This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 31-0041 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/24/2022 5: 22 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/24/2022 5: 22 pm ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[19] 19. NPR Date:
[10] 19. NPR Date:
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[16] 19. NPR Date:
[17] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY MEDICAL CENTER (31-0041) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1			SI GNATURE STATEMENT	
1	Rich Henwood		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Ri ch Henwood			2
3	Signatory Title	VP OF CORPORATE REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-3, 588, 434	794, 284	0	452, 068	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-1	-1, 597		0	7.00
200.00	Total	0	-3, 588, 435	792, 687	0	452, 068	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.

Health Financial Systems COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0041 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/24/2022 5: 22 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 99 ROUTE 37S 1.00 PO Box: 1.00 City: TOMS RIVER State: NJ Zip Code: 08755-6423 County: OCEAN 2.00 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, O, or N)
V XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY MEDICAL 310041 35154 07/01/1967 N 3.00 CENTER Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF COMMUNITY MEDICAL 315490 35154 02/10/2005 Ρ 0 9.00 CENTER 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 01/01/2021 12/31/2021 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to N 22 03 N N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as

Ν

22.04

23.00

counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

22.04 Did this hospital receive a geographic reclassification from urban to

yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

yes or "N" for no.

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

N

N

58 00

59.00

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

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

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	HEALTH CARE COMPLEX IDENTIFICATION DATA Provider		CN: 31-0041	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/24/2022 5:22	pared
			NAHE 413.89 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2. 00	3.00	
Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colus and instructions.	85? (se umn 1. R) NAHE mn 2.	ee If column 1 MA payment	Y	Υ		60.0
0.01   If line 60 is yes, complete columns 2 and 3 for each instructions)	program.	IME	Direct GME	23. 00	1 Direct GME	60.0
	·					
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1. 00 N	2. 00	3. 00	4.00	5.00	61. (
column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. (
Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61.
.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.
.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
	Program Name		Program Code Unweighted IM FTE Count		Unweighted Direct GME FTE Count	
10 00 11 575 1 11 11 15		1. 00	2. 00	3.00	4.00	
.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	01.
.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0.00	0. 00	61.
the direct GME FTE unweighted count.					1.00	
ACA Provisions Affecting the Health Resources and Ser .00 Enter the number of FTE residents that your hospital	trai ned			eriod for which	0.00	62.
your hospital received HRSA PCRE funding (see instruc 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	Teachi r			o your hospital	0.00	62.
Teaching Hospitals that Claim Residents in Nonprovide			- /		1	İ

Health Financial Systems	COMMUN	ITY MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider CC		riod: com 01/01/2021 12/31/2021	Worksheet S-2 Part I Date/Time Prep 5/24/2022 5:22	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Year			This base year	is your cost r	reporting	
period that begins on or after of the following seriod that begins on or after of the following seriod the number of the following seriod that the following seriod the following seriod that the following seriod the following seriod the following seriod	s yes, or your facili nber of unweighted no otations occurring in e number of unweighted our 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	64. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	0.00	0.00	0.000000 Ratio (col. 1/	65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided by column 1 divided by (column	unweighted non-prima occurring in all nonpo unweighted non-prima cal. Enter in column	rovider settings. ry care resident 3 the ratio of	0. 25	6. 38	0. 037707	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1.00 INTERNAL MEDICINE	2. 00	3. 00	4. 00 5. 52	5. 00 0. 000000	67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	INTERIVAL WEDICINE		0.00	5. 52	0.000000	67.00

	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	IN	Y	98.01
	title XIX.			
	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	N	Υ	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1			
	for title V, and in column 2 for title XIX.			
	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N	N	98. 03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1			
	for title V, and in column 2 for title XIX.			
	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	N	98. 04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and			
	in column 2 for title XIX.		.,	
	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	N	Υ	98. 05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in			
	column 2 for title XIX.	N.	Υ	00.04
	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	N	Y	98. 06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in			
	column 2 for title XIX.			
	Rural Providers	N		105 00
	Does this hospital qualify as a CAH?	IN		105. 00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment			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)			
	Litter 1 for yes or in for no fir cordinal 2. (see firstructions)			I

Health Financial Systems COMMUNITY MEDICA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	L CENTER Provider CO	N: 31_00/1 D	In Lie	worksheet S-	
INSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Frovider Co		rom 01/01/2021	Part I Date/Time Pr	epared:
			V	5/24/2022 5::	22 pm
			1. 00	2. 00	
108.00 Is this a rural hospital qualifying for an exception to the CR CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	NA fee sched	dul e? See 42	N		108. 0
	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	4.00	109. 0
				1.00	1
I10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Works applicable.	for yes or	"N" for no. If	yes,	N	110. 0
			1. 00	2.00	+
I11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addifor tele-health services.	reporting pumn 1 is Y, ecipating in	period? Enter enter the column 2.	N	2.00	111. 0
		1.00	2. 00	3.00	+
112.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting pe 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 the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.	ri od? Y", enter	N N	2.00	3.00	112. 0
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "	N" for no	N			0115. C
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) percent cludes				
116.00 s this facility classified as a referral center? Enter "Y" fo	r yes or	N			116. C
"N" for no. 117.00 Is this facility legally-required to carry malpractice insuran	ce? Enter	Υ			117. C
"Y" for yes or "N" for no.  18.00 Is the malpractice insurance a claims-made or occurrence polic if the policy is claim-made. Enter 2 if the policy is occurren	,	1			118.0
it the portey is craim-made. Enter 2 if the portey is occurren		Premi ums	Losses	Insurance	
18.01 List amounts of malpractice premiums and paid losses:		1. 00 4, 590, 712	2.00	3.00	0 118. 0
Total Later and Arte of market of promiting and part recessor.		1,0,0,7.12			
18.02 Are malpractice premiums and paid losses reported in a cost ce	nter other i	than the	1. 00 N	2. 00	118. (
Administrative and General? If yes, submit supporting schedul and amounts contained therein.			, and the second		
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	olumn 1, "Y' ifies for th	' for yes or ne Outpatient	N	N	119. ( 120. (
21.00 Did this facility incur and report costs for high cost implant	able devices	s charged to	Υ		121. (
patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.			N		122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	ves and "N"	for no If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below.  26.00  f this is a Medicare certified kidney transplant center, ente					126.
in column 1 and termination date, if applicable, in column 2.					127. (
27 On If this is a Medicare certified heart transplant content onten		cation date			' - ' . '
in column 1 and termination date, if applicable, in column 2.				1	
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certifi				
128.00 If this is a Medicare certified liver transplant center, enter	the certifi				128. (

