING	4, 254, 650	546, 423	4, 801, 073		4, 801, 073	
)3	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	-207	-207		-207	5
)4	00508 OTHER ADMIN & GENERAL	13, 313, 274	92, 272, 325	105, 585, 599	-624, 901	104, 960, 698	
00	00600 MAI NTENANCE & REPAI RS	0	0	0	-	0	6
00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	4, 000, 192 147, 971	11, 561, 896 1, 511, 186	15, 562, 088 1, 659, 157		15, 562, 088 1, 659, 157	8
00	00900 HOUSEKEEPING	4, 226, 402	1, 904, 819	6, 131, 221		6, 131, 221	
	01000 DI ETARY	4,049,676	2, 930, 366	6, 980, 042		4, 794, 873	
	01100 CAFETERI A	0	0	0	2, 185, 169	2, 185, 169	11
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12
	01300 NURSI NG ADMI NI STRATI ON	7,081,830	1, 629, 504	8, 711, 334 0	-377, 713	8, 333, 621	13
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	0	0	0	14
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	10
	01700 SOCIAL SERVICE	981, 939	103, 889	1, 085, 828	0	1, 085, 828	
	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	2
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	172 000	22 500	104 497	0	0	22
	02300 PARAMED ED PRGM-(PHARMACY) 02301 PARAMED ED PRGM-(LAB MLS)	173, 888 196, 398	22, 599 56, 723	196, 487 253, 121		356, 677 253, 121	
01	INPATIENT ROUTINE SERVICE COST CENTERS	170,070	00,720	200, 121		200, 121	1
00	03000 ADULTS & PEDIATRICS	42, 092, 431	8, 090, 390	50, 182, 821	-1, 635, 468	48, 547, 353	30
	03100 I NTENSI VE CARE UNI T	14, 257, 540	3, 084, 056	17, 341, 596		17, 341, 596	
	02060 NEONATAL INTENSIVE CARE	3, 478, 345	820, 924	4, 299, 269		4, 299, 269	
	04100 SUBPROVI DER – I RF 04300 NURSERY	1, 036, 587 0	570, 202 0	1, 606, 789 0		1, 606, 789 1, 922, 813	
00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	9	0	1, 722, 013	1, 722, 013	
00	05000 OPERATING ROOM	17, 174, 105	17, 060, 999			33, 911, 809	50
	05100 RECOVERY ROOM	6, 373, 923	1, 300, 196	7, 674, 119		7, 674, 119	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	3,041,144	641, 346 2, 725, 506	3, 682, 490 16, 727, 642		3, 682, 490 16, 727, 642	
	05400 RADI OLOGY-DI AGNOSTI C	14, 002, 136 4, 541, 101	2, 725, 506	7, 254, 449		7, 254, 449	
	05500 RADI OLOGY-THERAPEUTI C	1, 413, 770	1, 811, 021	3, 224, 791		3, 224, 791	
	05600 RADI OI SOTOPE	867, 062	1, 480, 804	2, 347, 866	0	2, 347, 866	56
	05700 CT SCAN	1, 645, 608	1, 349, 943			2, 995, 551	
		1,062,341	1, 134, 258			2, 196, 599	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	3, 395, 687 7, 087, 214	2, 553, 423 12, 249, 340	5, 949, 110 19, 336, 554		6, 539, 982 19, 336, 554	
	06300 BLOOD STORING, PROCESSING & TRANS.	416, 082	2, 575, 563	2, 991, 645		2, 991, 645	
	06400 I NTRAVENOUS THERAPY	355, 987	150, 083	506, 070		506, 070	64
	06500 RESPI RATORY THERAPY	4, 435, 870	1, 787, 605	6, 223, 475		6, 223, 475	
	06600 PHYSI CAL THERAPY	6,042,259	1, 949, 376	7, 991, 635		7, 991, 635	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1,737,846	472, 562	2, 210, 408		2, 210, 408	
	06900 ELECTROCARDI OLOGY	1, 460, 963 3, 282, 978	342, 398 1, 426, 012	1, 803, 361 4, 708, 990		1, 803, 361 4, 708, 990	
	07000 ELECTROENCEPHALOGRAPHY	833, 967	523, 353	1, 357, 320		1, 357, 320	
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	31, 334, 746	31, 334, 746		31, 167, 298	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	39, 395, 945			39, 295, 816	
	07300 DRUGS CHARGED TO PATIENTS	4, 619, 201	19, 810, 500	24, 429, 701		24, 269, 511	
	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON	124, 254 832, 186	1, 973, 660 136, 702	2, 097, 914 968, 888		2, 097, 914 968, 888	
<i>, ,</i>	OUTPATIENT SERVICE COST CENTERS	002,100	130, 702	700, 000	0	,00,000	1 '`
	09000 CLI NI C	2, 782, 892	987, 363				
	09100 EMERGENCY	8, 391, 152	2, 934, 550	11, 325, 702	0	11, 325, 702	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	4, 523, 483	873, 164	5, 396, 647	0	5, 396, 647	1101
. 00	SPECIAL PURPOSE COST CENTERS	4, 023, 483	073, 104	5, 590, 647	0	3, 370, 047	101
3. 00		201, 475, 428	329, 696, 834	531, 172, 262	-377, 713	530, 794, 549	1118
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190
	19100 RESEARCH	232, 943	92, 814				
	19200 PHYSI CLANS' PRI VATE OFFI CES	73, 158	295, 956	369, 114		369, 114	
+. UU	07950 OTHER NONREIMBURSEABLE 07951 ADVERTI SI NG	0	765, 444 506, 267	765, 444 506, 267		765, 444 506, 267	
1 01							

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Period:	Worksheet A	
				rom 07/01/2021 o 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 20 am
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194. 03 07953 FI TNESS POI NTE	1,002,309	664, 134	1, 666, 443	0	1, 666, 443	194.03
194.04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	243, 209	109, 694	352, 903	0	352, 903	194.04
194.05 07955 EINSTEIN BAGELS	153, 542	244, 486	398, 028	8 0	398, 028	194.05
194.0607956 NONRTHWESTERN IMAGING	356, 122	500, 050	856, 172	0	856, 172	194.06
200.00 TOTAL (SUM OF LINES 118 through 199)	204, 152, 724	341, 683, 090	545, 835, 814	0	545, 835, 814	200.00

	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF		Provi der CCN:	From 07/	/01/2021 /30/2022	repared:
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			
G	ENERAL SERVICE COST CENTERS	6.00	7.00			_
	00100 CAP REL COSTS-BLDG & FIXT	-144, 940	14, 167, 623			1.00
	0200 CAP REL COSTS-MVBLE EQUIP	2, 309, 767				2.00
	0300 OTHER CAP REL COSTS	2,007,707	0			3.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 967, 191	29, 016, 887			4.00
	00505 PURCHASING & RECEIVING STORES	0	607, 226			5.0
	00506 ADMI TTI NG	19, 961				5.0
5.03 0	0507 CASHI ERI NG/ACCOUNTS RECEI VABLE	5, 936, 204	5, 935, 997			5.0
5.04 0	0508 OTHER ADMIN & GENERAL	-48, 751, 758	56, 208, 940			5.0
5.00 0	0600 MAINTENANCE & REPAIRS	0	0			6.0
7.00 0	00700 OPERATION OF PLANT	-90, 853	15, 471, 235			7.0
	00800 LAUNDRY & LINEN SERVICE	0	1, 659, 157			8.0
	00900 HOUSEKEEPI NG	0	6, 131, 221			9.0
	1000 DI ETARY	-5, 422				10.0
	01100 CAFETERI A	-1, 700, 600				11.0
	1200 MAINTENANCE OF PERSONNEL	0	0			12.0
	1300 NURSI NG ADMI NI STRATI ON	194, 476				13.0
	1400 CENTRAL SERVICES & SUPPLY	0				14.0
	1500 PHARMACY	0	0			15.0
	1600 MEDI CAL RECORDS & LI BRARY	4, 610, 917				16.0
	1700 SOCIAL SERVICE	0	1, 085, 828			17.0
1	1900 NONPHYSICIAN ANESTHETISTS	0	0			19.0
1	22100 I & SERVICES-SALARY & FRINGES APPRV	0	0			21.0
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(PHARMACY)	0				22.0
		-20, 673	000/0//			23.0
	2301 PARAMED ED PRGM-(LAB MLS) NPATIENT ROUTINE SERVICE COST CENTERS	-20, 073	232, 448			23.0
	3000 ADULTS & PEDIATRICS	-3, 361	48, 543, 992			30. 0
	03100 I NTENSI VE CARE UNI T	-1, 513, 925				31.0
	22060 NEONATAL INTENSIVE CARE	-340, 078				31.0
	04100 SUBPROVIDER - IRF	0				41.0
	04300 NURSERY	0				43.0
	NCILLARY SERVICE COST CENTERS					
50.00 0	05000 OPERATING ROOM	0	33, 911, 809			50.00
51.00 0	05100 RECOVERY ROOM	0	7, 674, 119			51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	3, 682, 490			52.0
	5300 ANESTHESI OLOGY	-14, 831, 695	1, 895, 947			53.0
	05400 RADI OLOGY-DI AGNOSTI C	-5, 727				54.0
	05500 RADI OLOGY-THERAPEUTI C	0				55.0
	05600 RADI OI SOTOPE	0	2/01//000			56.0
	5700 CT SCAN	-7, 735				57.0
		-5, 255				58.0
	05900 CARDI AC CATHETERI ZATI ON	-3, 433				59.0
	06000 LABORATORY	-180, 613				60.0
	06300 BLOOD STORING, PROCESSING & TRANS.	-271				63.0
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	506, 070 6, 223, 475			64.0 65.0
	6600 PHYSI CAL THERAPY	0	7, 991, 635			66.0
	6700 OCCUPATIONAL THERAPY	0	2, 210, 408			67.0
	6800 SPEECH PATHOLOGY	0	1, 803, 361			68.0
	6900 ELECTROCARDI OLOGY	0	4, 708, 990			69.0
	7000 ELECTROENCEPHALOGRAPHY	0	1, 357, 320			70.0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				71.0
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	39, 295, 816			72.0
	7300 DRUGS CHARGED TO PATIENTS	-1, 796, 550				73.0
	07400 RENAL DI ALYSI S	0				74.0
	07697 CARDI AC REHABI LI TATI ON	0				76.9
	UTPATIENT SERVICE COST CENTERS					
	99000 CLINIC	-333, 092	3, 437, 163			90.0
	09100 EMERGENCY	-16	11, 325, 686			91.0
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 0
	THER REIMBURSABLE COST CENTERS					
	0100 HOME HEALTH AGENCY	266, 911	5, 663, 558			101. 0
	PECIAL PURPOSE COST CENTERS	50 /00 575	477 010 075			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-53, 430, 570	477, 363, 979			118. 0
	ONRELIMBURSABLE COST CENTERS	~				100.0
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190.0
	9100 RESEARCH	0				191.0
	9200 PHYSI CLANS' PRI VATE OFFI CES	390				192.0
	07950 OTHER NONRELMBURSEABLE	0	765, 444			194.0
	7951 ADVERTI SI NG	0	506, 267			194.0
	7952 RETAIL PHARMACY	0	9, 423, 424			194.0
194.030	07953 FITNESS POINTE 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	1, 666, 443 352, 903			194. 0 194. 0

COMMUNI TY HOSPI TAL

In Lieu of Form CMS-2552-10

Health Financial Systems

Health Financial Systems	COMMUNI TY	HOSPI TAL	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-0125		Worksheet A
			From 07/01/2021 To 06/30/2022	Date/Time Prepared: 11/22/2022 9:20 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
194.05 07955 EINSTEIN BAGELS	0	398, 028		194.05
194.0607956 NONRTHWESTERN I MAGI NG	0	856, 172		194.06
200.00 TOTAL (SUM OF LINES 118 through 199)	-53, 430, 180	492, 405, 634		200.00

Heal th	Financial Systems		COMMUNI TY H	OSPI TAL		In Lieu	u of Form CMS-	2552-10
RECLASS	SEFECATIONS			Provider C	CN: 15-0125	Peri od:	Worksheet A-	<u>,</u>
						From 07/01/2021 To 06/30/2022	Date/Time Pro 11/22/2022 9	epared: 20 am
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - BUILDING INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	315, 640				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	2 <u>1, 9</u> 16				2.00
	0		0	337, 556				
	B - CAFETERIA EXPENSE							
1.00	CAFETERI A		1, 267, 790	<u>917, 3</u> 79				1.00
	0		1, 267, 790	917, 379				
	C - RECLASS NURSERY							
1.00	NURSERY	43.00	1, 545, 839	376, 974				1.00
	0		1, 545, 839	376, 974				
	D - RECLASS PRECEPTOR TIME							
1.00	PARAMED ED PRGM-(PHARMACY)	23.00	160, 190	0				1.00
	0		160, 190	ō				
	E - COVID COSTS							
1.00	ADULTS & PEDIATRICS	30.00	0	287, 345				1.00
	0			287, 345				
	F - INTEREST EXPENSE		· · · ·					1
1.00		0.00	0	0				1.00
	0			0				
	G - NEUROSCIENCE RESEARCH							]
1.00	RESEARCH	191.00	319, 111	58, 602				1.00
	0		319, 111	58,602				1
	H - INVENTORY ADJ EXPENSE							1
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	125, 134				1.00
	PATI ENT							
2.00	IMPL. DEV. CHARGED TO	72.00	o	198, 161				2.00
	PATI ENTS							
3.00	CARDIAC CATHETERIZATION	59.00	О	590, 872				3.00
	0			914, 167				
500.00	Grand Total: Increases		3, 292, 930	2, 892, 023				500.00

Heal th	Financial Systems		COMMUNITY H	OSPI TAL		In Lie	u of Form CMS-2552-
RECLAS	SI FI CATI ONS			Provider (	CCN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet A-6 Date/Time Prepared 11/22/2022 9:20 am
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	°.	
	6.00	7.00	8.00	9.00	10.00		
	A - BUILDING INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.04	0	337, 556	1	12	1. (
2.00		0, 00	0	C		12	2.0
			0	337, 556		1	
	B - CAFETERIA EXPENSE	I	-1		1		
1.00	DI ETARY	10.00	1, 267, 790	917, 379		0	1.0
			1, 267, 790	917, 379		1	
	C - RECLASS NURSERY		112011110	,,,,,,,,,	1		
1.00	ADULTS & PEDIATRICS	30.00	1, 545, 839	376, 974		0	1.0
1.00			1, 545, 839	376, 974			
	D - RECLASS PRECEPTOR TIME		1, 343, 037	370, 774			
1.00	DRUGS CHARGED TO PATIENTS	73.00	160, 190	0		0	1. (
1.00			160, 190	0	<u> </u>		1. (
	E - COVID COSTS		100, 190				
1.00	OTHER ADMIN & GENERAL	5.04	0	287, 345	1	0	1. (
1.00	General			287, 345		9	1.0
	F - INTEREST EXPENSE		U	287, 345			
1 00	F - INTEREST EXPENSE	0.00			1		
1.00		0.00	0	0		<u>u</u>	1. (
			0	0			
	G - NEUROSCI ENCE RESEARCH	10.00			1		
1.00	NURSING ADMINISTRATION		319, 111	<u>58, 602</u>		Q	1. (
	0		319, 111	58, 602			
	H - INVENTORY ADJ EXPENSE						
1.00	OPERATING ROOM	50.00	0	323, 295		0	1. (
2.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	292, 582		0	2.0
	PATI ENT						
3.00	IMPL. DEV. CHARGED TO	72.00	0	298, 290		0	3. (
	PATI ENTS						
	0		0	914, 167			
500 00	Grand Total: Decreases		3, 292, 930	2, 892, 023			500.0

Health Financial Systems	COMMUNI TY I			In Lie	eu of Form CMS-2	2552-1
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 07/01/2021 To 06/30/2022		pared:
			Acqui si ti on	S		
	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAP						
1.00 Land	13, 617, 879	98, 267		0 98, 267	1, 198	1.00
2.00 Land Improvements	1, 565, 718	0		0 0	0	2.00
3.00 Buildings and Fixtures	397, 273, 956	9, 733, 990		0 9, 733, 990	1, 712, 815	3.00
4.00 Building Improvements	0	0		0 0	0	4.00
5.00 Fixed Equipment	0	0		0 0	0	5.00
6.00 Movable Equipment	161, 321, 239	10, 879, 920		0 10, 879, 920	7, 572, 550	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
8.00 Subtotal (sum of lines 1-7)	573, 778, 792	20, 712, 177		0 20, 712, 177	9, 286, 563	8.00
9.00 Reconciling Items	0	0		0 0	0	9.00
10.00 Total (line 8 minus line 9)	573, 778, 792	20, 712, 177		0 20, 712, 177	9, 286, 563	10.00
	Endi ng Bal ance	Fully				
	_	Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAP						
1.00 Land	13, 714, 948	0				1.00
2.00 Land Improvements	1, 565, 718	0				2.00
3.00 Buildings and Fixtures	405, 295, 131	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	0	0				5.00
6.00 Movable Equipment	164, 628, 609	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	585, 204, 406	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	585, 204, 406	0				10.00

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0125	Peri od:	Worksheet A-7	
					From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	narod
					10 00/30/2022	11/22/2022 9:	20 am
			SU	IMMARY OF CAP	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		9.00	10.00	11.00	instructions) 12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				12.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT	13, 025, 138			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12, 077, 839			0 0	0	2.00
3.00	Total (sum of lines 1-2)	25, 102, 977			0 0	0	3.00
		SUMMARY O					
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00				
		14.00	15.00	nd 0			
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK CAP REL COSTS-BLDG & FIXT	SHEEL A, CULUM					1 00
1.00 2.00	CAP REL COSTS-BLDG & FIXT	0	13, 996, 923				1.00 2.00
2.00	Total (sum of lines 1-2)	0	13, 985, 222 27, 982, 145				2.00
3.00	Total (Sull OF THES T-2)	l U	21, 902, 140				3.00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet A-7 Part III Date/Time Prep 11/22/2022 9:2	pared: 20 am
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets for Ratio		Insurance	
		Leases	(col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1	1			
1.00 CAP REL COSTS-BLDG & FIXT	420, 575, 797				0	1.00
2.00 CAP REL COSTS-MVBLE EQUI P	164, 628, 609				0	2.00
3.00 Total (sum of lines 1-2)	585, 204, 406	TION OF OTHER (	000/201/10		0 F CAPITAL	3.00
	ALLUCA	TION OF OTHER (	JAPITAL	SUIWARY U	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			1		504.454	
1.00 CAP REL COSTS-BLDG & FIXT	0			0 13, 327, 329		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 14, 387, 606		2.00
3.00 Total (sum of lines 1-2)	0		I JMMARY OF CAPI	0 27, 714, 935	2, 432, 037	3.00
		50	JIVIIVIARY OF CAPT	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
		10.00	10.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
1.00 CAP REL COSTS-BLDG & FIXT	INTERS 0	315, 640		0 0	14, 167, 623	1.00
2.00 CAP REL COSTS-BEDG & FIXT	0			0 0		2.00
3.00 Total (sum of lines 1-2)	0			0 0	30, 484, 528	2.00
	0	1 337, 330	1	SI 0	50, 404, 520	5.00

JUST	Financial Systems MENTS TO EXPENSES		COMMUNI TY	Provider CCN: 15-0125 P	eriod:	u of Form CMS-2 Worksheet A-8	
					rom 07/01/2021 o 06/30/2022	Date/Time Pre	
				Expense Classification on		11/22/2022 9:	
				To/From Which the Amount is			
					-		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5. 00	
00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		C	CAP REL COSTS-BLDG & FIXT	1.00	0	1
00	Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		ſ		0.00	0	
	(chapter 2)						
00	Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4
00	Refunds and rebates of		C		0.00	0	5
00	expenses (chapter 8) Rental of provider space by		C		0.00	0	e
	suppliers (chapter 8)						
00	Telephone services (pay stations excluded) (chapter		(	<i>)</i>	0.00	0	
00	21) Television and radio service		(		0.00	0	8
00	(chapter 21)		C		0.00	0	
00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 17,042,782-		0.00	0	10
	adjustment	A-0-2	-17,042,702	-		0	
00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	1
00	Related organization	A-8-1	-31, 352, 222			0	1:
00	transactions (chapter 10) Laundry and linen service		C		0.00	0	1:
00	Cafeteria-employees and guests		C		0.00	0	14
00	Rental of quarters to employee and others		C		0.00	0	1!
00	Sale of medical and surgical		C		0.00	0	10
	supplies to other than patients						
00	Sale of drugs to other than patients		C	D	0.00	0	1
00	Sale of medical records and		C		0.00	0	18
00	abstracts Nursing and allied health		C		0.00	0	10
	education (tuition, fees,				0.00	0	
00	books, etc.) Vending machines		C		0.00	0	20
	Income from imposition of		C		0.00	0	2'
	interest, finance or penalty charges (chapter 21)						
00	Interest expense on Medicare		C	D	0.00	0	22
	overpayments and borrowings to repay Medicare overpayments						
. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPIRATORY THERAPY	65.00		23
	limitation (chapter 14)						
. 00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24
	limitation (chapter 14)						
. 00	Utilization review - physicians' compensation		Ĺ	*** Cost Center Deleted ***	114.00		25
00	(chapter 21)				1 00		
. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		(	CAP REL COSTS-BLDG & FIXT	1.00	0	26
00	Depreciation - CAP REL COSTS-MVBLE EQUIP		(	CAP REL COSTS-MVBLE EQUIP	2.00	0	27
	Non-physician Anesthetist		C	NONPHYSICIAN ANESTHETISTS	19.00		28
	Physicians' assistant Adjustment for occupational	A-8-3	( (	) OCCUPATI ONAL THERAPY	0.00 67.00	0	29 30
50	therapy costs in excess of		(	Second Come TheMALL	07.00		
99	limitation (chapter 14) Hospice (non-distinct) (see		ſ	ADULTS & PEDIATRICS	30.00		30
	instructions)						
00	Adjustment for speech pathology costs in excess of	A-8-3	(	SPEECH PATHOLOGY	68.00		31
	limitation (chapter 14)						
00	CAH HIT Adjustment for Depreciation and Interest		(		0.00	0	32

33.00 /	ENTS TO EXPENSES			Expense Classification on		Worksheet A-8 Date/Time Prep 11/22/2022 9:2	pared:
	Cost Center Description			Expense Classification on		11/22/2022 9:	pared:
	Cost Center Description						∠u am
	Cost Center Description			To/From Which the Amount is			
	Cost Center Description				-		
	Cost Center Description						
			Amount	Cost Center		Wkst. A-7 Ref.	
	ANESTHESIA - NON-SALARIES,	1.00 A	2.00 -847.183	3.00 ANESTHESI OLOGY	4.00 53.00	5.00	33.00
	NON-BENEF						
	COVID DRUG DONATIONS NON-PATIENT CARE COST	B A		DRUGS CHARGED TO PATIENTS OTHER ADMIN & GENERAL	73.00 5.04	0	33. 01 33. 02
	OTHER REVENUE DTHER REVENUE	B B		EMPLOYEE BENEFITS DEPARTMENT OTHER ADMIN & GENERAL	4.00 5.04	0	33. 03 33. 04
33.05	OTHER REVENUE	В	-55, 266	OPERATION OF PLANT	7.00	0	33.05
	OTHER REVENUE OTHER REVENUE	B B	5, 422- 1, 700, 600-	DI ETARY CAFETERI A	10. 00 11. 00	0	33. 06 33. 07
	OTHER REVENUE	В	-38, 508	NURSING ADMINISTRATION	13.00	0	33.08
	OTHER REVENUE OTHER REVENUE	B B		PARAMED ED PRGM-(LAB MLS) ADULTS & PEDIATRICS	23. 01 30. 00	0	33. 09 33. 10
	OTHER REVENUE	В		INTENSIVE CARE UNIT	31.00	0	33.11
	OTHER REVENUE OTHER REVENUE	B B		RADI OLOGY-DI AGNOSTI C CARDI AC CATHETERI ZATI ON	54.00 59.00	0	33. 12 33. 13
	OTHER REVENUE	B B		LABORATORY	60.00	0	33.14
	OTHER REVENUE OTHER REVENUE	B		DRUGS CHARGED TO PATIENTS EMERGENCY	73.00 91.00	0	33. 15 33. 16
	PARENT ASSET DEPRECIATION ADJUSTMENT	A	-2, 672	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 17
33. 18	TAXABLE LABS	A		LABORATORY	60.00	0	33. 18
33. 19	TAXABLE LABS	A	-271	BLOOD STORING, PROCESSING & TRANS.	63.00	0	33. 19
	PATIENT TELEPHONE SERVICE PATIENT TELEPHONE PURCHASES	A A		OTHER ADMIN & GENERAL OTHER ADMIN & GENERAL	5.04 5.04	0	33. 20 33. 21
	PATIENT TV DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 22
	PATIENT TV PURCHASES DTHER ADJUSTMENTS (SPECIFY)	A	- 35, 587	OPERATION OF PLANT	7.00 0.00	0	33. 23 33. 24
	(3) DTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3) DTHER ADJUSTMENTS (SPECIFY)		C		0.00	0	33. 26
	(3) DTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3) DTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3) DTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3) DTHER ADJUSTMENTS (SPECIFY)		0		0.00	_	
	(3) DTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3) DTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3) DTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3) DTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3)		0			0	
	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		
	OTHER ADJUSTMENTS (SPECIFY) (3)		U		0.00	0	
	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	
	OTHER ADJUSTMENTS (SPECIFY) (3)		C		0.00	0	
	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	
	OTHER ADJUSTMENTS (SPECIFY) (3)		C		0.00	0	33. 40
	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-53, 430, 180				50. 00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	COMMUNI TY	' HOSPI TAL	In Lie	eu of Form CMS-	2552-10
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 07/01/2021		
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	20 am
	Erne no.			Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.04	OTHER ADMIN & GENERAL	PHYSICIAN ALLOCATION PER GL	0	21, 178, 181	1.00
2.00	5.04	OTHER ADMIN & GENERAL	HOME OFFICE ALLOCATION PER G	6 0	60, 543, 644	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOC-BLDG	220, 758	0	3.00
3.01		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOC-EQUIP	2, 319, 455	0	3. 01
3.02		OTHER ADMIN & GENERAL	HOME OFFICE ALLOC-SALARIES	16, 884, 819	0	3. 02
3.03			HOME OFFICE ALLOC-BENEFITS	3, 635, 004	0	3.03
3.04		MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOC-MEDICAL RE		0	3.04
3.05	5.03	CASHI ERI NG/ACCOUNTS RECEI VAB	HOME OFFICE ALLOC-PATIENT AC		0	3.05
3.06		OTHER ADMIN & GENERAL	HOME OFFICE ALLOC-OTHER NON	17, 266, 922	0	3.06
3.07		OTHER ADMIN & GENERAL	CANCER CARE ALLOCATION PER G		1, 129, 789	3.07
3.08		OTHER ADMIN & GENERAL	CANCER CARE ALLOC-ADMIN	108, 361	0	3.08
3.09		NURSING ADMINISTRATION	CANCER CARE ALLOC-REGISTRY	232, 984	0	3.09
3.10		OTHER ADMIN & GENERAL	CANCER CARE ALLOC-NAVIGATORS	264, 834	0	3. 10
4.00		CAP REL COSTS-BLDG & FIXT	CDC LEASE EXPENSE PER GL	0	261, 720	4.00
4.01		CAP REL COSTS-BLDG & FIXT	CDC LEASE-DEPRECIATION	56, 994	0	4.01
4.02		RADI OLOGY-DI AGNOSTI C	CDC LEASE-OTHER EXPENSES	3, 370	0	4.02
4.03		PHYSICIANS' PRIVATE OFFICES	CDC LEASE-OTHER EXPENSES	390	0	4.03
4.04		CAP REL COSTS-BLDG & FIXT	800 MAC LEASE EXPENSE PER GL		88, 700	4.04
4.05		CAP REL COSTS-BLDG & FIXT	800 MAC LEASE-DEPRECIATION	27, 111	0	4.05
4.06		ADMI TTI NG	800 MAC LEASE-OTHER EXPENSES		0	4.06
4.07		OTHER ADMIN & GENERAL	800 MAC LEASE-OTHER EXPENSES		0	4.07
4.08		PARAMED ED PRGM-(LAB MLS)	800 MAC LEASE-OTHER EXPENSES		0	4.08
4.09		CLINIC	800 MAC LEASE-OTHER EXPENSES		0	4.09
4.10		CAP REL COSTS-BLDG & FIXT	901 RIDGE RD LEASE EXPENSE F		96, 711	4.10
4.11		HOME HEALTH AGENCY	901 RIDGE RD LEASE-OTHER EXF		0	4.11
5.00	TOTALS (sum of lines 1-4).			51, 946, 523	83, 298, 745	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		
	Combal (1)	News	Development and a f	News	Demonstration of	
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	В	0.00 CFNI 100.00	6.00
7.00		0.00 0.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

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

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

Health Financial Systems COMMUNITY HO	SPI TAL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0125	Peri od:	Worksheet A-8-1	
OFFICE COSTS		From 07/01/2021 To 06/30/2022	Date/Time Prepared:	

						11/22/2022 9: 20 am
		Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			ENTS REQUIRED AS A RESULT OF TRAI	NSACTIONS WITH RELATED O	RGANIZATIONS OR C	LAIMED
	HOME OFFICE CO					
1.00	-21, 178, 181					1.00
2.00	-60, 543, 644					2.00
3.00	220, 758					3.00
3.01	2, 319, 455					3. 01
3.02	16, 884, 819					3. 02
3.03	3, 635, 004					3. 03
3.04	4, 610, 917					3.04
3.05	5, 936, 204					3.05
3.06	17, 266, 922					3.06
3.07	-1, 129, 789	1 1				3. 07
3.08	108, 361					3.08
3.09	232, 984					3.09
3.10	264, 834					3.10
4.00	-261, 720					4.00
4.01	56, 994					4. 01
4.02	3, 370					4. 02
4.03	390	1 1				4. 03
4.04	-88, 700	1 1				4.04
4.05	27, 111					4.05
4.06	19, 961					4.06
4.07	48, 205					4.07
4.08	9, 327					4.08
4.09	33, 996					4.09
4.10	-96, 711					4. 10
4.11	266, 911					4. 11
5.00	-31, 352, 222					5.00

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

 been peeted te normaneet n	cordinate rando 2, the amount arrowable should be that dated the of anit 1 of this part.	
Related Organization(s)		
and/or Home Office		
Type of Business		
51		
6, 00		
 B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HEALTHCARE	6.1	. 00
7.00		7.1	. 00
8.00		8.1	. 00
9.00		9.1	. 00
10.00		10.1	. 00
100.00		100. /	. 00

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

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

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

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.