Health Financial Systems	COMMUNI TY	MEDICAL CENTER			In Lie	eu of Form CMS	-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 31-0041	Peri od:		Worksheet S-	2	
					1/01/2021 2/31/2021	Part I Date/Time Pr	epared:	
						5/24/2022 5:	22 pm	
					1. 00	2.00	-	
131.00 If this is a Medicare certified in			rti fi cati on			2.00	131. 00	
date in column 1 and termination (			cation date				132. 00	
132.00 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								
133.00 Removed and reserved	(000)						133. 00	
134.00 If this is an organ procurement or and termination date, if applicable		r the UPU number i	n column I				134. 00	
All Providers								
140.00 Are there any related organization chapter 10? Enter "Y" for yes or '					Υ	H53560	140. 00	
are claimed, enter in column 2 the				.5				
1.00		2.00	1 110 11		3. 00	6 11		
If this facility is part of a chain home office and enter the home of				name and	address	of the		
141. 00 Name: RWJBARNABAS HEALTH		: NOVITAS SOLUTIONS		tor's Nur	mber: 1200	01	141. 00	
142.00 Street: 95 OLD SHORT HILLS ROAD	PO Box:		7: 0 1		070	-0	142.00	
143.00 Ci ty: WEST ORANGE	State:	NJ	Zi p Cod	e:	0705	52	143. 00	
						1.00		
144.00 Are provider based physicians' cos	sts included in Workshe	et A?				Y	144. 00	
					1. 00	2.00	-	
145.00 If costs for renal services are cl						2.00	145. 00	
inpatient services only? Enter "Y'	9							
no, does the dialysis facility inc period? Enter "Y" for yes or "N"		TON TOT THIS COST	reporting					
146.00 Has the cost allocation methodolog	gy changed from the pre			_	N		146. 00	
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o		b. 15-2, chapter 4	0, §4020) I	f				
yes, enter the approvar date (min/t	ad/yyyy) iii corullii z.							
4.7 ook		"11"				1.00	1.17.00	
147.00 Was there a change in the statisti 148.00 Was there a change in the order of						N N	147. 00 148. 00	
149.00 Was there a change to the simplifi				r no.		N	149. 00	
		Part A 1.00	Part B 2.00		tle V 3.00	Title XIX 4.00	_	
Does this facility contain a provi	der that qualifies for							
or charges? Enter "Y" for yes or '		ponent for Part A	and Part B.		CFR §413	3. 13)		
155.00 Hospi tal 156.00 Subprovi der - IPF		N N	N N		N N	N N	155. 00 156. 00	
157. 00 Subprovi der - IRF		N N	N		N	N	157. 00	
158. 00 SUBPROVI DER							158. 00	
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 00 160. 00	
161. 00 CMHC		IN IN	N		N	N	161. 00	
Mul ti campus						1.00		
165.00 Is this hospital part of a Multica	ampus hospital that has	one or more campu	ses in diff	erent CB	SAs?	N	165. 00	
Enter "Y" for yes or "N" for no.	Nama	County	Ctoto 7	'in Cada	CDCA	ETE /Compute		
	Name O	County 1.00	2. 00	i p Code 3.00	4. 00	FTE/Campus 5.00		
166.00 If line 165 is yes, for each	-	33					00 166. 00	
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)								
1.00								
Health Information Technology (HI	•			ent Act		NI	167.00	
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10				), enter	the	N	167. 00 168. 00	
reasonable cost incurred for the H	HIT assets (see instruc	tions)				1		
168.01 If this provider is a CAH and is reception under §413.70(a)(6)(ii)					shi p		168. 01	
169.00 If this provider is a meaningful u					nter the	0.0	00169.00	
transition factor. (see instruction	ons)					1		

Health Financial Systems	COMMUNITY MEDICAL CENTER				2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATION DATA	Peri od:	Worksheet S-2		
			From 01/01/2021	Part I	
			To 12/31/2021	Date/Time Pre 5/24/2022 5:2	pared:
				t e	2 piii
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider have	any days for indiv	iduals enrolled in	N	C	171. 00
section 1876 Medicare cost plans reported o					
"Y" for yes and "N" for no in column 1. If	column 1 is yes, en	ter the number of section	n		
1876 Medicare days in column 2. (see instru					

Heal th	Financial Systems COMMUNITY MED	DICAL CENTER		In Li∈	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	
				From 01/01/2021 Fo 12/31/2021	Part II Date/Time Pre	enared:
					5/24/2022 5: 2	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	N for all NO ro	enoneoe Entor	1.00	2.00	
	mm/dd/yyyy format.	N TOT ALL NO TE	sponses. Enter	all dates ill	riie	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation			_		
1. 00	Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in o	corumn 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare I		N			2. 00
	yes, enter in column 2 the date of termination and in colu	mn 3, "V" for				
3.00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includi	na management	N			3. 00
3.00	contracts, with individuals or entities (e.g., chain home					3.00
	or medical supply companies) that are related to the provide	der or its				
	officers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and other relationships? (see instructions)	er similar				
	rerationships: (see Thati detrons)		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C"	tified Public	Y	Α	04/30/2022	4. 00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit re	conciliation.		Y/N	Logal Open	
				1.00	Legal Oper. 2.00	
	Approved Educational Activities			1. 00	2.00	
6.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provider	N		6. 00
7.00	is the legal operator of the program?					7.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		ed during the	N N		7. 00 8. 00
0.00	cost reporting period? If yes, see instructions.	ca anazor renev	ica darring the	14		0.00
9.00	Are costs claimed for Interns and Residents in an approved	graduate medic	cal education	N		9. 00
10.00	program in the current cost report? If yes, see instruction					10.00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	ne current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than	I & R in an App	roved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Bad Debts				1. 00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	i ons.		Υ	12. 00
13.00	If line 12 is yes, did the provider's bad debt collection			st reporting	N	13. 00
	period? If yes, submit copy.					4.00
14.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents warved? If	yes, see inst	ructions.	N	14. 00
15. 00	Did total beds available change from the prior cost report	ina period? If	ves. see instr	ructions.	N	15. 00
	,		t A		t B	
		Y/N	Date	Y/N	Date	
	DC0D Data	1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	l N		N		16. 00
10.00	If either column 1 or 3 is yes, enter the paid-through	''		,,,		10.00
	date of the PS&R Report used in columns 2 and 4 (see					
17 00	instructions)	Y	02/01/2022	V	02 (01 (2022	17.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	03/01/2022	Y	03/01/2022	17. 00
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	1	1	1	I	I

	Financial Systems COMMUNITY MED	DI CAL CENTER		In Lie	u of Form CMS	-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 31-0041	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S- Part II Date/Time Pr 5/24/2022 5:	epared:		
		Descri	ption	Y/N	Y/N			
		C		1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
	The port data for other. Describe the other day astiments.	Y/N	Date	Y/N	Date			
21 00	Was the seat assess assessed only using the seasification	1.00	2. 00	3.00	4. 00	21.00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	OSPI TALS)					
	Capital Related Cost							
22.00	Have assets been relifed for Medicare purposes? If yes, see					22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisa	als made dur	ing the cost		23. 00		
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	porting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? I	f yes, see		26. 00		
27. 00	This tructions. Has the provider's capitalization policy changed during the copy.	e cost reportino	g period? If	yes, submit		27. 00		
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit e	ntered into duri	ing the cost	reporting		28. 00		
	period? If yes, see instructions.							
29. 00	DO Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions							
30. 00	00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see							
31. 00	instructions.  Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.							
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		d through co	ntractual		32. 00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		g to competi	tive bidding? If		33. 00		
	no, see instructions. Provider-Based Physicians							
34. 00	Are services furnished at the provider facility under an allf yes, see instructions.	rrangement with	provi der-ba	sed physicians?		34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based		35. 00		
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date			
				1. 00	2. 00			
	Home Office Costs							
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	repared by the I	home office?			36. 00 37. 00		
38. 00	If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home of					38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	d of the home of	ffi ce.			39. 00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00		
	instructions.							
		1. (	00	2.	00			
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position	RI CHARD		HENWOOD		41. 00		
42. 00	held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report	RWJBARNABAS HEA	ALTH			42. 00		
	preparer.							
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	732-923-8074		RI CH. HENWOOD@R	WJBH. ORG	43.00		

Health Fina	ancial Systems	CAL CENTER		In Lieu of Form CMS-2552-10			
HOSPITAL AN	ND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provider CCN: 31-0	F	eriod: rom 01/01/2021		
				To		Date/Time Pre 5/24/2022 5:2	
			3. 00				
Cost	Report Preparer Contact Information						
41.00 Ente	er the first name, last name and the title	/position \	/P OF CORPORATE				41.00
held	d by the cost report preparer in columns 1	, 2, and 3, F	REIMBURSEMENT				
resp	pecti vel y.						
42.00 Ente	er the employer/company name of the cost r	eport					42.00
prep	parer.						
43.00 Ente	er the telephone number and email address	of the cost					43.00
repo	ort preparer in columns 1 and 2, respectiv	el y.					

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: 
 Heal th Financial
 Systems
 COMMUNI

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 31-0041

					-	Γο 12/31/2021	Date/Time Pre 5/24/2022 5:2	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		236	86, 140	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	
7.00	Total Adults and Peds. (exclude observation			236	86, 140	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		165	60, 22	0.00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		12	4, 380	0.00	0	
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	
14. 00	Total (see instructions)			413	150, 74	0.00		
15. 00	CAH visits						0	
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER						_	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		25	9, 12		0	
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			438				27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	1			32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days							33.00
33. UI	LTCH site neutral days and discharges		l		I	1	I	33. 01

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/24/2022 5:22 pm	

						5/24/2022 5: 2	2 pm
		I/P Days	o/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	47, 475	681	64, 335	i		1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	28, 335	10, 833				2. 00
3. 00	HMO IPF Subprovider	20, 333	10, 633				3.00
4. 00	HMO IRF Subprovider	0	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF		0	0	1		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	0	ď			6.00
7. 00	Total Adults and Peds. (exclude observation	47, 475	681	64, 335			7.00
7.00	beds) (see instructions)	17, 170	001	01,000			7.00
8.00	INTENSIVE CARE UNIT	4, 397	695	43, 880	)		8. 00
9.00	CORONARY CARE UNIT	·		·			9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	o	58	3, 347			11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		2, 235	4, 846	,		13. 00
14.00	Total (see instructions)	51, 872	3, 669	116, 408	12. 14	1, 943. 73	14. 00
15. 00	CAH visits	0	0	C	)		15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	1, 992	0	2, 770	0.00	16. 74	1
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						23. 00 24. 00
24. 00 24. 10	HOSPICE (non-distinct part)			0			24. 00
25. 00	CMHC - CMHC			·			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	o d	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)	Ĭ	ĭ	Ĭ	12. 14	l e	27. 00
28. 00	Observation Bed Days		0	277		1, 700. 47	28. 00
29. 00	Ambul ance Trips	o	ĭ				29. 00
30.00	Employee discount days (see instruction)	, and the second		1, 337			30.00
31. 00	Employee discount days - IRF		ļ	,, ss,			31. 00
32. 00	Labor & delivery days (see instructions)	o	37	1, 179	,		32. 00
32. 01	Total ancillary labor & delivery room	]	-	,	)		32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	O					33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 31-0041

				To	12/31/2021	Date/Time Prep 5/24/2022 5:23	
		Full Time	_	Di scha	arges	0,21,2022 0.2.	<u> </u>
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	8, 391	459	23, 278	1. 00
2.00	HMO and other (see instructions)			4, 400	3, 873		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	8, 391	459	23, 278	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
00.00	outpatient days (see instructions)						00.00
33. 00	LTCH non-covered days			0			33. 00
33.01	LTCH site neutral days and discharges			0			33. 01

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2021	Part II
To 12/31/2021	Date/Time Prepared:
5/24/2022 5:22 pm	

						) 12/31/2021	5/24/2022 5: 2	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	A-6) 3. 00	3) 4.00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	0.00	
	SALARI ES							
1.00	Total salaries (see	200. 00	157, 029, 980	-1, 628, 345	155, 401, 635	4, 077, 785. 06	38. 11	1. 00
2.00	instructions) Non-physician anesthetist Part A		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3. 00
4. 00	Physician-Part A - Administrative		158, 890	0	158, 890	1, 575. 00	100. 88	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		21, 724 815, 122	0		82. 00 1, 274. 00	l e	1
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	774, 712	774, 712	26, 096. 00	29. 69	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	О	0.00	0.00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	1, 456, 354 339, 530			34, 817. 22 24, 452. 45		
	instructions) OTHER WAGES & RELATED COSTS		•	•	·	•		-
11. 00	Contract labor: Direct Patient Care		18, 404, 533	0	18, 404, 533	125, 008. 36	147. 23	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0. 00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		0	0	0	0. 00	0. 00	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14. 00
14. 01	Home office salaries		21, 113, 387	0	21, 113, 387	304, 492. 19	69. 34	14. 01
14. 02	Related organization salaries		0	0	0	0.00		1
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0.00	0. 00	16. 01
16 02	- Teaching Home office contract		0	0	0	0.00	0.00	16. 02
10.02	Physicians Part A - Teaching				Ĭ		0.00	10.02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		45, 502, 499	0	45, 502, 499			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00	Excluded areas		275, 173	О	275, 173			19. 00
20. 00	Non-physician anesthetist Part A		0	0	0			20.00
21. 00	Non-physician anesthetist Part B		0	0				21.00
22. 00	Physician Part A - Administrative		4, 828	0	4, 828			22.00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		251 26, 085	0	251 26, 085			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0 80, 003	0	0 80, 003			24. 00 25. 00
25. 50	approved program) Home office wage-related		5, 204, 901	0	5, 204, 901			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0	О			25. 52
	wage-related (core)							

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 01/01/2021 Part II

						rom 01/01/2021	Part II	
					T	o 12/31/2021	Date/Time Pre	
		WI A I :	A	D1: 6:+:	A -1: +1	Det al Harrisa	5/24/2022 5: 2	
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col . 2 ± col .	Salaries in	col . 5)	
		1.00	2.00	A-6)	3)	col . 4	/ 00	
05.50	LI CC: DI : : D : A	1.00	2.00	3.00	4.00	5. 00	6. 00	05 50
25. 53	Home office: Physicians Part A		U	U	0			25. 53
	- Teaching - wage-related							
	(core)  OVERHEAD COSTS - DIRECT SALARII							
26. 00	Employee Benefits Department	4.00	916, 147		916, 147	23, 556. 47	38. 89	26. 00
27. 00	Administrative & General	5.00	·					
			10, 168, 077					
28. 00	Administrative & General under		3, 870, 259	U	3, 870, 259	13, 123. 87	294. 90	28. 00
29. 00	contract (see inst.)	4 00	222 200		222 200	( 224 (0	25 70	29. 00
	Maintenance & Repairs	6.00	222, 208		222, 208			
30.00	Operation of Plant	7. 00	3, 384, 184	0	3, 384, 184			
31.00	Laundry & Linen Service	8. 00	4 0/4 /00	0	0	0.00		
32.00	Housekeepi ng	9. 00	4, 261, 632	0	4, 261, 632	,		
33. 00	Housekeeping under contract		Ü	0	0	0. 00	0. 00	33. 00
04.00	(see instructions)	40.00	0 407 000	F04 404	0 500 400	100 (00 0)	04 40	0.4.00
34.00	Dietary	10. 00	3, 187, 330	-594, 131	2, 593, 199	,		34. 00
35. 00	Di etary under contract (see		Ü	0	0	0. 00	0. 00	35. 00
27 00	instructions)	11 00	0	F04 101	F04 101	27 010 00	21 00	27.00
36.00	Cafeteria	11. 00	U	594, 131	594, 131	27, 018. 00		36.00
37. 00	Maintenance of Personnel	12.00	4 004 005	0 011	1 01/ 174	0.00		
38. 00	Nursing Administration	13. 00	4, 924, 985			,		
39. 00	Central Services and Supply	14. 00	1, 800, 329		1, 800, 329			
40. 00	Pharmacy	15. 00	5, 350, 541	-78, 110		118, 812. 27		
41. 00	Medical Records & Medical	16. 00	2, 785, 687	-65, 166	2, 720, 521	88, 122. 10	30. 87	41. 00
	Records Li brary	47.00	0 / 10 055			F0 470 00	45.40	
42.00	Soci al Servi ce	17. 00	2, 640, 255					42. 00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared: Provider CCN: 31-0041

					''	0 12/31/2021	5/24/2022 5: 22	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		160, 063, 393	-2, 403, 057	157, 660, 336	4, 063, 456. 93	38. 80	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 795, 884	360, 445	2, 156, 329	59, 269. 67	36. 38	2.00
	instructions)							
3.00	Subtotal salaries (line 1		158, 267, 509	-2, 763, 502	155, 504, 007	4, 004, 187. 26	38. 84	3.00
	minus line 2)							
4.00	Subtotal other wages & related		39, 517, 920	0	39, 517, 920	429, 500. 55	92. 01	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		50, 712, 228	0	50, 712, 228	0.00	32. 61	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		248, 497, 657	-2, 763, 502	245, 734, 155	4, 433, 687. 81	55. 42	6. 00
7.00	Total overhead cost (see		43, 511, 634	-1, 131, 764	42, 379, 870	1, 167, 471. 63	36. 30	7.00
	instructions)							

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 31-0041	Peri od: Worksheet S-3 From 01/01/2021 Part IV To 12/31/2021 Date/Time Prepared:

	To 12/31/2021	Date/Time Prep 5/24/2022 5: 2:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	7, 354, 814	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	240, 468	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	802, 360	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	373, 972	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	21, 910, 946	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	406, 072	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	57, 106	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	453, 737	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	225, 365	14. 00
	'Workers' Compensation Insurance	1, 479, 399	
16. 00		0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	11, 434, 157	1
	Medicare Taxes - Employers Portion Only	0	
	Unemployment Insurance	613, 430	
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
22.00	instructions))		22.00
	Day Care Cost and Allowances	0	
	Tuition Reimbursement	537, 013	
24. 00	Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost	45, 888, 839	24. 00
25.00			25 00
∠5. 00	OTHER WAGE RELATED COSTS (SPECIFY)	1	25. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 31-0041	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Prepared: 5/24/2022 5:22 pm
0 1 0 1 5 11		0	D C: 1 O 1