Heal th	Financial Syste	ems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period: From 07/01/2021	Worksheet A-8	3-2
						To 06/30/2022		epared:
			<b>T</b> 1 1				11/22/2022 9:	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component	
		rdentifier	Reliation	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	31.00	I NTENSI VE CARE UNI T	1, 430, 056	1, 430, 056	(		0	1.00
2.00		NEONATAL INTENSIVE CARE	292, 906					
3.00		ANESTHESI OLOGY	13, 210, 069		(			
4.00			346, 759		(		-	
5.00 6.00		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	83, 837 17, 172			°	0	
7.00		ANESTHESI OLOGY	774, 443				0	
8.00		CLINIC	20, 329		(	-	-	
9.00		EMPLOYEE BENEFITS DEPARTMENT	667, 021		(		0	
10.00	5. 04	OTHER ADMIN & GENERAL	150, 000	150, 000	(	0	0	10.00
11.00		NEONATAL INTENSIVE CARE	30, 000		(	0	0	
12.00		RADI OLOGY-DI AGNOSTI C	7, 200			0	0	12.00
13.00		CT SCAN	7, 735		(	-	-	
14. 00 200. 00	58.00	мкі	5, 255 17, 042, 782			-	0	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	WRSt. A EINC #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
1 00	1.00	2.00	8.00	9.00	12.00	13.00	14.00	1.00
1.00 2.00		I NTENSI VE CARE UNI T NEONATAL I NTENSI VE CARE	0	, s				
2.00		ANESTHESI OLOGY			(			
4.00		CLINIC		0	(			
5.00		INTENSIVE CARE UNIT	0	0	(			
6.00	31.01	NEONATAL INTENSIVE CARE	0	0	(	0	0	6.00
7.00		ANESTHESI OLOGY	0	0	(	0 0	0	7.00
8.00		CLINIC	0	0	(	0	0	
9.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	(	-		
10. 00 11. 00		OTHER ADMIN & GENERAL NEONATAL INTENSIVE CARE		0		°  °	0	
12.00		RADI OLOGY-DI AGNOSTI C		0				
12.00		CT SCAN		0	(	-	0	
14.00	58.00		0	0	(			
200.00			0	0	(			
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16.00	17.00	18.00		
1.00	31.00	I NTENSI VE CARE UNI T	0					1.00
2.00	31.01	NEONATAL INTENSIVE CARE	0	0				2.00
3.00		ANESTHESI OLOGY	0	-				3.00
4.00		CLINIC	0					4.00
5.00		INTENSIVE CARE UNIT	0					5.00
6.00		NEONATAL INTENSIVE CARE	0		(			6.00
7.00 8.00		ANESTHESI OLOGY CLI NI C	0					7.00 8.00
8.00 9.00		EMPLOYEE BENEFITS DEPARTMENT						9.00
10.00		OTHER ADMIN & GENERAL	0	-				10.00
11.00		NEONATAL INTENSIVE CARE	0	-	(			11.00
12.00		RADI OLOGY-DI AGNOSTI C	0	0	0			12.00
13.00		CT SCAN	0					13.00
14.00	58.00	MRI	0					14.00
200.00	l		0	0	(	17, 042, 782		200.00

					rom 07/01/2021 o 06/30/2022	Part I Date/Time Pre 11/22/2022 9:2	pared:
			CAPI TAL REL	ATED COSTS		1172272022 7.	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	PURCHASI NG & RECEI VI NG STORES	
		<u>col. 7)</u> 0	1.00	2.00	4.00	5. 01	
	GENERAL SERVICE COST CENTERS			2100		0101	
	00100 CAP REL COSTS-BLDG & FIXT	14, 167, 623	14, 167, 623				1.00
00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	16, 316, 905	20.072	16, 316, 905			2.00
00 01	00505 PURCHASING & RECEIVING STORES	29, 016, 887 607, 226	30, 073 125, 734	14, 971 388		840, 957	4. 00 5. 01
02	00506 ADMI TTI NG	4,821,034	118, 825	12, 794		775	5.02
03	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE	5, 935, 997	162, 278	C	0	0	5.03
04	00508 OTHER ADMIN & GENERAL	56, 208, 940	843, 959	631, 468	1, 904, 424	13, 072	
	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT	0 15, 471, 235	0 2, 151, 620	385, 060	572, 215	0 194	6.00 7.00
	00800 LAUNDRY & LINEN SERVICE	1, 659, 157	2, 131, 020	505, 000 C	21, 167	0	8.00
	00900 HOUSEKEEPI NG	6, 131, 221	60, 070	37, 712		2, 711	9.00
	01000 DI ETARY	4, 789, 451	172, 620	85, 649		6, 972	
		484, 569	179, 333	36, 707	181, 354	3, 002	11.00
	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0 8, 528, 097	0 67, 101	0 445, 405	0 967, 387	0 10, 748	12.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	0, 520, 077	07,101	443, 403	01, 307	10, 740	14.00
	01500 PHARMACY	0	0	C	0	0	15.00
	01600 MEDI CAL RECORDS & LI BRARY	4, 610, 917	21, 077	289		0	16.00
	01700 SOCIAL SERVICE	1,085,828	15, 513	C	140, 463	0	17.00
	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	19.00 21.00
	02200 I & SERVICES-SALART & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	21.00
	02300 PARAMED ED PRGM-(PHARMACY)	356, 677	3, 447	C	-	0	23.0
	02301 PARAMED ED PRGM-(LAB MLS)	232, 448	15, 452	2, 293	28, 094	290	23.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	48, 543, 992	2, 763, 796	525, 971		89, 470	
	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE	15, 827, 671 3, 959, 191	548, 009 167, 993	686, 312 113, 245		36, 408 9, 102	
	04100 SUBPROVIDER - IRF	1, 606, 789	103, 418	113, 243	148, 281	1, 549	
	04300 NURSERY	1, 922, 813	29, 438	33, 055		3, 583	
	ANCI LLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM 05100 RECOVERY ROOM	33, 911, 809	1, 194, 748	3, 379, 212		176, 228	50.00
	05200 DELIVERY ROOM & LABOR ROOM	7, 674, 119 3, 682, 490	589, 028 234, 036	162, 277 35, 241		11, 135 3, 776	
	05300 ANESTHESI OLOGY	1, 895, 947	18, 310	193, 587		20, 528	
	05400 RADI OLOGY-DI AGNOSTI C	7, 248, 722	307, 471	1, 306, 706		14, 331	54.0
	05500 RADI OLOGY-THERAPEUTI C	3, 224, 791	216, 558	1, 598, 790		1, 065	
	05600 RADI OI SOTOPE	2, 347, 866	60, 841	410, 542 780, 933		775	
	05700 CT SCAN 05800 MRI	2, 987, 816 2, 191, 344	88, 903 60, 826	458, 425		10, 167 3, 292	
	05900 CARDI AC CATHETERI ZATI ON	6, 536, 549	171, 668	1, 962, 110		48, 027	59.00
	06000 LABORATORY	19, 155, 941	395, 528	771, 680	1, 013, 805	252, 429	60.0
	06300 BLOOD STORING, PROCESSING & TRANS.	2,991,374	24, 569	20, 326		6, 875	63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	506, 070 6, 223, 475	62, 580 64, 606	47, 360 480, 114		2, 518 12, 685	64. 0 65. 0
	06600 PHYSI CAL THERAPY	7, 991, 635	448, 537	114, 456		8, 134	
	06700 OCCUPATI ONAL THERAPY	2, 210, 408	46, 130	18, 578		1, 162	
	06800 SPEECH PATHOLOGY	1, 803, 361	26, 051	41, 613		968	68.0
	06900 ELECTROCARDI OLOGY	4, 708, 990	243, 909	528, 171		11, 813	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 357, 320 31, 167, 298	40, 657	53, 812		5, 132	70.00
	07200 IMPL. DEV. CHARGED TO PATIENT	39, 295, 816	0	C		0	71.00
	07300 DRUGS CHARGED TO PATIENTS	22, 472, 961	79, 075	243, 306	637, 848	5, 907	73.00
	07400 RENAL DI ALYSI S	2, 097, 914	20, 033	C	17, 774	581	74.00
	07697 CARDIAC REHABILITATION	968, 888	68, 280	35, 016	119, 042	290	76.9
	OUTPATI ENT SERVI CE COST CENTERS	3, 437, 163	122, 983	4, 322	398, 084	9, 392	90.00
	09100 EMERGENCY	11, 325, 686	377, 566	215, 321		51, 997	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	11/020/000	0777000	2107021	1,200,02,	017777	92.00
ļ	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	5, 663, 558	0	C	647, 071	97	101.00
	SUPTOTALS (SUM OF LINES 1 through 117)	177 242 070	10 E44 004	15 070 017	20 422 204	007 100	110 00
8.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	477, 363, 979	12, 566, 326	15, 873, 217	28, 633, 304	837, 180	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 264	C	0	0	190. 00
	19100 RESEARCH	703, 470	4, 989	C			191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES						192.00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/22/2022 9:	pared: 20 am	
		CAPI TAL REL	ATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	PURCHASI NG & RECEI VI NG STORES		
	0	1.00	2.00	4.00	5.01		
194. 01 07951 ADVERTI SI NG	506, 267	0		0 0	0	194.01	
194. 02 07952 RETAIL PHARMACY	9, 423, 424	25, 129	54	1 88, 119	484	194.02	
194. 03 07953 FI TNESS POI NTE	1, 666, 443	699, 356	108, 71	5 143, 377	0	194.03	
194.04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	352, 903	22, 407	6, 69	6 34, 790	2, 324	194.04	
194.0507955EINSTEIN BAGELS	398, 028	9, 147	5, 75	2 21, 964	678	194.05	
194.0607956NONRTHWESTERN IMAGING	856, 172	40, 037	215, 21	0 50, 942	194	194.06	
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00   TOTAL (sum lines 118 through 201)	492, 405, 634	14, 167, 623	16, 316, 90	5 29, 061, 931	840, 957	202.00	

	Financial Systems	COMMUNI TY				u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 07/01/2021	Worksheet B Part I Data/Time Dro	narodi
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	0 06/30/2022 OTHER ADMIN &	Date/Time Pre 11/22/2022 9:	
	Cost center bescription	ADMITTING	OUNTS RECEI VABLE	Subtotal	GENERAL	REPAI RS	
		5.02	5.03	5A. 03	5. 04	6.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00505 PURCHASING & RECEIVING STORES						5. 01
5.02	00506 ADMI TTI NG	5, 562, 043					5.02
5.03 5.04	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	6, 098, 275 0	E0 401 942	E0 401 942		5.03 5.04
5.04 6.00	00508 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS	0	0	59, 601, 863 0	59, 601, 863 0	0	5.04 6.00
7.00	00700 OPERATI ON OF PLANT	0	0	18, 580, 324	2, 558, 715	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	1, 704, 001	234, 660	0	
9.00	00900 HOUSEKEEPI NG	0	0	6, 836, 288	941, 432	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	0	5, 452, 632 884, 965	750, 887 121, 869	0	10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	004, 903	121,007	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0	10, 018, 738	1, 379, 690	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	0 4, 632, 283	0 637, 916	0	15.00 16.00
17.00	01700 SOCIAL SERVICE	0	0	4, 032, 283	171, 010	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23. 00 23. 01	02300 PARAMED ED PRGM-(PHARMACY) 02301 PARAMED ED PRGM-(LAB MLS)	0	0	407, 913 278, 577	56, 174 38, 363	0	23.00 23.01
20101	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		<u> </u>	2707077	00,000		20101
30.00	03000 ADULTS & PEDI ATRI CS	451, 395	494, 931	58, 669, 567	8, 079, 471	0	
31.00	03100 I NTENSI VE CARE UNI T	91,098	99, 884	19, 328, 880	2, 661, 799	0	31.00
31.01 41.00	02060 NEONATAL INTENSIVE CARE 04100 SUBPROVIDER - IRF	55, 793 8, 288	61, 174 9, 087	4, 864, 065 1, 877, 412	669, 835 258, 540	0	31.01 41.00
43.00	04300 NURSERY	15, 428	16, 916	2, 242, 361	308, 798	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	815, 911	894, 398	42, 829, 010	5, 898, 026	0	50.00
51.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	90, 893 25, 982	99, 660 28, 488	9, 538, 883 4, 445, 040	1, 313, 609 612, 131	0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	136, 017	149, 136	4, 416, 489	608, 199	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	233, 721	256, 263	10, 016, 805	1, 379, 424	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	126, 809	139, 039	5, 509, 288	758, 690	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	94, 191 339, 699	103, 275 372, 461	3, 141, 521 4, 815, 378	432, 622 663, 131	0	56.00 57.00
58.00	05800 MRI	169, 633	185, 993	3, 221, 478	443, 633	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	417, 254	457, 497	10, 078, 848	1, 387, 968	0	59.00
	06000 LABORATORY	635, 907	697, 238	22, 922, 528	3, 156, 684	0	•
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	31, 720 12, 014	34, 779 13, 172	3, 169, 162 694, 637	436, 428 95, 659	0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY	62, 406	68, 425	7, 546, 249	1, 039, 201	0	65.00
66.00	06600 PHYSI CAL THERAPY	89, 191	97, 793	9, 614, 073	1, 323, 964	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	31, 884	34, 959	2, 591, 715	356, 908	0	67.00
68.00	06800 SPEECH PATHOLOGY	15, 831	17, 358	2, 114, 168	291, 144	0	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	225, 097 50, 474	246, 806 55, 342	6, 434, 406 1, 682, 033	886, 088 231, 634	0	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	172, 360	188, 983	31, 528, 641	4, 341, 841	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	238, 070	261, 031	39, 794, 917	5, 480, 198	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	387,687	425, 078	24, 251, 862	3, 339, 748	0	73.00
74.00 76.97	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	24, 634 10, 611	27, 009 11, 634	2, 187, 945 1, 213, 761	301, 304 167, 148	0	74.00 76.97
70.77	OUTPATIENT SERVICE COST CENTERS	10,011		1,210,701	107,110		/0. //
90.00	09000 CLI NI C	39, 052	42, 819	4, 053, 815	558, 255	0	
91.00	09100 EMERGENCY	438, 894	481, 224	14, 091, 017	1, 940, 488	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			0			92.00
101.00	10100 HOME HEALTH AGENCY	24, 099	26, 423	6, 361, 248	876, 014	0	101.00
118.00		5, 562, 043	6, 098, 275	474, 886, 590	57, 189, 298	0	118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		18, 264	2, 515	<u>^</u>	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0	787, 526	2, 515 108, 451		190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	1, 055, 148	145, 305	0	192.00
	07950 OTHER NONREI MBURSEABLE	0	0	979, 007	134, 820		194.00
	07951 ADVERTI SI NG 07952 RETAI L PHARMACY	0	0	506, 267 9, 537, 697	69, 719 1, 313, 446		194. 01 194. 02
	07952 RETAIL PHARMACT	0	0	2, 617, 891	360, 512		194.02 194.03
	07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	419, 120			194.04

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS				eriod: rom 07/01/2021	Worksheet B Part I	
		_		06/30/2022		
Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER ADMIN &	MAINTENANCE &	
		OUNTS		GENERAL	REPAI RS	
		RECEI VABLE				
	5.02	5.03	5A. 03	5.04	6.00	
194.0507955 EINSTEIN BAGELS	0	0	435, 569	59, 983	C	194.05
194.0607956 NONRTHWESTERN IMAGING	0	0	1, 162, 555	160, 097	C	194.06
200.00 Cross Foot Adjustments			C			200.00
201.00 Negative Cost Centers	0	0	C	0	C	201.00
202.00 TOTAL (sum lines 118 through 201)	5, 562, 043	6, 098, 275	492, 405, 634	59, 601, 863	C	202.00

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNI TY	Provi der CC		eriod: rom 07/01/2021	u of Form CMS-: Worksheet B Part I	
				To		Date/Time Pre 11/22/2022 9:	pared: 20 am
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	T
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00505 PURCHASING & RECEIVING STORES						5.0
5.02	00506 ADMI TTI NG						5.02
5.03	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.0
5.04 6.00	00508 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS						5.0
7.00	00700 OPERATION OF PLANT	21, 139, 039					7.0
8.00	00800 LAUNDRY & LINEN SERVICE	46, 624	1, 985, 285				8.0
9.00	00900 HOUSEKEEPI NG	118, 287	0	7, 896, 007			9.0
10.00	01000 DI ETARY	339, 914	0	127, 965	6, 671, 398		10.0
11.00 12.00		353, 133	0	132, 942	0	1, 492, 909 0	
12.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	132, 131	0	49, 743	0	61, 267	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	01,207	1
15.00	01500 PHARMACY	0	0	0	0	0	15.0
16.00	01600 MEDI CAL RECORDS & LI BRARY	41, 503	0	15, 624	0	0	
17.00	01700 SOCIAL SERVICE	30, 547	0	11, 500	0	11, 633	
19.00 21.00	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	1
23.00	02300 PARAMED ED PRGM-(PHARMACY)	6, 788	0	2, 555	0	3, 878	
23. 01	02301 PARAMED ED PRGM-(LAB MLS)	30, 428	0	11, 455	0	1, 551	23.0
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	E 440 01E	1 525 700	2 040 025	F 222 (/0	277 (00	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 442, 315 1, 079, 109	1, 535, 789 255, 188	2, 048, 835 406, 246	5, 223, 668 453, 595	377, 689 107, 800	
31.00	02060 NEONATAL INTENSIVE CARE	330, 804	79, 461	124, 536	433, 373	27, 919	
41.00	04100 SUBPROVI DER - I RF	203, 645	49, 737	76, 665	136, 663	12, 409	
43.00	04300 NURSERY	57, 967	65, 110	21, 823	0	13, 184	43.00
	ANCI LLARY SERVI CE COST CENTERS	2 252 (22	0	005 (00	0	170 1/0	
50.00 51.00	05100 RECOVERY ROOM	2, 352, 633 1, 159, 882	0	885, 682 436, 654	326, 274	172, 169 62, 043	
52.00	05200 DELIVERY ROOM & LABOR ROOM	460, 850	0	173, 494	128, 377	25, 593	
53.00	05300 ANESTHESI OLOGY	36, 055	0	13, 573	0	38, 001	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	605, 456	0	227, 932	0	51, 185	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	426, 433 119, 805	0	160, 537	0	11,633	
57.00	05700 CT SCAN	175, 063	0	45, 102 65, 905	0	7, 755 17, 837	
58.00	05800 MRI	119, 775	0	45, 091	0	10, 082	
59.00	05900 CARDI AC CATHETERI ZATI ON	338, 038	0	127, 259	0	28, 695	
60.00	06000 LABORATORY	778, 852	0	293, 210	0	89, 962	
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	48, 381 123, 229	0	18, 214 46, 391	0	3, 878 3, 102	
65.00	06500 RESPIRATORY THERAPY	123, 229	0	40, 391	0	36, 450	
66.00	06600 PHYSI CAL THERAPY	883, 235	0	332, 506	0	62, 043	
67.00	06700 OCCUPATI ONAL THERAPY	90, 836	0	34, 197	0	16, 286	67.0
68.00	06800 SPEECH PATHOLOGY	51, 298	0	19, 312	0	13, 184	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	480, 292 80, 059	0	180, 813 30, 139	0	37, 226 10, 082	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	00,039	0	30, 137	0	10, 002	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	155, 711	0	58, 620	0	39, 552	
	07400 RENAL DI ALYSI S	39, 449	0	14, 851	0	1, 551	
/6.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	134, 453	0	50, 617	0	8, 531	76.9
90.00	09000 CLINIC	242, 171	0	91, 169	0	29, 470	90.00
	09100 EMERGENCY	743, 482	0	279, 894	402, 821	84, 534	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	-	-				
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
118.00		17, 985, 851	1, 985, 285	6, 708, 944	6, 671, 398	1, 478, 174	118.00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	35, 965	0	13, 540	0		190. 0
	19100 RESEARCH	9,825	0	3, 699 500 510	0		191.0
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSEABLE	1, 329, 526 210, 284	0	500, 519 79, 164	0		192. 0 194. 0
		210,264	0	79, 104	U		
194.00		0	0	0	ol	0	194.0
194. 00 194. 01	07951 ADVERTI SI NG 07952 RETAI L PHARMACY	0 49, 482	0	0 18, 628	0 0		
194.00 194.01 194.02 194.03	07951 ADVERTI SI NG	0 49, 482 1, 377, 133 44, 123	0 0 0 0	0 18, 628 518, 441 16, 611	0 0 0 0	6, 204 0	194.0 194.0 194.0 194.0

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0125		Peri od:	Worksheet B		
				From 07/01/2021	Part I		
				To 06/30/2022			
				1	11/22/2022 9:	<u>20 am</u>	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A		
	PLANT	LINEN SERVICE					
	7.00	8.00	9.00	10.00	11.00		
194.0607956 NONRTHWESTERN IMAGING	78, 838	0	29, 68	30 0	0	194.06	
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	21, 139, 039	1, 985, 285	7, 896, 00	6, 671, 398	1, 492, 909	202.00	

Health Fina	ncial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	ATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2021	Worksheet B Part I	
					To 06/30/2022		pared: 20 am
	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		12.00	13.00	14.00	15.00	16.00	
	RAL SERVICE COST CENTERS		1				1.00
	O CAP REL COSTS-BEDG & FIXT						2.00
	O EMPLOYEE BENEFITS DEPARTMENT						4.00
	5 PURCHASING & RECEIVING STORES						5.01
	6 ADMI TTI NG 7 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02 5.03
	8 OTHER ADMIN & GENERAL						5.04
	O MAINTENANCE & REPAIRS						6.00
1	O OPERATION OF PLANT O LAUNDRY & LINEN SERVICE						7.00
	O HOUSEKEEPI NG						9.00
	O DI ETARY						10.00
	O CAFETERIA O MAINTENANCE OF PERSONNEL	0					11.00
	O NURSI NG ADMI NI STRATI ON	0	11, 641, 569				13.00
	O CENTRAL SERVICES & SUPPLY	0	0		0		14.00
	O PHARMACY O MEDI CAL RECORDS & LI BRARY				0 0	5, 327, 326	15.00
	0 SOCIAL SERVICE		o o		0 0	0, 327, 320	1
	0 NONPHYSICIAN ANESTHETISTS	C	0 0		0 0	0	
	0 I & R SERVICES-SALARY & FRINGES APPRV 0 I & R SERVICES-OTHER PRGM COSTS APPRV				0 0 0 0	0	
	O PARAMED ED PRGM-(PHARMACY)				0 0	0	
23.01 0230	1 PARAMED ED PRGM-(LAB MLS)	C	0		0 0	0	23.01
	TI ENT ROUTI NE SERVI CE COST CENTERS		4 922 914		0 0	422.250	1 20 00
	OINTENSIVE CARE UNIT		.,		0 0	432, 359 87, 256	
	O NEONATAL INTENSIVE CARE	C			0 0	53, 440	
	O SUBPROVIDER - IRF	0			0 0	7, 938	
	O NURSERY LLARY SERVICE COST CENTERS	C	164, 826		0 0	14, 777	43.00
50.00 0500	O OPERATING ROOM	C	2, 199, 605		0 0	781, 347	50.00
	O RECOVERY ROOM	0			0 0	87,060	
	0 DELIVERY ROOM & LABOR ROOM 0 ANESTHESIOLOGY		323, 334		0 0	24, 886 130, 281	
	0 RADI OLOGY-DI AGNOSTI C	C	0		0 0	223, 865	
	O RADI OLOGY-THERAPEUTI C	0	0		0 0	121, 461	
	0 RADI OI SOTOPE 0 CT SCAN				0 0	90, 219 325, 373	
	0 MRI	0	0		0 0	162, 479	1
59.00 0590	O CARDI AC CATHETERI ZATI ON	0	0		0 0	399, 658	
	0 LABORATORY 0 BLOOD STORING, PROCESSING & TRANS.					609, 090 30, 382	1
	O I NTRAVENOUS THERAPY	0	o o		0 0	11, 507	
	O RESPIRATORY THERAPY	0	0		0 0	59, 774	
	O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY				0 0	85, 430 30, 540	
	0 SPEECH PATHOLOGY				0 0	15, 164	
	0 ELECTROCARDI OLOGY	C	0 0		0 0	215, 604	69.00
	0 ELECTROENCEPHALOGRAPHY 0 MEDICAL SUPPLIES CHARGED TO PATIENT		0		0 0	48, 345 165, 091	
	O IMPL. DEV. CHARGED TO PATIENTS				0 0	228, 030	
73.00 0730	O DRUGS CHARGED TO PATIENTS	C	0		0 0	371, 338	
	O RENAL DI ALYSI S	0	0		0 0	23, 595	
	7 CARDIAC REHABILITATION ATIENT SERVICE COST CENTERS	<u> </u>	)0		0 0	10, 163	76.97
90.00 0900	O CLINIC	C	380, 219		0 0	37, 405	90.00
	O EMERGENCY	C	1, 076, 034		0 0	420, 386	
	O OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS						92.00
	O HOME HEALTH AGENCY	C	0		0 0	23, 083	101.00
SPEC	I AL PURPOSE COST CENTERS	1					
118.00	SUBTOTALS (SUM OF LINES 1 through 117) EIMBURSABLE COST CENTERS	C	11, 641, 569		0 0	5, 327, 326	1118.00
	OGIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0	0	190.00
191.001910	0 RESEARCH	0			0 0	0	191.00
	O PHYSI CI ANS' PRI VATE OFFI CES		0		0 0		192.00
	0 OTHER NONREI MBURSEABLE 1 ADVERTI SI NG						194.00 194.01
194.020795	2 RETAIL PHARMACY	c	0		0 0	0	194.02
	3 FI TNESS POI NTE	0	0		0 0		194.03
194.04 0795	4 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	ין 0		uj 0	0	194.04

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0125	Period: Worksheet B			
				From 07/01/2021	Part I		
				To 06/30/2022	Date/Time Pre		
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON			RECORDS &		
			SUPPLY		LI BRARY		
	12.00	13.00	14.00	15.00	16.00		
194.0507955 EINSTEIN BAGELS	0	0		0 0	0	194.05	
194.0607956 NONRTHWESTERN IMAGING	0	0		0 0	0	194.06	
200.00 Cross Foot Adjustments						200. 00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	11, 641, 569		0 0	5, 327, 326	202.00	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNI TY	HOSPI TAL Provi der C	1	In Lie Period: From 07/01/2021 Fo 06/30/2022	Worksheet B Part I Date/Time Pre 11/22/2022 9:	pared:
				I NTERNS 8	RESI DENTS		
	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	Y & FRINGES		PARAMED ED PRGM-(PHARMACY	
		17.00	19.00	APPRV 21.00	APPRV 22.00	23.00	
1 00	GENERAL SERVICE COST CENTERS				1		1.00
12.00 13.00 14.00 15.00 16.00 17.00	00100 CAP REL COSTS-BLOG & FIAT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00505 PURCHASING & RECEIVING STORES 00506 ADMITTING 00507 CASHIERING/ACCOUNTS RECEIVABLE 00508 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	1, 466, 494	C				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ \end{array}$
21. 00 22. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0			0	477 209	21.00 22.00
	02300 PARAMED ED PRGM-(PHARMACY) 02301 PARAMED ED PRGM-(LAB MLS)	0				477, 308	23.00 23.01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 134, 459	C		0 0	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	188, 503	C		o o	0	31.00
	02060 NEONATAL INTENSIVE CARE 04100 SUBPROVIDER - IRF	58, 696 36, 740	0		0 0		31.01 41.00
43.00	04300 NURSERY	48, 096	0				43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	C		0 0	0	50.00
	05100 RECOVERY ROOM	0	0				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	53.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C			0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56.00
	05700 CT SCAN 05800 MRI	0	0				57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	60.00 63.00
	06400 I NTRAVENOUS THERAPY	0	C			0	64.00
	06500 RESPIRATORY THERAPY	0	0			0	65.00 66.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0				0	67.00
	06800 SPEECH PATHOLOGY	0	C		o o	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0			0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0				477, 308	73.00 74.00
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0		76.97
90.00	OUTPATIENT SERVICE COST CENTERS	0	C		0 0	0	90.00
	09100 EMERGENCY	0	0			0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	C		0 10	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS						101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 466, 494	C	(	0 0	477, 308	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0					191.00 192.00
194.00	07950 OTHER NONREI MBURSEABLE	0	C			0	194.00
	07951 ADVERTI SI NG	0	0				194.01
194.02	07952 RETAIL PHARMACY	0	0	y (	0 lu	0	194. 02

Health Financial Systems	COMMUNI TY HOSPI TAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				From 07/01/2021 To 06/30/2022	Part     Date/Time Pre	narod
				10 00/30/2022	11/22/2022 9:	20 am
			I NTERNS	& RESI DENTS		
			0501/1 050 041 4			
Cost Center Description	SOCIAL SERVICE	ANESTHETI STS	Y & FRINGES	RSERVICES-OTHER PRGM COSTS		
		ANESTHETISIS	APPRV	APPRV	PRGM-(PHARMACY	
	17.00	19.00	21.00	22,00	23.00	
194. 03 07953 FI TNESS POI NTE	0	0		0 0		194.03
194. 04 07954 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY	0	0		0 0	0	194.04
194.0507955EINSTEIN BAGELS	0	0		0 0	0	194.05
194.0607956NONRTHWESTERN IMAGING	0	0		0 0		194.06
200.00 Cross Foot Adjustments	_	0		0 0	-	200.00
201.00 Negative Cost Centers	0	0		0 0	-	201.00
202.00  TOTAL (sum lines 118 through 201)	1, 466, 494	0		0 0	477, 308	202.00

ST ALL	LOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 07/01/2021	Worksheet B Part I
				T		Date/Time Prepar 11/22/2022 9:20
	Cost Center Description	PARAMED ED PRGM-(LAB MLS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.01	24.00	25.00	26.00	
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT					· · ·
00     00       00     00       01     00       02     00       03     00       04     00       00     00	0200 CAP REL COSTS-MVBLE EQUI P 0400 EMPLOYEE BENEFI TS DEPARTMENT 0505 PURCHASI NG & RECEI VI NG STORES 0506 ADMI TTI NG 0507 CASHI ERI NG/ACCOUNTS RECEI VABLE 0508 OTHER ADMI N & GENERAL 0600 MAI NTENANCE & REPAI RS 0700 OPERATI ON OF PLANT					
0 0	0800 LAUNDRY & LI NEN SERVI CE 0900 HOUSEKEEPI NG 1000 DI ETARY					10
	1100 CAFETERIA					1
	1200 MAI NTENANCE OF PERSONNEL 1300 NURSI NG ADMI NI STRATI ON					12
	1400 CENTRAL SERVICES & SUPPLY					1
	1500 PHARMACY					1!
1	1600 MEDI CAL RECORDS & LI BRARY 1700 SOCI AL SERVI CE					
	1900 NONPHYSI CI AN ANESTHETI STS					1
	2100 I & R SERVICES-SALARY & FRINGES APPRV 2200 I & R SERVICES-OTHER PRGM COSTS APPRV					2
	2300 PARAMED ED PRGM-(PHARMACY)					22
01 0	2301 PARAMED ED PRGM-(LAB MLS)	360, 374				23
	NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS	0	87, 766, 966	5 O	87, 766, 966	30
	3100 I NTENSI VE CARE UNI T	0	25, 942, 965			3
	2060 NEONATAL INTENSIVE CARE	0	6, 562, 283	1		3
	4100 SUBPROVI DER – I RF 4300 NURSERY	0	2, 813, 156 2, 936, 942			4
IA	NCILLARY SERVICE COST CENTERS			1		
	5000 OPERATING ROOM 5100 RECOVERY ROOM	0	55, 118, 472 13, 717, 619			50
	5200 DELIVERY ROOM & LABOR ROOM	0	6, 193, 705	1		5
00 0	5300 ANESTHESI OLOGY	0	5, 242, 598	3 0	5, 242, 598	5
	5400 RADI OLOGY-DI AGNOSTI C 5500 RADI OLOGY-THERAPEUTI C	0	12, 504, 667			54
	5600 RADI OLOGI - THERAPEUTI C	0	6, 988, 042 3, 837, 024		6, 988, 042 3, 837, 024	5
00 0	5700 CT SCAN	0	6,062,687	0	6, 062, 687	5
		0	4,002,538			50
	5900 CARDI AC CATHETERI ZATI ON 6000 LABORATORY	0 360, 374	12, 360, 466 28, 210, 700			51
00 00	6300 BLOOD STORING, PROCESSING & TRANS.	0	3, 706, 445	5 0	3, 706, 445	6
	6400 I NTRAVENOUS THERAPY	0	974, 525		974, 525	6
	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY	0	8, 856, 785 12, 301, 251		8, 856, 785 12, 301, 251	6
00 00	6700 OCCUPATI ONAL THERAPY	0	3, 120, 482	2 0	3, 120, 482	6
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	0	2, 504, 270 8, 234, 429		2, 504, 270 8, 234, 429	6
1	7000 ELECTROEARDI OLOGI 7000 ELECTROENCEPHALOGRAPHY	0	2, 082, 292			70
00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	36, 035, 573		36, 035, 573	7
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	45, 503, 145			7:
	7300 DRUGS CHARGED TO PATIENTS 7400 RENAL DIALYSIS	0	28, 694, 139 2, 568, 695	5 0	2, 568, 695	7:
97 0	7697 CARDI AC REHABI LI TATI ON	0	1, 584, 673	3 0		70
	UTPATI ENT SERVI CE COST CENTERS 9000 CLI NI C	0	5, 392, 504	1 O	5, 392, 504	90
	9100 EMERGENCY	0	5, 392, 504 19, 038, 656			9
00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART			0		93
	THER REIMBURSABLE COST CENTERS 0100 HOME HEALTH AGENCY	0	7, 260, 345	5 0	7, 260, 345	10
	PECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	360, 374	468, 119, 039	1		11
	ONREI MBURSABLE COST CENTERS		70.02		70.001	
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9100 RESEARCH	0	70, 284 914, 154			190 19
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 031, 274			19
4. 00 0 <sup>-</sup>	7950 OTHER NONREI MBURSEABLE	0	1, 403, 275	5 0	1, 403, 275	19
	7951 ADVERTI SI NG	0	575, 986	5 O	575, 986	194

Health Financial Systems	COMMUNI TY F	COMMUNI TY HOSPI TAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B			
				From 07/01/2021 To 06/30/2022	Part I Date/Time Prepared:			
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	11/22/2022 9:20 am			
	PRGM-(LAB MLS)		Residents Cos					
			& Post					
			Stepdown					
			Adjustments					
	23.01	24.00	25.00	26.00				
194.0307953 FITNESS POINTE	0	4, 873, 977		0 4, 873, 977	194. 03			
194.0407954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	537, 571		0 537, 571	194. 04			
194.0507955EINSTEIN BAGELS	0	523, 447		0 523, 447	194.05			
194.0607956NONRTHWESTERN IMAGING	0	1, 431, 170		0 1, 431, 170	194.06			
200.00 Cross Foot Adjustments	0	0		0 0	200.00			
201.00 Negative Cost Centers	0	0		0 0	201.00			
202.00   TOTAL (sum lines 118 through 201)	360, 374	492, 405, 634		0 492, 405, 634	202.00			

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	COMMUNI TY	Provider C		<u>In Lieu</u> eriod: rom 07/01/2021	u of Form CMS-: Worksheet B Part II	2552-1(
			To		Date/Time Pre 11/22/2022 9:	
		CAPI TAL REI	LATED COSTS		11/22/2022 7.	
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assi gned New				BENEFI TS	
	Capital Related Costs				DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS1.0000100CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00505 PURCHASING & RECEIVING STORES	0 5 0	30, 073 125, 734		45, 044 126, 122	45, 044 167	4.00 5.01
5. 02 00506 ADMITTING	0	118, 825		131, 619	945	5. 02
5.03 00507 CASHI ERI NG/ACCOUNTS RECEI VABI 5.04 00508 OTHER ADMIN & GENERAL	.E 0	162, 278		162, 278	0	
5. 04 00508 OTHER ADMIN & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS	0	843, 959 0	631, 468 0	1, 475, 427 0	2, 956 0	5.04
7.00 00700 OPERATION OF PLANT	0	2, 151, 620	385, 060	2, 536, 680	888	7.00
8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING	0	23, 677 60, 070	0 37, 712	23, 677 97, 782	33 938	•
10. 00 01000 DI ETARY	0	172, 620		258, 269	618	
11.00 01100 CAFETERIA	0	179, 333	36, 707	216, 040	281	11.00
12.00 01200 MAINTENANCE OF PERSONNEL 13.00 01300 NURSING ADMINISTRATION	0	0 67, 101	0 445, 405	0 512, 506	0 1, 501	12.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0 21, 077	0 289	0	0	15.00 16.00
17. 00 01700 SOCIAL SERVICE	0	15, 513		21, 366 15, 513	218	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
21.00 02100 I &R SERVI CES-SALARY & FRI NGES 22.00 02200 I &R SERVI CES-OTHER PRGM COSTS		0	0	0	0	
23. 00 02300 PARAMED ED PRGM-(PHARMACY)		3, 447	0	3, 447	74	22.00
23. 01 02301 PARAMED ED PRGM-(LAB MLS)	0	15, 452	2, 293	17, 745	44	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CEN           30. 00         03000         ADULTS & PEDI ATRI CS	IERS 0	2, 763, 796	525, 971	3, 289, 767	8, 943	30.00
31.00 03100 INTENSIVE CARE UNIT	0	548, 009	686, 312	1, 234, 321	3, 165	1
31. 01 02060 NEONATAL INTENSIVE CARE 41. 00 04100 SUBPROVIDER - IRF	0	167, 993		281, 238	772 230	•
43. 00 04300 NURSERY	0	103, 418 29, 438		103, 418 62, 493	343	
ANCI LLARY SERVICE COST CENTERS		4 404 740	0.070.040	4 570 0/0	0.040	50.00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0	1, 194, 748 589, 028		4, 573, 960 751, 305	3, 813 1, 415	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	234, 036		269, 277	675	1
53. 00 05300 ANESTHESI OLOGY	0	18, 310		211, 897	3, 108	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	307, 471 216, 558	1, 306, 706 1, 598, 790	1, 614, 177 1, 815, 348	1, 008 314	•
56. 00 05600 RADI OI SOTOPE	0	60, 841	410, 542	471, 383	192	56.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	88, 903		869, 836		57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	60, 826 171, 668		519, 251 2, 133, 778	236 754	58.00 59.00
60. 00 06000 LABORATORY	0	395, 528	771, 680	1, 167, 208	1, 573	
63.00 06300 BLOOD STORING, PROCESSING & 1 64.00 06400 INTRAVENOUS THERAPY	RANS. 0	24, 569 62, 580		44, 895 109, 940	92 79	
65. 00 06500 RESPI RATORY THERAPY	0	64, 606		544, 720	985	•
66. 00 06600 PHYSI CAL THERAPY	0	448, 537	114, 456	562, 993	1, 341	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	46, 130 26, 051	18, 578 41, 613	64, 708 67, 664	386 324	
69. 00 06900 ELECTROCARDI OLOGY	0	243, 909		772, 080	729	
70. 00 07000 ELECTROENCEPHALOGRAPHY		40, 657	53, 812	94, 469	185	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO F 72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	79, 075	243, 306	322, 381	990	
74.00 07400 RENAL DIALYSIS	0	20, 033		20, 033	28	
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	68, 280	35, 016	103, 296	185	76.97
90. 00 09000 CLINIC	0	122, 983		127, 305	618	•
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTING	0 T DADT	377, 566	215, 321	592, 887 0	1, 863	91.00 92.00
OTHER REI MBURSABLE COST CENTERS						/2.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	1, 004	101.00
SPECIAL PURPOSE COST CENTERS118.00SUBTOTALS (SUM OF LINES 1 thr	ough 117) 0	12, 566, 326	15, 873, 217	28, 439, 543	44, 378	118.00
NONREI MBURSABLE COST CENTERS			1			
190.00 19000 GI FT, FLOWER, COFFEE SHOP & ( 191.00 19100 RESEARCH	CANTEEN O	18, 264 4, 989		18, 264 4, 989		190.00 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	4, 989 675, 179		4, 989 675, 179		191.00
194.0007950 OTHER NONREI MBURSEABLE	0	106, 789	106, 774	213, 563	0	194.00
194. 01 07951 ADVERTI SI NG	0	0	0	0	0	194.01

Health Financial Systems	COMMUNI TY	In Lie	u of Form CMS-	2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Pre	pared:
					11/22/2022 9:	20 am
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
194. 02 07952 RETAIL PHARMACY	0	25, 129	54	1 25, 670	137	194. 02
194. 03 07953 FI TNESS POI NTE	0	699, 356	108, 71	5 808, 071	223	194. 03
194.0407954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	22, 407	6, 69	29, 103	54	194.04
194.0507955EINSTEIN BAGELS	0	9, 147	5, 75	14, 899	34	194.05
194.0607956NONRTHWESTERN IMAGING	0	40, 037	215, 21	0 255, 247	79	194.06
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	14, 167, 623	16, 316, 90	30, 484, 528	45, 044	202.00