		0 12/31/2021	5/24/2022 5: 22	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	45, 888, 839	1.00
2.00	Hospi tal	0	45, 888, 839	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospi tal -Based SNF	0	0	8. 00
9. 00	Hospi tal -Based NF			9. 00
10. 00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
14. 00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17.00
18. 00	Other	0	0	18. 00

	UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 3		Peri od:	Worksheet S-10	0
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/24/2022 5: 22	
						Z DIII
Un	compensated and indigent care cost computation				1. 00	
	ost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 2	202 column	8)	0. 179872	1.
	dicaid (see instructions for each line)					
	et revenue from Medicaid				40, 886, 659	2.
	d you receive DSH or supplemental payments from Medicaid?			10	Y	3.
	fline 3 is yes, does line 2 include all DSH and/or supplementa fline 4 is no, then enter DSH and/or supplemental payments fro		om Medicai	ď?	N 050 022	4.
1	edicaid charges	Jii wedi cai u			2, 958, 923 266, 097, 634	5. 6.
	edicaid cost (line 1 times line 6)				47, 863, 514	
4	fference between net revenue and costs for Medicaid program (I	ine 7 minus s	sum of line	es 2 and 5; if	4, 017, 932	
	zero then enter zero)					
	ildren's Health Insurance Program (CHIP) (see instructions for	each line)			0	,
	et revenue from stand-alone CHIP tand-alone CHIP charges				0	
	tand-alone CHIP cost (line 1 times line 10)				0	11
	fference between net revenue and costs for stand-alone CHIP (I	ine 11 minus	line 9; it	f < zero then	0	
	nter zero)					
	her state or local government indigent care program (see instr			. 1	101 407	1 1 2
	et revenue from state or local indigent care program (Not inclunarges for patients covered under state or local indigent care				131, 407 2, 401, 827	
10		program (Not	Ther dued i	II ITIIes 0 01	2, 401, 627	14
	tate or local indigent care program cost (line 1 times line 14)	)			432, 021	15
00 Di	fference between net revenue and costs for state or local indi	gent care pro	ogram (line	a 15 minus line	300, 614	1 16
		gent care pro	gram (TTT	, 10 1111103 11110	300, 014	1 10
	3; if < zero then enter zero)					10
Gr	ants, donations and total unreimbursed cost for Medicaid, CHIP					10
Gra i n		and state/lo	ocal indige		ns (see	
Gr. i n . 00 Pr . 00 Go	ants, donations and total unreimbursed cost for Medicaid, CHIP estructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of ho	P and state/londing charity	care	ent care program	os (see	17 18
Gr. i n . 00 Pr . 00 Go . 00 To	ants, donations and total unreimbursed cost for Medicaid, CHIP estructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of hope	P and state/londing charity	care	ent care program	ns (see	17. 18.
Gr. i n . 00 Pr . 00 Go . 00 To	ants, donations and total unreimbursed cost for Medicaid, CHIP estructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of ho	P and state/lo nding charity ospital operat indigent care	care i ons programs	ent care program	0 0 4,318,546	17 18
Gr. i n . 00 Pr . 00 Go . 00 To	ants, donations and total unreimbursed cost for Medicaid, CHIP estructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of hope	P and state/lo nding charity ospital operat indigent care	care	ent care program	os (see	17. 18.
Gr. i n 00 Pr 00 Go 00 To 8,	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)	P and state/lo nding charity ospital operat indigent care	care i ons programs	ent care program (sum of lines	0 0 4,318,546 Total (col. 1	17 18
Gr. i n 00 Pr 00 Go 00 To 8,	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line)	P and state/lo	care cions programs programs ninsured patients 1.00	(sum of lines  Insured patients 2.00	0 0 4,318,546 Total (col. 1 + col. 2) 3.00	17 18 19
00 Pr 00 Go 00 To 8,	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of hostal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line) marity care charges and uninsured discounts for the entire faci	P and state/lo	care i ons programs ni nsured pati ents	(sum of lines  Insured patients 2.00	0 0 4,318,546 Total (col. 1 + col. 2) 3.00	17 18 19
00 Pr 00 Go 00 To 8,	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line)	P and state/lo nding charity pospital operat indigent care	care cions programs programs ninsured patients 1.00	(sum of lines Insured patients 2.00 3 2,129,378	0 0 4,318,546 Total (col. 1 + col. 2) 3.00 41,472,581	17 18 19
00 Pr 00 Go 00 To 8,	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line)  arity care charges and uninsured discounts for the entire facione instructions)  set of patients approved for charity care and uninsured discountstructions)	P and state/lo nding charity pspital operat indigent care	care iions programs ni nsured pati ents 1.00 39,343,200 7,076,74	(sum of lines Insured patients 2.00 2,129,378 1 2,129,378	0 0 4,318,546 Total (col. 1 + col. 2) 3.00 41,472,581 9,206,119	17 18 19 20 21
Gr.   i n   OO   Pr   OO   Ch   (s   OO   Co   i n   OO   Pa	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  Incompensated Care (see instructions for each line) are ty care charges and uninsured discounts for the entire facions of patients approved for charity care and uninsured discours structions) asyments received from patients for amounts previously written of	P and state/lo nding charity pspital operat indigent care	care iions programs ni nsured pati ents 1.00 39,343,200 7,076,74	(sum of lines Insured patients 2.00 3 2,129,378	0 0 4,318,546 Total (col. 1 + col. 2) 3.00 41,472,581 9,206,119	17 18 19 20 21
00 Pr 00 Go 00 To 8, 00 Ch 00 Ch 00 Ch 00 Pa ch	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  Incompensated Care (see instructions for each line) The property of the entire facions of patients approved for charity care and uninsured discourts for the entire facions of patients approved for charity care and uninsured discourts for each line) The property of the entire facions of patients approved for charity care and uninsured discourts for patients received from patients for amounts previously written charity care	P and state/lo nding charity pspital operat indigent care	care cions programs programs 1.00 39, 343, 200 7, 076, 74	(sum of lines  Insured patients 2.00  3 2,129,378 1 2,129,378	0 0 4,318,546 Total (col. 1 + col. 2) 3.00 41,472,581 9,206,119	17 18 19 20 21 22
Gr. in   OO   Pr   OO   Ch   Cs   OO   Co   in   OO   Pa   Ch   Ch   Cs   Ch   Cs   Ch   Cs   Ch   Cs   Ch   Cs   Ch   Ch	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line) rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  Incompensated Care (see instructions for each line) are ty care charges and uninsured discounts for the entire facions of patients approved for charity care and uninsured discours structions) asyments received from patients for amounts previously written of	P and state/lo nding charity pspital operat indigent care	care iions programs ni nsured pati ents 1.00 39,343,200 7,076,74	(sum of lines  Insured patients 2.00  3 2,129,378 1 2,129,378	0 0 4,318,546 Total (col. 1 + col. 2) 3.00 41,472,581 9,206,119	17 18 19 20 21 22
00 Pr 00 Gc 00 To 8, 00 Ch (s 00 Cc i n 00 Cc	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  ivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line)  marity care charges and uninsured discounts for the entire facions of patients approved for charity care and uninsured discounts structions)  asymmetrs received from patients for amounts previously written charity care ost of charity care (line 21 minus line 22)	P and state/lo adding charity pspital operat indigent care  U  Iity  hts (see	care cions programs ni nsured pati ents 1.00 29, 343, 200 7, 076, 74	(sum of lines  Insured patients 2.00  2,129,378 2,129,378 0 0 1,2,129,378	0 0 4,318,546 Total (col. 1 + col. 2) 3.00 41,472,581 9,206,119	177 188 19 20 21 22
00 Pr 00 Go 00 To 8, 00 Ch (sc 00 Co in 00 Co	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  ivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  compensated Care (see instructions for each line)  arity care charges and uninsured discounts for the entire facing see instructions)  set of patients approved for charity care and uninsured discournstructions)  ayments received from patients for amounts previously written constructions  arity care  set of charity care (line 21 minus line 22)  sees the amount on line 20 column 2, include charges for patients	P and state/lo adding charity pspital operat indigent care  U  Iity nts (see off as	care cions programs ni nsured pati ents 1.00 29, 343, 200 7, 076, 74	(sum of lines  Insured patients 2.00  2,129,378 2,129,378 0 0 1,2,129,378	0 0 4, 318, 546  Total (col. 1 + col. 2) 3. 00  41, 472, 581 9, 206, 119 0 9, 206, 119	177 188 19 20 21 22 23
OO   DO   If	rants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  ivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line)  marity care charges and uninsured discounts for the entire facisee instructions)  set of patients approved for charity care and uninsured discounts received from patients for amounts previously written charity care  past of charity care (line 21 minus line 22)  set the amount on line 20 column 2, include charges for patient apposed on patients covered by Medicaid or other indigent care past line 24 is yes, enter the charges for patient days beyond the	P and state/lo adding charity ospital operat indigent care lity ats (see off as	care cions programs programs 1.00 29, 343, 200 7, 076, 74 a Length of	(sum of lines  Insured patients 2.00  2,129,378 0 0 1 2,129,378 of stay limit	Total (col. 1 + col. 2) 3.00 41,472,581 9,206,119 0 9,206,119	177 188 19 20 21 22 23
00 Pr 00 Gc 00 To 8, 00 Cc in 00 Cc	rants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line)  arity care charges and uninsured discounts for the entire facions of patients approved for charity care and uninsured discourstructions)  asyments received from patients for amounts previously written charity care  ast of charity care (line 21 minus line 22)  best the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care partially limit	P and state/lo adding charity ospital operat indigent care  U  Iity ost (see off as  t days beyond orogram? e indigent care	care cions programs programs 1.00 29, 343, 200 7, 076, 74 a Length of	(sum of lines  Insured patients 2.00  2,129,378 0 0 1 2,129,378 of stay limit	0 0 4, 318, 546  Total (col. 1 + col. 2) 3.00  41, 472, 581  9, 206, 119  0 9, 206, 119  1.00  N	177 188 19 20 21 22 23 24 25
00 Pr 00 Ch (s 00 Cc 00	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  Incompensated Care (see instructions for each line)  Appropriation of the entire facion instructions and uninsured discounts for the entire facion instructions)  But of patients approved for charity care and uninsured discounts received from patients for amounts previously written constructions and the patients for amounts previously written constructions are cost of charity care (line 21 minus line 22)  But of patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and patients are patient and patients and patients are patient and patients are patient and patients are patients and pa	P and state/lo adding charity pospital operation indigent care  lity ats (see aff as  t days beyond arogram? e indigent care tructions)	care ions programs ni nsured patients 1.00 29,343,200 7,076,74 20 a length of the program'	(sum of lines  Insured patients 2.00  2,129,378 0 0 1 2,129,378 of stay limit	0 0 4, 318, 546  Total (col. 1 + col. 2) 3. 00  41, 472, 581 9, 206, 119 0 9, 206, 119 1. 00 N 0 12, 945, 425	17 18 19 20 21 22 23 24 25 26
00 Pr 00 Go 00 To 8, 00 Co in 00 Co	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  ivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line)  arity care charges and uninsured discounts for the entire facions of patients approved for charity care and uninsured discounts structions)  asyments received from patients for amounts previously written charity care ost of charity care (line 21 minus line 22)  best the amount on line 20 column 2, include charges for patient apposed on patients covered by Medicaid or other indigent care patients and the charges for patient days beyond the tay limit total bad debt expense for the entire hospital complex (see insteadicare reimbursable bad debts for the entire hospital complex	P and state/lo adding charity pospital operat indigent care lity nts (see pff as  t days beyond program? e indigent care tructions) (see instruct	care ii ons programs ni nsured pati ents 1.00 39,343,200 7,076,74  a length of	(sum of lines  Insured patients 2.00  2,129,378 0 0 1 2,129,378 of stay limit	0 0 4, 318, 546  Total (col. 1 + col. 2) 3.00  41, 472, 581  9, 206, 119  0 9, 206, 119  1.00  N  0  12, 945, 425 1, 687, 721	177 188 19 20 21 22 23 24 25 26 27
. 00   Gr.   in.	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  Incompensated Care (see instructions for each line)  Appropriation of the entire facion instructions and uninsured discounts for the entire facion instructions)  But of patients approved for charity care and uninsured discounts received from patients for amounts previously written constructions and the patients for amounts previously written constructions are cost of charity care (line 21 minus line 22)  But of patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and proposed on patients covered by Medicaid or other indigent care patient and patients are patient and patients and patients are patient and patients are patient and patients are patients and pa	P and state/lo adding charity pospital operat indigent care lity nts (see pff as  t days beyond program? e indigent care tructions) (see instruct	care ii ons programs ni nsured pati ents 1.00 39,343,200 7,076,74  a length of	(sum of lines  Insured patients 2.00  2,129,378 0 0 1 2,129,378 of stay limit	0 0 4, 318, 546  Total (col. 1 + col. 2) 3. 00  41, 472, 581 9, 206, 119 0 9, 206, 119 1. 00 N 0 12, 945, 425	177 188 19 20 21 22 23 24 25 26 27 27
. 00 Pr . 00 Go . 00 To . 00 Co . 00 Co . 00 If . 00 If . 00 Me . 00 M	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  rivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line)  marity care charges and uninsured discounts for the entire facinese instructions)  ast of patients approved for charity care and uninsured discounts structions)  asyments received from patients for amounts previously written consists of charity care (line 21 minus line 22)  ast of charity care (line 21 minus line 22)  as the amount on line 20 column 2, include charges for patient apposed on patients covered by Medicaid or other indigent care provided in the charges for patient days beyond the tay limit and debt expense for the entire hospital complex (see instead care reimbursable bad debts for the entire hospital complex edicare allowable bad debts for the entire hospital complex (see	P and state/lo adding charity ospital operat indigent care  U  Iity ats (see off as  t days beyond orogram? e indigent care tructions) (see instruction	care cions e programs ni nsured catients 1.00 39, 343, 200 7, 076, 74 a length of the program' cions) is)	(sum of lines  Insured patients 2.00  2,129,378 0 0 1 2,129,378 of stay limit	0 0 4, 318, 546  Total (col. 1 + col. 2) 3.00  41, 472, 581  9, 206, 119  0 9, 206, 119  1.00  N  0  12, 945, 425 1, 687, 721 2, 596, 495	20 21 22 23 24 25 26 27 27 28
Gr. in	ants, donations and total unreimbursed cost for Medicaid, CHIP istructions for each line)  ivate grants, donations, or endowment income restricted to fur overnment grants, appropriations or transfers for support of he otal unreimbursed cost for Medicaid, CHIP and state and local 12 and 16)  accompensated Care (see instructions for each line)  arity care charges and uninsured discounts for the entire facisee instructions)  ast of patients approved for charity care and uninsured discounts for patients received from patients for amounts previously written constructions)  asyments received from patients for amounts previously written constructions of charity care (line 21 minus line 22)  best the amount on line 20 column 2, include charges for patient apposed on patients covered by Medicaid or other indigent care patient by limit to the charges for the entire hospital complex (see instead local bad debt expense for the entire hospital complex (see instead care allowable bad debts for the entire hospital complex (see instead care allowable bad debts for the entire hospital complex (see instead care bad debt expense (see instructions)	P and state/lo adding charity pospital operation indigent care indigent care  Iity ats (see off as  t days beyond program? e indigent care tructions) (see instructions ee instructions eense (see inst	care cions e programs ni nsured catients 1.00 39, 343, 200 7, 076, 74 a length of the program' cions) is)	(sum of lines  Insured patients 2.00  2,129,378 0 0 1 2,129,378 of stay limit	0 0 4, 318, 546  Total (col. 1 + col. 2) 3.00  41, 472, 581  9, 206, 119  0 9, 206, 119  1.00  N  0  12, 945, 425 1, 687, 721 2, 596, 495 10, 348, 930	20 21 22 23 24 25 26 27 27 27 28 29 30

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	COMMUNITY MEDI	CAL CENTER Provi der CO	N: 31_0041	In Lie Period:	u of Form CMS-: Worksheet A	2552-10
NECLAS	STITE OF THE ADJUST WENTS OF THE DALANCE OF	EXI ENSES	Trovider co	1	From 01/01/2021 Fo 12/31/2021	Date/Time Pre	narod:
						5/24/2022 5: 2	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				( 1 001 . 2)	ons (see A o)	(col . 3 +-	
		1.00	2.00	3. 00	4.00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		9, 007, 331	9, 007, 33		11, 219, 418	1
2. 00 3. 00	O0200 CAP REL COSTS-MVBLE EQUIP   O0300 OTHER CAP REL COSTS		7, 705, 137		7 1, 878, 961 0 0	9, 584, 098 0	1
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	916, 147	30, 658, 617		-	32, 410, 855	1
5.00	00500 ADMINISTRATIVE & GENERAL	10, 168, 077	120, 621, 579		-20, 093, 689	110, 695, 967	5. 00
6. 00 7. 00	OO600   MAI NTENANCE & REPAI RS   OO700   OPERATI ON OF PLANT	222, 208	563, 393 7, 125, 857	785, 60° 10, 510, 04°		781, 608 10, 508, 863	
8. 00	00800 LAUNDRY & LINEN SERVICE	3, 384, 184 0	7, 125, 657		1 -1, 178 1, 070, 546	1, 070, 546	
9.00	00900 HOUSEKEEPI NG	4, 261, 632	1, 456, 005		7 -66, 465	5, 651, 172	9. 00
10.00	01000 DI ETARY	3, 187, 330	2, 360, 694			4, 488, 473	
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	4, 924, 985	595, 348		1, 028, 279 3 -4, 481	1, 028, 279 5, 515, 852	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 800, 329	2, 619, 658			3, 384, 453	1
15. 00	01500 PHARMACY	5, 350, 541	37, 654, 095				
16. 00 17. 00	01600   MEDI CAL RECORDS & LI BRARY   01700   SOCI AL SERVI CE	2, 785, 687 2, 640, 255	695, 595 1, 480, 579			3, 485, 176 4, 120, 834	•
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD	2, 040, 233	1, 400, 379		846, 061	846, 061	•
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	2, 487, 188	671, 281			2, 003, 628	1
23. 00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	155, 348	16, 421	171, 76	9 84, 133	255, 902	23. 00
30. 00	03000 ADULTS & PEDIATRICS	31, 101, 270	8, 530, 222	39, 631, 492	9, 248, 541	48, 880, 033	30.00
31.00	03100 INTENSIVE CARE UNIT	21, 273, 849	4, 079, 412			23, 213, 336	1
34.00	03400 SURGICAL INTENSIVE CARE UNIT	2, 736, 437	552, 765			3, 006, 585	
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	993, 106 1, 456, 354	4, 172 1, 382, 560			2, 824, 389 2, 387, 299	1
11.00	ANCILLARY SERVICE COST CENTERS	1, 100, 001	1, 002, 000	2,000,71	101,010	2,007,277	1 11.00
50.00	05000 OPERATI NG ROOM	7, 033, 297	20, 183, 992				1
51. 00 52. 00	O5100 RECOVERY ROOM   O5200 DELIVERY ROOM & LABOR ROOM	1, 423, 425 3, 306, 072	98, 472 610, 380	1, 521, 89 3, 916, 452		1, 437, 505 3, 394, 641	1
52. 01	03190 OP INFUSION	1, 469, 234	234, 409				1
53. 00	05300 ANESTHESI OLOGY	79, 136	513, 916				
54. 00 55. 00	05400   RADI OLOGY-DI AGNOSTI C   05500   RADI OLOGY-THERAPEUTI C	5, 497, 074 3, 111, 480	4, 053, 601 4, 211, 549	9, 550, 67! 7, 323, 029		7, 809, 377 7, 686, 208	1
56. 00	05600 RADI OLOGT - THERAPEUTI C	436, 029	906, 648			1, 374, 274	1
57.00	05700 CT SCAN	1, 278, 000	909, 724	2, 187, 72	-136, 615	2, 051, 109	57. 00
58. 00	05800 MRI	694, 168	234, 073 6, 775, 538			901, 412	1
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	2, 804, 982 5, 091, 787	13, 565, 580			3, 702, 225 14, 790, 849	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	2, 129, 321	2, 129, 321	1
65. 00	06500 RESPIRATORY THERAPY	2, 736, 362	862, 565			3, 217, 326	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 804, 625 936, 288	224, 639 -23				•
	06800 SPEECH PATHOLOGY	226, 135	4, 956			229, 679	
69.00	06900 ELECTROCARDI OLOGY	2, 057, 506	965, 115			2, 839, 688	
70. 00 70. 01	07000   ELECTROENCEPHALOGRAPHY   07001   SLEEP LAB	619, 844 5, 199	617, 844	1, 237, 688 5, 199		1, 216, 477 6, 194	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0, 177	0		18, 139, 393	18, 139, 393	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	14, 436, 514	14, 436, 514	
73. 00 76. 97	07300   DRUGS CHARGED TO PATIENTS   07697   CARDI AC REHABILITATION	0 314, 789	0 15, 538	330, 32	45, 609, 800 -4, 187	45, 609, 800 326, 140	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	314, 621	314, 62	· ·	300, 746	1
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLINIC	417, 708	1, 169, 970		· ·	1, 010, 856	1
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART	11, 814, 503	6, 788, 363	18, 602, 86	-2, 173, 611	16, 429, 255	91. 00 92. 00
92. 01	09201 OBSERVATION BEDS-DISTINCT	2, 843, 228	642, 843	3, 486, 07 <sup>-</sup>	-234, 353	3, 251, 718	
05.00	OTHER REIMBURSABLE COST CENTERS		074 005	074 001	-1 0	074 005	05.00
95.00	O9500 AMBULANCE SERVICES   SPECIAL PURPOSE COST CENTERS	0	971, 885	971, 88!	5 0	971, 885	95. 00
113.00	11300   NTEREST EXPENSE		3, 863, 981	3, 863, 98	1 -3, 863, 981	0	113. 00
118.00		156, 845, 798	306, 520, 900	463, 366, 698	3 0	463, 366, 698	118. 00
194 00	NONREI MBURSABLE COST CENTERS 07950 MI SCELLANEOUS	ol	0		ol o	0	194. 00
	07951 PUBLI C RELATIONS	o	551	55			194. 01
194. 03	07952 LI GHTHOUSE	43, 486	7, 474	50, 960	0	50, 960	194. 03
	07953 KIDS & FAMILY 07954 OTHER NON REIMBURABLE	0 140, 696	834 1, 359	834 142, 05!		834 142, 055	194.04
	07955 GRANTS/TRI ALS	140, 696	1, 359 550	142, 05:			194. 05
194. 07	07956 RETAIL PHARMACY	ō	0		0	0	194. 07
200.00	TOTAL (SUM OF LINES 118 through 199)	157, 029, 980	306, 531, 668	463, 561, 648	0	463, 561, 648	200. 00