Health Financial Systems	COMMUNI TY F	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	Fi	eriod: com 07/01/2021	Worksheet B Part II	norodi
Cost Caster Description					Date/Time Pre 11/22/2022 9:	20 am
Cost Center Description	PURCHASING & RECEIVING	ADMI TTI NG	CASHI ERI NG/ACC OUNTS	GENERAL	REPAIRS	
	STORES 5.01	5.02	RECEI VABLE 5. 03	5.04	6.00	
GENERAL SERVICE COST CENTERS	1					1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00505 PURCHASING & RECEIVING STORES 5. 02 00506 ADMITTING	126, 289 116	132, 680				5.01 5.02
5. 03 00507 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	162, 278			5.03
5. 04 00508 OTHER ADMIN & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS	1, 963 0	0	0	1, 480, 346	0	5.04 6.00
7. 00 00700 OPERATION OF PLANT	29	0	0	63, 545	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0 407	0	0	5, 828	0 0	8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY	1,047	0	0	23, 380 18, 648	0	9.00 10.00
11.00 01100 CAFETERIA	451	0	0	3, 027	0	11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON	0 1, 614	0	0	0 34, 264	0	12.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0 15, 842	0	15.00 16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	4, 247	0	17.00
19.00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0 0	19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21.00 22.00
23. 00 02300 PARAMED ED PRGM- (PHARMACY)	0	0	0	1, 395	0	23.00
23. 01 02301 PARAMED ED PRGM-(LAB MLS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	44	0	0	953	0	23.01
30. 00 03000 ADULTS & PEDI ATRI CS	13, 436	10, 752	13, 219	200, 807	0	30.00
31.00 03100 INTENSIVE CARE UNIT 31.01 02060 NEONATAL INTENSIVE CARE	5, 467 1, 367	2, 170 1, 329	2, 668 1, 634	66, 105 16, 635	0	31.00 31.01
41. 00 04100 SUBPROVI DER – I RF	233	197	243	6, 421	0	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	538	367	452	7, 669	0	43.00
50. 00 05000 OPERATI NG ROOM	26, 465	19, 633	23, 283	146, 475	0	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 672 567	2, 165 619	2, 662 761	32, 623 15, 202	0	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	3, 083	3, 240	3, 983	15, 104	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 152 160	5, 567 3, 020	6, 845 3, 714	34, 257 18, 842	0	54.00 55.00
56. 00 05600 RADI OI SOTOPE	116	2, 244	2, 758	10, 744	0	56.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	1, 527 494	8, 091 4, 040	9, 948 4, 968	16, 469 11, 017	0 0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	7, 212	4, 040 9, 939	4, 908	34, 470	0	
60.00 06000 LABORATORY	37, 909	15, 147	18, 623	78, 395	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	1, 032 378	756 286	929 352	10, 839 2, 376	0	63.00 64.00
65. 00 06500 RESPI RATORY THERAPY	1, 905	1, 486		25, 808	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	1, 221 174	2, 124 759	2, 612 934	32, 880 8, 864	0	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	145	377	464	7, 230	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 774 771	5, 362 1, 202	6, 592 1, 478	22, 006 5, 753	0	69.00 70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	4, 105	5, 048	107, 828	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0 887	5, 671 9, 234	6, 972 11, 354	136, 099 82, 941	0 0	72.00 73.00
74.00 07400 RENAL DIALYSIS	87	7, 234 587	721	7, 483	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	44	253	311	4, 151	0	76.97
90. 00 09000 CLINIC	1, 410	930	1, 144	13, 864	0	90.00
91.00 09100 EMERGENCY	7, 809	10, 454	12, 853	48, 191	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	I I					92.00
101.00 10100 HOME HEALTH AGENCY	15	574	706	21, 755	0	101.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)	125, 721	132, 680	162, 278	1, 420, 432	0	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	62	0	190.00
191. 00 19100 RESEARCH	15	0	0	2, 693	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 OTHER NONREI MBURSEABLE	0	0	0	3, 609 3, 348		192.00 194.00
194. 01 07951 ADVERTI SI NG	0	0	0	1, 731	0	194. 01
194. 02 07952 RETALL PHARMACY 194. 03 07953 FLTNESS POLNTE	73 0	0	0	32, 619 8, 953		194. 02 194. 03
194. 04 07954 FI TNESS POINTE SPA/PRO SHOP/DI ETARY	349	0	0	1, 433		194.03

ealth Financial Systems COMMUNITY HOSPITAL In Lieu					u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		eri od:	Worksheet B	
				rom 07/01/2021	Part II	
			1	0 06/30/2022	Date/Time Pre 11/22/2022 9:	
Cost Center Description	PURCHASING &	ADMI TTI NG	CASHI ERI NG/ACC	OTHER ADMIN &	MAINTENANCE &	
	RECEI VI NG		OUNTS	GENERAL	REPAI RS	
	STORES		RECEI VABLE			
	5.01	5.02	5.03	5.04	6.00	
194.0507955 EINSTEIN BAGELS	102	0	0	1, 490	(	194.05
194.0607956NONRTHWESTERN IMAGING	29	0	0	3, 976	(	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	(	201.00
202.00 TOTAL (sum lines 118 through 201)	126, 289	132, 680	162, 278	1, 480, 346	(	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	COMMUNI TY	HOSPI TAL Provi der CO	CN: 15-0125 Pe	In Lieu eriod:	<u>ı of Form CMS-:</u> Worksheet B	2552-10
ALLOATION OF GATTIAL RELATED COSTS				om 07/01/2021	Part II Date/Time Pre 11/22/2022 9:	pared: 20 am
Cost Center Description	OPERATI ON OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	7.00	8.00	9.00	10.00	11.00	
GENERAL         SERVI CE         COST         CENTERS           1.00         00100         CAP         REL         COSTS-BLDG & FIXT           2.00         00200         CAP         REL         COSTS-BLDG & FIXT           2.00         00200         CAP         REL         COSTS-BLDG & FIXT           2.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.01         00505         PURCHASING & RECEI VING         STORES           5.02         00506         ADMITTING         STORES           5.03         00507         CASHI ERING/ACCOUNTS         RECEI VABLE           5.04         00508         OTHER         ADMIN         & GENERAL           6.00         00600         MAI NTENANCE         & REPAI RS           7.00         00700         OPERATION OF PLANT         SO0         00800           8.00         00800         LAUNDRY & LI NEN SERVI CE         SO         00900         HOUSEKEEPI NG           10.00         01000         DI ETARY         11.00         O1100         CAFETERI A           12.00         01200         MAI NTENANCE OF PERSONNEL         13.00         O1300         NURSI NG ADMI NI STRATI ON           14.00	2, 601, 142 5, 737 14, 555 41, 826 43, 453 0 16, 259 0 0 5, 107 3, 759 0 0 0 835 2, 744	35, 275 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	137, 062 2, 221 2, 308 0 863 0 0 271 200 0 0 0 0 44	322, 629 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	265, 560 0 10, 898 0 0 0 2, 069 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12.00 13.00 14.00 15.00 16.00 17.00 19.00 21.00 22.00 23.00
23. 01 02301 PARAMED ED PRGM-(LAB MLS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3, 744	0	199	0	276	23.01
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	669, 676 132, 783	27, 288 4, 534	7, 052	252, 617 21, 936	67, 183 19, 176	
31. 01 02060 NEONATAL INTENSIVE CARE 41. 00 04100 SUBPROVIDER - IRF	40, 705 25, 058	1, 412 884	2, 162 1, 331	0 6, 609	4, 966 2, 207	31.01 41.00
43. 00 04300 NURSERY	7, 133	1, 157	379	0	2, 345	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	289, 490	0	15, 374	0	30, 626	50.00
51.00       05100       RECOVERY ROOM         52.00       05200       DELIVERY ROOM & LABOR ROOM         53.00       05300       ANESTHESI OLOGY         54.00       05400       RADI OLOGY-DI AGNOSTI C         55.00       05500       RADI OLOGY-THERAPEUTI C         56.00       05600       RADI OLOGY-THERAPEUTI C         57.00       05700       CT SCAN         58.00       05800       MRI	142, 723 56, 707 4, 436 74, 501 52, 472 14, 742 21, 541 14, 738	0 0 0 0 0 0 0 0 0 0	7, 580 3, 012 236 3, 957 2, 787 783 1, 144 783	15, 779 6, 208 0 0 0 0 0 0 0	11, 036 4, 552 6, 760 9, 105 2, 069 1, 380 3, 173 1, 793	52.00 53.00 54.00 55.00 56.00 57.00
59.00         05900         CARDI AC CATHETERI ZATI ON           60.00         06000         LABORATORY           63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.           64.00         06400         I NTRAVENOUS THERAPY           65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY	41, 595 95, 837 5, 953 15, 163 15, 654 108, 681	0 0 0 0	2, 209 5, 090 316		5, 104 16, 003 690 552 6, 484 11, 036	59.00 60.00 63.00 64.00 65.00
<ul> <li>67. 00 06700 OCCUPATI ONAL THERAPY</li> <li>68. 00 06800 SPEECH PATHOLOGY</li> <li>69. 00 06900 ELECTROCARDI OLOGY</li> <li>70. 00 07000 ELECTROENCEPHALOGRAPHY</li> <li>71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT</li> <li>72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS</li> </ul>	11, 177 6, 312 59, 100 9, 851 0	0 0 0 0 0	594 335 3, 139 523 0		2, 897 2, 345 6, 622 1, 793 0 0	67.00 68.00 69.00 70.00 71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	19, 160 4, 854	0	1, 018 258	0	7, 036 276	73.00 74.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	16, 544	0	879	0	1, 517	76.97
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	29, 799 91, 485	0 0		0 19, 480	5, 242 15, 037	
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 213, 145	35, 275	116, 458	322, 629	262, 938	118.00
NONREI MBURSABLE COST CENTERS           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN           191.00         19100         RESEARCH           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES           194.00         07950         OTHER NONREI MBURSEABLE           194.01         07951         ADVERTI SI NG           194.02         07952         RETAI L	4, 426 1, 209 163, 597 25, 875 0 6, 089	0 0 0 0 0 0 0 0 0	235 64 8, 688 1, 374 0 323	0 0 0 0 0 0	828 138 0 0	190. 00 191. 00 192. 00 194. 00 194. 01 194. 02
194. 03 07953 FI TNESS POLNTE 194. 04 07954 FI TNESS POLNTE SPA/PRO SHOP/DI ETARY 194. 05 07955 EI NSTELN BAGELS	169, 455 5, 429 2, 216		8, 999 288 118	0 0 0	0 0	194. 03 194. 04 194. 05

Health Financial Systems	ystems COMMUNITY HOSPITAL In Lieu					
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
				From 07/01/2021	Part II	
				To 06/30/2022		
					11/22/2022 9:	<u>20 am</u>
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7.00	8.00	9.00	10.00	11.00	
194.0607956 NONRTHWESTERN IMAGING	9, 701	0	51	5 0	0	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 601, 142	35, 275	137, 06	2 322, 629	265, 560	202.00

Health Financial Systems	COMMUNI TY			In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Pre	
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	11/22/2022 9: MEDI CAL	20 am
	PERSONNEL	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
GENERAL SERVICE COST CENTERS	12.00	13.00	14.00	15.00	16.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00505 PURCHASING & RECEIVING STORES						4.00 5.01
5. 02 00506 ADMI TTI NG						5.02
5. 03 00507 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 04 00508 OTHER ADMI N & GENERAL						5.03 5.04
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	(	577, 905				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY			(			14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	(	0 0	(		42, 586	
17.00 01700 SOCIAL SERVICE	(	0	(	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV			(		0	
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	(	0 0	(		0	22.00
23.00  02300  PARAMED ED PRGM-(PHARMACY) 23.01  02301  PARAMED ED PRGM-(LAB MLS)		-	(		0	
INPATIENT ROUTINE SERVICE COST CENTERS	`	<u> </u>		,		20.01
30. 00 03000 ADULTS & PEDI ATRI CS			(		3, 525	
31.00 03100 INTENSIVE CARE UNIT 31.01 02060 NEONATAL INTENSIVE CARE			(		711 436	31.00 31.01
41.00 04100 SUBPROVIDER - IRF	(		(		65	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	[ (	8, 182	(	0	120	43.00
50. 00 05000 OPERATI NG ROOM		0 109, 192	(		5, 520	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0 39, 376 0 16, 051	(		710 203	
53. 00 05300 ANESTHESI OLOGY			(		1, 062	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	(	0	(	0	1, 825	•
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE			(		990 736	
57. 00 05700 CT SCAN	(	0 0	(	0 0	2, 653	
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON			(		1, 325 3, 259	•
60. 00 06000 LABORATORY	(	0 0	C	0	4, 966	
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY			(		248 94	•
65. 00 06500 RESPIRATORY THERAPY			(		487	65.00
66. 00 06600 PHYSI CAL THERAPY	(	0	(	0	697	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY			(		249 124	
69. 00 06900 ELECTROCARDI OLOGY	(	0 0	(	0 0	1, 758	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			(		394 1, 346	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0 0	C	0	1, 859	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S			(		3, 028 192	
76. 97 07697 CARDI AC REHABI LI TATI ON	(		(		83	1
OUTPATIENT SERVICE COST CENTERS		40.075			0.05	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY		D 18, 875 D 53, 416	(		305 3, 428	90.00 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					·	92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	(	0 0	(	0	188	101.00
SPECIAL PURPOSE COST CENTERS				5	100	101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	(	577, 905	(	0	42, 586	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(	0 0	(		0	190.00
191. 00 19100 RESEARCH	(	0	(	0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 OTHER NONREI MBURSEABLE		0 ע		ן ע ה		192.00 194.00
194. 01 07951 ADVERTI SI NG		0 0	0	0	0	194. 01
194. 02 07952 RETALL PHARMACY 194. 03 07953 FLTNESS POLNTE			(			194. 02 194. 03
194. 04 07954 FITNESS_POINTE_SPA/PRO_SHOP/DI ETARY			0			194.03

Heal th Financial Systems COMMUNITY HOSPITAL					In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Peri od:	Worksheet B			
				From 07/01/2021	Part II			
				To 06/30/2022	Date/Time Pre			
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL			
	PERSONNEL	ADMI NI STRATI ON	SERVICES &		RECORDS &			
			SUPPLY		LI BRARY			
	12.00	13.00	14.00	15.00	16.00			
194.0507955 EINSTEIN BAGELS	0	0		0 0	0	194.05		
194.0607956 NONRTHWESTERN IMAGING	0	0		0 0	0	194.06		
200.00 Cross Foot Adjustments						200.00		
201.00 Negative Cost Centers	0	0		0 0	0	201.00		
202.00 TOTAL (sum lines 118 through 201)	0	577, 905		0 0	42, 586	202.00		

	Financial Systems FION OF CAPITAL RELATED COSTS	COMMUNI TY			Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Pre 11/22/2022 9:	pared
				I NTERNS 8	RESIDENTS	11/22/2022 7.	
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	Y & FRINGES		PARAMED ED PRGM-(PHARMACY	
		17.00	19.00	APPRV 21.00	APPRV 22.00	23.00	
+	GENERAL SERVICE COST CENTERS	1		1	1	·	
	00100 CAP REL COSTS-BLDG & FLXT						1.
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 4.
	00505 PURCHASING & RECEIVING STORES						5.
	00506 ADMI TTI NG						5.
03	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.
	00508 OTHER ADMIN & GENERAL						5.
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 7.
	00800 LAUNDRY & LINEN SERVICE						8.
	00900 HOUSEKEEPING						9.
	01000 DI ETARY						10.
. 00	01100 CAFETERI A						11.
	01200 MAINTENANCE OF PERSONNEL						12.
	01300 NURSI NG ADMI NI STRATI ON						13.
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 15.
	01600 MEDICAL RECORDS & LIBRARY						16.
	01700 SOCIAL SERVICE	26,006					17.
	01900 NONPHYSICIAN ANESTHETISTS	0	c				19.
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		(	C		21.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0			0		22.
	02300 PARAMED ED PRGM-(PHARMACY)	0				6, 485	
	02301 PARAMED ED PRGM-(LAB MLS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	1				23.
	03000 ADULTS & PEDIATRICS	20, 117					30.
	03100 I NTENSI VE CARE UNI T	3, 343					31.
	02060 NEONATAL INTENSIVE CARE	1, 041					31.
. 00	04100 SUBPROVI DER – I RF	652					41.
	04300 NURSERY	853					43.
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0					50.
	05100 RECOVERY ROOM	0					51.
	05200 DELIVERY ROOM & LABOR ROOM	0					52.
	05300 ANESTHESI OLOGY	0					53.
	05400 RADI OLOGY-DI AGNOSTI C	0					54.
	05500 RADI OLOGY-THERAPEUTI C	0					55.
	05600 RADI OI SOTOPE 05700 CT SCAN	0					56.
	05700 CT SCAN 05800 MRI						57. 58.
	05900 CARDI AC CATHETERI ZATI ON	0					59.
	06000 LABORATORY	0					60.
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0					63
	06400 I NTRAVENOUS THERAPY	0					64.
	06500 RESPI RATORY THERAPY	0					65.
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY						66
	06800 SPEECH PATHOLOGY	0					68.
	06900 ELECTROCARDI OLOGY	0					69
. 00	07000 ELECTROENCEPHALOGRAPHY	0					70
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0					71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS						73
	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	0					76
	OUTPATIENT SERVICE COST CENTERS	. 0	1	I		1	1 ' '
	09000 CLINIC	0					90
	09100 EMERGENCY	0					91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	OTHER REIMBURSABLE COST CENTERS	^		1		I	101
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	1				101.
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	26,006	C		0 0	0	1118
	NONREIMBURSABLE COST CENTERS	20,000		ч <b>у</b>	- U	0	1.10
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.
1. 00	19100 RESEARCH	0					191.
	19200 PHYSICIANS' PRIVATE OFFICES	0					192.
	07950 OTHER NONREI MBURSEABLE	0				1	194.
	07951 ADVERTI SI NG	-					194

Health Financial Systems	COMMUNI TY	HOSPI TAL	In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	pared:
					11/22/2022 9:	20 am
			I NTERNS a	RESI DENTS		
Cost Center Description	SOCI AL SERVI CE			RSERVI CES-OTHER		
		ANESTHETI STS	Y & FRINGES		PRGM-(PHARMACY	
			APPRV	APPRV		
	17.00	19.00	21.00	22.00	23.00	
194. 03 07953 FI TNESS POI NTE	0				l	194.03
194.04 07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0					194.04
194.05 07955 EINSTEIN BAGELS	0					194.05
194.0607956NONRTHWESTERN IMAGING	0					194.06
200.00 Cross Foot Adjustments		0		0 0	6, 485	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	26, 006	0		0 0	6, 485	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	COMMUNITY I			eri od:	u of Form CMS-2552- Worksheet B
				Fr To	rom 07/01/2021 0 06/30/2022	Part II Date/Time Prepared
	Cost Center Description	PARAMED ED PRGM-(LAB MLS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	11/22/2022 9:20 am
	L	23.01	24.00	25.00	26.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00505 PURCHASING & RECEIVING STORES 00506 ADMITTING 00507 CASHIERING/ACCOUNTS RECEIVABLE 00508 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY					1. ( 2. ( 4. ( 5. ( 5. ( 5. ( 5. ( 7. ( 8. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 14. ( 15. (
17. 00 17. 00 19. 00 21. 00 22. 00 23. 00 23. 01	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(PHARMACY) 02301 PARAMED ED PRGM-(LAB MLS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	23, 005				10. ( 17. ( 19. ( 21. ( 22. ( 23. ( 23. (
30. 00 31. 00 31. 01 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE 04100 SUBPROVIDER - IRF 04300 NURSERY ANCLLIARY SERVICE COST CENTERS		4, 852, 302 1, 571, 668 371, 247 155, 163 92, 031	3 O 7 O 3 O	4, 852, 302 1, 571, 668 371, 247 155, 163 92, 031	30. ( 31. ( 31. ( 41. ( 43. (
72.00 73.00 74.00 76.97 90.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 09000 CLI NI C		5, 243, 831 1, 009, 046 373, 834 252, 909 1, 753, 394 1, 899, 716 505, 078 934, 747 558, 645 2, 250, 539 1, 440, 751 65, 750 130, 025 600, 188 729, 357 90, 742 85, 320 879, 162 116, 419 118, 327 150, 601 458, 029 34, 519 127, 263		5, 243, 831 1, 009, 046 373, 834 252, 909 1, 753, 394 1, 899, 716 505, 078 934, 747 558, 645 2, 250, 539 1, 440, 751 1, 440, 751 1, 440, 751 130, 025 600, 188 729, 357 90, 742 85, 320 879, 162 116, 419 118, 327 150, 601 458, 029 34, 519 127, 263	50. 51. 52. 53. 54. 55. 55. 56. 57. 58. 60. 63. 64. 65. 66. 67. 67. 67. 67. 67. 67. 67. 67. 67
91.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS		861, 762		861, 762	91. ( 92. (
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		24, 242	2 0	24, 242	101. (
118.00		0	27, 937, 682	2 0	27, 937, 682	118. (
191.00 192.00 194.00 194.0	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OTHER NONREI MBURSEABLE 07951 ADVERTI SI NG 207952 RETAIL PHARMACY		22, 987 9, 921 851, 227 244, 160 1, 731 66, 015		22, 987 9, 921 851, 227 244, 160 1, 731 66, 015	190. ( 191. ( 192. ( 194. ( 194. ( 194. ( 194. (

Health Financial Systems	COMMUNITY F	IOSPI TAL		In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0125	Peri od:	Worksheet B	
				From 07/01/2021 To 06/30/2022	Part II Date/Time Prepared: 11/22/2022 9:20 am	
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
	PRGM-(LAB MLS)		Residents Cos	st		
			& Post			
			Stepdown			
			Adjustments			
	23.01	24.00	25.00	26.00		
194. 03 07953 FI TNESS POI NTE		995, 701		0 995, 701	194.03	
194.0407954 FITNESS POINTE SPA/PRO SHOP/DIETARY		36, 656		0 36, 656	194.04	
194.05 07955 EINSTEIN BAGELS		19, 411		0 19, 411	194.05	
194.0607956NONRTHWESTERN IMAGING		269, 547	1	0 269, 547	194.06	
200.00 Cross Foot Adjustments	23,005	29, 490	1	0 29, 490	200.00	
201.00 Negative Cost Centers	0	0		0 0	201.00	
202.00 TOTAL (sum lines 118 through 201)	23, 005	30, 484, 528		0 30, 484, 528	202.00	

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY	HOSPI TAL Provi der CC	CN: 15-0125 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
					rom 07/01/2021 o 06/30/2022	Date/Time Pre	pared:
		CAPI TAL RE	LATED COSTS			11/22/2022 9:	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS	PURCHASI NG & RECEI VI NG STORES (COSTED REQ)	ADMI TTI NG (GROSS REVENUE)	
		1.00	2.00	SALARIES) 4.00	5. 01	5.02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	937, 039					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 989	39, 519, 927 36, 259	203, 163, 893			2.00 4.00
5.01	00505 PURCHASING & RECEIVING STORES	8, 316		752, 263			5.01
5.02	00506 ADMI TTI NG	7,859		4, 254, 650		2, 171, 940, 542	
5.03 5.04	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE 00508 OTHER ADMIN & GENERAL	10, 733 55, 819		0 13, 313, 274	-	0	
6.00	00600 MAI NTENANCE & REPAI RS	03,017	0	13, 513, 274	0		
7.00	00700 OPERATION OF PLANT	142, 307		4, 000, 192		0	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	1,566		147, 971		0	
9.00 10.00	01000 DI ETARY	3, 973 11, 417		4, 226, 402 2, 781, 886		0	
11.00	01100 CAFETERI A	11, 861		1, 267, 790		0	1
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	-	0	12.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	4, 438	1, 078, 781	6, 762, 719	111	0	13.00 14.00
15.00	01500 PHARMACY	0	0	0	-	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 394		0	-	0	16.00
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	1,026	0	981, 939		0	17.00
19.00 21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV		0	0	-	0	19.00 21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	-	0	1
23.00	02300 PARAMED ED PRGM-(PHARMACY)	228		334, 078		0	
23.01	02301 PARAMED ED PRGM-(LAB MLS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,022	5, 554	196, 398	3	0	23.01
30.00	03000 ADULTS & PEDIATRICS	182, 796	1, 273, 914	40, 546, 592	924	176, 257, 364	30.00
31.00	03100 I NTENSI VE CARE UNI T	36, 245		14, 257, 540		35, 571, 109	
31. 01 41. 00	02060 NEONATAL INTENSIVE CARE 04100 SUBPROVIDER - IRF	11, 111 6, 840		3, 478, 345 1, 036, 587			1
43.00	04300 NURSERY	1, 947		1, 545, 839		6, 024, 116	
	ANCI LLARY SERVI CE COST CENTERS		0.404.500			010 707 010	50.00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	79, 020 38, 958					
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 479		3, 041, 144			
53.00	05300 ANESTHESI OLOGY	1, 211		14, 002, 136			1
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	20, 336		4, 541, 101 1, 413, 770			
56.00	05600 RADI OLOGI - ITILKAP LUTI C	4, 024					
	05700 CT SCAN	5, 880	1, 891, 437	1, 645, 608	105	132, 642, 917	57.00
58.00		4,023		1,062,341			1
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	11, 354 26, 160		3, 395, 687 7, 087, 214		162, 926, 240 248, 304, 264	
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	1, 625		416, 082		12, 385, 785	
64.00	06400 I NTRAVENOUS THERAPY	4, 139		355, 987		4, 691, 054	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 273 29, 666		4, 435, 870 6, 042, 259		24, 367, 884 34, 826, 671	
67.00	06700 OCCUPATI ONAL THERAPY	3, 051		1, 737, 846			
68.00	06800 SPEECH PATHOLOGY	1, 723		1, 460, 963			
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	16, 132 2, 689		3, 282, 978 833, 967			•
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,009	0	033, 407		67, 301, 676	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	92, 959, 763	
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 230		4, 459, 011		151, 381, 018	1
74.00 76.97	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON	1, 325 4, 516		124, 254 832, 186		9, 618, 712 4, 143, 247	
70.77	OUTPATIENT SERVICE COST CENTERS	1,010	01,007	002,100		1, 110, 21,	/0. //
	09000 CLINIC	8, 134					
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 972	521, 513	8, 391, 152	537	171, 376, 167	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS	1			1		/2.00
101.00	10100 HOME HEALTH AGENCY	0	0	4, 523, 483	1	9, 409, 969	101. 00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	831, 130	38, 445, 303	200, 167, 486	0 616	2, 171, 940, 542	118 00
118.UU	NONREIMBURSABLE COST CENTERS	831,130	y 30, 445, 303	200, 107, 486	8, 040	2, 171, 940, 542	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 208		0			190. 00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	330 44, 656		552, 054 73, 158			191. 00 192. 00
	07950 OTHER NONREIMBURSEABLE	7,063					192.00 194.00
							·

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 20 am
	CAPI TAL REI	LATED COSTS				
Cost Center Description		MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	PURCHASI NG & RECEI VI NG STORES (COSTED REQ)	ADMI TTI NG (GROSS REVENUE)	
	1.00	2.00	4.00	5. 01	5. 02	
194. 01 07951 ADVERTI SI NG	0			0 0		194.01
194. 02 07952 RETAIL PHARMACY	1, 662					194. 02
194. 03 07953 FI TNESS POI NTE	46, 255					194.03
194.0407954 FITNESS POINTE SPA/PRO SHOP/DIETARY	1, 482					194.04
194.0507955EINSTEIN BAGELS	605					194.05
194.0607956 NONRTHWESTERN IMAGING	2, 648	521, 244	356, 12	2 2	0	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	14, 167, 623	16, 316, 905	29, 061, 93	1 840, 957	5, 562, 043	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	15. 119566	0. 412878	0.14304	7 96. 828670	0. 002561	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			45, 04	4 126, 289	132, 680	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0.00022	2 14. 541048	0. 000061	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST A	Financial Systems NLLOCATION - STATISTICAL BASIS	COMMUNITY F	Provi der CC			u of Form CMS-2 Worksheet B-1	
					06/30/2022	Date/Time Pre 11/22/2022 9:	
	Cost Center Description	CASHI ERI NG/ACC F	Reconciliation			OPERATION OF	
		OUNTS RECEI VABLE (GROSS		GENERAL (ACCUM. COST)	REPAI RS (SQUARE FEET)	PLANT (SQUARE FEET)	
		REVENUE)	54.04		(		
	GENERAL SERVICE COST CENTERS	5.03	5A. 04	5.04	6.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00505 PURCHASING & RECEIVING STORES						5.01
5.02 5.03	00506 ADMI TTI NG 00507 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 171, 940, 542					5.02 5.03
5.03	00508 OTHER ADMIN & GENERAL	2, 171, 740, 342	-59, 601, 863	432, 803, 771			5.03
6.00	00600 MAI NTENANCE & REPAI RS	0	0	0			6.00
7.00	00700 OPERATION OF PLANT	0	0	18, 580, 324		710, 016	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	1, 704, 001		1, 566	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	0	6, 836, 288 5, 452, 632		3, 973 11, 417	9.00 10.00
11.00	01100 CAFETERI A	0	0	884, 965		11, 417	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0	10, 018, 738	4, 438	4, 438	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00		0	0	0	0	0	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	4, 632, 283 1, 241, 804		1, 394 1, 026	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	1, 241, 004		1, 020	19.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0		0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(PHARMACY)	0	0	407, 913		228	23.00
23. 01	02301 PARAMED ED PRGM-(LAB MLS)	0	0	278, 577	1, 022	1, 022	23.01
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	176, 257, 364	0	58, 669, 567	182, 796	182, 796	30.00
31.00	03100 I NTENSI VE CARE UNI T	35, 571, 109	0	19, 328, 880		36, 245	
31.01	02060 NEONATAL INTENSIVE CARE	21, 785, 651	0	4, 864, 065		11, 111	31.01
41.00	04100 SUBPROVI DER – I RF	3, 236, 056	0	1, 877, 412	6, 840	6, 840	41.00
43.00	04300 NURSERY	6, 024, 116	0	2, 242, 361	1, 947	1, 947	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	318, 707, 318	0	42, 829, 010	79, 020	79, 020	50.00
51.00	05100 RECOVERY ROOM	35, 491, 400	0	9, 538, 883		38, 958	
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 145, 160	0	4, 445, 040		15, 479	
53.00	05300 ANESTHESI OLOGY	53, 110, 976	0	4, 416, 489		1, 211	
54.00	05400 RADI OLOGY-DI AGNOSTI C	91, 261, 680	0	10, 016, 805		20, 336	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	49, 515, 352 36, 778, 977	0	5, 509, 288 3, 141, 521		14, 323 4, 024	
	05700 CT SCAN	132, 642, 917	0	4, 815, 378		4, 024 5, 880	
58.00	05800 MRI	66, 236, 862	0	3, 221, 478			
59.00	05900 CARDI AC CATHETERI ZATI ON	162, 926, 240	0	10, 078, 848		11, 354	
60.00	06000 LABORATORY	248, 304, 264	0	22, 922, 528		26, 160	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	12, 385, 785	0	3, 169, 162		1,625	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	4, 691, 054 24, 367, 884	0	694, 637 7, 546, 249		4, 139 4, 273	
66. 00	06600 PHYSI CAL THERAPY	34, 826, 671	0	9, 614, 073		29,666	
67.00	06700 OCCUPATI ONAL THERAPY	12, 449, 951	0	2, 591, 715		3, 051	67.00
68.00	06800 SPEECH PATHOLOGY	6, 181, 746	О	2, 114, 168	1, 723	1, 723	
69.00	06900 ELECTROCARDI OLOGY	87, 894, 046	0	6, 434, 406		16, 132	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	19, 708, 655	0	1, 682, 033		2, 689	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	67, 301, 676 92, 959, 763	0	31, 528, 641 39, 794, 917		0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	151, 381, 018	0	24, 251, 862		5, 230	
74.00	07400 RENAL DI ALYSI S	9, 618, 712	Ō	2, 187, 945		1, 325	74.00
76.97	07697 CARDI AC REHABI LI TATI ON	4, 143, 247	0	1, 213, 761	4, 516	4, 516	76.97
00.00	OUTPATIENT SERVICE COST CENTERS	15 040 75	-1	4 050 015	0.451	0.46	00.05
90.00 91.00	09000 CLINIC 09100 EMERGENCY	15, 248, 756	0	4, 053, 815 14, 091, 017			
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	171, 376, 167	0	14, 091, 017	24, 972	24, 972	91.00 92.00
00	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					12.00
101.00	10100 HOME HEALTH AGENCY	9, 409, 969	0	6, 361, 248	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	· · · · · · · · · · · · · · · · · · ·	2, 171, 940, 542	-59, 601, 863	415, 284, 727	746, 414	604, 107	118.00
100.00	NONREIMBURSABLE COST CENTERS			10 0/4	1 200	1 200	100.00
	) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN ) 19100 RESEARCH	0	0	18, 264 787, 526			190. 00 191. 00
101 00	117 TOO NEGENNON	U	0				
	19200 PHYSI CLANS' PRI VATE OFFI CES		0	1,055,148	44.000	44.656	192.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0 0	1, 055, 148 979, 007		44, 656 7, 063	192.00 194.00
192.00 194.00 194.01		0 0 0	0 0 0 0		7, 063 0	7, 063 0	

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		eri od:	Worksheet B-1	
				rom 07/01/2021 o 06/30/2022	Date/Time Pre 11/22/2022 9:	
Cost Center Description	CASHI ERI NG/ACC	Reconciliation	OTHER ADMIN &	MAINTENANCE &	OPERATION OF	
	OUNTS		GENERAL	REPAI RS	PLANT	
	RECEI VABLE		(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	
	(GROSS					
	REVENUE)					
	5.03	5A. 04	5.04	6.00	7.00	
194. 03 07953 FI TNESS POI NTE	0	0	2, 617, 891			
194.0407954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	419, 120			194.04
194.0507955EINSTEIN BAGELS	0	0	435, 569			194.05
194.06 07956 NONRTHWESTERN IMAGING	0	0	1, 162, 555	2, 648	2, 648	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	6, 098, 275		59, 601, 863	0	21, 139, 039	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 002808		0. 137711	0.000000	29. 772623	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	162, 278	-	1, 480, 346	0	2, 601, 142	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000075		0.003420	0. 000000	3. 663498	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
	I	I	I	1	I	I

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY	HOSPI TAL Provi der CCN	l: 15-0125	In Lie Period:	u of Form CMS-2 Worksheet B-1	
0001 1					From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	11/22/2022 9: MAINTENANCE OF	20 am
		LINEN SERVICE (TOTAL PATI		(PATI ENT MEALS)	(FTES)	PERSONNEL (NUMBER	
		ENT DAYS)		· · ·	11.00	HOUSED)	
	GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	12.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.01	00505 PURCHASING & RECEIVING STORES						5.01
5.02 5.03	00506 ADMI TTI NG 00507 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02 5.03
5.04	00508 OTHER ADMIN & GENERAL						5.04
6.00 7.00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	87, 296					8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	704, 477 11, 417	328, 48	5		9.00 10.00
11.00	01100 CAFETERI A	0	11, 861		0 1, 925		11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	0 4, 438		0 0 0 79	0	12.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0 1, 394		0 0 0 0		15.00 16.00
17.00	01700 SOCIAL SERVICE	0	1, 026		0 15	0	17.00
19.00 21.00	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	19.00 21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
23. 00 23. 01	02300 PARAMED ED PRGM-(PHARMACY) 02301 PARAMED ED PRGM-(LAB MLS)	0	228 1, 022		0 5 0 2	0	23.00 23.01
23.01	INPATIENT ROUTINE SERVICE COST CENTERS						23.01
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	67, 531 11, 221	182, 796 36, 245	257, 20 22, 33		0	30.00 31.00
31.00	02060 NEONATAL INTENSIVE CARE	3, 494	11, 111		0 36		31.00
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	2, 187 2, 863	6, 840 1, 947	6, 72	9 16 0 17	0	41.00 43.00
43.00	ANCILLARY SERVICE COST CENTERS	2,003				0	43.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	79, 020 38, 958	16, 06	0 222 5 80	0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	15, 479	6, 32	1 33	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	1, 211 20, 336		0 49 0 66		53.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	14, 323		0 15		55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	4, 024 5, 880		0 10 0 23	0	56.00 57.00
58.00	05800 MRI	0	4, 023		0 13	0	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	11, 354 26, 160		0 37 0 116		59.00 60.00
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	1, 625		0 5	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	4, 139 4, 273		0 4 0 47	0	64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	0	29, 666		0 80	-	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	3, 051 1, 723		0 21 0 17	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	16, 132		0 48	-	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 689 0		0 13 0 0	0	70.00 71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	5, 230		0 51	0	73.00
	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	0	1, 325 4, 516		0 11	0	74.00 76.97
00.00	OUTPATIENT SERVICE COST CENTERS	0	0 124		20		
	09000 CLINIC 09100 EMERGENCY	0 0	8, 134 24, 972	19, 83	0 38 4 109		90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	87, 296	598, 568	328, 48	5 1, 906	0	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 208		0 0		190.00
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	330 44, 656		0 6 0 1		191. 00 192. 00
194.00	07950 OTHER NONREI MBURSEABLE	0	7, 063		0 0	0	194.00
	07951 ADVERTI SI NG 07952 RETAI L PHARMACY	0	0 1, 662		0 0 0 8		194. 01 194. 02
	07953 FI TNESS POI NTE	0	46, 255		0 0		194. 03