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	u of Form CMS-2552-1
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		Provi der CC	CN: 31-0041	Peri od:	Worksheet A
				From 01/01/2021 To 12/31/2021	Date/Time Prepared:
				12, 01, 2021	5/24/2022 5: 22 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8) 6.00	For Allocation 7.00			
GENERAL SERVICE COST CENTERS	0.00	7.00	I		
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-325, 776	10, 893, 642			1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	-278, 679	9, 305, 419			2.00
3.00 O0300 OTHER CAP REL COSTS	0	1			3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	311, 658				4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-48, 873, 163				5. 00
6. 00 00600 MAINTENANCE & REPAIRS	-35, 606				6. 00
7. 00   00700   OPERATION OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE	73, 442	10, 582, 305 1, 070, 546			7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG	-33		•		9. 00
10. 00   01000 DI ETARY	-25, 610		•		10.00
11. 00   01100   CAFETERI A	-807, 192	1			11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-97, 630				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	-33, 979				14. 00
15. 00 01500 PHARMACY	-6, 472	6, 079, 854			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-28, 134	3, 457, 042			16. 00
17. 00   01700   SOCI AL   SERVI CE	-1, 106				17. 00
21. 00   02100   I &R SERVI CES-SALARY & FRI NGES APPRVD	0	846, 061			21. 00
22. 00   02200   1 &R SERVICES-OTHER PRGM. COSTS APPRVD	-469, 317				22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	-463	255, 439			23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00   03000   ADULTS & PEDI ATRI CS	-1, 644, 622	47, 235, 411			30.00
31. 00   03100   NTENSI VE CARE UNI T	-1, 044, 022				31. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	-1, 286		1		34. 00
43. 00   04300   NURSERY	-3, 232				43. 00
44.00 04400 SKILLED NURSING FACILITY	-20, 121	2, 367, 178			44. 00
ANCILLARY SERVICE COST CENTERS			•		
50. 00 05000 OPERATING ROOM	-90, 234	10, 617, 993			50. 00
51. 00   05100   RECOVERY ROOM	-766				51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	-2, 064	3, 392, 577			52. 00
52. 01   03190   OP   NFUSI ON	-1, 369				52. 0
53. 00   05300   ANESTHESI OLOGY	-490				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	-528, 162 -402, 752				54. 00 55. 00
56. 00   05600   RADI OLOGI - THERAPEUTI C	-402, 732				56. 00
57. 00   05700   CT   SCAN	0	2, 051, 109			57. 00
58. 00   05800   MRI	-2, 015				58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	-75, 644				59. 00
60. 00   06000   LABORATORY	-517, 379				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				63. 00
65. 00 06500 RESPIRATORY THERAPY	-50, 625	3, 166, 701			65. 00
66. 00   06600   PHYSI CAL THERAPY	-15, 894				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	-426				67. 00
68. 00   06800   SPEECH PATHOLOGY	-98				68. 00
69. 00  06900  ELECTROCARDI OLOGY 70. 00  07000  ELECTROENCEPHALOGRAPHY	-71, 054				69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY 70. 01   07001   SLEEP LAB	-257, 441 -6, 358		1		70. 00 70. 0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-678				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	-793				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	-2, 507	45, 607, 293			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	-193	325, 947			76. 9
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	300, 746			76. 98
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLI NI C	-98		•		90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART	-2, 664, 760	13, 764, 495			91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART 92. 01   09201   OBSERVATION BEDS-DISTINCT	-861	2 250 057			92. 00 92. 0
OTHER REIMBURSABLE COST CENTERS	-801	3, 250, 857			92.0
95. 00 09500 AMBULANCE SERVI CES	25, 218	997, 103			95. 00
SPECIAL PURPOSE COST CENTERS	20,210	7,7,700	·		75. 00
113. 00 11300   NTEREST EXPENSE	0	0			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-56, 943, 183	406, 423, 515			118. 00
NONREI MBURSABLE COST CENTERS					
194. 00 07950 MI SCELLANEOUS	0				194. 00
194. 01 07951 PUBLIC RELATIONS	0		•		194. 0
194. 03 07952 LI GHTHOUSE	0	50, 960	1		194. 0
194. 04 07953 KIDS & FAMILY		834			194. 0
194. 05 07954 OTHER NON REIMBURABLE	0	142, 055			194. 09 194. 00
194. 06 07955  GRANTS/TRI ALS 194. 07 07956  RETAI L PHARMACY		550			194. 0
200.00 TOTAL (SUM OF LINES 118 through 199)	-56, 943, 183	"			200. 00
	20, , 10, 100		1		1200.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Provider CCN: 31-0041 Date/Time Prepared: 5/24/2022 5: 22 pm

	Cost Center	Increases Line #	Salary	Othor	
	2. 00	3. 00	Sal ary 4.00	0ther 5.00	
	A - MEDICAL SURGICAL SUPPLIES		ما	10 100 000	4.00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	18, 139, 393	1. 00
2.00	OCCUPATI ONAL THERAPY	67. 00	О	484	2. 00
3.00		0.00	0	0	3. 00
4. 00 5. 00		0. 00 0. 00	0	0	4. 00 5. 00
6. 00		0.00	o	0	6. 00
7.00		0.00	0	0	7. 00
8. 00 9. 00		0. 00 0. 00	0	0	8. 00 9. 00
10. 00		0.00	o	0	10. 00
11. 00		0.00	0	0	11. 00
12. 00 13. 00		0. 00 0. 00	0	0	12. 00 13. 00
14. 00		0.00	o	0	14. 00
15. 00		0.00	o	0	15. 00
16. 00 17. 00		0. 00 0. 00	0	0 0	16. 00 17. 00
18. 00		0.00	o	0	18. 00
19. 00		0.00	0	0	19. 00
20. 00 21. 00		0. 00 0. 00	0	0 0	20. 00 21. 00
22. 00		0.00	o	0	22. 00
23. 00		0.00	0	0	23. 00
24. 00 25. 00		0. 00 0. 00	0	0	24. 00 25. 00
26. 00		0.00	o	0	26. 00
27. 00		0.00	0	0	27. 00
28. 00 29. 00		0. 00 0. 00	0	0	28. 00 29. 00
30. 00		0.00	Ö	0	30. 00
31.00		0.00	0	0	31.00
32. 00 33. 00		0. 00 0. 00	0	0	32. 00 33. 00
34. 00		0.00	0	0	34. 00
	O B - IMPLANTABLES			18, 139, 877	
1. 00	IMPL. DEV. CHARGED TO	72.00	o	14, 436, 514	1. 00
0.00	PATI ENTS	0.00			0.00
2. 00 3. 00		0. 00 0. 00	0	0	2. 00 3. 00
4.00		0.00	О	0	4. 00
5.00		0. 00 0. 00	0	0	5. 00
6. 00 7. 00		0.00	0	0	6. 00 7. 00
8.00		0. 00	О	0	8. 00
9. 00 10. 00		0. 00 0. 00	0	0	9. 00 10. 00
11. 00		0.00	0	0	11. 00
	0			14, 436, 514	
1. 00	C - DRUGS AND IV SOLUTIONS DRUGS CHARGED TO PATIENTS	73.00	0	45, 609, 800	1.00
2. 00	DROGS CHARGED TO FATTENTS	0.00	o	43, 667, 666	2. 00
3.00		0.00	0	0	3. 00
4. 00 5. 00		0. 00 0. 00	0	0	4. 00 5. 00
6. 00		0.00	o	0	6. 00
7.00		0.00	0	0	7. 00
8. 00 9. 00		0. 00 0. 00	0	0	8. 00 9. 00
10. 00		0. 00	Ö	0	10. 00
11.00		0.00	0	0	11. 00
12. 00 13. 00		0. 00 0. 00	0	0	12. 00 13. 00
14.00		0. 00	0	0	14. 00
15.00		0.00	0	0	15. 00
16. 00 17. 00		0. 00 0. 00	0	0	16. 00 17. 00
18.00		0. 00	Ö	0	18. 00
19.00		0.00	0	0	19.00
20. 00 21. 00		0. 00 0. 00	0	0	20. 00 21. 00
22. 00		0.00	o	0	22. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | To 12/31/2021 | Date/Time Prepared: | 5/24/2022 5: 22 pm Provider CCN: 31-0041