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2021	Worksheet B-1	
					To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 20 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DIETARY	CAFETERI A	MAINTENANCE OF	
		LINEN SERVICE	(SQUARE FEET)	(PATI ENT	(FTES)	PERSONNEL	
		(TOTAL PATI		MEALS)		(NUMBER	
		ENT DAYS)				HOUSED)	
		8.00	9.00	10.00	11.00	12.00	
	07954 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	1, 482		0 0		194.04
	07955 EINSTEIN BAGELS	0	605		0 4		194.05
194.06	07956 NONRTHWESTERN I MAGI NG	0	2, 648		0 0	0	194.06
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	1, 985, 285	7, 896, 007	6, 671, 39	8 1, 492, 909	0	202.00
203.00	Part I)	22. 741993	11. 208325	20. 30959	7 775. 537143	0. 000000	202.00
	Unit cost multiplier (Wkst. B, Part I)						203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	35, 275	137, 062	322, 62	9 265, 560	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 404085	0. 194559	0. 98217	3 137. 953247	0. 000000	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
207 00	(per Wkst. B-2)						207.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
I	raits III anu IV)		I I		1	l	I

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY	HOSPI TAL Provi der CO		Peri od:	u of Form CMS-: Worksheet B-1	2552-10
					From 07/01/2021 To 06/30/2022		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	11/22/2022 9: SOCI AL SERVI CE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQ)	RECORDS & LI BRARY	(TOTAL PATI	
		(NURSI NG	(COSTED REQ)		(GROSS	ENT DAYS)	
		HOURS) 13.00	14.00	15.00	REVENUE) 16.00	17.00	
	GENERAL SERVICE COST CENTERS	10100	11100	10100	10100		
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	00505 PURCHASING & RECEIVING STORES 00506 ADMITTING						5. 01 5. 02
5.02	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5.04	00508 OTHER ADMIN & GENERAL						5.04
6.00 7.00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
	01100 CAFETERIA						11.00
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	2 444 015					12.00
	01400 CENTRAL SERVICES & SUPPLY	2, 446, 815 0	0				13.00 14.00
15.00	01500 PHARMACY	0	0		D		15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0		2, 171, 940, 542	87, 296	16.00 17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	07,270	19.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	(	0	0	21.00
	02200 I & SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(PHARMACY)	0	0			0	22.00 23.00
	02301 PARAMED ED PRGM-(LAB MLS)	0	0			0	
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1,013,655	0		0 176, 257, 364	67, 531	30.00
	03100 I NTENSI VE CARE UNI T	288, 910	0			11, 221	31.00
	02060 NEONATAL INTENSIVE CARE	74, 304	0			3, 494	
	04100 SUBPROVIDER - IRF 04300 NURSERY	32, 243 34, 643	0			2, 187 2, 863	41.00 43.00
	ANCI LLARY SERVICE COST CENTERS	1					
	05000 OPERATING ROOM 05100 RECOVERY ROOM	462, 311 166, 717	0			0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	67, 958	0	(	0 10, 145, 160	0	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	53.00 54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0			0	55.00
	05600 RADI OI SOTOPE	0	0	(	36, 778, 977	0	56.00
	05700 CT SCAN 05800 MRI	0	0			0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	162, 926, 240	0	59.00
	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		248, 304, 264 12, 385, 785	0	60.00 63.00
	06400 I NTRAVENOUS THERAPY	0	0		4, 691, 054	0	64.00
	06500 RESPIRATORY THERAPY	0	0	(	24, 367, 884	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0 34, 826, 671 0 12, 449, 951	0	66.00 67.00
	06800 SPEECH PATHOLOGY	0	0	(	6, 181, 746	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0		0 87, 894, 046 0 19, 708, 655	0	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	67, 301, 676	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	92, 959, 763 151, 381, 018	0	72.00 73.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0			0	74.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	(	4, 143, 247	0	76.97
90.00	OUTPATIENT SERVICE COST CENTERS	79, 914	0		15, 248, 756	0	90.00
91.00	09100 EMERGENCY	226, 160	0			0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	0	(	9, 409, 969	0	101.00
	SPECIAL PURPOSE COST CENTERS	0.444.045				07.00/	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 446, 815	0	(	2, 171, 940, 542	87, 296	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0		190. 00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				191. 00 192. 00
	07950 OTHER NONREIMBURSEABLE	0	0				192.00 194.00
	07951 ADVERTI SI NG	0	0	(			194.01
194.02	07952 RETAIL PHARMACY	0	0	(	ןס וי	0	194. 02

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
				From 07/01/2021		
				To 06/30/2022		
Cost Contor Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	11/22/2022 9: SOCIAL SERVICE	
Cost Center Description	ADMI NI STRATI ON		(COSTED REQ)	RECORDS &	SUCIAL SERVICE	
		SUPPLY	(CUSTED REQ)	LIBRARY	(TOTAL PATI	
	(NURSI NG	(COSTED REQ)		(GROSS	ENT DAYS)	
	HOURS)	(COSILD KLU)		REVENUE)	LINI DATS)	
	13.00	14.00	15.00	16.00	17.00	
194. 03 07953 FI TNESS POI NTE	13.00	14.00	15.00	0 0		194.03
194. 04 07954 FI TNESS POINTE SPA/PRO SHOP/DI ETARY	0	0				194.03
194. 05 07955 EINSTEIN BAGELS	0	0				194.04
194. 06 07956 NONRTHWESTERN I MAGI NG	0	0				194.05
	0	0		0 0	0	200.00
						200.00
5	11 (41 540			о <u>Бартар</u>	1 444 404	
202.00 Cost to be allocated (per Wkst. B, Part I)	11, 641, 569	0		0 5, 327, 326	1, 466, 494	202.00
	4 757044	0,000000	0 00000	0 000450	1/ 700007	202 00
203.00 Unit cost multiplier (Wkst. B, Part I)	4. 757846		0.00000			
204.00 Cost to be allocated (per Wkst. B, Part II)	577, 905	0		0 42, 586	26, 006	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0, 236187	0. 000000	0.00000	0. 000020	0. 297906	205 00
	0. 230107	0.000000	0.00000	0.000020	0.297900	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						200.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						207.00
	1	I I		1	I	I

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY		CN: 15-0125 F	In Lie Period:	u of Form CMS-: Worksheet B-1	
					From 07/01/2021 Fo 06/30/2022		
			I NTERNS &	RESI DENTS		11/22/2022 9:	20 am
	Cost Center Description		SERVI CES-SALAR	SERVICES-OTHER	R PARAMED ED	PARAMED ED	
		ANESTHETI STS	Y & FRINGES	PRGM COSTS	PRGM-(PHARMACY		
		(ASSIGNED TIME)	APPRV (ASSI GNED	APPRV (ASSI GNED	) (ASSI GNED	(ASSI GNED	
		19.00	TIME) 21.00	TIME) 22.00	TI ME) 23.00	TIME) 23.01	
	GENERAL SERVICE COST CENTERS	17.00	21.00	22.00	23.00	23.01	
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	00505 PURCHASING & RECEIVING STORES 00506 ADMITTING						5.01 5.02
5.03	00507 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
5.04 6.00	00508 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS						5.04 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11.00 12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17.00	01700 SOCIAL SERVICE						17.00
19.00 21.00	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	(		þ			19.00 21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			(			22.00
23. 00 23. 01	02300 PARAMED ED PRGM-(PHARMACY) 02301 PARAMED ED PRGM-(LAB MLS)				100	100	23.00 23.01
	I NPATIENT ROUTINE SERVICE COST CENTERS			1			1
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT		-			0	30.00 31.00
31.00	02060 NEONATAL INTENSIVE CARE		-			0	
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY		-			0	41.00
43.00	ANCI LLARY SERVICE COST CENTERS						43.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM		-			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM				-	0	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C				0	0	53.00 54.00
54.00 55.00	05500 RADI OLOGY-THERAPEUTI C					0	1
	05600 RADI OI SOTOPE	(			0	-	
57.00 58.00	05700 CT SCAN 05800 MRI					0	
59.00	05900 CARDI AC CATHETERI ZATI ON	(			0	0	59.00
60.00 63.00	06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS.					100 0	60.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	(			0	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY					0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0			0 0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY					0	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	(				0	71.00
	07300 DRUGS CHARGED TO PATIENTS				100	0	
	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON					0	74.00 76.97
70.97	OUTPATIENT SERVICE COST CENTERS					0	/0.9/
	09000 CLI NI C 09100 EMERGENCY	(				0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	91.00
	OTHER REIMBURSABLE COST CENTERS	- 					
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		) C	<u>и (</u>	0 0	0	101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	(	D C	) (	100	100	118.00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(			0 0	0	190.00
191.00	19100 RESEARCH	0				0	191.00
	19200 PHYSI CLANS' PRI VATE OFFICES 07950 OTHER NONRELMBURSEABLE				0 0 0 0		192.00 194.00
		•	•	•	,		·

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2021	Worksheet B-1	
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		INTERNS &	RESI DENTS			
Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHEF PRGMCOSTS APPRV	R PARAMED ED PRGM- (PHARMACY	PARAMED ED PRGM-(LAB MLS)	
	TIME)	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
	,	TIME)	TIME)	TIME)	TIME)	
	19.00	21.00	22.00	23.00	23.01	
194. 01 07951 ADVERTI SI NG	0	0	(	0 0		194.01
194.0207952 RETAIL PHARMACY	0	0	(	0 0		194. 02
194. 03 07953 FI TNESS POI NTE	0	0	(	0 0		194.03
194. 04 07954 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY	0	0	(	0 0		194.04
194.0507955 EINSTEIN BAGELS	0	0	(	0 0		194.05
194.06 07956 NONRTHWESTERN I MAGI NG	0	0	(	0 0	0	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers				(77.000		201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	0	0	(	477, 308	360, 374	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.00000	4, 773. 080000	3, 603. 740000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0	(	6, 485	23, 005	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	64. 850000	230. 050000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0	0	206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000	0.000000	207. 00

	inancial Systems	COMMUNI TY				u of Form CMS-	2552-10
COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/22/2022 9:	pared:
			Title	XVIII	Hospi tal	PPS	20 011
					Costs	110	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	87, 766, 966		87, 766, 9			
	3100 INTENSIVE CARE UNIT	25, 942, 965		25, 942, 9	65 0	25, 942, 965	31.00
	2060 NEONATAL INTENSIVE CARE	6, 562, 283		6, 562, 2		-,,	
	4100 SUBPROVI DER – I RF	2, 813, 156		2, 813, 1		_, ,	
	4300 NURSERY	2, 936, 942		2, 936, 9	42 0	2, 936, 942	43.00
	VCILLARY SERVICE COST CENTERS	- 1		1			
	5000 OPERATING ROOM	55, 118, 472		55, 118, 4			
	5100 RECOVERY ROOM	13, 717, 619		13, 717, 6		- 1 - 1 -	1
	5200 DELIVERY ROOM & LABOR ROOM	6, 193, 705		6, 193, 70			
	5300 ANESTHESI OLOGY	5, 242, 598		5, 242, 5			
	5400 RADI OLOGY-DI AGNOSTI C	12, 504, 667		12, 504, 6		12, 504, 667	
	5500 RADI OLOGY-THERAPEUTI C	6, 988, 042		6, 988, 0		6, 988, 042	
	5600 RADI OI SOTOPE	3, 837, 024		3, 837, 0		3, 837, 024	
	5700 CT SCAN	6, 062, 687		6, 062, 6		6, 062, 687	
		4,002,538		4,002,5		.,,	
	5900 CARDI AC CATHETERI ZATI ON	12, 360, 466		12, 360, 4		1 1	
	6000 LABORATORY	28, 210, 700		28, 210, 70			
	6300 BLOOD STORING, PROCESSING & TRANS.	3, 706, 445		3, 706, 4		3, 706, 445	
	6400 I NTRAVENOUS THERAPY 6500 RESPI RATORY THERAPY	974, 525		974, 5		974, 525	
	6600 PHYSICAL THERAPY	8, 856, 785 12, 301, 251	0				
	6700 OCCUPATI ONAL THERAPY	3, 120, 482					1
	6800 SPEECH PATHOLOGY	2, 504, 270		2, 504, 2		2, 504, 270	1
	6900 ELECTROCARDI OLOGY	8, 234, 429		8, 234, 4			
	7000 ELECTROENCEPHALOGRAPHY	2, 082, 292		2, 082, 2		2, 082, 292	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	36, 035, 573		36, 035, 5		36, 035, 573	
	7200 I MPL. DEV. CHARGED TO PATIENTS	45, 503, 145		45, 503, 1			
	7300 DRUGS CHARGED TO PATIENTS	28, 694, 139		28, 694, 1		28, 694, 139	
	7400 RENAL DIALYSIS	2, 568, 695		2, 568, 6			
	7697 CARDI AC REHABI LI TATI ON	1, 584, 673		1, 584, 6		_,,	1
	JTPATIENT SERVICE COST CENTERS	.,		.,		.,	
	9000 CLINIC	5, 392, 504		5, 392, 50	04 0	5, 392, 504	90.00
	9100 EMERGENCY	19, 038, 656		19, 038, 6			
	9200 OBSERVATION BEDS (NON-DISTINCT PART	17, 491, 950		17, 491, 9		17, 491, 950	
	THER REIMBURSABLE COST CENTERS			· · · · ·			1
101.0010	D100 HOME HEALTH AGENCY	7, 260, 345		7, 260, 3	45	7, 260, 345	101.00
200.00	Subtotal (see instructions)	485, 610, 989	0	485, 610, 9	39 0		
201.00	Less Observation Beds	17, 491, 950		17, 491, 9		17, 491, 950	
202.00	Total (see instructions)	468, 119, 039	0	468, 119, 03	39 0	468, 119, 039	202.00

	Financial Systems	COMMUNI TY H				u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/22/2022 9:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Inpatient	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	7100	10100	
30.00	03000 ADULTS & PEDI ATRI CS	125, 042, 707		125, 042, 70	07		30.00
31.00	03100 I NTENSI VE CARE UNI T	35, 571, 109		35, 571, 10			31.00
31.01	02060 NEONATAL INTENSIVE CARE	21, 785, 651		21, 785, 6			31.01
41.00	04100 SUBPROVI DER – I RF	3, 236, 056		3, 236, 0			41.00
43.00	04300 NURSERY	6, 024, 116		6, 024, 1			43.00
10.00	ANCI LLARY SERVI CE COST CENTERS	0,021,110		0,021,1	10		10.00
50.00	05000 OPERATI NG ROOM	107, 797, 983	210, 909, 335	318, 707, 3	0. 172944	0.00000	50.00
51.00	05100 RECOVERY ROOM	7, 409, 960	28, 081, 440			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 854, 924	1, 290, 236			0. 000000	
53.00	05300 ANESTHESI OLOGY	15, 075, 701	38, 035, 275			0. 000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 144, 101	78, 117, 579			0.000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 215, 378	47, 299, 974			0.000000	
56.00	05600 RADI OI SOTOPE	3, 458, 128	33, 320, 849			0.000000	
57.00	05700 CT SCAN	38, 516, 561	94, 126, 356			0.000000	
58.00	05800 MRI	15, 180, 119	51,056,743			0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	53, 579, 735	109, 346, 505			0.000000	
60.00	06000 LABORATORY	75, 452, 255	172, 852, 009			0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	7, 682, 663	4, 703, 122			0.000000	
64.00	06400 I NTRAVENOUS THERAPY	35, 666	4, 655, 388			0.000000	
65.00	06500 RESPIRATORY THERAPY	21, 211, 512	3, 156, 372			0.000000	
66.00	06600 PHYSI CAL THERAPY	9, 290, 840	25, 535, 831			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	7, 474, 985	4, 974, 966			0.000000	
68.00	06800 SPEECH PATHOLOGY	2, 324, 928	3, 856, 818			0.000000	
69.00	06900 ELECTROCARDI OLOGY	26, 823, 193	61, 070, 853			0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 180, 806	17, 527, 849			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	33, 078, 297	34, 223, 379			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	49, 497, 411	43, 462, 352			0. 000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	87, 597, 398	63, 783, 620			0.000000	
74.00	07400 RENAL DIALYSIS	7, 740, 961	1, 877, 751			0.000000	
76.97	07697 CARDI AC REHABI LI TATI ON	425, 948	3, 717, 299			0.000000	
,0. ,1	OUTPATIENT SERVICE COST CENTERS	723, 740	5, 717, 277	I 7, 173, 2	0.302471	0.00000	1 '0. //
90.00	09000 CLINIC	448,042	14, 800, 714	15, 248, 7	56 0. 353636	0.00000	90.00
90.00 91.00	09100 EMERGENCY	57, 942, 374	113, 433, 793			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 652, 766	44, 561, 891			0.000000	
,2.00	OTHER REIMBURSABLE COST CENTERS	5,052,700	11, 301, 371	1 01, 217, 0	0. 041042	0.000000	1 2.00
101 00	10100 HOME HEALTH AGENCY	0	9, 409, 969	9, 409, 9	59		101.00
200.00		-	1, 319, 188, 268				200.00
		002,102,214	., , 100, 200				201.00
201.00							

Heal th Financial Systems     COMMUNITY HOSPITAL     In Lieu of Form CM       COMPUTATION OF RATIO OF COSTS TO CHARGES     Provider CCN: 15-0125     Period: From 07/01/2021     Worksheet ( Part I Date/Time F 11/22/2022       Cost Center Description     PPS Inpatient Ratio     PS Inpatient     Period: From 07/01/2021	Prepared: 9:20 am
Cost Center Description PPS Inpatient	
Ratio	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS	30.00
31. 00 03100 I NTENSI VE CARE UNI T	31.00
31. 01 02060 NEONATAL INTENSIVE CARE	31.01
41. 00 04100 SUBPROVIDER - IRF	41.00
43. 00 04300 NURSERY	43.00
ANCILLARY SERVICE COST CENTERS	- 10100
50.00 [05000] OPERATI NG ROOM 0. 172944	50.00
51. 00   05100   RECOVERY ROOM 0. 385505	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 610508	52.00
53. 00 05300 ANESTHESI OLOGY 0. 098710	53.00
54. 00   05400  RADI 0LOGY-DI AGNOSTI C 0. 137020	54.00
55. 00   05500   RADI 0L0GY-THERAPEUTI C 0. 141129	55.00
56. 00 05600 RADI 0I SOTOPE 0. 104327	56.00
57. 00 05700 CT SCAN 0. 045707	57.00
58. 00 05800 MRI 0. 060428	58.00
59. 00 05900 CARDIAC CATHETERIZATION 0. 075865	59.00
60. 00 06000 LABORATORY 0. 113613	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 299250	63.00
64. 00 06400 I NTRAVENOUS THERAPY 0. 207741	64.00
65. 00 06500 RESPI RATORY THERAPY 0. 363461	65.00
66. 00 06600 PHYSI CAL THERAPY 0. 353214	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 250642	67.00
68. 00 06800 SPEECH PATHOLOGY 0. 405107	68.00
69. 00 06900 ELECTROCARDI OLOGY 0. 093686	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 105654	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 535434	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 489493	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 189549	73.00
74. 00 07400 RENAL DIALYSIS 0. 267052	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 382471	76.97
OUTPATIENT SERVICE COST CENTERS	- /0. //
90. 00 09000 CLINIC 0. 353636	90.00
91. 00 09100 EMERGENCY 0. 111093	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0. 341542	91.00
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	101 00
	101.00
200.00 Subtotal (see instructions)	200.00
201.00 Less Observation Beds	201.00
202.00   Total (see instructions)	202.00

Health Fir	nancial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/22/2022 9:	pared: 20 am
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
I NF	PATIENT ROUTINE SERVICE COST CENTERS			_			
30.00 030	000 ADULTS & PEDIATRICS	87, 766, 966		87, 766, 96	0 0	87, 766, 966	30.00
31.00 031	100 INTENSIVE CARE UNIT	25, 942, 965		25, 942, 96	5 0	25, 942, 965	31.00
31.01 020	060 NEONATAL INTENSIVE CARE	6, 562, 283		6, 562, 28	3 0	6, 562, 283	31.01
41.00 041	100 SUBPROVI DER – I RF	2, 813, 156		2, 813, 15	6 0	2, 813, 156	41.00
	300 NURSERY	2, 936, 942		2, 936, 94	2 0	2, 936, 942	43.00
ANC	CILLARY SERVICE COST CENTERS						
	DOOOOPERATING ROOM	55, 118, 472		55, 118, 47	2 0	55, 118, 472	50.00
51.00 051	100 RECOVERY ROOM	13, 717, 619		13, 717, 61	9 0	13, 717, 619	
	200 DELIVERY ROOM & LABOR ROOM	6, 193, 705		6, 193, 70	05 0	6, 193, 705	52.00
	300 ANESTHESI OLOGY	5, 242, 598		5, 242, 59	0 8	5, 242, 598	53.00
	400 RADI OLOGY-DI AGNOSTI C	12, 504, 667		12, 504, 66		12, 504, 667	
	500 RADI OLOGY-THERAPEUTI C	6, 988, 042		6, 988, 04		6, 988, 042	
	600 RADI OI SOTOPE	3, 837, 024		3, 837, 02		3, 837, 024	
	700 CT SCAN	6, 062, 687		6, 062, 68		6, 062, 687	
	800 MRI	4, 002, 538		4, 002, 53		4, 002, 538	
	900 CARDI AC CATHETERI ZATI ON	12, 360, 466		12, 360, 46		12, 360, 466	
	DOO LABORATORY	28, 210, 700		28, 210, 70		28, 210, 700	
	300 BLOOD STORING, PROCESSING & TRANS.	3, 706, 445		3, 706, 44		3, 706, 445	
	400 I NTRAVENOUS THERAPY	974, 525		974, 52		974, 525	
	500 RESPI RATORY THERAPY	8, 856, 785				8, 856, 785	
	600 PHYSI CAL THERAPY	12, 301, 251				12, 301, 251	
	700 OCCUPATI ONAL THERAPY	3, 120, 482		0/120/10		3, 120, 482	
	800 SPEECH PATHOLOGY	2, 504, 270		2, 504, 27		2, 504, 270	1
	900 ELECTROCARDI OLOGY	8, 234, 429		8, 234, 42		8, 234, 429	
	000 ELECTROENCEPHALOGRAPHY	2, 082, 292		2, 082, 29		2, 082, 292	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	36, 035, 573		36, 035, 57		36, 035, 573	
	200 IMPL. DEV. CHARGED TO PATIENTS	45, 503, 145		45, 503, 14		45, 503, 145	
	300 DRUGS CHARGED TO PATIENTS	28, 694, 139		28, 694, 13		28, 694, 139	
	400 RENAL DIALYSIS	2, 568, 695		2, 568, 69		2, 568, 695	
	697 CARDI AC REHABI LI TATI ON	1, 584, 673		1, 584, 67	3 0	1, 584, 673	76.97
	TPATIENT SERVICE COST CENTERS	5 000 504		<u> </u>	. d	E 000 E01	
		5, 392, 504		5, 392, 50		5, 392, 504	
	100 EMERGENCY	19, 038, 656		19, 038, 65		19, 038, 656	
	200 OBSERVATION BEDS (NON-DISTINCT PART HER REIMBURSABLE COST CENTERS	17, 491, 950		17, 491, 95	0	17, 491, 950	92.00
	100 HOME HEALTH AGENCY	7, 260, 345		7, 260, 34	c	7, 260, 345	101 00
200.00	Subtotal (see instructions)	485, 610, 989				7, 260, 345 485, 610, 989	
200.00	Less Observation Beds	485, 610, 989		485, 610, 98		485, 610, 989	
201.00	Total (see instructions)	468, 119, 039					
202.00		400, 117, 039	0	400, 119, 03	<sup>17</sup>	400, 117, 039	202.00

	Financial Systems	COMMUNI TY H				u of Form CMS-2552-10	
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre	epared:
						11/22/2022 9:	
				e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col.		TEFRA	
				+ col. 7)	Ratio	Inpatient	
		(				Ratio	
	UNDATIONT DOUTING CODVING COCT CONTERC	6.00	7.00	8.00	9.00	10.00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	105 040 707		105 040 7	07		20.00
30.00	03000 ADULTS & PEDIATRICS	125, 042, 707		125, 042, 7			30.00
31.00	03100 I NTENSI VE CARE UNI T	35, 571, 109		35, 571, 1			31.00
31.01	02060 NEONATAL INTENSIVE CARE	21, 785, 651		21, 785, 6			31.01
41.00	04100 SUBPROVIDER - IRF	3, 236, 056		3, 236, 0			41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	6, 024, 116		6, 024, 1	10		43.00
50.00	05000 OPERATING ROOM	107, 797, 983	210, 909, 335	210 707 2	0. 172944	0. 000000	50.00
50.00	05100 RECOVERY ROOM	7, 409, 960	28, 081, 440			0.000000	
51.00	05200 DELIVERY ROOM & LABOR ROOM	8, 854, 924	28, 081, 440			0.000000	
52.00	05300 ANESTHESI OLOGY						
53.00	05400 RADI OLOGY-DI AGNOSTI C	15,075,701	38,035,275			0.000000	
54.00	05500 RADI OLOGY-DI AGNOSTI C	13, 144, 101	78, 117, 579			0.000000	
55.00	05600 RADI OLOGY - THERAPEUTI C	2, 215, 378	47, 299, 974			0.000000	
	05700 CT SCAN	3, 458, 128	33, 320, 849			0.000000	
57.00 58.00	05800 MRI	38, 516, 561 15, 180, 119	94, 126, 356 51, 056, 743			0. 000000 0. 000000	
58.00	05900 CARDI AC CATHETERI ZATI ON	53, 579, 735	109, 346, 505			0.000000	
60.00	06000 LABORATORY	75, 452, 255	172, 852, 009			0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	7, 682, 663	4, 703, 122			0.000000	
64.00	06400 INTRAVENOUS THERAPY	35,666	4, 655, 388			0.000000	
65.00	06500 RESPIRATORY THERAPY	21, 211, 512	4, 055, 388			0.000000	
66.00	06600 PHYSI CAL THERAPY	9, 290, 840	25, 535, 831			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	7, 474, 985	4, 974, 966			0.000000	
68.00	06800 SPEECH PATHOLOGY	2, 324, 928	3, 856, 818			0.000000	
69.00	06900 ELECTROCARDI OLOGY	26, 823, 193	61, 070, 853			0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 180, 806	17, 527, 849			0.000000	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	33, 078, 297	34, 223, 379			0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	49, 497, 411	43, 462, 352			0.000000	
72.00	07300 DRUGS CHARGED TO PATIENTS	87, 597, 398	63, 783, 620			0.000000	
74.00	07400 RENAL DIALYSIS	7, 740, 961	1, 877, 751			0.000000	
76.97	07607 CARDI AC REHABI LI TATI ON	425, 948	3, 717, 299			0.000000	
/0. 7/	OUTPATIENT SERVICE COST CENTERS	423, 740	5, 717, 277	4, 143, 2	0. 302471	0.000000	/0. 7/
90.00	09000 CLINIC	448.042	14, 800, 714	15, 248, 7	56 0. 353636	0.000000	90.00
91.00	09100 EMERGENCY	57, 942, 374	113, 433, 793			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 652, 766	44, 561, 891			0.000000	
, 2. 00	OTHER REIMBURSABLE COST CENTERS	0,002,700	11,001,071	01,214,0	0.011042	0.00000	/2.00
101.00	10100 HOME HEALTH AGENCY	0	9, 409, 969	9, 409, 9	69		1101.00
200.00		-	1, 319, 188, 268				200.00
201.00		552, 752, 271	., ,				201.00
	00001 1011 0000	852, 752, 274		1	1		0

Health Financial Systems	COMMUNI TY HO	OSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0125	Peri od:	Worksheet C	
			From 07/01/2021 To 06/30/2022	Part I Date/Time Pre	pared:
				11/22/2022 9:	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00  03100   NTENSI VE CARE UNI T					31.00
31. 01 02060 NEONATAL INTENSIVE CARE					31.00
41. 00  04100  SUBPROVIDER - IRF					41.00
43. 00  04300 NURSERY					41.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM	0. 172944				50.00
51. 00 05100 RECOVERY ROOM	0. 386505				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 610508				52.00
53. 00 05300 ANESTHESI OLOGY	0.098710				53.00
54. 00  05400 RADI OLOGY-DI AGNOSTI C	0. 137020				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 137020				55.00
56. 00 05600 RADI 01 SOTOPE	0. 104327				56.00
57. 00 05700 CT SCAN	0. 104327				57.00
58. 00   05800 MRI	0. 043707				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 075865				59.00
60. 00 06000 LABORATORY	0. 113613				60.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0. 299250				63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 207741				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 363461				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 353214				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 250642				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 405107				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 093686				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 105654				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 535434				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 489493				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 189549				73.00
74. 00 07400 RENAL DI ALYSI S	0. 267052				74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 382471				76.97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 353636				90.00
91. 00 09100 EMERGENCY	0. 111093				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 341542				92.00
OTHER REIMBURSABLE COST CENTERS					1
101.00 10100 HOME HEALTH AGENCY					101.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Heal th Financial Systems CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RAT REDUCTIONS FOR MEDICAID ONLY Cost Center Description	Total Cost			Period: From 07/01/2021	Worksheet C Part II	
				To 06/30/2022	Date/Time Pre 11/22/2022 9:1	pared: 20 am
			e XIX	Hospi tal	PPS	
ANCI LLARY SERVI CE COST CENTERS		Capital Cost	Operating Cos	t Capital	Operating Cost	
ANCI LLARY SERVI CE COST CENTERS	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	Al Reduction	Reduction	
ANCI LLARY SERVI CE COST CENTERS	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
ANCI LLARY SERVI CE COST CENTERS			col. 2)			
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	55, 118, 472	5, 243, 831	49, 874, 64	1 0	0	50.00
51.00 05100 RECOVERY ROOM	13, 717, 619	1, 009, 046	12, 708, 57	/3 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 193, 705				0	52.00
53. 00 05300 ANESTHESI OLOGY	5, 242, 598				0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	12, 504, 667	1, 753, 394			0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	6, 988, 042				0	55.00
56. 00 05600 RADI OI SOTOPE	3, 837, 024				0	56.00
57. 00 05700 CT SCAN	6,062,687	934, 747	5, 127, 94		0	57.00
58. 00 05800 MRI	4,002,538				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	12, 360, 466				0	59.00
60. 00 06000 LABORATORY	28, 210, 700		26, 769, 94	-	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 706, 445				0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	974, 525		844, 50		0	
65. 00 06500 RESPIRATORY THERAPY	8, 856, 785				0	65.00
66. 00 06600 PHYSI CAL THERAPY	12, 301, 251	729, 357	11, 571, 89		0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY	3, 120, 482				0	67.00
68. 00 106800 SPEECH PATHOLOGY	2, 504, 270				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	8, 234, 429				0	69.00
70. 00 107000 ELECTROCARDI OLOGI 70. 00 107000 ELECTROENCEPHALOGRAPHY	2, 082, 292				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	36, 035, 573				0	71.00
					-	
	45, 503, 145		45, 352, 54		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	28, 694, 139				0	
74.00 07400 RENAL DI ALYSI S	2, 568, 695				0	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	1, 584, 673	127, 263	1, 457, 41	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	5, 392, 504				0	
91. 00 09100 EMERGENCY	19, 038, 656				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 491, 950	967, 060	16, 524, 89	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	7, 260, 345					101.00
200.00 Subtotal (sum of lines 50 thru 199)	359, 588, 677					200.00
201.00 Less Observation Beds	17, 491, 950					201.00
202.00  Total (line 200 minus line 201)	342, 096, 727	20, 895, 271	321, 201, 45	6 0	0	202.00

ealth Financial Systems ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE	COMMUNITY RATIOS NET OF		CN: 15-0125	Period:	u of Form CMS- Worksheet C	2002
EDUCTIONS FOR MEDICALD ONLY			0111 10 0120	From 07/01/2021	Part II	
				To 06/30/2022	Date/Time Pre	parec
		T: +1	e XIX	11	11/22/2022 9: PPS	20 an
Cost Center Description	Cost Net of	Total Charges		Hospi tal	PP5	
cost center bescription	Capital and	(Worksheet C,	Cost to Char	<b>a</b> 0		
	Operating Cost					
	Reduction	8)	/ col. 7	0		
	6.00	7.00	8,00			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00			
D. 00 05000 OPERATING ROOM	55, 118, 472	318, 707, 318	0. 1729	44		50.
1. 00 05100 RECOVERY ROOM	13, 717, 619					51.
2. 00 05200 DELIVERY ROOM & LABOR ROOM	6, 193, 705					52.
3. 00 05300 ANESTHESI OLOGY	5, 242, 598					53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 504, 667	91, 261, 680				54.
5. 00 05500 RADI OLOGY-THERAPEUTI C	6, 988, 042	49, 515, 352				55.
6. 00 05600 RADI OI SOTOPE	3, 837, 024					56.
7. 00 05700 CT SCAN	6, 062, 687	132, 642, 917				57.
B. 00 05800 MRI	4, 002, 538	66, 236, 862				58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	12, 360, 466					59.
D. 00 06000 LABORATORY	28, 210, 700					60.
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 706, 445	12, 385, 785				63.
4. 00 06400 I NTRAVENOUS THERAPY	974, 525	4, 691, 054				64.
5. 00 06500 RESPI RATORY THERAPY	8, 856, 785					65.
6. 00 06600 PHYSI CAL THERAPY	12, 301, 251	34, 826, 671				66.
7. 00 06700 OCCUPATI ONAL THERAPY	3, 120, 482	12, 449, 951				67.
B. 00 06800 SPEECH PATHOLOGY	2, 504, 270	6, 181, 746				68.
9. 00 06900 ELECTROCARDI OLOGY	8, 234, 429					69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	2, 082, 292					70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	36, 035, 573	67, 301, 676				71.
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	45, 503, 145	92, 959, 763				72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	28, 694, 139					73.
4. 00 07400 RENAL DIALYSIS	2, 568, 695					74.
6. 97 07697 CARDI AC REHABI LI TATI ON	1, 584, 673					76.
OUTPATIENT SERVICE COST CENTERS	1, 304, 073	7, 175, 247	0.3024	· · · ·		1 '0.
D. 00 09000 CLINIC	5, 392, 504	15, 248, 756	0. 3536	36		90.
1. 00 09100 EMERGENCY	19, 038, 656					91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 491, 950					92.
OTHER REIMBURSABLE COST CENTERS	17, 171, 750	51,211,037	0.0410	·~		1
D1. 00 10100 HOME HEALTH AGENCY	7, 260, 345	9, 409, 969	0. 7715	59		101.
00.00 Subtotal (sum of lines 50 thru 199)		1, 980, 280, 903		~		200.
01.00 Less Observation Beds	17, 491, 950					200.
D2. 00 Total (line 200 minus line 201)		1, 980, 280, 903				201.

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS		Provider CCN: 15-0125		Date/Time Pre 11/22/2022 9:	pared: 20 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 852, 302	C	4, 852, 30	2 84, 340	57.53	30.00
31.00 INTENSIVE CARE UNIT	1, 571, 668		1, 571, 66	8 11, 221	140.06	31.00
31.01 NEONATAL INTENSIVE CARE	371, 247		371, 24	7 3, 494	106.25	31.01
41.00 SUBPROVIDER – IRF	155, 163	C	155, 16	3 2, 187	70.95	41.00
43.00 NURSERY	92, 031		92, 03	1 2, 863	32.14	43.00
200.00 Total (lines 30 through 199)	7,042,411		7, 042, 41	1 104, 105		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	27,436	1, 578, 393				30.00
31.00 INTENSIVE CARE UNIT	3, 500	490, 210				31.00
31.01 NEONATAL INTENSIVE CARE	0	0				31.01
41.00 SUBPROVIDER - IRF	1, 552	110, 114	ļ			41.00
43.00 NURSERY	0		1			43.00
200.00 Total (lines 30 through 199)	32, 488	2, 178, 717	,			200. 00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	r		-	r	
50.00 05000 OPERATI NG ROOM	5, 243, 831					
51.00 05100 RECOVERY ROOM	1, 009, 046					
52.00 05200 DELIVERY ROOM & LABOR ROOM	373, 834					
53. 00 05300 ANESTHESI OLOGY	252, 909					
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 753, 394	91, 261, 680	0. 0192	4, 924, 110	94, 607	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	1, 899, 716	49, 515, 352	0. 03836	6 1, 029, 535	39, 499	55.00
56. 00 05600 RADI OI SOTOPE	505, 078	36, 778, 977	0. 01373	1, 590, 030	21, 836	56.00
57.00 05700 CT SCAN	934, 747	132, 642, 917	0.00704	15, 533, 779	109, 467	57.00
58. 00 05800 MRI	558, 645	66, 236, 862	0.00843	5, 866, 947	49, 482	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 250, 539	162, 926, 240	0. 0138	3 23, 479, 521	324, 323	59.00
60. 00 06000 LABORATORY	1, 440, 751	248, 304, 264	0.00580	28, 296, 105	164, 174	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	65, 750	12, 385, 785	0.00530	2, 585, 316	13, 725	63.00
64.00 06400 I NTRAVENOUS THERAPY	130, 025	4, 691, 054	0. 0277	0 8	0	64.00
65. 00 06500 RESPI RATORY THERAPY	600, 188	24, 367, 884	0. 02463	7, 728, 561	190, 354	65.00
66. 00 06600 PHYSI CAL THERAPY	729, 357	34, 826, 671	0. 02094	3, 536, 773	74,067	66.00
67.00 06700 OCCUPATI ONAL THERAPY	90, 742	12, 449, 951	0.00728	2, 815, 775	20, 524	67.00
68.00 06800 SPEECH PATHOLOGY	85, 320					68.00
69. 00 06900 ELECTROCARDI OLOGY	879, 162	87, 894, 046	0.0100	11, 617, 777	116, 213	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	116, 419			737,076		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	118, 327					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	150, 601					
73.00 07300 DRUGS CHARGED TO PATIENTS	458, 029					
74. 00 07400 RENAL DI ALYSI S	34, 519					
76. 97 07697 CARDI AC REHABI LI TATI ON	127, 263					76.97
OUTPATIENT SERVICE COST CENTERS		.,,			., ., .,	1
90. 00 09000 CLINIC	201,075	15, 248, 756	0. 01318	36 174, 695	2, 304	90.00
91. 00 09100 EMERGENCY	861, 762					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	967,060					
200.00 Total (lines 50 through 199)		1, 970, 870, 934		251, 995, 285		

Health Financial Systems	COMMUNI TY F	IOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COST			Period: From 07/01/2021 To 06/30/2022	11/22/2022 9:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATI ENT ROUTINE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS           31.00         03100         INTENSIVE CARE UNIT           31.01         02060         NEONATAL INTENSIVE CARE           41.00         04100         SUBPROVIDER - IRF           43.00         04300         NURSERY           200.00         Total (lines 30 through 199)	S 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0	31.00 31.01 41.00
Cost Center Description	Amount (see	Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00	Total Patient Days 6.00	Per Diem (col. 5 ÷ col. 6) 7.00	Inpatient Program Days 8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNIT 31. 01 02060 NEONATAL I NTENSI VE CARE 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0	0 0 0 0 0	11, 22 3, 49 2, 18 2, 86	1 0.00 4 0.00 7 0.00 3 0.00	0 1, 552 0	31.00 31.01 41.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x <u>col. 8)</u> 9.00		1 101,10	~ <u>1</u>	32,400	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         INTENSI VE CARE UNI T           31. 01         02060         NEONATAL INTENSI VE CARE           41. 00         04100         SUBPROVI DER - IRF           43. 00         04300         NURSERY           200. 00         Total (lines 30 through 199)	S 0 0 0 0 0 0 0 0					30. 00 31. 00 31. 01 41. 00 43. 00 200. 00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	6 Provider C	CN: 15-0125	Peri From To	od: n 07/01/2021 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	pared: 20 am
		Title	e XVIII		Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Po	lied Health ost-Stepdown djustments	Allied Health	
	1.00	2A	2.00		3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	0	0		0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	0	57.00
58. 00 05800 MRI	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	360, 374	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	477, 308	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	0		0	0	0	90.00
91. 00 09100 EMERGENCY	0	0		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92.00
200.00  Total (lines 50 through 199)	0	0		0	0	837, 682	200. 00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
		Title	e XVIII	Hospi tal	11/22/2022 9: PPS	<u>20 am</u>
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
COST CENTER Description	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Educati on Cost		Cost (sum of		$(col. 5 \div col.$	
		4)	col s. 2, 3,	8)	7)	
		.,	and 4)	-,	(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 318, 707, 318	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 35, 491, 400	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 10, 145, 160	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 53, 110, 976	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 91, 261, 680	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 49, 515, 352	0.000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 36, 778, 977	0. 000000	56.00
57.00 05700 CT SCAN	0	0		0 132, 642, 917	0. 000000	57.00
58.00 05800 MRI	0	0		0 66, 236, 862	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 162, 926, 240		59.00
60. 00 06000 LABORATORY	0	360, 374	360, 37	248, 304, 264	0. 001451	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 12, 385, 785	0. 000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 4, 691, 054	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 24, 367, 884	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 34, 826, 671	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 12, 449, 951	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 6, 181, 746	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 87, 894, 046	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 19, 708, 655	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 67, 301, 676	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 92, 959, 763	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	477, 308	477, 30	08 151, 381, 018	0.003153	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 9, 618, 712	0.000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 143, 247	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS	_				-	
90. 00 09000 CLINIC	0	0		0 15, 248, 756		
91.00 09100 EMERGENCY	0	0		0 171, 376, 167		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 51, 214, 657		
200.00  Total (lines 50 through 199)	0	837, 682	837, 68	32 1, 970, 870, 934		200. 00

Health Financial Systems	COMMUNITY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	-	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0.000000	39, 179, 328		0 57, 342, 541	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	2, 676, 065		0 7, 858, 641	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	20, 090		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0.000000	5, 471, 885		0 9, 598, 639	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	4, 924, 110		0 17, 842, 404	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	1, 029, 535		0 20, 659, 734	0	55.00
56. 00 05600 RADI OI SOTOPE	0.000000	1, 590, 030		0 11, 985, 595	0	56.00
57.00 05700 CT SCAN	0.000000	15, 533, 779		0 27, 503, 211	0	57.00
58. 00 05800 MRI	0.000000	5, 866, 947		0 13, 950, 209	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	23, 479, 521		0 44, 591, 590	0	59.00
60. 00 06000 LABORATORY	0. 001451	28, 296, 105	41, 05	58 17, 040, 620	24, 726	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	2, 585, 316		0 1, 403, 070	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 2, 195, 575	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0.000000	7, 728, 561		0 933, 011	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	3, 536, 773		0 358, 310	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	2, 815, 775		0 320, 159	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	756, 368		0 311, 660	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	11, 617, 777		0 22, 679, 242	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	737, 076		0 4, 625, 360	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	12, 784, 848		0 11, 219, 148	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	22, 449, 853		0 15, 792, 813	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.003153	29, 315, 175	92, 43	25, 969, 492	81, 882	73.00
74.00 07400 RENAL DIALYSIS	0.000000	2, 936, 162		0 1,077,538	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	146, 208		0 1, 771, 475	0	76.97
OUTPATIENT SERVICE COST CENTERS	. · · · · · · · · · · · · · · · · · · ·			- · · · ·		
90. 00 09000 CLINIC	0.000000	174, 695		0 6, 097, 049	0	90.00
91. 00 09100 EMERGENCY	0.000000	23, 103, 793		0 18, 352, 166		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3, 239, 510		0 12,065,055		92.00
200.00 Total (lines 50 through 199)		251, 995, 285				200.00
						•

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0125	Period: From 07/01/2021 To 06/30/2022		pared:
					11/22/2022 9:	20 am
			XVIII	Hospi tal	PPS Costs	
Cast Castar Description	Cost to Charge	DDC Deimburged	Charges Cost	Cost	PPS Services	
Cost Center Description		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(See Thst.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coi ns			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATI NG ROOM	0. 172944	57, 342, 541		0 0	9, 917, 048	50.00
51.00 05100 RECOVERY ROOM	0. 386505			0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 610508			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 098710			0 0	947, 482	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 137020			0 0	2, 444, 766	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 141129			0 0	2, 915, 688	
56. 00 05600 RADI OI SOTOPE	0. 104327			0 0	1, 250, 421	56.00
57. 00 05700 CT SCAN	0. 045707	27, 503, 211		0 0	1, 257, 089	57.00
58. 00 05800 MRI	0. 060428			0 0	842, 983	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 075865			0 0		59.00
60. 00 06000 LABORATORY	0. 113613			0 0		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 299250			0 0	419, 869	1
64. 00 06400 I NTRAVENOUS THERAPY	0. 207741			0 0	456, 111	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 363461	933, 011		0 0	339, 113	
66. 00 06600 PHYSI CAL THERAPY	0. 353214			0 0	126, 560	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 250642			0 0		67.00
68. 00 06800 SPEECH PATHOLOGY	0. 405107			0 0	126, 256	
69. 00 06900 ELECTROCARDI OLOGY	0. 093686			0 0	2, 124, 727	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 105654			0 0	488, 688	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 535434			0 0	6, 007, 113	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 489493			0 0	7, 730, 471	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 189549			0 72,659		73.00
74. 00 07400 RENAL DIALYSIS	0. 267052			0 0		
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 382471			0 0		1
OUTPATIENT SERVICE COST CENTERS		.,	1	-		
90. 00 09000 CLI NI C	0. 353636	6, 097, 049		0 0	2, 156, 136	90.00
91.00 09100 EMERGENCY	0. 111093			0 0	2, 038, 797	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 341542			0 0	4, 120, 723	92.00
200.00 Subtotal (see instructions)		353, 544, 307		0 72, 659		
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		353, 544, 307		0 72,659	60, 034, 455	202.00

	Ith Financial Systems		HOSPI TAL			In Lieu of Form CMS-2552		
APPOR I I ONM	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0125	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pr 11/22/2022 9	epared: :20 am	
		_	Title	XVIII	Hospi tal	PPS		
		Cos	sts					
	Cost Center Description	Cost	Cost					
		Reimbursed	Reimbursed					
		Servi ces	Services Not					
		Subject To	Subject To					
		Ded. & Coins.	Ded. & Coins.					
		(see inst.)	(see inst.)	-				
		6.00	7.00					
	LLARY SERVICE COST CENTERS	1						
	DO OPERATING ROOM	0					50.00	
	DO RECOVERY ROOM	0					51.00	
	DO DELIVERY ROOM & LABOR ROOM	0	0	1			52.00	
	DO ANESTHESI OLOGY	0	0	1			53.00	
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	0	0				54.00	
55.00 0550	00 RADI OLOGY-THERAPEUTI C	0	0				55.0	
56.00 0560	DO RADI OI SOTOPE	0	0				56.0	
57.00 0570	DO CT SCAN	0	C				57.0	
58.00 0580	DO MRI	0	0				58.00	
59.00 0590	DO CARDI AC CATHETERI ZATI ON	0	C	)			59.00	
60.00 0600	DO LABORATORY	0	0	)			60.00	
63.00 0630	DO BLOOD STORING, PROCESSING & TRANS.	0	0				63.0	
64.00 0640	DO INTRAVENOUS THERAPY	0	0				64.0	
65.00 0650	00 RESPI RATORY THERAPY	0	0				65.0	
66.00 0660	00 PHYSI CAL THERAPY	0	0				66.0	
67.00 0670	00 OCCUPATIONAL THERAPY	0	0				67.0	
58.00 0680	DO SPEECH PATHOLOGY	0	0				68.0	
69.00 0690	DO ELECTROCARDI OLOGY	0	0				69.0	
70.00 0700	00 ELECTROENCEPHALOGRAPHY	0	0				70.0	
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.0	
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0	
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0	13, 772				73.0	
74.00 0740	DO RENAL DIALYSIS	0					74.00	
76.97 0769	7 CARDIAC REHABILITATION	0	c				76.9	
	PATIENT SERVICE COST CENTERS							
	DO CLINIC	0	C				90.00	
	DO EMERGENCY	0					91.00	
	OO OBSERVATION BEDS (NON-DISTINCT PART	0					92.00	
200.00	Subtotal (see instructions)	0	-				200. 00	
201.00	Less PBP Clinic Lab. Services-Program	0					201.00	
	Only Charges							
202.00	Net Charges (line 200 - line 201)	0	13, 772				202.00	

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Concernent (	CN: 15-0125 CCN: 15-T125	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Pre 11/22/2022 9:	pared: 20 am
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)				5.00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	F 040 001	210 707 210	0.01(4)	04 754	1 204	50.00
50. 00 05000 OPERATI NG ROOM	5, 243, 831					
51.00 05100 RECOVERY ROOM	1,009,046				148	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	373, 834				0	52.00
53. 00 05300 ANESTHESI OLOGY	252, 909					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 753, 394					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 899, 716					55.00
56. 00 05600 RADI OI SOTOPE	505, 078				0	56.00
57. 00 05700 CT SCAN	934, 747					
58.00 05800 MRI	558, 645					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 250, 539				0	59.00
60. 00 06000 LABORATORY	1, 440, 751					
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	65, 750					63.00
64. 00 06400 I NTRAVENOUS THERAPY	130, 025				-	64.00
65. 00 06500 RESPI RATORY THERAPY	600, 188					65.00
66. 00 06600 PHYSI CAL THERAPY	729, 357		0. 02094		16, 036	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	90, 742				5, 393	
68.00 06800 SPEECH PATHOLOGY	85, 320					68.00
69. 00 06900 ELECTROCARDI OLOGY	879, 162					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	116, 419					
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	118, 327					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	150, 601					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	458, 029					73.00
74.00 07400 RENAL DIALYSIS	34, 519					74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	127, 263	4, 143, 247	0. 0307	16 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					-	
90. 00 09000 CLINIC	201, 075					
91. 00 09100 EMERGENCY	861, 762					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				, v	92.00
200.00   Total (lines 50 through 199)	20, 871, 029	1, 970, 870, 934	l	3, 203, 863	34, 976	200.00

Health Financial Systems	COMMUNI TY	HOSPI TAL			In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0125	Peri od:	(0004	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T125	From 07/01 To 06/30	/2021	Part IV Date/Time Pre	nared
		component	56N. 15 1125		17 2022	11/22/2022 9:	20 am
		Title	e XVIII	Subprovi d	ler -	PPS	
				I RF			
Cost Center Description	Non Physician		Nursi ng			Allied Health	
	Anesthetist Cost	Program Post-Stepdown	Program	Post-Ste			
	COST	Adjustments		Adjustm	ents		
	1.00	2A	2.00	3A		3.00	
ANCI LLARY SERVICE COST CENTERS					I		
50. 00 05000 OPERATI NG ROOM	0	0	I	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	0	57.00
58. 00 05800 MRI	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	360, 374	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0		0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00 73.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0	0		0	0	477, 308	73.00
74. 00 107400 RENAL DIALYSIS 76. 97 107697 CARDIAC REHABILITATION	0	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS	0	0		0	U	0	/0.9/
90. 00 09000 CLINIC	0	0		0	0	0	90.00
91. 00 09100 EMERGENCY	0	0		õ	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			Ō	Ű	0	92.00
200.00 Total (lines 50 through 199)	0	о		0	0	837, 682	
				,			

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider CO		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2021	Part IV	
		Component (	CCN: 15-T125	To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 20 am
		Title	XVIII	Subprovider -	PPS	20 4
				I RF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 318, 707, 318	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 35, 491, 400	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 10, 145, 160	0.00000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 53, 110, 976	0. 000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 91, 261, 680	0.00000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 49, 515, 352	0. 000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 36, 778, 977	0. 000000	56.00
57.00 05700 CT SCAN	0	0	1	0 132, 642, 917	0. 000000	57.00
58. 00 05800 MRI	0	0	1	0 66, 236, 862	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 162, 926, 240	0. 000000	59.00
60. 00 06000 LABORATORY	0	360, 374	360, 37	4 248, 304, 264	0. 001451	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 12, 385, 785	0.00000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 4, 691, 054	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 24, 367, 884	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 34, 826, 671	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 12, 449, 951	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 6, 181, 746	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 87, 894, 046	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 19, 708, 655	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 67, 301, 676	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 92, 959, 763	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	477, 308	477, 30			
74.00 07400 RENAL DI ALYSI S	0	0		0 9, 618, 712	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 143, 247	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0		0 15, 248, 756	0.00000	90.00
91.00 09100 EMERGENCY	0	0		0 171, 376, 167	0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 51, 214, 657	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	837, 682	837, 68	1, 970, 870, 934		200.00
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Health Financial Systems	COMMUNI TY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0125	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T125	From 07/01/2021 To 06/30/2022	Part IV Date/Time Pre	nored.
		component	CCN: 15-1125	To 06/30/2022	11/22/2022 9:	
		Title	× XVIII	Subprovider -	PPS	20 4
				I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1	-	-	
50. 00 05000 OPERATING ROOM	0. 000000	84, 754		0 0	0	
51.00 05100 RECOVERY ROOM	0. 000000	5, 211		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	13, 676		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	55, 544		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	61, 058		0 0	0	57.00
58. 00 05800 MRI	0. 000000	28, 728		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 001451	325, 666		3 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	17, 423		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	148, 762		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	765, 751		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	739, 861		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	154, 606		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	9, 787		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	3, 069		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	103, 625		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	14, 486		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 003153	562, 170	1, 77	3 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0. 000000	106, 113		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	· · · · · ·		•			1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	3, 573		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		3, 203, 863	2, 24	6 0	0	200.00

Health Financial Systems	COMMUNI TY HOSPI TAL			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	Provider CCN: 15-0125		Worksheet D Part I Date/Time Pre 11/22/2022 9:	pared: 20 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	-	1	1	r	
30. 00 ADULTS & PEDIATRICS	4, 852, 302		1,002,00			
31.00 INTENSIVE CARE UNIT	1, 571, 668		1, 571, 66			
31.01 NEONATAL INTENSIVE CARE	371, 247		371, 24			
41. 00 SUBPROVI DER – I RF	155, 163	0	155, 16			
43. 00 NURSERY	92, 031		92, 03			
200.00 Total (lines 30 through 199)	7, 042, 411		7, 042, 41	1 104, 105		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00			•	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 ADULTS & PEDIATRICS	670					30.00
31.00 INTENSIVE CARE UNIT	681	95, 381	•			31.00
31. 01 NEONATAL INTENSIVE CARE	112		1			31.01
41.00 SUBPROVIDER - IRF	0	0				41.00
43.00 NURSERY	119		•			43.00
200.00 Total (lines 30 through 199)	1, 582	149, 651				200.00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2021 To 06/30/2022	11/22/2022 9:	pared: 20 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		I	1	1		
50.00 O5000 OPERATING ROOM	5, 243, 831					
51.00 05100 RECOVERY ROOM	1, 009, 046					
52.00 05200 DELIVERY ROOM & LABOR ROOM	373, 834					
53. 00 05300 ANESTHESI OLOGY	252, 909					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 753, 394					
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 899, 716					
56. 00 05600 RADI OI SOTOPE	505, 078					
57.00 05700 CT SCAN	934, 747	132, 642, 917			3, 510	
58. 00 05800 MRI	558, 645	66, 236, 862			1, 347	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 250, 539			13 260, 630	3, 600	59.00
60. 00 06000 LABORATORY	1, 440, 751	248, 304, 264	0.00580	1, 000, 745	5, 806	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	65, 750	12, 385, 785	0.00530	9 43, 134	229	63.00
64.00 06400 INTRAVENOUS THERAPY	130, 025	4, 691, 054	0. 02771	18 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	600, 188	24, 367, 884	0. 02463	30 222, 469	5, 479	65.00
66. 00 06600 PHYSI CAL THERAPY	729, 357	34, 826, 671	0. 02094	112, 099	2, 348	66.00
67.00 06700 OCCUPATI ONAL THERAPY	90, 742	12, 449, 951	0. 00728	58, 768	428	67.00
68.00 06800 SPEECH PATHOLOGY	85, 320	6, 181, 746	0. 01380	54, 449	752	68.00
69. 00 06900 ELECTROCARDI OLOGY	879, 162			237, 250	2, 373	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	116, 419	19, 708, 655	0.00590	07 137, 574	813	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	118, 327	67, 301, 676	0.00175	312, 756	550	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	150, 601	92, 959, 763	0. 00162	105, 754	171	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	458,029	151, 381, 018	0. 00302	1, 167, 515	3, 533	73.00
74.00 07400 RENAL DIALYSIS	34, 519					
76. 97 07697 CARDI AC REHABI LI TATI ON	127, 263	4, 143, 247	0. 03071	1, 292	40	76.97
OUTPATIENT SERVICE COST CENTERS				1 1		1
90. 00 09000 CLI NI C	201,075	15, 248, 756	0. 01318	36 0	0	90.00
91.00 09100 EMERGENCY	861, 762				1, 919	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	967,060					92.00
200.00 Total (lines 50 through 199)		1, 970, 870, 934		6, 560, 722		200.00
		•		,	•	

Health Financial Systems	COMMUNI TY HO	OSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	OTHER PASS THROUGH COSTS		F	Period: From 07/01/2021 To 06/30/2022	11/22/2022 9:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATI ENT ROUTI NE SERVI CE COST CENTER           30.00         03000         ADULTS & PEDI ATRI CS           31.00         03100         INTENSI VE CARE UNI T           31.01         02060         NEONATAL INTENSI VE CARE           41.00         04100         SUBPROVI DER - I RF           43.00         04300         NURSERY           200.00         Total (Lines 30 through 199)	RS 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0			0 0 0 0 0 0 0	31. 00 31. 01 41. 00
Cost Center Description	Adjustment ( Amount (see	Total Costs sum of cols. 1 through 3, inus col. 4) 5.00	Total Patient Days 6.00	Per Diem (col. 5 ÷ col. 6) 7.00	Inpatient Program Days 8.00	
INPATIENT ROUTINE SERVICE COST CENTER		0.00	0.00	7.00	0.00	
30.00         O3000         ADULTS & PEDIATRICS           31.00         03100         INTENSIVE CARE UNIT           31.01         02060         NEONATAL INTENSIVE CARE           41.00         04100         SUBPROVIDER - IRF           43.00         04300         NURSERY           200.00         Total (lines 30 through 199)	0	0 0 0 0	84, 34( 11, 22 3, 494 2, 18 2, 86 104, 105	4 0.00 7 0.00 3 0.00	670 681 112 0 119 1 582	31.00 31.01 41.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00				.,	200100
INPATI ENT ROUTI NE SERVI CE COST CENTER           30.00         03000         ADULTS & PEDI ATRI CS           31.00         03100         INTENSI VE CARE UNI T           31.01         02060         NEONATAL INTENSI VE CARE           41.00         04100         SUBPROVI DER - I RF           43.00         04300         NURSERY           200.00         Total (lines 30 through 199)	RS 0 0 0 0 0 0 0					30. 00 31. 00 31. 01 41. 00 43. 00 200. 00

Health Financial Systems	h Financial Systems COMMUNITY HOSPITAL						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	6 Provider C	CN: 15-0125	Peri Fror To	iod: m 07/01/2021 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	
		Titl	e XIX		Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Pc	llied Health ost-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS							
50.00         05000         OPERATI NG ROOM           51.00         05100         RECOVERY ROOM           52.00         05200         DELI VERY ROOM & LABOR ROOM           53.00         05300         ANESTHESI OLOGY           54.00         05400         RADI OLOGY-DI AGNOSTI C           55.00         05500         RADI OLOGY-THERAPEUTI C           56.00         05600         RADI OSOTOPE		0 0 0 0 0 0 0		0 0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0 0	50.00 51.00 52.00 53.00 54.00 55.00 56.00
57.00       05700       CT_SCAN         58.00       05800       MRI         59.00       05900       CARDI AC_CATHETERI ZATI ON         60.00       06000       LABORATORY         63.00       06300       BLOOD_STORI NG, PROCESSI NG & TRANS.         64.00       I NTRAVENOUS_THERAPY		0 0 0 0 0 0 0 0		0 0 0 0 0		0 0 360, 374 0 0	57.00 58.00 59.00 60.00 63.00 64.00
65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           67.00         06700         OCCUPATI ONAL THERAPY           68.00         06800         SPEECH PATHOLOGY           69.00         06900         ELECTROCARDI OLOGY           70.00         07000         ELECTROENCEPHALOGRAPHY           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	65.00 66.00 67.00 68.00 69.00 70.00 71.00
72.00         07200         I MPL.         DEV.         CHARGED TO PATIENTS           73.00         07300         DRUGS         CHARGED TO PATIENTS           74.00         07400         RENAL DI ALYSI S           76.97         07697         CARDIAC         REHABILITATION           0UTPATIENT SERVICE         COST CENTERS	0 0 0	0 0 0 0		0 0 0 0	0 0 0 0	0 477, 308 0 0	72.00 73.00 74.00 76.97
90.00         09000         CLINIC           91.00         09100         EMERGENCY           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART           200.00         Total (lines 50 through 199)	0 0 0 0	0 0 0		0 0 0 0	0 0 0	0 0 0 837, 682	

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 07/01/2021 To 06/30/2022		pared:
		Title XIX		Hospi tal	11/22/2022 9: PPS	20 811
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
Cost center beschiption	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		$(col. 5 \div col.$	
		4)	col s. 2, 3,	8)	7)	
		.,	and 4)	0)	(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 318, 707, 318	0. 000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 35, 491, 400	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 10, 145, 160	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 53, 110, 976	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 91, 261, 680	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 49, 515, 352	0. 000000	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 36, 778, 977	0.000000	56.00
57.00 05700 CT SCAN	0	0		0 132, 642, 917	0.000000	57.00
58. 00 05800 MRI	0	0		0 66, 236, 862	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 162, 926, 240		59.00
60. 00 06000 LABORATORY	0	360, 374	360, 37	4 248, 304, 264	0.001451	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 12, 385, 785	0.00000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 4, 691, 054	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 24, 367, 884	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 34, 826, 671	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	1	0 12, 449, 951	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1	0 6, 181, 746	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 87, 894, 046	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 19, 708, 655	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 67, 301, 676	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 92, 959, 763	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	477, 308	477, 30	8 151, 381, 018	0. 003153	73.00
74.00 07400 RENAL DI ALYSI S	0	0	1	0 9, 618, 712	0. 000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 143, 247	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	0	0		0 15, 248, 756		
91. 00 09100 EMERGENCY	0	0		0 171, 376, 167		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 51, 214, 657		
200.00  Total (lines 50 through 199)	0	837, 682	837, 68	2 1, 970, 870, 934		200. 00

Health Financial Systems	COMMUNI TY HO	OSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 07/01/2021 To 06/30/2022	11/22/2022 9:	pared: 20 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			r	1	r	
50.00 05000 OPERATING ROOM	0. 000000	1, 031, 723		0 0	-	50.00
51.00 05100 RECOVERY ROOM	0. 000000	56, 070		0 0	-	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	64, 925		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	152, 733		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	192, 795		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	27, 745		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	22, 788		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	498, 089		0 0	0	57.00
58. 00 05800 MRI	0. 000000	159, 769		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	260, 630		0 0	0	59.00
60. 00 06000 LABORATORY	0. 001451	1, 000, 745	1, 4	52 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	43, 134		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	222, 469		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	112,099		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	58, 768		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	54, 449		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	237, 250		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	137, 574		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	312, 756		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	105, 754		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.003153	1, 167, 515		31 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0.000000	199, 028		0 0	-	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0, 000000	1, 292		0 0		76.97
OUTPATIENT SERVICE COST CENTERS	21000000	17272				1
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	381, 652		0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 000000	58, 970		0 0	-	
200.00 Total (lines 50 through 199)	0.00000	6, 560, 722			-	200.00
	1			1	-	

eal th Financial Systems	COMMUNI TY				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0125	Period: From 07/01/2021	Worksheet D Part II	
		Component	CCN: 15-T125	To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared:
		Ti †I	e XIX	Subprovider -	PPS	20 811
				IRF	110	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,			I. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	5, 243, 831					50.0
51.00 05100 RECOVERY ROOM	1, 009, 046					51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	373, 834					52.0
53. 00 05300 ANESTHESI OLOGY	252, 909				-	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 753, 394					54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	1, 899, 716	49, 515, 352	0. 0383	66 0	0	55.0
6. 00 05600 RADI 0I SOTOPE	505,078	36, 778, 977	0. 0137		-	56.0
7. 00 05700 CT SCAN	934, 747	132, 642, 917	0.0070	47 0	0	57.0
i8. 00 05800 MRI	558, 645	66, 236, 862	0.0084	34 0	0	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	2, 250, 539	162, 926, 240	0. 0138	13 0	0	59.0
0. 00 06000 LABORATORY	1, 440, 751	248, 304, 264	0.0058	02 0	0	60.0
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	65, 750	12, 385, 785	0.0053	09 0	0	63.0
4.00 06400 INTRAVENOUS THERAPY	130, 025	4, 691, 054	0. 0277	18 0	0	64.0
5. 00 06500 RESPI RATORY THERAPY	600, 188	24, 367, 884	0. 0246	30 0	0	65.0
6. 00 06600 PHYSI CAL THERAPY	729, 357	34, 826, 671	0. 0209	42 0	0	66. (
7. 00 06700 OCCUPATI ONAL THERAPY	90, 742	12, 449, 951	0.0072	89 0	0	67.0
8.00 06800 SPEECH PATHOLOGY	85, 320	6, 181, 746	0. 0138	02 0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	879, 162	87, 894, 046	0. 0100	03 0	0	69. (
0.00 07000 ELECTROENCEPHALOGRAPHY	116, 419	19, 708, 655	0.0059	07 0	0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	118, 327	67, 301, 676	0.0017	58 0	0	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	150, 601			20 0	0	72.
3.00 07300 DRUGS CHARGED TO PATIENTS	458, 029				0	73.0
4.00 07400 RENAL DIALYSIS	34, 519			89 0	0	74.0
6. 97 07697 CARDI AC REHABI LI TATI ON	127, 263			16 0	0	76. 9
OUTPATIENT SERVICE COST CENTERS				1		1
0. 00 09000 CLI NI C	201,075	15, 248, 756	0.0131	86 0	0	90.0
01. 00 09100 EMERGENCY	861, 762					
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.0
200.00 Total (lines 50 through 199)	20 971 020	1, 970, 870, 934		0		200.0

Health Financial Systems	COMMUNI TY	HOSPI TAL			In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0125	Peri od:		Worksheet D	
THROUGH COSTS		Component	CCN: 15-T125	From 07/0 To 06/3	0/2021	Part IV Date/Time Pre	narod
		component	GCN. 15-1125	10 00/3	072022	11/22/2022 9:	20 am
		Titl	e XIX	Subprovi	der -	PPS	
				I RF			
Cost Center Description	Non Physician		Nursi ng			Allied Health	
	Anestheti st	Program	Program	Post-Ste			
	Cost	Post-Stepdown		Adj ustn	nents		
	1.00	Adjustments 2A	2.00	3A		3.00	
ANCILLARY SERVICE COST CENTERS	1.00	28	2.00			3.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	o	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0	0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	0	57.00
58. 00 05800 MRI	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	360, 374	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	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	0		0	0	477, 308	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76. 97
		0	1				00.00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0	0		0	0	0	91.00 92.00
200.00 Total (lines 50 through 199)		_		0	0	837, 682	
	0		1		ų	037,002	200.00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2021	Part IV	
		Component (	CCN: 15-T125	To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 20 am
		Titl	e XIX	Subprovider -	PPS	20 011
				I RF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS			_			
50.00 05000 OPERATI NG ROOM	0	0		0 318, 707, 318	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 35, 491, 400	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 10, 145, 160	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	1	0 53, 110, 976	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 91, 261, 680	0.000000	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	1	0 49, 515, 352	0. 000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0	1	0 36, 778, 977	0. 000000	56.00
57.00 05700 CT SCAN	0	0	1	0 132, 642, 917	0.000000	57.00
58. 00 05800 MRI	0	0		0 66, 236, 862	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 162, 926, 240	0.000000	59.00
60. 00 06000 LABORATORY	0	360, 374	360, 37	4 248, 304, 264	0.001451	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 12, 385, 785	0.000000	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 4, 691, 054	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 24, 367, 884	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 34, 826, 671	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 12, 449, 951	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 6, 181, 746	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 87, 894, 046	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 19, 708, 655	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 67, 301, 676	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 92, 959, 763	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	477, 308	477, 30	151, 381, 018	0.003153	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0 9, 618, 712	0. 000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 143, 247	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0		0 15, 248, 756	0.000000	90.00
91.00 09100 EMERGENCY	0	0		0 171, 376, 167	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 51, 214, 657	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	837, 682	837, 68	2 1, 970, 870, 934		200. 00
•						

Health Financial Systems	COMMUNITY HO	SPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0125	Peri od:	Worksheet D	
THROUGH COSTS		C	00N 1E T10E	From 07/01/2021	Part IV	
		Component	CCN: 15-T125	To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 20 am
		Titl	e XIX	Subprovider -	PPS	20 411
				I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	0.000000			0		
50. 00 05000 OPERATI NG ROOM	0. 000000	0		0 0	-	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	-	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57. 00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 001451	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 003153	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	-	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1	-1	1	
90. 00 09000 CLI NI C	0. 000000	0		0 0		90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0		92.00
200.00   Total (lines 50 through 199)		0	1	0 0	0	200. 00

OMPUT	Financial Systems COMMUNITY HC ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0125	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	
		Title XVIII	Hospi tal	11/22/2022 9: PPS	20 a
	Cost Center Description		nospi tui		
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	I NPATI ENT DAYS				1.
00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			84, 340 84, 340	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	04, 540	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	bod dave)		67, 531	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	07, 531	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	nom davs) after Decomber	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	Juli days) atter beceniber	ST OF THE COST	0	0
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	~ 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			07.404	
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding	g swing-bed and	27, 436	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	5 1		
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	ix only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
. 00	Total nursery days (title V or XIX only)		5 /	0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (	of the cost	0.00	17
. 00	reporting period 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost				
	reporting period			0.00	10
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through becember 31 of	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ns)		87, 766, 966	21
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	ber 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportio	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	or 21 of the cost report	ng pariod (line	0	24
	7 x line 19)		51	0	
6. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		87, 766, 966	27
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	28
	Private room charges (excluding swing-bed charges)		0	0	
	Semi-private room charges (excluding swing-bed charges)	Line 20)		0	
. 00 . 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- 1110 20)		0. 000000 0. 00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li		,	0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	-		0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	87, 766, 966	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
					1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 040. 63	
3.00 9.00 0.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	e instructions) e 38)		1, 040. 63 28, 550, 725 0	39

	nancial Systems ON OF INPATIENT OPERATING COST	COMMUNI TY	HOSPI TAL Provi der CO	N. 15_0125	In Lie Period:	u of Form CMS- Worksheet D-1	
COM UTATI				511. 13 0123	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared:
			Title	XVIII	Hospi tal	PPS	20 011
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	3.00	4.00	<u>4)</u> 5. 00	
	RSERY (title V & XIX only)	0				0	42.00
	tensive Care Type Inpatient Hospital Units						
	TENSIVE CARE UNIT	25, 942, 965				8, 092, 000	
	ONATAL INTENSIVE CARE RONARY CARE UNIT	6, 562, 283	3, 494	1, 878. 1	16 0	0	43.01 44.00
	RN INTENSIVE CARE UNIT						45.00
	RGICAL INTENSIVE CARE UNIT						46.00
47.00 OTH	HER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
49.00 Dr	ogram inpatient ancillary service cost (Wks	+ D 2 col 2	Line 200)			1.00	48.00
	tal Program inpatient costs (sum of lines 4			ns)		50, 385, 468 87, 028, 193	
	SS THROUGH COST ADJUSTMENTS		300 111311 40110	1137		07, 020, 170	17.00
50.00 Pas	ss through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sun	of Parts I and	2, 068, 603	50.00
	·						
	ss through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	2, 456, 270	51.00
	d IV) tal Program excludable cost (sum of lines 5	50 and 51)				4, 524, 873	52.00
	tal Program inpatient operating cost exclud		lated, non-phy	si ci an anesth	netist, and	82, 503, 320	
	<u>dical education costs (line 49 minus line 5</u>						
	RGET AMOUNT AND LIMIT COMPUTATION						
	ogram discharges					0	
	rget amount per discharge rget amount (line 54 x line 55)					0. 00 0	
	fference between adjusted inpatient operati	ng cost and ta	rget amount (l	ine 56 minus	line 53)	0	
	nus payment (see instructions)		. g			0	
	sser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, u	pdated and co	ompounded by the	0.00	59.00
	rket basket					0.00	1 ( 0 . 00
	sser of lines 53/54 or 55 from prior year o line 53/54 is less than the lower of lines				the amount by	0. 00 0	
	ich operating costs (line 53) are less than					0	01.00
	ount (line 56), otherwise enter zero (see i				5		
	lief payment (see instructions)					0	
	lowable Inpatient cost plus incentive payme DGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
	dicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of the	cost reporti	ng period (See	0	64.00
	structions)(title XVIII only)					-	
	dicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the c	ost reporting	period (See	0	65.00
	structions)(title XVIII only)	a acata (lina	(1 plup lipp (	E) (+; +  > V)/		0	44.00
	tal Medicare swing-bed SNF inpatient routir H (see instructions)	ne costs (IThe	64 prus rine 6	5)(title XVII	i only). For	0	66.00
	tle V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	porting period	0	67.00
(1 i	ine 12 x line 19)	0					
	tle V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68.00
1 -	ine 13 x line 20) tal title V or XIX swing-bed NF inpatient r	coutine costs (	line 67 + line	68)		0	69.00
	RT III - SKILLED NURSING FACILITY, OTHER NU					0	
	illed nursing facility/other nursing facili						70.00
	justed general inpatient routine service co		ine 70 ÷ line	2)			71.00
	ogram routine service cost (line 9 x line 7 dically percessary private room cost applies		(line 14 y )	no 25)			72.00
	dically necessary private room cost applica tal Program general inpatient routine servi	0					73.00
	pital-related cost allocated to inpatient r				Part II, column		75.00
	, line 45)		, i i i i i i i i i i i i i i i i i i i				
1	r diem capital-related costs (line 75 ÷ lir						76.00
	ogram capital-related costs (line 9 x line						77.00
	patient routine service cost (line 74 minus gregate charges to beneficiaries for excess	,	rovider record	c)			78.00 79.00
	tal Program routine service costs for compa	• •		· · · · · · · · · · · · · · · · · · ·	nus line 79)		80.00
81.00 I np	patient routine service cost per diem limit				· ·		81.00
	patient routine service cost limitation (li						82.00
	asonable inpatient routine service costs (s		S)				83.00
	ogram inpatient ancillary services (see ins ilization review – physician compensation (		ns)				84.00 85.00
	tal Program inpatient operating costs (sum						86.00
	RT IV - COMPUTATION OF OBSERVATION BED PASS						]
	tal observation bed days (see instructions)					16, 809	
A 00 88 00 BB	justed general inpatient routine cost per o		line 2)			1, 040. 63	
	servation bed cost (line 87 x line 88) (see	inctruction-`				17, 491, 950	00 00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:2	pared: 20 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	4, 852, 302	87, 766, 966	0. 05528	6 17, 491, 950	967, 060	90.00
91.00 Nursing Program cost	0	87, 766, 966	0.00000	0 17, 491, 950	0	91.00
92.00 Allied health cost	0	87, 766, 966	0.00000	0 17, 491, 950	0	92.00
93.00 All other Medical Education	0	87, 766, 966	0.00000	0 17, 491, 950	0	93.00

MPUTA	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0125	Period: From 07/01/2021	Worksheet D-1	
		Component CCN: 15-T125	To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description			1.00	
- H	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day:			2, 187	1 1
	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-			2, 187	
	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	
	do not complete this line.		-		
	Semi-private room days (excluding swing-bed and observation by		n 21 of the east	2, 187	
00	Total swing-bed SNF type inpatient days (including private row reporting period	on days) through becenbe	a si oi the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	-			
00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			0	
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 552	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	com davc)	0	10
00	through December 31 of the cost reporting period (see instruct		ooni uays)	0	
	Swing-bed SNF type inpatient days applicable to title XVIII of	nly (including private r	oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, en			_	
	Swing-bed NF type inpatient days applicable to titles V or XL through December 31 of the cost reporting period	X only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar years)	ear, enter O on this lin	ie)		
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			0	
	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17
00	reporting period	an after December 21 of	the east	0.00	10
00	Medicare rate for swing-bed SNF services applicable to service reporting period	es alter December 31 01	the cost	0.00	18
00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
	reporting period				
00	Medicaid rate for swing-bed NF services applicable to service: reporting period	s after December 31 of t	he cost	0.00	20
00	Total general inpatient routine service cost (see instructions	s)		2, 813, 156	21
00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22
00	5 x line 17)			0	
	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ig period (iine 6	0	23
	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	period (line 8	0	25
	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 813, 156	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		<u> </u>		
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)	nuc line 22) (cos instant	tions)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li	, ,		0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 813, 156	
ł	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			1, 286. 31	38
	Program general inpatient routine service cost (line 9 x line			1, 996, 353	
	Medically necessary private room cost applicable to the Progra	. ,		0	
00	Total Program general inpatient routine service cost (line 39	$\pm$ line 40)		1, 996, 353	1 41

MPUT	Financial Systems ATION OF INPATIENT OPERATING COST		HOSPI TAL Provi der	CCN: 15-0125	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-T125	From 07/01/2021 To 06/30/2022	Date/Time Pre	
			Ti tl	e XVIII	Subprovi der -	11/22/2022 9: PPS	: 20
	Cost Center Description	Total	Total	Average Pe	IRF r Program Days	Program Cost	
	cost center bescription	Inpatient Cost	Inpatient Day	vsDiem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
00	NUDSEDV (title V & VIV eply)	1.00	2.00	3.00 0 0.	4.00 00 0	5.00	0 4
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0 0.	00 0	γ <u></u>	4
00	INTENSIVE CARE UNIT	0		0 0.	00 0	) (	5 4
	NEONATAL INTENSIVE CARE	0		0 0.	00 0	0 0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						4
00 00	SURGICAL INTENSIVE CARE UNIT						4
	OTHER SPECIAL CARE (SPECIFY)						4
	Cost Center Description						
20		+ D 2 2	11 == 200)	-		1.00	
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines			ons)		844, 099 2, 840, 452	
00	PASS THROUGH COST ADJUSTMENTS		see mstructi	0115)		2, 840, 432	4
00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, su	m of Parts I and	110, 114	4 5
	111)						
00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II						37, 222	2 5
00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				147, 336	5 5
00	Total Program inpatient operating cost exclude		lated, non-ph	nysician anest	hetist, and	2, 693, 116	
	medical education costs (line 49 minus line		· · ·	-	-		
00	TARGET AMOUNT AND LIMIT COMPUTATION					-	- -
	Program discharges Target amount per discharge					0.00	) 5 ) 5
	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operat	ng cost and ta	rget amount (	(line 56 minus	line 53)	0	5 5
00	Bonus payment (see instructions)					(	
00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	) 5
00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	0 6
	If line 53/54 is less than the lower of line					(	
	which operating costs (line 53) are less than		s (lines 54 >	(60), or 1% o	f the target		
00	amount (line 56), otherwise enter zero (see i	nstructions)					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymu	ent (see instru	ctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						1
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	ne cost report	ing period (See	(	0 6
00	instructions)(title XVIII only)	to often Decemb	ar 21 of the	aget reportin	a portion (Coo		0 6
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er si or the	cost reportin	g period (see	0	י ר
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	II only). For	0	) 6
	CAH (see instructions)				5.		
00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost r	eporting period	0	0 6
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost ren	orting period	0	0 6
50	(line 13 x line 20)			the cost rep	or tring period		1
00	Total title V or XIX swing-bed NF inpatient					0	0 6
00	PART III - SKILLED NURSING FACILITY, OTHER NU				<b>`</b>	1	
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of				)		7
	Program routine service cost (line 9 x line			, <u>_</u> )			7
	Medically necessary private room cost application		(line 14 x l	ine 35)			7
00	Total Program general inpatient routine serv	ice costs (line	72 + line 73	3)			7
00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		7
00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					7
	Program capital -related costs (line 9 x line						7
	Inpatient routine service cost (line 74 minu						7
	Aggregate charges to beneficiaries for excess				10		7
00 00	Total Program routine service costs for company Inpatient routine service cost per diem limi		ost iimitatio	on (line 78 mi	nus line /9)		8
	Inpatient routine service cost per drem find Inpatient routine service cost limitation (1)		)				8
	Reasonable inpatient routine service costs (						8
00	Program inpatient ancillary services (see in	structions)					8
	Utilization review - physician compensation	•					8
00	Total Program inpatient operating costs (sum		rough 85)				8
00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions						5 8
00	Adjusted general inpatient routine cost per		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see	•	,				0 8

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
		Component (		To 06/30/2022	Date/Time Prep 11/22/2022 9:2	pared: 20 am
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•				
90.00 Capital-related cost	155, 163	2, 813, 156	0. 05515	6 0	0	90.00
91.00 Nursing Program cost	0	2, 813, 156	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 813, 156	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 813, 156	0.00000	0 0	0	93.00

	Financial Systems COMMUNITY HO ATLON OF INPATIENT OPERATING COST	Provider CCN: 15-0125	Period: From 07/01/2021	u of Form CMS-2 Worksheet D-1	
			To 06/30/2022	Date/Time Pre 11/22/2022 9:2	
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS			04.240	1
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			84, 340 84, 340	
00	Private room days (excluding swing-bed and observation bed da	5,	rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		67, 531	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	5.1		0	
00	Total swing-bed NF type inpatient days (including private roc	m days) through December	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	6
~~	reporting period (if calendar year, enter 0 on this line)			(70	
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	g swing-bed and	670	Ģ
00	Swing-bed SNF type inpatient days applicable to title XVIII c		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	, , , , , , , , , , , , , , , , , , ,	-	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	1:
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	an (exer daring swring bed	uuys)	2, 863	
. 00	Nursery days (title V or XIX only)			119	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (	of the cost	0.00	17
00	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es alter December 31 01	the cost	0.00	10
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	s)		87, 766, 966	2
. 00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0,,,,00,,,00	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportio	na period (line 6	0	23
. 00	x line 18)			0	
. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		87, 766, 966	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abaamvation had a		0	1
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	a and observation bed ci	larges)	0	
00	Semi-private room charges (excluding swing bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)	-		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instrue	ctions)	0.00	34
00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	87, 766, 966	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
~~	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			4 0 10 1 -	
. 00	Adjusted general inpatient routine service cost per diem (see			1, 040. 63 697, 222	
00					
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			097,222	

	Financial Systems TATION OF INPATIENT OPERATING COST	COMMUNI TY	HOSPITAL Provider CO	CN: 15-0125 F	In Lie Period:	u of Form CMS-2 Worksheet D-1	
					rom 07/01/2021 o 06/30/2022	Date/Time Pre 11/22/2022 9:	
			Titl	e XIX	Hospi tal	PPS	20 411
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2, 936, 942					42.00
	Intensive Care Type Inpatient Hospital Units				1		
43.00	INTENSIVE CARE UNIT	25, 942, 965					
43.01	NEONATAL INTENSIVE CARE	6, 562, 283	3, 494	1, 878. 16	112	210, 354	
44.00 45.00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T						44.00
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	. line 200)			1, 217, 040	48.00
49.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS			ns)		3, 821, 162	
50.00	Pass through costs applicable to Program inpa	of Parts I and	149, 651	50.00			
51.00	III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I						
F0.00	and IV)	0 and 51				04/ 070	E0.00
52.00 53.00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5	tist, and	216, 278 3, 604, 884				
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program di scharges					0	
55.00 56.00	Target amount per discharge Target amount (line 54 x line 55)					0.00 0	
57.00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	
58.00	Bonus payment (see instructions)	5	<u>J</u>			0	
59.00	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, u	pdated and com	pounded by the	0.00	59.00
40.00	market basket	act conart un	datad by the m	arkat backat		0.00	60.00
60.00 61.00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				he amount by	0.00	
01100	which operating costs (line 53) are less than					Ū	
	amount (line 56), otherwise enter zero (see i	nstructions)			0		
62.00 63.00	Relief payment (see instructions)	ont (coo inctru	(ations)			0	
03.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.00
64.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost reportir	g period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65.00
	instructions) (title XVIII only)			-			
66.00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	f the cost rep	orting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r	routine costs (	line 67 + line	68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						1 70 00
70.00 71.00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70.00
72.00	Program routine service cost (line 9 x line 7		The 70 ÷ The	2)			72.00
73.00	Medically necessary private room cost applica		ı(line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine servi						74.00
75.00	Capital-related cost allocated to inpatient r 26, line 45)		costs (from W	orksheet B, Pa	rt II, column		75.00
76.00	Per diem capital -related costs (line 75 ÷ lin Program capital related costs (line 0 × line						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.00 78.00
79.00	Aggregate charges to beneficiaries for excess		rovi der record	s)			79.00
80.00	Total Program routine service costs for compa	• •			is line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
82.00	Inpatient routine service cost limitation (li						82.00
83.00 84.00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		5)				83.00 84.00
84.00 85.00	Utilization review - physician compensation (		ns)				85.00
86.00	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	5 THROUGH COST					
87.00	Total observation bed days (see instructions)					16, 809	
	Adjusted general inpatient routine cost per c Observation bed cost (line 87 x line 88) (see					1, 040. 63 17, 491, 950	
	TOPSCIVATION DEA COST (THE OF X THE OO) (SEE	, mariuctiuns)				11,471,700	1 07.0

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 20 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	4, 852, 302	87, 766, 966	0. 05528	6 17, 491, 950	967,060	90.00
91.00 Nursing Program cost	0	87, 766, 966	0.00000	0 17, 491, 950	0	91.00
92.00 Allied health cost	0	87, 766, 966	0.00000	0 17, 491, 950	0	92.00
93.00 All other Medical Education	0	87, 766, 966	0.00000	0 17, 491, 950	0	93.00

JMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0125	Peri od:	Worksheet D-1	
		Component CCN: 15-T125	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:2	
		Title XIX	Subprovider -	PPS	200
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed	<b>J</b> · · · · · · · · · · · · · · · · · · ·		2, 187	1
00 00	Inpatient days (including private room days, excluding swill		ivete reem deve	2, 187 0	2
00	Private room days (excluding swing-bed and observation bed do not complete this line.	days). It you have only pr	ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation	n bed davs)		2, 187	
00	Total swing-bed SNF type inpatient days (including private		r 31 of the cost	0	5
	reporting period			_	
00	Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private	room days) through December	31 of the cost	0	
00	reporting period	Toolin days) thi ough becember	ST OF the cost	0	'
00	Total swing-bed NF type inpatient days (including private	room days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	e to the Program (excluding	swing-bed and	0	9
D. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVII	Lonly (including private r	oom dave)	0	10
5.00	through December 31 of the cost reporting period (see inst		oom uays)	0	
1.00	Swing-bed SNF type inpatient days applicable to title XVII		oom days) after	0	1
	December 31 of the cost reporting period (if calendar year		•		
2.00	Swing-bed NF type inpatient days applicable to titles V or	XIX only (including privat	e room days)	0	1:
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or	XIX only (including privat	a room dave)	0	13
3.00	after December 31 of the cost reporting period (if calenda			0	'`
4.00	Medically necessary private room days applicable to the Pro-			0	14
5.00	Total nursery days (title V or XIX only)			2, 863	15
6.00	Nursery days (title V or XIX only)			119	10
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	vices through December 21 c	f the cost	0.00	1 1
7.00	reporting period	vices through becember 31 c	T the cost	0.00	'·
3. 00	Medicare rate for swing-bed SNF services applicable to service	vices after December 31 of	the cost	0.00	18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to serv	ices through December 31 of	the cost	0.00	10
D. 00	reporting period Medicaid rate for swing-bed NF services applicable to serv	ices after December 31 of t	he cost	0.00	20
0.00	reporting period		ne cost	0.00	2
1.00	Total general inpatient routine service cost (see instruct	i ons)		2, 813, 156	2'
2.00	Swing-bed cost applicable to SNF type services through Dec	ember 31 of the cost report	ing period (line	0	22
2 00	5 x line 17) Swing had east appliable to SNE type conviges after Decem	han 21 of the cost reportin	a partial (line (	0	
3.00	Swing-bed cost applicable to SNF type services after Decem x line 18)	bei 31 01 the cost reportin	g period (inte o	0	23
4.00	Swing-bed cost applicable to NF type services through Dece	mber 31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December	er 31 of the cost reporting	period (line 8	0	25
6. 00	x line 20) Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost	st (line 21 minus line 26)		2, 813, 156	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			2,010,100	
3. 00	General inpatient routine service charges (excluding swing	-bed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	2
	Semi-private room charges (excluding swing-bed charges)	27 . Line 20)		0	30
	General inpatient routine service cost/charge ratio (line : Average private room per diem charge (line 29 ÷ line 3)	21 ÷ 11 ne 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 3)	4)		0.00	
. 00	Average per diem private room charge differential (line 32		tions)	0.00	
	Average per diem private room cost differential (line 34 $\boldsymbol{x}$	line 31)		0.00	3!
o. 00	Private room cost differential adjustment (line 3 x line 3			0	30
7.00	General inpatient routine service cost net of swing-bed cost	st and private room cost di	fferential (line	2, 813, 156	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST /	ADJUSTMENTS			
3. 00	Adjusted general inpatient routine service cost per diem (			1, 286. 31	38
	Program general inpatient routine service cost (line 9 x l			0	39
		ogram (line 14 v line 2E)		0	40
0. 00	Medically necessary private room cost applicable to the Pro Total Program general inpatient routine service cost (line				4

OMPUTATION OF INPA	tems TIENT OPERATING COST	COMMUNI TY F		CN: 15-0125	Peri od:	eu of Form CMS- Worksheet D-	
			Component	CCN: 15-T125	From 07/01/2021 To 06/30/2022	Date/Time Pre	
			Titl	e XIX	Subprovider -	11/22/2022 9: PPS	: 20
Cost Ce	nter Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient Costl	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
00 NURSERY (titl	eV&XIX only)	1.00	2.00 C	3.00	4.00 00 0	5.00	0 4
	e Type Inpatient Hospital Units	<u> </u>		0.	00 0		
00 INTENSIVE CAR		0	C				) 4
01 NEONATAL INTE		0	C	0.	00 0	0	) 4
00 CORONARY CAR							4
	INSI VE CARE UNI T						4
00 OTHER SPECIAL							4
Cost Ce	nter Description					1.00	+-
00 Program inpa	ient ancillary service cost (Wk	st D-3 col 3	Line 200)			1.00	0 4
	inpatient costs (sum of lines			ons)			3 4
	COST ADJUSTMENTS						
U U	costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, su	m of Parts I and	(	D 5
00 Pass through	costs applicable to Drogram inp	ationt ancillar	convisor (fr	om Wkat D	cum of Dorte II		5 5
and IV)	costs applicable to Program inpa		Services (II	UNI WKSL. D,	Sum of Parts II		J 3
	excludable cost (sum of lines	50 and 51)				(	5 ס
.00 Total Program	inpatient operating cost exclu	ding capital rel	ated, non-phy	vsician anest	hetist, and		) 5
	tion costs (line 49 minus line AND LIMIT COMPUTATION	52)					-
. 00 Program disch						(	5 5
	per di scharge					0.00	
	(line 54 x line 55)						D 5
	tween adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)		) 5
	(see instructions) es 53/54 or 55 from the cost re	porting poriod (	nding 1006	undated and c	omnounded by the		0 5 0 5
market baske			inut ng 1990, t	ipuateu anu c	ompounded by the	0.00	5
.00 Lesser of lin	es 53/54 or 55 from prior year					0.00	
	is less than the lower of line					(	) 6
	ng costs (line 53) are less than 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
	t (see instructions)						0 6
	atient cost plus incentive paym	ent (see instruc	ctions)			(	0 6
	IENT ROUTINE SWING BED COST						
	g-bed SNF inpatient routine cos (title XVIII only)	ts through Decer	iber 31 of the	e cost report	ing period (See	(	) 6
	g-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reportin	a period (See		0 6
	(title XVIII only)				5 1 2 2 2 2		
	e swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	o5)(title XVI	II only). For	0	) 6
CAH (see ins	ructions) X swing-bed NF inpatient routing	a costs through	December 21 c	f the cost r	oporting poriod		0 6
.00  Title V or X  (line 12 x li		e costs through	December 31 C	in the cost i	eporting period		10
	X swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost rep	orting period	(	0 6
(line 13 x li					-		
	'or XIX swing-bed NF inpatient   ILLED NURSING FACILITY, OTHER NU					(	<u>)</u> 6
	ng facility/other nursing facil				)		7
	ral inpatient routine service of	5			<i>,</i>		7
U U	ne service cost (line 9 x line		<i></i>	>			7
5	essary private room cost application	U U	•	,			7
U U	general inpatient routine serv ed cost allocated to inpatient				Part II column		7
26, line 45)	sa sest arrotated to ripatient			.s. Konoot D,			'
.00 Per diem capi	tal-related costs (line 75 ÷ li						7
<b>U</b> 1	al-related costs (line 9 x line						7
	tine service cost (line 74 minu: rges to beneficiaries for excess		ovider record	ls)			7
55 5	routine service costs for comp	• •		· · · · · · · · · · · · · · · · · · ·	nus line 79)		8
5	tine service cost per diem limi				,		8
	tine service cost limitation (I						8
	patient routine service costs (		5)				8
- · ·	ient ancillary services (see in: eview - physician compensation		ls)				8
	inpatient operating costs (sum						8
5	PUTATION OF OBSERVATION BED PASS						ľ
	tion bed days (see instructions						2 8
	eral inpatient routine cost per o		líne 2)			0.00	
.00 Observation b	ed cost (line 87 x line 88) (se	= instructions)				I C	2  8

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
		Component (		To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 20 am
		Titl	e XIX	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•			•	
90.00 Capital-related cost	155, 163	2, 813, 156	0. 05515	6 0	0	90.00
91.00 Nursing Program cost	0	2, 813, 156	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 813, 156	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 813, 156	0.00000	0 0	0	93.00

Health Financial Systems COMMUNITY HOSPI	TAL		In Li	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pr	rovider CO	CN: 15-0125	Peri od:	Worksheet D-3	
			From 07/01/2021 To 06/30/2022		narod
			10 00/30/2022	11/22/2022 9:	
	Title	XVIII	Hospi tal	PPS	20 411
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
		5	Charges	(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			49, 879, 322	2	30.00
31.00 03100 INTENSIVE CARE UNIT			11, 504, 989	2	31.00
31. 01 02060 NEONATAL INTENSIVE CARE			(		31.01
41.00 04100 SUBPROVIDER - IRF			(		41.00
43. 00 04300 NURSERY		1			43.00
ANCI LLARY SERVI CE COST CENTERS		•			
50. 00 05000 OPERATI NG ROOM		0. 1729	44 39, 179, 328	6, 775, 830	50.00
51.00 05100 RECOVERY ROOM		0. 3865	05 2, 676, 065	1, 034, 313	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 6105	08 20, 090	12, 265	52.00
53. 00 05300 ANESTHESI OLOGY		0. 0987	10 5, 471, 885	540, 130	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1370	20 4, 924, 110	674, 702	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1411			
56. 00 05600 RADI 0I SOTOPE		0. 1043			56.00
57. 00 05700 CT SCAN		0. 0457			57.00
58. 00 05800 MRI		0.0604			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0758	65 23, 479, 521	1, 781, 274	59.00
60. 00 06000 LABORATORY		0. 1136			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2992	50 2, 585, 316	773, 656	63.00
64. 00 06400 INTRAVENOUS THERAPY		0. 2077			64.00
65. 00 06500 RESPI RATORY THERAPY		0. 3634	61 7, 728, 56 <sup>-</sup>	2, 809, 031	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3532			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2506			
68.00 06800 SPEECH PATHOLOGY		0. 4051			
69. 00 06900 ELECTROCARDI OLOGY		0.0936			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1056			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 5354			
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0. 4894			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1895			
74. 00 07400 RENAL DI ALYSI S		0. 2670			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 3824			
OUTPATI ENT SERVICE COST CENTERS		0.0021	113,200		1
90. 00 09000 CLINIC		0. 3536	36 174, 695	61, 778	90.00
91. 00 09100 EMERGENCY		0. 1110			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.3415			1
200.00 Total (sum of lines 50 through 94 and 96 through 98)			251, 995, 285		
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		201,770,200		201.00
202.00 Net charges (line 200 minus line 201)			251, 995, 285		202.00
		I	201,770,200	.1	-02.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0125	Period:	Worksheet D-3	,
	Component	CCN: 15-T125	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	+
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
. 00 03000 ADULTS & PEDIATRICS					1 30
. 00 03100 I NTENSI VE CARE UNI T					3
. 01 02060 NEONATAL INTENSIVE CARE					3
. 00 04100 SUBPROVIDER - IRF			2, 304, 685		4
. 00 04300 NURSERY					4:
ANCI LLARY SERVI CE COST CENTERS					
. 00 05000 OPERATING ROOM		0. 1729	44 84, 754	14, 658	50
. 00 05100 RECOVERY ROOM		0. 38650	5, 211	2, 014	5
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 61050	0 80	0	52
. 00 05300 ANESTHESI OLOGY		0. 0987		1, 350	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1370		7, 611	
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 14112		0	
. 00 05600 RADI 0I SOTOPE		0. 1043		0	
. 00 05700 CT SCAN		0.04570		2, 791	
. 00 05800 MRI		0.06042		1, 736	
. 00 05900 CARDI AC CATHETERI ZATI ON		0.0758		0	-
. 00 06000 LABORATORY		0. 1136		37,000	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2992		5, 214	
. 00 06400 I NTRAVENOUS THERAPY . 00 06500 RESPI RATORY THERAPY		0. 2077		0 54, 069	
. 00 06600 PHYSI CAL THERAPY		0. 3634		270, 474	
. 00 06700 OCCUPATI ONAL THERAPY		0. 3532		185, 440	
. 00 06800 SPEECH PATHOLOGY		0. 40510		62, 632	
. 00 06900 ELECTROCARDI OLOGY		0. 0936		917	
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1056		324	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 5354		55, 484	
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4894		7, 091	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1895		106, 559	
. 00 07400 RENAL DI ALYSI S		0. 2670		28, 338	
. 97 07697 CARDIAC REHABILITATION		0. 3824		0	
OUTPATIENT SERVICE COST CENTERS					1
. 00 09000 CLINIC		0. 3536	36 0	0	90
. 00 09100 EMERGENCY		0. 1110	93 3, 573	397	9
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3415	42 0	0	
0.00 Total (sum of lines 50 through 94 and 96 through 9			3, 203, 863	844, 099	
1.00 Less PBP Clinic Laboratory Services-Program only (	charges (line 61)		0		201
2.00 Net charges (line 200 minus line 201)			3, 203, 863		202

Health Financial Systems COMMUNITY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0125	Peri od:	Worksheet D-3	
			From 07/01/2021		
			To 06/30/2022		
		VIV		11/22/2022 9:	20 am
	liti	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 629, 281		30.00
31.00 03100 INTENSIVE CARE UNIT			531, 455		31.00
31. 01 02060 NEONATAL INTENSIVE CARE			321, 659		31.01
41. 00 04100 SUBPROVI DER – I RF			0		41.00
43. 00 04300 NURSERY			418, 562		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1729	1, 031, 723	178, 430	50.00
51.00 05100 RECOVERY ROOM		0. 38650	56, 070	21, 671	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 61050	08 64, 925	39, 637	52.00
53.00 05300 ANESTHESI OLOGY		0. 0987	10 152, 733	15, 076	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1370			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1411			
56. 00 05600 RADI 0I SOTOPE		0. 1043			
57. 00 05700 CT SCAN		0. 04570			•
58. 00 05800 MRI		0.06042			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0758			•
60. 00 06000 LABORATORY		0. 1136			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2992			63.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 2077			64.00
65. 00 06500 RESPI RATORY THERAPY		0. 3634		-	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3532			
					•
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2506			•
68. 00 06800 SPEECH PATHOLOGY		0.40510			•
69. 00 06900 ELECTROCARDI OLOGY		0.0936			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1056			•
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT		0. 5354			•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4894			•
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1895			73.00
74.00 07400 RENAL DIALYSIS		0. 2670			•
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 3824	71 1, 292	494	76.97
OUTPATI ENT SERVICE COST CENTERS				1	
90. 00 09000 CLINIC		0. 3536			90.00
91. 00 09100 EMERGENCY		0. 1110	93 381, 652	42, 399	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART		0.3415			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			6, 560, 722	1, 217, 040	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	-		6, 560, 722		202.00
· · · · · · · · · · · · · · · · · · ·		1	-,,/	1	

NPATIENT ANC	ILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0125	Peri od		Worksheet D-3	3
		Component	CCN: 15-T125		7/01/2021 6/30/2022	Date/Time Pre 11/22/2022 9:	
		Titl	e XIX		ovider – IRF	PPS	
C	ost Center Description		Ratio of Cos		patient	I npati ent	
			To Charges		rogram harges	Program Costs (col. 1 x col. 2)	
			1.00		2.00	3.00	-
	INT ROUTINE SERVICE COST CENTERS						
	DULTS & PEDIATRICS						30.
	NTENSIVE CARE UNIT						31.
	EONATAL INTENSIVE CARE						31.
	UBPROVIDER – IRF				1		41.
3.00 04300 N							43.
	RY SERVICE COST CENTERS		0.1700				1 - 0
	PERATING ROOM		0. 1729		0	0	
	ECOVERY ROOM		0. 3865		0	0	
	ELIVERY ROOM & LABOR ROOM		0. 6105		0	0	
	NESTHESI OLOGY		0.0987		0	0	
	ADI OLOGY-DI AGNOSTI C		0. 1370		0	0	
	ADI OLOGY-THERAPEUTI C		0. 1411		0	0	
	ADI OI SOTOPE		0. 1043 0. 0457		0	0	
7.00 05700 C 8.00 05800 M			0.0457		0	0	
	ARDI AC CATHETERI ZATI ON		0.0804		0	0	
	ABORATORY		0. 0738		0	0	
	LOOD STORING, PROCESSING & TRANS.		0. 2992		0	0	
	NTRAVENOUS THERAPY		0. 2077		0	0	
	ESPI RATORY THERAPY		0.3634		0	0	
	HYSI CAL THERAPY		0. 3532		0	0	
	CCUPATIONAL THERAPY		0. 2506		0	0	
	PEECH PATHOLOGY		0. 4051		0	0	
	LECTROCARDIOLOGY		0. 0936		0	0	
	LECTROENCEPHALOGRAPHY		0. 1056		0	0	70.
	EDICAL SUPPLIES CHARGED TO PATIENT		0. 5354		0	0	
	MPL. DEV. CHARGED TO PATIENTS		0. 4894		0	0	
3. 00 07300 D	RUGS CHARGED TO PATIENTS		0. 1895	49	0	0	73.
4. 00 07400 R	ENAL DIALYSIS		0. 2670	52	0	0	74.
6. 97 07697 C	ARDIAC REHABILITATION		0. 3824	71	0	0	76.
	ENT SERVICE COST CENTERS						
0.00 09000 C			0. 3536	36	0	0	90.
1.00 09100 E	MERGENCY		0. 1110	93	0	0	91.
	BSERVATION BEDS (NON-DISTINCT PART		0. 3415	42	0	0	
	otal (sum of lines 50 through 94 and 96 through				0	0	200.
	ess PBP Clinic Laboratory Services-Program only	charges (line 61)			0		201.
02.00 N	et charges (line 200 minus line 201)				0		202

	Financial Systems COMMUNITY HC ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0125	Peri od: From 07/01/2021 To 06/30/2022	u of Form CMS-: Worksheet E Part A Date/Time Pre	pared
		Title XVIII	Hospi tal	11/22/2022 9: PPS	20 am
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ring prior to October 1 (	see	0 17, 160, 625	
02	instructions) DRG amounts other than outlier payments for discharges occurr	ring on or after October	1 (see	51, 353, 436	1.0
03	instructions) DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	for discharges occurring	prior to October	0	1.0
04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	for discharges occurring	on or after	0	1.0
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.0
02	Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0	2.0
03	Outlier payments for discharges occurring prior to October 1			222, 674	2.0
04	Outlier payments for discharges occurring on or after October	r 1 (see instructions)		814, 071	2.0
00 00	Managed Care Simulated Payments	arting pariod (can instru	uctions)	0 245 90	3.0
	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment			345.89	1
00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)			0.00	
00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)			0.00	
00 01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0.00 0.00	7. 7.
00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.
01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8.
02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8.
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir instructions)	nes (8, 8,01 and 8,02)	see	0.00	9.
0.00	FTE count for allopathic and osteopathic programs in the curr	rent year from your recor	ds	0.00	
. 00 2. 00	FTE count for residents in dental and podiatric programs.			0.00 0.00	
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00	
. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Sep	otember 30, 1997,	0.00	
5. 00	Sum of lines 12 through 14 divided by 3.			0.00	15.
. 00	Adjustment for residents in initial years of the program			0.00	16.
. 00	Adjustment for residents displaced by program or hospital clo	osure		0.00	
. 00 . 00	Adjusted rolling average FTE count	4)		0.00	
	Current year resident to bed ratio (line 18 divided by line 4 Prior year resident to bed ratio (see instructions)	4).		0. 000000 0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
. 00	IME payment adjustment (see instructions)			0	22.
. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42	22 of the MMA		0	22.
. 00	Number of additional allopathic and osteopathic IME FTE resid (f)(1)( $iv$ )(C).		CFR 412.105	0.00	23.
. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.
00	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	
. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
. 00	IME payments adjustment factor. (see instructions)			0. 000000	
. 00	IME add-on adjustment amount (see instructions)	- \		0	28.
. 01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	
. 00 . 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		0	29. 29.
00	Disproportionate Share Adjustment	antiont down (ny 1 /	tiono)	0.10	1 22
	Percentage of SSI recipient patient days to Medicare Part A p	patient days (see instruc	CTIONS)	3.40	
. 00 . 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			17.66 21.06	
	Allowable disproportionate share percentage (see instructions	5)		6.59	
	Disproportionate share adjustment (see instructions)	- /		1, 128, 769	

	Financial Systems COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125	Period:	u of Form CMS-2 Worksheet E	-002-
JALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN. 15-0125	From 07/01/2021	Part A	
			To 06/30/2022	Date/Time Prep 11/22/2022 9:2	
		Title XVIII	Hospi tal	PPS	20 01
		· · · ·	Prior to 10/1	On/After 10/1	
			1.00	2.00	
5.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		9 200 014 E21	7 102 009 710	35.
5.00	Factor 3 (see instructions)		8, 290, 014, 521 0. 000370892	7, 192, 008, 710 0. 000276448	35.
5. 02	Hospital uncompensated care payment (If line 34 is zero, en	ter zero on this line) (se			35.
0.02	instructions)		0,0,1,0,0	1, ,00, 21,	00.
5.03	Pro rata share of the hospital uncompensated care payment a		774, 993		35.
6.00	Total uncompensated care (sum of columns 1 and 2 on line 35		2, 262, 070		36.
0.00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges (see instructions)	discharges (lines 40 throu	igh 46) 0		40.
0.00			Before 1/1	On/After 1/1	40.
			1.00	1.01	
1. 00	Total ESRD Medicare discharges (see instructions)		0	0	41.
1.01	Total ESRD Medicare covered and paid discharges (see instru	-	0	0	41.
2.00	Divide line 41 by line 40 (if less than 10%, you do not qua	lify for adjustment)	0.00		42.
3.00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0.00000		43. 44.
4.00	days)	a by the 41 alvided by 7	0.000000		44.
5.00	Average weekly cost for dialysis treatments (see instructio	ns)	0.00	0.00	45.
6.00	Total additional payment (line 45 times line 44 times line	41.01)	0		46.
7.00	Subtotal (see instructions)		72, 941, 645		47.
8.00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	0		48.
				Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instructio			72, 941, 645	49.
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I			5, 499, 224	50.
1.00	Exception payment for inpatient program capital (Wkst. L, P Direct graduate medical education payment (from Wkst. E-4,			0	51. 52.
3.00	Nursing and Allied Health Managed Care payment	The 47 see that detrons).		61, 517	53.
4.00	Special add-on payments for new technologies			618, 517	54.
4.01	Islet isolation add-on payment			0	54.
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	55.
6.00	Cost of physicians' services in a teaching hospital (see in	-		0	56.
7.00 8.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	122,400	57. 58.
9.00	Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58)			133, 489 79, 254, 392	50. 59.
7.00	Primary payer payments			39, 174	60.
0.00	Total amount payable for program beneficiaries (line 59 min	us line 60)		79, 215, 218	61.
				5, 990, 571	62.
1. 00	Deductibles billed to program beneficiaries			261, 282	63.
1.00 2.00 3.00	Coinsurance billed to program beneficiaries				
1.00 2.00 3.00 4.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			695, 680	
1.00 2.00 3.00 4.00 5.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	atruati ana)		452, 192	65.
1.00 2.00 3.00 4.00 5.00 6.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in	structions)		452, 192 134, 581	65. 66.
1.00 2.00 3.00 4.00 5.00 6.00 7.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)		see instructions)	452, 192 134, 581 73, 415, 557	65. 66. 67.
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in	r applicable to MS-DRGs (s		452, 192 134, 581	65. 66. 67. 68.
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	r applicable to MS-DRGs (s ).(For SCH see instruction	ns)	452, 192 134, 581 73, 415, 557 0	65. 66. 67. 68. 69. 70.
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon	r applicable to MS-DRGs (s ).(For SCH see instruction stration) adjustment (see	ns)	452, 192 134, 581 73, 415, 557 0 0 0 0 0	65. 66. 67. 68. 69. 70. 70.
1.00         2.00         3.00         4.00         5.00         6.00         7.00         8.00         9.00         0.00 </td <td>Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio</td> <td>r applicable to MS-DRGs (s ).(For SCH see instruction stration) adjustment (see</td> <td>ns)</td> <td>452, 192 134, 581 73, 415, 557 0 0 0 0 0 0</td> <td>65. 66. 67. 68. 69. 70. 70. 70.</td>	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio	r applicable to MS-DRGs (s ).(For SCH see instruction stration) adjustment (see	ns)	452, 192 134, 581 73, 415, 557 0 0 0 0 0 0	65. 66. 67. 68. 69. 70. 70. 70.
1.00         2.00         3.00         4.00         5.00         6.00         7.00         8.00         9.00         0.50         0.800	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only)	r applicable to MS-DRGs (s ).(For SCH see instruction stration) adjustment (see n	ns)	452, 192 134, 581 73, 415, 557 0 0 0 0 0	65. 66. 68. 69. 70. 70. 70.
1.00         2.00         3.00         4.00         5.00         6.00         7.00         8.00         9.00         0.50         0.87         0.88         0.89	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in	r applicable to MS-DRGs (s ).(For SCH see instruction stration) adjustment (see n structions)	ns)	452, 192 134, 581 73, 415, 557 0 0 0 0 0 0 0 0 0 0	65. 66. 67. 68. 69. 70. 70. 70. 70. 70.
1.00         2.00         3.00         4.00         5.00         6.00         7.00         8.00         9.00         0.50         0.87         0.88         0.89         0.90	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECLFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)	r applicable to MS-DRGs (s ).(For SCH see instruction stration) adjustment (see n structions)	ns)	452, 192 134, 581 73, 415, 557 0 0 0 0 0 0 0 0 0	65. 66. 67. 68. 70. 70. 70. 70. 70. 70.
1.00         2.00         3.00         4.00         5.00         6.00         7.00         8.00         9.00         0.50         0.87         0.88         0.90         0.91	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in	r applicable to MS-DRGs (s ).(For SCH see instruction stration) adjustment (see n structions)	ns)	452, 192 134, 581 73, 415, 557 0 0 0 0 0 0 0 0 0 0	65. 66. 67. 68. 70. 70. 70. 70. 70. 70. 70. 70.
50.00 51.00 52.00 53.00 55.00 55.00 56.00 56.00 56.00 57.00 58.00 70.50 70.87 70.88 70.89 70.90 70.91 70.91 70.92 70.93	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)	r applicable to MS-DRGs (s ).(For SCH see instruction stration) adjustment (see n structions)	ns)	452, 192 134, 581 73, 415, 557 0 0 0 0 0 0 0 0 0	64. 65. 67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70. 70. 70
1.00         2.00         3.00         4.00         5.00         6.00         7.00         8.00         9.00         0.500         0.500         0.500         0.500         0.500         0.500         0.500         0.500         0.500         0.500         0.500         0.700         0.87         0.900         0.900         0.910         0.92         0.93         0.94	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	r applicable to MS-DRGs (s ).(For SCH see instruction stration) adjustment (see n structions)	ns)	452, 192 134, 581 73, 415, 557 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 66. 67. 68. 70. 70. 70. 70. 70. 70. 70. 70. 70. 70

	Financial Systems COMMUNITY HC ATION OF REIMBURSEMENT SETTLEMENT	SPI TAL Provi der C	CN: 15-0125	Peri od:	u of Form CMS-2 Worksheet E	
			0.11 10 0120	From 07/01/2021 To 06/30/2022	Part A Date/Time Pre	parec
					11/22/2022 9:	
			XVIII	Hospi tal	PPS	
			FF Y	<u>′ (уууу)</u> 0	<u>Amount</u> 1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.
	the corresponding federal year for the period prior to 10/1)					
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.
0.00	the corresponding federal year for the period ending on or af	fter 10/1)			0	70
D. 98 D. 99	Low Volume Payment-3 HAC adjustment amount (see instructions)				0	70. 70.
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			71, 799, 043	
1.01	Sequestration adjustment (see instructions)	o, u , o,			179, 498	
	Demonstration payment adjustment amount after sequestration				0	
1.03	Sequestration adjustment-PARHM pass-throughs					71.
2.00	Interim payments				70, 590, 821	
	Interim payments-PARHM				0	72.
3.00 3.01	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)				0	73. 73.
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.0	12 72 and			1, 028, 724	
Ŧ. 00	73)	52, 72, and			1,020,724	, .
4.01	Balance due provider/program-PARHM (see instructions)					74.
5.00	Protested amounts (nonallowable cost report items) in accorda	ance with			1, 198, 186	75.
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	of 2.02	1		0	1 00
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	01 2.03			0	90.
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
	Operating outlier reconciliation adjustment amount (see instr	ructions)			0	92.
	Capital outlier reconciliation adjustment amount (see instruc				0	93.
4.00	The rate used to calculate the time value of money (see instr	ructions)			0.00	94.
	Time value of money for operating expenses (see instructions)				0	95.
6.00	Time value of money for capital related expenses (see instruc	ctions)		Duci aut 45 10/1	0	96.
				Prior to 10/1		
				1 00 1	2 00	1
	HSP Bonus Payment Amount			1.00	2.00	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)			1.00		100.
00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	
00. 00 01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 000000000	0.000000000	101.
00. 00 01. 00 02. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructior	ns)		0	0.000000000	101.
00. 00 01. 00 02. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructior HRR Adjustment for HSP Bonus Payment	ns)		0.000000000	0.000000000 0	102.
00. 00 01. 00 02. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103.
00. 00 01. 00 02. 00 03. 00 04. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	5)	stment	0.000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102.
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	s) tration) Adju		0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103. 104.
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	s) tration) Adju		0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103. 104.
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) tration) Adju eriod under t		0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103. 104. 200.
00.00 01.00 02.00 03.00 04.00 00.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	s) tration) Adju eriod under t		0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103. 104. 200.
00.00 01.00 02.00 03.00 04.00 00.00 00.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)	s) tration) Adju eriod under t		0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103. 104. 200. 201. 202.
00.00 01.00 02.00 03.00 04.00 00.00 00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	5) tration) Adju eriod under t ne 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 000000000 0 0. 0000 0. 0000 0	101. 102. 103. 104. 200. 201. 202.
00.00 01.00 02.00 03.00 04.00 00.00 00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)	5) tration) Adju eriod under t ne 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 000000000 0 0. 0000 0. 0000 0	101. 102. 103. 104. 200. 201. 202.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir	5) tration) Adju eriod under t ne 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 000000000 0 0. 0000 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204.
00.00         01.00         02.00         03.00         04.00         00.00         01.00         02.00         03.00         04.00         03.00         04.00         05.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	5) tration) Adju eriod under 1 ne 49) n first year	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 000000000 0 0. 0000 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205.
00.00         01.00         02.00         03.00         04.00         00.00         01.00         02.00         03.00         04.00         05.00         06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	5) tration) Adju eriod under 1 ne 49) n first year	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 000000000 0 0. 0000 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205.
00.00         01.00         02.00         03.00         04.00         00.00         01.00         02.00         03.00         04.00         05.00         05.00         05.00         06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) tration) Adju eriod under 1 ne 49) n first year	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 000000000 0 0. 0000 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
00.00 11.00 12.00 03.00 04.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 16.00 17.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 000000000 0 0. 0000 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 06.00 07.00 08.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 000000000 0 0. 0000 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 02.00 03.00 04.00 05.00 06.00 06.00 07.00 08.00 09.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	s) tration) Adju eriod under 1 ne 49) n first year ) tructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 208. 209. 201.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	s) tration) Adju eriod under 1 ne 49) n first year ) tructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 208. 209. 210.
00.00 01.00 02.00 03.00 04.00 01.00 02.00 03.00 03.00 04.00 05.00 05.00 05.00 05.00 05.00 05.00 01.00 01.00 01.00 01.00 01.00 02.00 01.00 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	5) tration) Adju eriod under 1 ne 49) n first year ) tructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 210. 211. 211. 212.
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 10. 00 11. 00 11. 00 12. 00 13. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) tration) Adju eriod under t ne 49) n first year ) tructions) line 59) ) 211)	of the curre	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0 0	101. 102. 103.

	Financial Systems COMMUNITY HOSE ATION OF REIMBURSEMENT SETTLEMENT	PITAL Provider CCN: 15-0125	Peri od:	u of Form CMS-2 Worksheet E	2552-10
			From 07/01/2021 To 06/30/2022	Part B Date/Time Pre	
		Title XVIII	Hospi tal	11/22/2022 9: PPS	20 am
			ioopi tui		
	PART B - MEDI CAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			13, 772	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instructi	ons)		59, 927, 847 58, 239, 368	•
3.00 4.00	OPPS payments Outlier payment (see instructions)			58, 239, 368	•
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	tions)		0. 000 0	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	•
8.00	Transitional corridor payment (see instructions)	/ 10 line 200		0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IN Organ acquisitions	7, COL. 13, TIME 200		106, 608 0	9.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			13, 772	
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12.00	Ancillary service charges			72, 659	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lir	ne 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			72, 659	14.00
15.00	Aggregate amount actually collected from patients liable for pa	ayment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for	1 5	n a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18.00	Total customary charges (see instructions)			72, 659	18.00
19.00	Excess of customary charges over reasonable cost (complete only instructions)	/ifline 18 exceeds li	ne 11) (see	58, 887	19.00
20.00	Excess of reasonable cost over customary charges (complete only	/ifline 11 exceeds li	ne 18) (see	0	20.00
04 00	instructions)			40.770	01.00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			13, 772 0	1
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	•
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			58, 396, 602	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line	24 (for CAH, see instr		9, 982, 874	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl instructions)	us the sum of lines 22	and 23] (see	48, 427, 500	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			48, 427, 500 31, 191	
32.00	Subtotal (line 30 minus line 31)			48, 396, 309	
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		0	
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 967, 573	
35.00	Adjusted reimbursable bad debts (see instructions)			628, 922	35.00
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	uctions)		353, 174 49, 025, 231	
38.00	MSP-LCC reconciliation amount from PS&R			22, 883	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	36, 121	1
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			49, 002, 348 122, 506	•
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			48, 705, 978	40.03
41.00	Interim payments-PARHM			46, 703, 978	41.00
42.00	Tentative settlement (for contractors use only)			0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			173, 864	42.01
43.00	Balance due provider/program-PARHM (see instructions)			175,004	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR				-
	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00 0	•
	Total (sum of lines 91 and 93)				94.00

Health Financial Systems	COMMUNI TY HOSPI TAL	In Lieu of Form CMS-2552-1				
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125	Peri od:	Worksheet E			
		From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:		
			11/22/2022 9:			
	Title XVIII	Hospi tal	PPS			
			1.00			
MEDI CARE PART B ANCI LLARY COSTS						
200.00 Part B Combined Billed Days			0	200. 00		

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	N: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part I Date/Time Prep 11/22/2022 9:2	parec
		Title		Hospi tal	PPS	
		Inpatien	t Part A	Par	тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		70, 162, 9 427, 8		48, 132, 573 573, 405	1.0
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.
. 02				0	0	3. 3.
. 03				0	0	3. 3.
. 05				0	0	3.
	Provider to Program					
. 50	ADJUSTMENTS TO PROGRAM			0	0	3.
. 51 . 52				0	0	3. 3.
. 52				0	0	3.
. 54				0	0	3.
. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		70, 590, 8	21	48, 705, 978	4.
00	TO BE COMPLETED BY CONTRACTOR 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 PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.
50 51				0	0	
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)		1 000 7	24	170 0/ 4	6.
. 01 . 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		1, 028, 7	24	173, 864 0	6. 6.
. 02	Total Medicare program liability (see instructions)		71, 619, 54	45	48, 879, 842	
	,			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1	1.00	2.00	

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0125 CCN: 15-T125	Period: From 07/0 To 06/3	01/2021 30/2022	Worksheet Part I Date/Time 11/22/2022	Prep	
		Title	e XVIII	Subprovi I RF		PP		
		I npati er	nt Part A			t B		
		mm/dd/yyyy	Amount	mm/dd/		Amount		
. 00	Total interim novmente paid te provider	1.00	2.00	3. (	00	4.00	0	1. C
. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 915, 5	0			0	2.0
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							3. (
01	ADJUSTMENTS TO PROVIDER			0			0	3.0
. 02				0			0	3. (
. 03 . 04				0			0	3. 3.
. 04				0			0	3.
	Provider to Program		1	-1			-	
50	ADJUSTMENTS TO PROGRAM			0			0	3.
51				0			0	3.
52				0			0	3.
53 54				0			0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0			0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 915, 5	18			0	4.
	TO BE COMPLETED BY CONTRACTOR		-					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							5.
	Program to Provider		1					
01	TENTATI VE TO PROVI DER			0			0	5.
02 03				0 0			0	5. 5.
55	Provider to Program		I	<u> </u>			0	5.
50	TENTATI VE TO PROGRAM			0			0	5.
51				0			0	5.
52				0			0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0			0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)							6.
01	SETTLEMENT TO PROVIDER		7,8	33			0	6.
02	SETTLEMENT TO PROGRAM			0			0	6.
00	Total Medicare program liability (see instructions)		2, 923, 3				0	7.
				Contra Numb		NPR Date (Mo/Day/Yr		
			0	1. (		2.00	,	

Heal th	Financial Systems COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-	2552-10			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part II Date/Time Pre 11/22/2022 9:	pared:			
		Title XVIII	Hospi tal	PPS				
				1.00				
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				1.00			
1.00								
2.00	2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)							
0.00		3.00						
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2							
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of line		a plus for cost		4.00			
F 00	reporting periods beginning on or after 10/01/2013, line 32				F 00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00			
7.00	CAH only - The reasonable cost incurred for the purchase of line 168 $$	Certified HII technology	WKST. S-2, PT. I		7.00			
8.00	Calculation of the HIT incentive payment (see instructions)				8.00			
9.00	Sequestration adjustment amount (see instructions)				9.00			
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00			
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH							
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00			
31.00	Other Adjustment (specify)				31.00			
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	lline 31) (see instruction	ns)		32.00			

		Y HOSPITAL		u of Form CMS-2	
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125 Component CCN: 15-T125	Period: From 07/01/2021 To 06/30/2022		pare
		Title XVIII	Subprovider -	11/22/2022 9: PPS	20 a
			I RF	115	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
00	Net Federal PPS Payment (see instructions)			2, 866, 995	
00 00	Medicare SSI ratio (IRF PPS only) (see instructions) Inpatient Rehabilitation LIP Payments (see instructions)			0. 0168 51, 033	
00	Outlier Payments			28, 285	
00	Unweighted intern and resident FTE count in the most recei	nt cost reporting period en	ding on or prior	0.00	
	to November 15, 2004 (see instructions)	1 3 1	5 1		
01	Cap increases for the unweighted intern and resident FTE (			0.00	5
	program or hospital closure, that would not be counted wi	thout a temporary cap adjust	ment under 42		
00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	6
00	New Teaching program adjustment. (see instructions) Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth n	eriod of a "new	0.00	
00	teaching program" (see instructions)	The new program growth p		0.00	'
00	Current year's unweighted I&R FTE count for residents with	hin the new program growth p	eriod of a "new	0.00	8
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education ad	djustment (see instructions)		0.00	
. 00	Average Daily Census (see instructions)			5. 991781	
. 00	Teaching Adjustment Factor (see instructions)			0.000000	
. 00 . 00	Teaching Adjustment (see instructions) Total PPS Payment (see instructions)			2, 946, 313	12
00	Nursing and Allied Health Managed Care payments (see inst	ruction)		2, 940, 313	
00	Organ acquisition (DO NOT USE THIS LINE)			0	15
00	Cost of physicians' services in a teaching hospital (see i	instructions)		0	
00	Subtotal (see instructions)	,		2, 946, 313	1
. 00	Primary payer payments			0	18
. 00	Subtotal (line 17 less line 18).			2, 946, 313	
. 00	Deductibles			16, 324	
. 00	Subtotal (line 19 minus line 20)			2, 929, 989	
00	Coinsurance			4,823	
. 00	Subtotal (line 21 minus line 22) Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		2, 925, 166 5, 025	
. 00	Adjusted reimbursable bad debts (see instructions)			3, 266	
00	Allowable bad debts for dual eligible beneficiaries (see i	instructions)		0,200	
. 00	Subtotal (sum of lines 23 and 25)			2, 928, 432	
. 00	Direct graduate medical education payments (from Wkst. E-	4, line 49)		0	
00	Other pass through costs (see instructions)			2, 246	20
00	Outlier payments reconciliation			0	30
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	
98 99	Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestrati	ion		0	-
. 00	Total amount payable to the provider (see instructions)	TOT		2, 930, 678	
. 01	Sequestration adjustment (see instructions)			7, 327	
. 02	Demonstration payment adjustment amount after sequestration	on		0	
. 00	Interim payments			2, 915, 518	
. 00	Tentative settlement (for contractor use only)			0	34
. 00	Balance due provider/program (line 32 minus lines 32.01, 3			7, 833	
. 00	Protested amounts (nonallowable cost report items) in access115.2	ordance with CMS Pub. 15-2,	chapter 1,	0	36
	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			28, 285	
. 00	Outlier reconciliation adjustment amount (see instructions	s)		0	
. 00	The rate used to calculate the Time Value of Money			0.00	
. 00	Time Value of Money (see instructions)	AND DECLANNING DECODE THE EN		0	53
. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020				99
111	Teaching Adjustment Factor for the cost reporting period i	immediatery preceding rebrua	iy 27, 2020.	0.000000	1 22

	Financial Systems COMMUNITY   E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider CO		Period: From 07/01/2021	u of Form CMS-2 Worksheet G	
ly)				Fo 06/30/2022	Date/Time Pre 11/22/2022 9:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	10, 265	(	0 0	0	1.0
00	Temporary investments	0	(		0	
00	Notes receivable	0	(	-	0	3.0
00 00	Accounts receivable Other receivable	75, 140, 373 1, 906, 656		-	0	
00	Allowances for uncollectible notes and accounts receivable	1, 900, 030		-	0	
00	Inventory	14, 323, 658		- -	0	
00	Prepaidexpenses	0	(	0 0	0	8.
00	Other current assets	4, 866, 049	(	-	0	
. 00	Due from other funds	0	(	-	0	10.
. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	96, 247, 001	(	0 0	0	11.
. 00	Land	0	(	0 0	0	12.
	Land improvements	0			0	13.
	Accumulated depreciation	0	(		0	
	Bui I di ngs	186, 785, 045	(	0 0	0	15.
	Accumulated depreciation	0	(	-	0	16.
	Leasehold improvements	0	(	-	0	17.
	Accumulated depreciation Fixed equipment	0		- -	0	18. 19.
	Accumulated depreciation	0		- -	0	20.
	Automobiles and trucks	0	(	-	0	20.
	Accumulated depreciation	0	(	0 0	0	
. 00	Major movable equipment	0	(	0 0	0	23.
	Accumulated depreciation	0	(	-	0	24.
	Minor equipment depreciable	0	(	- -	0	25.
	Accumulated depreciation	0		- -	0	26.
	HIT designated Assets Accumulated depreciation	0		- -	0	27.
	Mi nor equi pment-nondepreci abl e	0		-	0	20.
	Total fixed assets (sum of lines 12-29)	186, 785, 045			0	
	OTHER ASSETS					
	Investments	0	(		0	31.
	Deposits on Leases	0	(		0	32.
	Due from owners/officers	0	(	- -	0	33.
. 00 . 00	Other assets Total other assets (sum of lines 31-34)	7, 467, 438 7, 467, 438		-	0	34. 35.
	Total assets (sum of lines 11, 30, and 35)	290, 499, 484		-	0	
. 00	CURRENT LIABILITIES	270, 177, 101			0	00.
. 00	Accounts payable	3, 580, 121	(	0 0	0	37.
	Salaries, wages, and fees payable	31, 249, 728	(		0	
	Payroll taxes payable	0	(	0 0	0	
	Notes and Loans payable (short term)	0	(	0	0	40
	Deferred income Accelerated payments	0	(	0 0	0	41.
	Due to other funds	0	(	0	0	
	Other current liabilities	34, 930, 356		-	0	
	Total current liabilities (sum of lines 37 thru 44)	69, 760, 205	(		0	
	LONG TERM LIABILITIES		r			
	Mortgage payable	0	(		0	
	Notes payable	0	(	-	0	47.
	Unsecured Loans	0 7, 778, 353		-	0	48. 49.
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	7, 778, 353		-	0	49. 50.
	Total liabilities (sum of lines 45 and 50)	77, 538, 558			0	51.
	CAPI TAL ACCOUNTS			· · · · ·		
. 00	General fund balance	212, 960, 926				52.
	Specific purpose fund		(	ן		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
. 00 . 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56. 57.
	Plant fund balance - reserve for plant improvement,				0	
. 50	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	212, 960, 926	(	0 0	0	59.
	Total liabilities and fund balances (sum of lines 51 and	290, 499, 484	(	0 0	0	60.

Heal th	Financial Systems	COMMUNITY F	IOSPI TAL			In Li	eu of Form CMS	-2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0125	From 07/01/2021 To 06/30/2022 Date/Ti		Worksheet G-	1 epared:
		General	Fund	Speci al	Purpo	se Fund	Endowment Fun	b
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RESTRICTED CONTRIBUTIONS INVESTMENT INCOME Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFERRED TO/FROM AFFILIATES NET ASSETS RELEASED Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	325, 415 6, 277 0 0 0 0 0 0 0 0 22, 791, 303 249, 999 0 0 0 0 0	23, 041, 302 212, 960, 926		0 0 0 0 0 0 0 0 0 0 0 0 0 0	(		$ \begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 0.4.00\\ 0.5.00\\ 0.5.00\\ 0.6.00\\ 0.7.00\\ 0.8.00\\ 0.9.00\\ 10.00\\ 11.00\\ 12.00\\ 0.13.00\\ 0.13.00\\ 0.14.00\\ 0.15.00\\ 0.15.00\\ 0.16.00\\ 0.17.00\\ 18.00\\ 19.00\\ \end{array} $
		Endowment Fund	PI ant					
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0			1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RESTRICTED CONTRIBUTIONS INVESTMENT INCOME	0	0 0 0 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 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFERRED TO/FROM AFFILIATES NET ASSETS RELEASED Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0	0 0 0 0 0 0		0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

TATEME	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	15-0125	Period: From 07/01/2021 To 06/30/2022		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	·		1.00	2.00	3.00	
	PART I – PATIENT REVENUES				•	
	General Inpatient Routine Services					1
	Hospi tal		132, 306, 34	10	132, 306, 340	1.00
	SUBPROVIDER - IPF					2.00
00	SUBPROVIDER - IRF		3, 017, 82	20	3, 017, 820	3.00
	SUBPROVI DER					4.00
00	Swing bed - SNF			0	0	5.00
00	Swing bed - NF			0	0	6.00
00	SKILLED NURSING FACILITY					7.00
00	NURSING FACILITY					8.00
00	OTHER LONG TERM CARE					9.00
0. 00	Total general inpatient care services (sum of lines 1-9)		135, 324, 16	50	135, 324, 160	10.00
Ì	Intensive Care Type Inpatient Hospital Services	•				1
1.00	INTENSIVE CARE UNIT		36, 402, 81	12	36, 402, 812	11.00
1.01	NEONATAL INTENSIVE CARE		21, 849, 81	19	21, 849, 819	11.01
2.00	CORONARY CARE UNIT					12.00
3.00	BURN INTENSIVE CARE UNIT					13.00
1.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
5.00	OTHER SPECIAL CARE (SPECIFY)					15.00
5.00	Total intensive care type inpatient hospital services (sum of	lines	58, 252, 63	31	58, 252, 631	16.00
	11-15)					
7.00	Total inpatient routine care services (sum of lines 10 and 16)	)	193, 576, 79	91	193, 576, 791	17.00
3.00	Ancillary services		659, 175, 48	34 C	659, 175, 484	18.00
9.00	Outpatient services			0 1, 311, 339, 328	1, 311, 339, 328	19.00
0.00	RURAL HEALTH CLINIC			0 0	0	20.00
	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
	HOME HEALTH AGENCY			9, 409, 969	9, 409, 969	
	AMBULANCE SERVI CES					23.00
	СМНС					24.00
	AMBULATORY SURGICAL CENTER (D. P.)					25.00
	HOSPI CE					26.00
	PHYSI CI AN REVENUE		24, 271, 30			
	TAXABLE LAB		077 000 57	0 1, 429, 307		
	Total patient revenues (sum of lines 17-27)(transfer column 3	to WKST.	877,023,57	76 1, 374, 271, 914	2, 251, 295, 490	28.00
	G-3, line 1) PART II - OPERATING EXPENSES					
	Operating expenses (per Wkst. A, column 3, line 200)			545, 835, 814	1	29.00
	ADD (SPECIFY)			0		30.00
1.00	ADD (SFECTIT)			0		31.00
2.00				0		32.0
3.00				0		33.0
1.00				0		34.0
5.00				0		35.0
	Total additions (sum of lines 30-35)			0		36.00
	DEDUCT (SPECIFY)			0		37.0
3.00				0		38.0
9.00				0		39.0
0.00				0		40.0
1.00				0		41.0
	Total deductions (sum of lines 37-41)			· (		42.0
	Total operating expenses (sum of lines 29 and 36 minus line 4)	2)(transfer		545, 835, 814		43.0
	to Wkst. G-3, line 4)	, , , , , , , , , , , , , , , , , , , ,				

Health Financial Systems	COMMUNI TY HOSPI T	AL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES	Pr	ovider CCN: 15-0125	Peri od:	Worksheet G-3	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	arad
			10 06/30/2022	11/22/2022 9:2	
				1.00	
1.00 Total patient revenues (from Wkst. G-2,		)		2, 251, 295, 490	1.00
2.00 Less contractual allowances and discount				1, 657, 349, 905	2.00
3.00 Net patient revenues (line 1 minus line				593, 945, 585	3.00
4.00 Less total operating expenses (from Wkst				545, 835, 814	4.00
5.00 Net income from service to patients (lin	e 3 minus line 4)			48, 109, 771	5.00
OTHER INCOME					
6.00 Contributions, donations, bequests, etc				1, 831, 085	6.00
7.00 Income from investments				295, 672	7.00
8.00 Revenues from telephone and other miscel		vi ces		0	8.00
9.00 Revenue from television and radio servic	e			0	9.00
10.00 Purchase di scounts				0	10.00
11.00 Rebates and refunds of expenses				0	11.00
12.00 Parking lot receipts				0	12.00
13.00 Revenue from Laundry and Linen service				0	13.00
14.00 Revenue from meals sold to employees and	guests			2, 219, 165	
15.00 Revenue from rental of living quarters				0	15.00
16.00 Revenue from sale of medical and surgica		patients		0	16.00
17.00 Revenue from sale of drugs to other than				9, 997, 305	
18.00 Revenue from sale of medical records and				0	18.00
19.00 Tuition (fees, sale of textbooks, unifor				0	19.00
20.00 Revenue from gifts, flowers, coffee shop	s, and canteen			0	20.00
21.00 Rental of vending machines				16, 889	
22.00 Rental of hospital space				953, 941	22.00
23.00 Governmental appropriations				0	23.00
24.00 REVENUE - CLASSES				31, 380	
24.01 ASSETS RELEASED FROM RESTRICTION				252, 609	
24.02 FITNESS POINTE/BEAUTY SHOP INCOME				2, 485, 142	
24.03 GAINS ON SALE OF ASSETS				96, 184	
24.04 OTHER INCOME				360, 293	
24. 05 GRANT I NCOME				1, 904, 610	
24.50 COVI D-19 PHE Funding				0	24.50
25.00 Total other income (sum of lines 6-24)				20, 444, 275	
26.00 Total (line 5 plus line 25)				68, 554, 046	26.00
27.00 OTHER EXPENSES (SPECI FY)				0	27.00
28.00 Total other expenses (sum of line 27 and				0	28.00
29.00 Net income (or loss) for the period (lin	e 26 minus line 28)			68, 554, 046	29.00

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS		Provider C	CN: 15-0125	Period: From 07/01/2021	Worksheet H	
				HHA CCN:	15-7487	To 06/30/2022		pared:
						Home Health	11/22/2022 9: PPS	20 am
						Agency I	PP5	
		Sal ari es		Transportati on	Contracted/Pu		Total (sum of	
			Benefits	(see	chased		cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	0.00	
1.00	Capital Related - Bldg. &			0		0	0	1.00
2.00	Fixtures Capital Related - Movable			0		0	0	2.00
2.00	Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0 0	0	3.00
4.00	Transportation	0	0	0		0 0	0	4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	1, 323, 935	140, 811	567	-1, 86	52, 891	1, 516, 339	5.00
6.00	Skilled Nursing Care	1, 619, 255	172, 221	44, 385		0 0	1, 835, 861	6.00
7.00	Physical Therapy	1, 141, 755		45, 767		0 0	1, 308, 957	
8.00	Occupational Therapy	330, 684		11, 232		0 0	377, 087	
9.00	Speech Pathology	62,070		5, 400		0 0	74,072	
10.00 11.00	Medical Social Services Home Health Aide	1, 408 44, 375				0 0	1, 558 52, 131	
12.00	Supplies (see instructions)	0	-, , 20	0		0 230, 642	230, 642	
13.00	Drugs	0	-	0		0 0	0	13.00
14.00	DME	0	0	0		0 0	0	14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respi ratory Therapy	0	-	0		0 0	0	16.00
17.00	Private Duty Nursing	0	0	0		0 0	0	17.00
18.00	Clinic	0	0	0		0 0	0	18.00
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0			0 0	0	20.00
22.00	Homemaker Service	0	0	0		0 0	0	22.00
23.00	All Others (specify)	0	0	0		0 0	0	23.00
23.50	Tel emedi ci ne	0	0	0		0 0	0	23.50
24.00	Total (sum of lines 1-23)	4, 523, 482 Recl assi fi cati		110,387 Adjustments	-1,86 Net Expenses		5, 396, 647	24.00
		on	Trial Balance	naj as tilon to	for Allocatio			
			(col. 6 +		(col. 8 + col			
		7.00	col . 7) 8. 00	9.00	9) 10.00	_		-
	GENERAL SERVICE COST CENTERS	7.00	0.00	9.00	10.00			
1.00	Capital Related - Bldg. &	0	0	0		0		1.00
	Fixtures					2		0.00
2.00	Capital Related - Movable Equipment	0	0	0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation	0		0		0		4.00
5.00	Administrative and General	0	1, 516, 339	266, 911	1, 783, 25	50		5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	1, 835, 861	0	1, 835, 86	51		6.00
7.00	Physical Therapy	-50, 360		0				7.00
8.00	Occupational Therapy	45, 718		0	422, 80	05		8.00
		1			1 70 71	4		9.00
9.00	Speech Pathol ogy	4, 642		0	78, 71			
9. 00 10. 00	Medical Social Services	0	1, 558	0	1, 55	58		10.00
9.00 10.00 11.00	Medical Social Services Home Health Aide		1, 558 52, 131	0	1, 55 52, 13	58 31		11.00
9. 00 10. 00	Medical Social Services	0	1, 558 52, 131 230, 642	0 0 0 0	1, 55 52, 13 230, 64	58 31		
9.00 10.00 11.00 12.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 0 0	1, 558 52, 131 230, 642 0		1, 55 52, 13 230, 64	58 31		11. 00 12. 00
9.00 10.00 11.00 12.00 13.00 14.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES		1, 558 52, 131 230, 642 0 0	0 0	1, 55 52, 13 230, 64	58 11 12 0 0		11.00 12.00 13.00 14.00
9.00 10.00 11.00 12.00 13.00 14.00 15.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services		1, 558 52, 131 230, 642 0 0	0	1, 55 52, 13 230, 64	58 11 12 0 0		11.00 12.00 13.00 14.00 15.00
9.00 10.00 11.00 12.00 13.00 14.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES		1, 558 52, 131 230, 642 0 0	0 0	1, 55 52, 13 230, 64	58 11 12 0 0		11.00 12.00 13.00 14.00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic		1, 558 52, 131 230, 642 0 0	0 0	1, 55 52, 13 230, 64	58 11 12 0 0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities		1, 558 52, 131 230, 642 0 0	0 0	1, 55 52, 13 230, 64	58 11 12 0 0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program		1, 558 52, 131 230, 642 0 0	0 0	1, 55 52, 13 230, 64	58 11 12 0 0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		1, 558 52, 131 230, 642 0 0	0 0	1, 55 52, 13 230, 64	58 11 12 0 0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)		1, 558 52, 131 230, 642 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	1, 55 52, 13 230, 64	58 11 12 0 0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine		1, 558 52, 131 230, 642 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 55 52, 13 230, 64	58 51 12 0 0 0 0 0 0 0 0 0 0 0 0 0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 23. 50
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)		1, 558 52, 131 230, 642 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 55 52, 13 230, 64	58 51 12 0 0 0 0 0 0 0 0 0 0 0 0 0		11. ( 12. ( 13. ( 14. ( 15. ( 15. ( 15. ( 17. ( 18. ( 19. ( 20. ( 21. ( 22. ( 23. (

Heal th	Financial Systems		COMMUNI TY F	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provider C	CN: 15-0125	Period: From 07/01/2021	Worksheet H-1 Part I	
				HHA CCN:	15-7487	To 06/30/2022		
						Home Health	PPS	20 am
_			Capital Rel	ated Costs		Agency I		
								-
		Net Expenses for Cost	Bldgs & Fixtures	Movable Equipment	Plant Operation &	Transportation	Subtotal (cols. 0-4)	
		Allocation (from Wkst. H,			Mai ntenance			
		col. 10)						
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				0	1.00
2.00	Fixtures Capital Related - Movable	0		0			0	2.00
	Equipment		_	-				
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3.00 4.00
5.00	Administrative and General	1, 783, 250	0	0		0 0	1, 783, 250	
6.00	HHA REIMBURSABLE SERVICES	1, 835, 861	0	0		0 0	1, 835, 861	6.00
7.00	Physical Therapy	1, 258, 597	0	0		0 0	1, 258, 597	7.00
8.00 9.00	Occupational Therapy Speech Pathology	422, 805 78, 714	0	0		0 0	422, 805 78, 714	
10.00	Medical Social Services	1, 558	0	0		0 0	1, 558	10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	52, 131 230, 642	0	0		0 0	52, 131 230, 642	
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0	0 0		0 0 0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00 20.00	Health Promotion Activities Day Care Program	0	0	0		0 0 0 0	0	19.00 20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0	0 0		0 0 0 0	0	
23.50	Tel emedi ci ne	0	0	0		0 0 0 0	0	
24.00	Total (sum of lines 1-23)	5,663,558 Administrative	Total (cols.	0		0 0	5, 663, 558	24.00
		& General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	5.00	0.00					
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2.00
3.00	Equipment Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	1, 783, 250						5.00
6.00	Skilled Nursing Care	843, 695						6.00
7.00 8.00	Physical Therapy Occupational Therapy	578, 406 194, 306	1, 837, 003 617, 111					7.00 8.00
9.00	Speech Pathology	36, 174	114, 888					9.00
10. 00 11. 00	Medical Social Services Home Health Aide	716 23, 958	2, 274 76, 089					10.00 11.00
12.00	Supplies (see instructions)	105, 995	336, 637					12.00
13.00 14.00	Drugs DME	0	0					13.00 14.00
15 00	HHA NONREI MBURSABLE SERVI CES							15 00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0 0					15.00 16.00
17.00	Private Duty Nursing	0	0					17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0 0					18.00 19.00
20.00	Day Care Program	0	0					20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0 0					21.00 22.00
23. 00 23. 50	All Others (specify) Telemedicine	0	0					23.00 23.50
	Total (sum of lines 1-23)		5, 663, 558					23.50

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:	CN: 15-0125 15-7487	Period: From 07/01/2021 To 06/30/2022	Worksheet H-1 Part II	pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	Transportatio (MI LEAGE)	onReconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related – Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	100		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	instructions)							
5.00	Administrative and General	0	0	100		0 -1, 783, 250	3, 880, 308	5.00
	HHA REIMBURSABLE SERVICES				1		4 995 974	
6.00	Skilled Nursing Care	0	-	0		0 0		6.00 7.00
7.00 8.00	Physical Therapy Occupational Therapy		0	0		0 0	1, 258, 597 422, 805	
9.00	Speech Pathol ogy		0	0		0 0	422, 803	
10.00	Medical Social Services		0	0		0 0	1, 558	
11.00	Home Heal th Aide	0	0	0		0 0	52, 131	
12.00	Supplies (see instructions)	0	0	0		0 0	230, 642	
13.00	Drugs	l o	0	0		0	0	
14.00	DME	0	0	0		0 0	0	
	HHA NONREI MBURSABLE SERVI CES				•			
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	16.00
17.00	Private Duty Nursing	0	0	0		0 0	0	17.00
18.00	Clinic	0	0	0		0 0	0	18.00
19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	22.00
23.00 23.50	All Others (specify) Telemedicine	0	0	0			0	23.00 23.50
23.50	Total (sum of lines 1-23)		0	100		0 -1, 783, 250	-	
24.00	Cost To Be Allocated (per		0	0		0 -1,703,230	1, 783, 250	
20.00	Worksheet H-1, Part I)			0		Ĭ	1,703,230	20.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0.0000	00	0. 459564	26.00

	n Financial Systems ATION OF GENERAL SERVICE COSTS <sup>-</sup>	TO HHA COST CEN	COMMUNI TY TERS	Provider CO	CN: 15-0125 15-7487		riod: om 07/01/2021		pared:
							Home Health Agency I	PPS	
			CAPI TAL REL	ATED COSTS			Agency		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT		PURCHASI NG & RECEI VI NG STORES	ADMI TTI NG	-
		0	1.00	2.00	4.00		5. 01	5.02	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 21.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 2, 679, 556 1, 837, 003 617, 111 114, 888 2, 274 76, 089 336, 637 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		231, 6 163, 3 47, 3 8, 8 2 6, 3	530 325 303 379 201 348 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	97 C C C C C C C C C C C C C C C C C C C		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE		OTHER ADMIN & GENERAL	REPAI RS	&	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
1 00	Administrative and Capacel	5.03	5A. 03	5.04	6.00	0	7.00	8.00	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	26, 423 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	240, 004 2, 911, 186 2, 000, 328 664, 414 123, 767 2, 475 82, 437 336, 637 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	400, 903 275, 467 91, 497 17, 044 341 11, 352 46, 359 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Heal th	n Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOC	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider C HHA CCN:		Period: From 07/01/2021 To 06/30/2022	Worksheet H-2 Part I Date/Time Pre 11/22/2022 9:	pared:
-						Home Health Agency I	PPS	
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	MAINTENANCE C PERSONNEL		CENTRAL SERVI CES & SUPPLY	
		9.00	10.00	11.00	12.00	13.00	14.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 13.00\\ 14.00\\ 15.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 20.00\\ 21.00\\ \end{array}$	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						$\begin{array}{c} 2,00\\ 3,00\\ 4,00\\ 5,00\\ 6,00\\ 7,00\\ 8,00\\ 9,00\\ 10,00\\ 11,00\\ 12,00\\ 13,00\\ 14,00\\ 15,00\\ 16,00\\ 17,00\\ 18,00\\ 19,00\\ 19,50\\ \end{array}$
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS		SERVI CES-OTHER PRGM COSTS APPRV	
1 00	Admini strastiva and Carsard	15.00	16.00	17.00	19.00	21.00	22.00	1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00 21.00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)							$\begin{array}{c} 2, 00\\ 3, 00\\ 4, 00\\ 5, 00\\ 6, 00\\ 7, 00\\ 8, 00\\ 9, 00\\ 10, 00\\ 11, 00\\ 12, 00\\ 13, 00\\ 14, 00\\ 15, 00\\ 16, 00\\ 17, 00\\ 18, 00\\ 19, 00\\ 19, 50\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

LLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS	Provider C	CN: 15-0125	Peri	od: n 07/01/2021	Worksheet H-2 Part I	
			HHA CCN:	15-7487	То	06/30/2022	Date/Time Prep 11/22/2022 9:2	
					Ho	ome Health Agency I	PPS	
Cost Center Description	PARAMED ED	PARAMED ED	Subtotal	Intern &		Subtotal	Allocated HHA	
	· · ·	PRGM-(LAB MLS)		Residents Co	st		A&G (see Part	
	)			& Post Stepdown			11)	
				Adjustments	s			
00 Administrative and Cananal	23.00	23.01	24.00	25.00	0	26.00 296.138	27.00	1.00
.00 Administrative and General .00 Skilled Nursing Care		-	296, 138 3, 312, 089		0 0	3, 312, 089		
. 00 Physical Therapy			2, 275, 795		0	2, 275, 795		3.00
.00 Occupational Therapy	C	0	755, 911		0	755, 911	32, 144	4.00
. 00 Speech Pathol ogy	C	-	140, 811		0	140, 811		
.00 Medical Social Services .00 Home Health Aide		-	2, 816 93, 789		0 0	2, 816 93, 789		
.00 Supplies (see instructions)		-	382, 996		0	382, 996		
. 00 Drugs	0	-	0		0	0		9.00
0. OO DME	C	-	0		0	0	0	10.00
1.00 Home Dialysis Aide Services	C	-	0		0	0	0	11.00
2.00 Respiratory Therapy 3.00 Private Duty Nursing		-	0 0		0 0	0	0	12.00 13.00
4.00 Clinic		1 1	0		0	0	0	14.00
5.00 Health Promotion Activities	C	0	0		0	0	0	15.00
6.00 Day Care Program	C	-	0		0	0	0	16. 0
7.00 Home Delivered Meals Program	C	-	0		0	0	0	17.0
8.00 Homemaker Service 9.00 All Others (specify)		-	0		0	0	0	18.0 19.0
9. 50 Tel emedi ci ne		-	0		0	0		19.50
0.00 Total (sum of lines 1-19) (2)	C	0	7, 260, 345		0	7, 260, 345	296, 138	20.00
1.00 Unit Cost Multiplier: column							0. 042523	21.00
26, line 1 divided by the sum of column 26, line 20 minus								
column 26, line 1, rounded to								
6 decimal places.								
Cost Center Description	Total HHA							
	<u>Costs</u> 28.00	-						
.00 Administrative and General								1.00
.00 Skilled Nursing Care	3, 452, 927							2.00
00 Physical Therapy	2, 372, 569							3.00
.00 Occupational Therapy .00 Speech Pathology	788, 055							4.00 5.00
. 00 Medical Social Services	2,936							6.00
.00 Home Health Aide	97, 777							7.00
.00 Supplies (see instructions)	399, 282							8.00
. 00 Drugs	0							9.00
0.00 DME 1.00 Home Dialysis Aide Services								10. 0 11. 0
2.00 Respiratory Therapy								12.0
3.00 Private Duty Nursing	C							13.0
4.00 Clinic	C							14.0
5.00 Health Promotion Activities 6.00 Day Care Program								15.0
6.00 Day Care Program 7.00 Home Delivered Meals Program								16.0 17.0
8.00 Homemaker Service								18.0
9.00 All Others (specify)	C							19.0
9.50 Telemedicine								19.5
0.00 Total (sum of lines 1–19) (2) 1.00 Unit Cost Multiplier: column	7, 260, 345							20.0
1.00 Unit Cost Multiplier: column 26, line 1 divided by the sum								21.0
of column 26, line 20 minus								
column 26, line 1, rounded to								
6 decimal places.	1	1						

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS TO		COMMUNI TY		N. 15 0125	Period:	u of Form CMS-2 Worksheet H-2	
BASIS	U HHA CUST CEN	TERS STATISTIC	HHA CCN:	15-7487	From 07/01/2021	Part II Date/Time Prep 11/22/2022 9:2	pared:
					Home Health	PPS	
	CAPI TAL REL	ATED COSTS			Agency I		
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASI NG 8 RECEI VI NG STORES (COSTED REQ)	(GROSS REVENUE)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS REVENUE)	
	1.00	2.00	4.00	5.01	5. 02	5.03	
<ul> <li>1.00 Administrative and General</li> <li>2.00 Skilled Nursing Care</li> <li>3.00 Physical Therapy</li> <li>4.00 Occupational Therapy</li> <li>5.00 Speech Pathology</li> <li>6.00 Medical Social Services</li> <li>7.00 Home Health Aide</li> <li>8.00 Supplies (see instructions)</li> <li>9.00 Drugs</li> <li>10.00 DME</li> <li>11.00 Home Dialysis Aide Services</li> <li>12.00 Respiratory Therapy</li> <li>13.00 Private Duty Nursing</li> <li>14.00 Clinic</li> <li>15.00 Health Promotion Activities</li> <li>16.00 Day Care Program</li> <li>17.00 Home Delivered Meals Program</li> <li>18.00 Homemaker Service</li> <li>19.00 All Others (specify)</li> <li>19.50 Telemedicine</li> <li>20.00 Total (sum of lines 1-19)</li> <li>21.00 Total cost to be allocated</li> <li>22.00 Unit cost multiplier</li> </ul>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		97.00000 OPERATION OF	LAUNDRY &	9, 409, 969 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21.00
		GENERAL (ACCUM. COST)	REPAI RS (SQUARE FEET)	PLANT (SQUARE FEET	LINEN SERVICE (TOTAL PATI ENT DAYS)	(SQUARE FEET)	
	5A. 04	5.04	6.00	7.00	8.00	9.00	
<ul> <li>1.00 Administrative and General</li> <li>2.00 Skilled Nursing Care</li> <li>3.00 Physical Therapy</li> <li>4.00 Occupational Therapy</li> <li>5.00 Speech Pathology</li> <li>6.00 Medical Social Services</li> <li>7.00 Home Health Aide</li> <li>8.00 Supplies (see instructions)</li> <li>9.00 Drugs</li> <li>10.00 DME</li> <li>11.00 Home Dialysis Aide Services</li> <li>12.00 Respiratory Therapy</li> <li>13.00 Private Duty Nursing</li> <li>14.00 Clinic</li> <li>15.00 Home Delivered Meals Program</li> <li>17.00 Home mealtive Service</li> <li>19.00 All Others (specify)</li> <li>19.50 Telemedicine</li> <li>20.00 Unit cost to be allocated</li> <li>22.00 Unit cost multiplier</li> </ul>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	240, 004 2, 911, 186 2, 000, 328 664, 414 123, 767 2, 475 82, 437 336, 637 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0. 00000	0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0         0       0       0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00 21.00

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Li€	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN			CN: 15-0125	Period: From 07/01/2021	Worksheet H-2 Part II	
BASI S				HHA CCN:	15-7487	To 06/30/2022		pared: 20 am
						Home Health	PPS	20 am
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSING	Agency I CENTRAL	PHARMACY	
	cost center bescription	(PATI ENT	(FTES)	PERSONNEL	ADMI NI STRATI C		(COSTED REQ)	
		MEALS)		(NUMBER		SUPPLY		
				HOUSED)	(NURSING HOURS)	(COSTED REQ)		
		10.00	11.00	12.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	C		0 0	0	
2.00	Skilled Nursing Care	0	0	0		0 0	0	2.00
3.00 4.00	Physical Therapy Occupational Therapy	0	0	0		0 0	0	
4.00 5.00	Speech Pathol ogy	0	0	0		0 0	0	5.00
6.00	Medical Social Services	0	0	0		0 0	0	
7.00	Home Health Aide	0	0	C		0 0	0	
8.00	Supplies (see instructions)	0	0	0		0 0	0	8.00
9. 00 10. 00	Drugs DME	0	0	0		0 0	0	
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	
12.00	Respiratory Therapy	0	0	C	þ	0 0	0	
13.00	Private Duty Nursing	0	0	C		0 0	0	
14.00	Clinic	0	0	0		0 0	0	14.00
15.00 16.00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
17.00	Home Delivered Meals Program	0	0	0		0 0	0	17.00
18.00	Homemaker Service	0	0	C	þ	0 0	0	
19.00	All Others (specify)	0	0	0		0 0	0	19.00
19.50	Tel emedi ci ne	0	0	0		0 0	0	
20. 00 21. 00	Total (sum of lines 1–19) Total cost to be allocated	0	0	0			0	20.00 21.00
21.00	Unit cost multiplier	0. 000000	0. 000000	0. 000000	0. 00000	0.00000	0. 000000	
						& RESI DENTS		
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	SERVICES_SAL	RSERVI CES-OTHER	PARAMED ED	
	cost center bescription	RECORDS &	SOUTAL SERVICE	ANESTHETI STS	Y & FRINGES	PRGM COSTS	PRGM-(PHARMACY	
		LI BRARY	(TOTAL PATI	(ASSI GNED	APPRV	APPRV	)	
		(GROSS	ENT DAYS)	TIME)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		REVENUE) 16.00	17.00	19.00	TIME) 21.00	TI ME) 22.00	TI ME) 23.00	
1.00	Administrative and General	9, 409, 969	0	0		0 0	0	1.00
2.00	Skilled Nursing Care	0	0	C		0 0	0	2.00
3.00	Physical Therapy	0	0	0	0	0 0	0	
4.00 5.00	Occupational Therapy Speech Pathology	0	0	U			0	4.00 5.00
6.00	Medical Social Services	0	0	C		0 0	0	6.00
7.00	Home Health Aide	0	0	C		0 0	0	7.00
8.00	Supplies (see instructions)	0	0	C		0 0	0	0.00
9. 00 10. 00	Drugs DME	0	0	C		0 0	0	
11.00	Home Dialysis Aide Services	0	0	0			0	
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00	Private Duty Nursing	0	0	0		0 0	0	
14.00	Clinic	0	0	0	D	0 0	0	
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
17.00	Home Delivered Meals Program	0	0	0		0 0	0	
18.00	Homemaker Service	0	0	C	þ	0 0	0	
19.00	All Others (specify)	0	0	C		0 0	0	
19.50	Telemedicine	0	0	0		0 0	0	
20.00	Total (sum of lines 1–19) Total cost to be allocated	9, 409, 969 23, 083	0	0	2	0	0	
			(1)	0	)	() ()		
21.00 22.00	Unit cost multiplier	0. 002453	0. 000000	0 0. 000000	0.00000	0 0.00000	0 0. 000000	21.00 22.00

Heal th	Financial Systems		COMMUNI TY HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS	FO HHA COST CENT	ERS STATISTICAL	Provider CCN:	15-0125	Period:	Worksheet H-2	
BASI S				HHA CCN:	15-7487	From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	nared
					13 / 40/	10 00/30/2022	11/22/2022 9:	
						Home Health	PPS	
						Agency I		
	Cost Center Description	PARAMED ED						
		PRGM-(LAB MLS)						
		(ASSI GNED						
		TIME)						
		23.01						
1.00	Administrative and General	0						1.00
2.00	Skilled Nursing Care	0						2.00
3.00	Physical Therapy	0						3.00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathology	0						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	0						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10. 00 11. 00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0						11.00
12.00	Private Duty Nursing	0						12.00
14.00	Clinic	0						13.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
19.50	Tel emedi ci ne	0						19.50
20.00	Total (sum of lines 1–19)	0						20.00
21.00	Total cost to be allocated	0						21.00
22.00	Unit cost multiplier	0. 000000						22.00

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	TS		Provider C	CN: 15-0125	Peri od:	Worksheet H-3	
				HHA CCN:	15-7487	From 07/01/2021 To 06/30/2022	11/22/2022 9:	pared: 20 am
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst. H-2, Part I)		Costs (col s.	1	Per Visit (col. 3 ÷ col.	
		col. 28, line	H-Z, Part I)	Costs (from Part II)	+ 2)		(COL 3 ÷ COL 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE P	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	MITATION COST, OF	5	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00			3, 452, 92			
2.00	Physical Therapy	3.00						
3.00 4.00	Occupational Therapy Speech Pathology	4.00 5.00		0			135.38 248.39	
5.00	Medical Social Services	6.00	2, 936		2, 93			
6.00	Home Health Aide	7.00			97, 77			
7.00	Total (sum of lines 1-6)		6, 861, 063	0				7.00
					Program Visit	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject 1			
					Deducti bl es			
		0	1.00	2.00	Coi nsurance 3.00	4.00	5.00	
	Limitation Cost Computation		1.00	2.00	3.00	4.00	3.00	
8.00	Skilled Nursing Care		23844	0				8.00
9.00	Physical Therapy		23844	0	7,01			9.00
10.00 11.00	Occupational Therapy Speech Pathology		23844 23844		2,97			10.00
12.00	Medical Social Services		23844	0		3		12.00
13.00	Home Health Aide		23844	0				13.00
14.00		Freeze Wirst 11.0		0	24, 28		Datia (asl 2	14.00
	Cost Center Description	From Wkst. H-2 Part I, col.	(from Wkst.		Total HHA Costs (cols.		Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
		0	1.00	Part II) 2.00	2.00	4.00	F 00	
	Supplies and Drugs Cost Comput		1.00	2.00	3.00	4.00	5.00	
15.00	Cost of Medical Supplies	8.00	399, 282	0	399, 28	32 410, 889	0. 971751	15.00
16.00	Cost of Drugs	9.00		0		0 0	0. 000000	16.00
			Program Visits		Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles & Coinsurance	Deductibles & Coinsurance		Deductibles & Coinsurance	Deductibles &	
		6.00	7.00	8.00	9.00	10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F		GGREGATE OF TH		ITATION COST, OF	2	
	BENEFICIARY COST LIMITATION							
1.00	Cost Per Visit Computation Skilled Nursing Care	0	12, 763			0 1, 633, 153		1.00
2.00	Physical Therapy	0	7,015			0 1, 171, 856		2.00
3.00	Occupational Therapy	0	2, 976			0 402, 891		3.00
4.00	Speech Pathology Medical Social Services	0	304 3			0 75, 511		4.00
5.00 6.00	Home Health Aide	0	1, 225			0 551 0 60, 344		5.00 6.00
7.00	Total (sum of lines 1-6)	0	24, 286			0 3, 344, 306		7.00
	Cost Center Description							
		6 00	7.00	8.00	9.00	10.00	11.00	
	limitation Cost Computation	6.00						
8.00	Limitation Cost Computation Skilled Nursing Care	0.00						8.00
9.00	Skilled Nursing Care Physical Therapy	0.00						9.00
9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy	0.00						9.00 10.00
9.00 10.00 11.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0.00						9.00 10.00 11.00
9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy							9.00 10.00

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL			In Lie	u of Form CMS-:	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider CO	CN: 15-0125 15-7487		d: 07/01/2021 06/30/2022		pared:
				Ti tl e	XVIII		e Health gency I	PPS	
		Prog	ram Covered Cha	arges	Cost of Services				
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to	Part A	Not Dedu	Part B Subject to uctibles & nsurance	Subject to Deductibles & Coinsurance	
	I	6.00	7.00	8.00	9.00		10.00	11.00	
15. 00 16. 00	Supplies and Drugs Cost Computa Cost of Medical Supplies Cost of Drugs	ons 0	400, 383	0		0	389, 073		
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00				·			_
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MI TATI (	ON COST, OF	2	_
1.00 2.00	Cost Per Visit Computation Skilled Nursing Care Physical Therapy	1, 633, 153 1, 171, 856							1.00
3.00 4.00	Occupational Therapy Speech Pathology	402, 891 75, 511							3.00 4.00
5.00 6.00	Medical Social Services Home Health Aide	551 60, 344							5.00 6.00
7.00	Total (sum of lines 1-6) Cost Center Description	3, 344, 306			-				7.00
	Limitation Cost Computation	12.00							
8.00 9.00 10.00 11.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology								8.00 9.00 10.00 11.00
12.00 13.00 14.00	Medical Social Services Home Health Aide Total (sum of lines 8-13)								12.00 13.00 14.00

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C		Period:	Worksheet H-3	
				HHA CCN:	15-7487	From 07/01/2021 To 06/30/2022	Part II Date/Time Pre 11/22/2022 9:	
				Title	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physical Therapy	66.00	0. 353214	C	)	0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 250642	C	)	0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 405107	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 535434	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 189549	0		0 col. 2, line 1	6. 00	5.00

LCULA	TION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0125	Peri	od: 07/01/2021	Worksheet H-4 Part I-II	
		HHA CCN:	15-7487	То	06/30/2022		
		Title	XVIII		me Health Agency I	PPS	
				· · · · ·		tВ	
			Part A			Subject to Deductibles &	
		-	1 00	C	oi nsurance	Coi nsurance	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGES	1.00		2.00	3.00	
Ī	Reasonable Cost of Part A & Part B Services						
	Reasonable cost of services (see instructions) Total charges			0 0	0		
- H	Customary Charges				0	0	
0	Amount actually collected from patients liable for payment for	servi ces		0	0	0	
0	on a charge basis (from your records) Amount that would have been realized from patients liable for	payment		0	0	0	
	for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			-		-	
0	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00	0.000000	0.00000	
	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (	complata		0	0	0	
	only if line 6 exceeds line 1)	comprete		0	0	0	
0	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	0	
C	Primary payer amounts			0	0	0	
					Part A	Part B	
				-	Services 1.00	Services 2.00	
- H	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			_			
	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0	0 3, 411, 040	
	Total PPS Reimbursement - Full Episodes with Outliers				0	661, 929	
	Total PPS Reimbursement - LUPA Episodes				0	55, 689	
00	Total PPS Reimbursement - PEP Episodes				0	23, 826	1
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	165, 448	1
	Total PPS Outlier Reimbursement – PEP Episodes				0	2, 928	
	Total Other Payments				0	0	1
	DME Payments				0	0	1
	Oxygen Payments				0	0	1
	Prosthetic and Orthotic Payments	``			0	0	2
	Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21)	rance)			0	0	2
	Excess reasonable cost (from line 8)				0	4, 320, 860 0	2
	Subtotal (line 22 minus line 23)				0	4, 320, 860	
	Coinsurance billed to program patients (from your records)				0	4, 320, 000	2
	Net cost (line 24 minus line 25)				0	4, 320, 860	
	Reimbursable bad debts (from your records)				0	0 0 0	2
	Reimbursable bad debts for dual eligible beneficiaries (see in	structions)			0		
	Total costs - current cost reporting period (line 26 plus line				0	4, 320, 860	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	0	3
	Pioneer ACO demonstration payment adjustment (see instructions	)			0	0	3
	Demonstration payment adjustment amount before sequestration				0	0	3
	Subtotal (see instructions)				0	4, 320, 860	
	Sequestration adjustment (see instructions)				0	11, 677	3
	Demonstration payment adjustment amount after sequestration	+			0	0	3
	Sequestration adjustment for non-claims based amounts (see ins	tructions)			0	0	3
	Interim payments (see instructions) Tentative settlement (for contractor use only)				0	4, 309, 183 0	3
	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, a	nd 33)			0	0	3
	Protested amounts (nonallowable cost report items) in accordan	,	Pub 15_2		0	0	3
		CC WILLI UND	1 UD. 10-Z.	1	0	0	

IALYS	I Financial Systems COMMUNITY H SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider CC	CN: 15-0125	Peri od:	Worksheet H-5	
) PR(	DGRAM BENEFICIARIES	HHA CCN:	15-7487	From 07/01/2021 To 06/30/2022	Date/Time Prep 11/22/2022 9:2	pare
				Home Health Agency I	PPS	20 0
		I npati en	t Part A		rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00		1.00	2.00	3.00	4.00	1
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0 0	4, 309, 183 0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3
	Program to Provider					
01				0	0	3
)2				0	0	3
03				0	0	3
)4 )5				0 0	0	
5	Provider to Program			0	0	
0				0	0	
i1				0	0	3
52				0	0	1
53				0	0	
54 99	Subtatal (sum of lines 2.01.2.40 minus sum of lines			0	0	
19	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	4, 309, 183	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1				0	0	5
)2 )3				0	0	5
,5	Provider to Program			<u> </u>	0	
0				0	0	Ę
51				0	0	Ę
2				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					e
)1	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)			0	4, 309, 183	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0	<b>`</b>	1.00	(MO/Day/YF) 2.00	

Title XVIII         Hospital           ART 1 - FULLY PROSPECTIVE METHOD         1.00           CAPITAL FEDERAL AMOUNT         5.23           1.00         Capital DRG other than outlier         5.23           1.01         Model 4 BPCI Capital DRG other than outlier payments         3           2.01         Model 4 BPCI Capital DRG outlier payments         3           2.01         Model 4 BPCI Capital DRG outlier payments         3           0.00         Total inpatient days divided by number of days in the cost reporting period (see instructions)         2           0.01         Indirect medical education percentage (see instructions)         3           0.00         Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01, columns 1 and 1.01, objections)         2           3.00         Percentage of Medicaid patient days to total days (see instructions)         22           3.00         Percentage of Medicaid patient days to total days (see instructions)         22           3.00         Number of inters and 8         22           3.00         Program inpatient met orgital cost (see instructions)         22           3.00         Total prospective capital payments (see instructions)         22           3.00         Total inpatient capital cost (see instructions)         22	CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0125	Period: From 07/01/2021 To 06/30/2022	Worksheet L Parts I-III Date/Time Pre 11/22/2022 9:	
PART 1 - FULLY PROSPECTIVE METHOD           CAPI Tal. FEDERAL MOUNT           Capi Tal. DRG other then outlier           Capi Tal. DRG outlier payments           Capi Tal. DRG outlier payments           Total inpatient days divided by number of days in the cost reporting period (see instructions)           Indirect medical education percentage (see instructions)           Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01 (see instructions)           Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01 (see instructions)           00         Indirect medical education percentage (see instructions)           00         See instructions)           00         See instructions)           00         Forcentage of Medical d patient days to total days (see Instructions)           00         Sum of lines 7 and 8           0.00         I onoble signoportionate share percentage (see instructions)           00         Forgram inpatient ancillary capital cost (see instructions)           00         Forgram inpatient copital cost (see instructions)           00         Forgram inpatient copital cost (see instructions)           01         Forgra			Title XVIII	Hospi tal	PPS	20 0
PART 1 - FULLY PROSPECTIVE METHOD           CAPI TL FEDERAL ANDUNT           Capital DRG other than outlier           Capital DRG outlier payments           Total inpatient days divided by number of days in the cost reporting period (see instructions)           Indirect medical education percentage (see instructions)           Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01; see instructions)           OP Percentage of SI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)           OB isoproportionate share percentage (see instructions)           OD bisoproportionate share adjustment (see instructions)           OD bisoproportionate share adjustment (see instructions)           OD Program inpatient routine capital cost (see instructions)           OD Program inpatient routine capital cost (see instructions)           OT Total inpatient program capital cost (see instructions)           OT Total inpatient program capital cost (see instructions)           OT Total inpatient capital					1 00	
CAPITAL FEDERAL AMOUNT         5.23           0         Capital DRG other than outlier         5.23           01         Model 4 BPCI Capital DRG other payments         3           01         Model 4 BPCI Capital DRG outlier payments         3           01         Indirect madical payments         3           01         Indirect madical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)         1           01         Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)         1           01         Sum of lines 7 and 8		PART L - FULLY PROSPECTIVE METHOD			1.00	
00       Capital DRG other than outlier       5,23         10       Model 4 PRC1 Capital DRG other than outlier       3         01       Capital DRG outlier payments       3         01       Model 4 PRC1 Capital DRG outlier payments       3         01       Indirect medical education percentage (see instructions)       2         01       Indirect medical education percentage (see instructions)       2         02       Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)       2         02       Bercentage of SI recipient patient days to total days (see instructions)       2         03       Giese instructions)       2       2         04       Percentage of Medicaid patient days to total days (see instructions)       2       2         05       Sum of lines 7 and 8       2       2         00       Disproportionate share adjustment (see instructions)       2       2         00       Total inpatient routine capital cost (see instructions)       5       4         00       Program inpatient routine capital cost (see instructions)       5       4         00       Program inpatient capital cost (line 1 plus line 2)       5       4       1       1       0         01       T						1
01       Model 4 BPCI Capital DRG other than outlier       3         02       Capital DRG outlier payments       3         01       Model 4 BPCI Capital DRG outlier payments       3         01       Model 4 BPCI Capital DRG outlier payments       3         01       Indirect madical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)       2         01       Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)       1         01       Percentage of Medical days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)       0         02       Percentage of Medical days to total days (see instructions)       2         03       Sum of lines 7 and 8       2         04       All owable di sproportionate share percentage (see instructions)       2         03       Di sproportionate share adjustment (see instructions)       2         04       All owable di sproportionate share adjustment (see instructions)       2         05       Program inpatient routine capital cost (see instructions)       2         04       Program inpatient capital cost (see instructions)       7         05       Program inpatient capital cost (see instructions)       7         06       Program inpatient capi					5, 232, 139	1 1.
00       Capital DRG outlier payments       3         10       Model 4 PRCI Capital DRG outlier payments       2         00       Total inpatient days divided by number of days in the cost reporting period (see instructions)       2         01       Indirect medical education percentage (see instructions)       2         01       Indirect medical education percentage (see instructions)       2         02       Indirect medical education percentage (see instructions)       2         03       (see instructions)       2         04       Indirect medical education percentage (see instructions)       2         05       (see instructions)       2         06       Percentage of Medicaid patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)       2         05       Sum of lines 7 and 8       2         06       Pirogramitipatient days to total days (see instructions)       2         07       Total inpatient routine capital cost (see instructions)       5,49         08       Program inpatient ancillary capital cost (see instructions)       2         09       Program inpatient capital cost (line 1 plus line 2)       2         00       Total inpatient program capital cost (line 3 x line 4)       1.00         100       Program inpatient capital costs (see					0	
01       Model 4 BPCI Capital DRG outlier payments       2         01       Total inpatient days divided by number of days in the cost reporting period (see instructions)       2         01       Indirect medical education percentage (see instructions)       1         01       Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)       2         01       Percentage of SBI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)       2         02       Percentage of Medicaid patient days to total days (see instructions)       22         03       Olisproportionate share percentage (see instructions)       22         04       Disproportionate share adjustment (see instructions)       22         05       Total prospective capital payments (see instructions)       22         06       Program inpatient routine capital cost (see instructions)       22         07       Total inpatient program capital cost (see instructions)       22         08       Program inpatient capital cost (see instructions)       22         09       Total inpatient program capital cost (line 1 plus line 2)       23         00       Capital cost symmet factor (see instructions)       1.00         00       Total inpatient capital costs (see instructions)       1.00 </td <td></td> <td></td> <td></td> <td></td> <td>39, 487</td> <td></td>					39, 487	
00       Total inpatient days divided by number of days in the cost reporting period (see instructions)       2         00       Number of interns & residents (see instructions)       1         01       Indirect medical education percentage (see instructions)       1         01       Indirect medical education percentage (see instructions)       1         01       Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01, isee instructions)       2         02       Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)       2         03       Sue of lines 7 and 8       2         04       Allowable disproportionate share percentage (see instructions)       2         05       Sum of lines 7 and 8       2         06       Program inpatient routine capital cost (see instructions)       2         07       Program inpatient routine capital cost (see instructions)       2         08       Total inpatient program capital cost (line 1 plus line 2)       2         00       Capital cost spayment factor (see instructions)       1.00         00       Program inpatient capital costs (ine 1 minus line 2)       1.00         01       Total inpatient program capital cost (line 1 minus line 2)       1.00         02       Capital					0	
00       Number of interns & residents (see instructions)       1100 (100 (100 (100 (100 (100 (100 (100			reporting period (see inst	tructions)	227.20	
00       Indirect medical education percentage (see instructions)         00       Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)         00       Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)         00       Percentage of Medicaid patient days to total days (see instructions)         00       Percentage of Medicaid patient days to total days (see instructions)         01       Sie instructions)         020       Total prospective capital payments (see instructions)         01       Total prospective capital payments (see instructions)         02       Total prospective capital cost (see instructions)         03       Total program inpatient ancillary capital cost (see instructions)         04       Program inpatient ancillary capital cost (see instructions)         05       Total inpatient program capital cost (ine 1 plus line 2)         04       Capital cost payment factor (see instructions)         05       Program inpatient capital costs (or extraordinary circumstances (see instructions)         04       Program inpatient capital costs (see instructions)         05       Program inpatient capital costs (see instructions)         06       Program inpatient capital costs (see instructions)         07       Program inpatient capital c			reperting period (see this		0.00	
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