						)22 5: 22 pm
2			Increases			
23.00						
24 00	22 00	2.00				22.00
25.00			•	- 1	-	4
25.00			•			4
D				O	0	•
BLOOD STORING, PROCESSING 8   G3.00   0   2.129,321   1.00   2.00   3.		0		0	45, 609, 800	
TRANS						
2.00	1.00		63.00	0	2, 129, 321	1.00
3.00	2 00	TRANS.	0 00	0	0	2 00
1.00				-		
1.00   CAP			0.00	0	0	4. 00
1.00   CAP REL COSTS-SUBJE EQUIP   2.00   0   2.082,526   1.00   2.00	5.00		•	0	0	5. 00
F - INTEREST EXPENSE     1	6.00		0.00		0	6. 00
1.00   CAP REL COSTS-BLOG & FIXT   1.00   0   2.082 (226   2.00		U INTEDEST EVDENSE		0	2, 129, 321	
CAP REL COSTS - MARNE FOULP   2.00   0   1.781,455   2.00   1.00   2.0	1 00		1 00	٥	2 082 526	1 00
1.00   CAP REL COSTS-MBLE EQUIP   2.00   0   129,566   1.00   2			•	-		
1.00			<del> </del>			
CAP REL COSTS-MURLE EQUIP   2.00   0   97.506   7   7   7   7   7   7   7   7   7						
1.00   RADI OLOGY FIRS   1.00   227, 067						•
C - RADIOLOCY FIRST   C - RADIOLOCY THEAPPUTIC   55.00   241.810   9.054   1.00	2.00	CAP REL COSTS-MVBLE EQUIP				2.00
1.00   RADI OLOGY-THERAPEUTI C   55.00   341,810   9.054   1.0182   2.00   RADI OSTOPE   55.00   42,584   1.128   2.00   RADI OSTOPE   55.00   42,584   1.0182   7.00		G - RADI OLOGY RNS		U	221, 061	
ADDIO SOTOPE	1.00		55.00	341, 810	9, 054	1.00
H - DIETARY						•
1.00		0		384, 394	10, 182	
1.00	4 00		44.00	504 404	101 110	1.00
1.00	1.00	CAFETERIA		+		1.00
1.00		J - LINFN		374, 131	434, 140	
3. 00 4. 00 5. 00 6. 00 6. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 11. 00 12. 00 13. 00 14. 00 14. 00 15. 00 16. 00 17. 00 18. 00 9. 00 16. 00 17. 00 18. 00 9. 00 18. 00 9. 00 19. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19	1.00		8.00	0	1, 070, 546	1. 00
4. 00	2.00		0.00	О	0	2. 00
5.00				0	0	
6.00 7.00 8.00 9.00 9.00 10.00				0		
7. 00				0		
8. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 11. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 17. 00 18. 00 19.			•	0		l
9.00 10.00 10.00 10.00 10.00 11.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 16.00 16.00 16.00 16.00 17.00 18.00 19.00 1			•	o		
11.00			<u> </u>	o		
12.00	10.00		0.00	O	0	10.00
13. 00			•	0	0	
14. 00			•	- 1		•
15.00						
16. 00				- 1		•
17.00			•			•
18. 00				-1		
20.00				О	0	
21. 00 22. 00 22. 00 23. 00 0. 00 0. 00 0. 00 0. 00 0. 00 22. 00 23. 00 24. 00 0. 00	19.00		0.00	О		19. 00
22. 00 23. 00 24. 00 24. 00 25. 00 0				•	0	
23. 00 24. 00 24. 00 25. 00 0.				-		
24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 0. 00 0. 00 0. 00 0. 00 0. 00 27. 00 28. 00 0. 0				-		
25. 00 26. 00 26. 00 27. 00 28. 00 0			•	- 1	-	
26. 00 27. 00 28. 00 0.				- I		
27.00				o	0	
The state of the				O	0	
The state of the	28. 00		0.00			28. 00
1. 00 NURSERY 43. 00 1, 575, 579 251, 532 0 1. 00    M - MALPRACTI CE		0 NOTHER PARK		0	1, 070, 546	
Note	1 00		43 00	1 575 570	251 522	1 00
M - MALPRACTI CE	1.00	0	43.00			1.00
1. 00       MEDI CAL RECORDS & LI BRARY       16. 00       0       3, 897       1. 00         2. 00       I &R SERVI CES-OTHER PRGM.       22. 00       0       15, 029       2. 00         3. 00       ADULTS & PEDI ATRI CS       30. 00       0       2, 534       3. 00         4. 00       OPERATI NG ROOM       50. 00       0       421       4. 00         5. 00       RADI OLOGY-DI AGNOSTI C       54. 00       0       344       5. 00         6. 00       RADI OLOGY-THERAPEUTI C       55. 00       0       10, 817       6. 00         7. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       5, 741       7. 00         8. 00       RESPI RATORY THERAPY       65. 00       0       7, 822       8. 00         9. 00       ELECTROCARDI OLOGY       69. 00       0       11, 713       9. 00		M - MALPRACTICE		., 3.3, 3, 7	201,002	
COSTS APPRVD 3. 00 ADULTS & PEDI ATRI CS 30. 00 0 2, 534 4. 00 OPERATI NG ROOM 50. 00 0 421 5. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 344 6. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 10, 817 7. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 5, 741 8. 00 RESPI RATORY THERAPY 65. 00 0 7, 822 9. 00 ELECTROCARDI OLOGY 69. 00 0 11, 713	1.00	MEDICAL RECORDS & LIBRARY	16.00	0	3, 897	1. 00
3.00 ADULTS & PEDIATRICS 30.00 0 2,534 3.00 4.00 OPERATING ROOM 50.00 0 421 4.00 5.00 RADI OLOGY-DI AGNOSTI C 54.00 0 344 5.00 6.00 RADI OLOGY-THERAPEUTI C 55.00 0 10,817 6.00 7.00 CARDI AC CATHETERI ZATI ON 59.00 0 5,741 6.00 8.00 RESPI RATORY THERAPY 65.00 0 7,822 8.00 9.00 ELECTROCARDI OLOGY 69.00 0 11,713 9.00	2.00		22. 00	o	15, 029	2. 00
4. 00       OPERATING ROOM       50. 00       0       421       4. 00         5. 00       RADI OLOGY-DI AGNOSTI C       54. 00       0       344       5. 00         6. 00       RADI OLOGY-THERAPEUTI C       55. 00       0       10, 817       6. 00         7. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       5, 741       7. 00         8. 00       RESPI RATORY THERAPY       65. 00       0       7, 822       8. 00         9. 00       ELECTROCARDI OLOGY       69. 00       0       11, 713       9. 00	2.00		20.00		2 524	0.00
5. 00     RADI OLOGY-DI AGNOSTI C     54. 00     0     344     5. 00       6. 00     RADI OLOGY-THERAPEUTI C     55. 00     0     10, 817     6. 00       7. 00     CARDI AC CATHETERI ZATI ON     59. 00     0     5, 741     7. 00       8. 00     RESPI RATORY THERAPY     65. 00     0     7, 822     8. 00       9. 00     ELECTROCARDI OLOGY     69. 00     0     11, 713     9. 00						1
6. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 10, 817 6. 00 7. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 5, 741 7. 00 8. 00 RESPI RATORY THERAPY 65. 00 0 7, 822 8. 00 9. 00 ELECTROCARDI OLOGY 69. 00 0 11, 713 9. 00						
7. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       5, 741       7. 00         8. 00       RESPI RATORY THERAPY       65. 00       0       7, 822       8. 00         9. 00       ELECTROCARDI OLOGY       69. 00       0       11, 713       9. 00				-		
8.00 RESPIRATORY THERAPY 65.00 0 7,822 8.00 9.00 ELECTROCARDI OLOGY 69.00 0 11,713 9.00				-		•
				0		
10. 00   ELECTROENCEPHALOGRAPHY   70. 00   0   5, 791   10. 00				l l		
	10. 00	JELECTRUENCEPHALOGRAPHY	70. 00	0	5, 791	10.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 31-0041 

					10	12/31/202	5/24/2022 5:22 pm
		Increases			<u> </u>		
	Cost Center	Li ne #	Sal ary	0ther			
	2.00	3.00	4.00	5. 00			11.00
11. 00	SLEEP LAB	<u></u>	0	<u>995</u> 65, 104			11. 00
	N - BENEFITS DIRECTLY ASSIGNED		<u> </u>	05, 104			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	836, 091			1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	О	617			2. 00
3.00		0.00	o	0			3.00
4.00		0.00	0	0			4.00
	0		0	836, 708			
	Q - TRANSPORT						
1.00	ADULTS & PEDIATRICS	30.00	314, 068	6, 952			1.00
2.00	INTENSIVE CARE UNIT	31.00	212, 120	4, 695			2.00
3. 00 4. 00	SURGICAL INTENSIVE CARE UNIT	34. 00 50. 00	16, 139	357 340			3. 00 4. 00
5. 00	DELIVERY ROOM & LABOR ROOM	52. 00	15, 349 10, 793	239			5. 00
6.00	RADI OLOGY-THERAPEUTI C	55. 00	35, 991	797			6. 00
7. 00	CARDI AC CATHETERI ZATI ON	59.00	4, 048	90			7. 00
8. 00	PHYSI CAL THERAPY	66.00	305, 291	6, 757			8. 00
9. 00	ELECTROCARDI OLOGY	69. 00	138, 696	3, 070			9. 00
10.00	ELECTROENCEPHALOGRAPHY	70. 00	6, 347	140			10.00
11.00	EMERGENCY	91.00	85, 171	1, 885			11. 00
	0		1, 144, 013	25, 322			
	R - PHARMACY RESIDENTS						
1.00	PARAMED ED PRGM-(SPECIFY)	2300	7 <u>0, 1</u> 92	1 <u>3, 9</u> 41			1.00
	0		70, 192	13, 941			
4 00	W - WAGE INDEX	10.00		0.011			1.00
1.00	NURSI NG ADMI NI STRATI ON	13.00		8, 311			1.00
2.00	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00		7, 918 65, 166			2.00
4. 00	SOCIAL SERVICE	17. 00		1, 302			4.00
5.00	I &R SERVI CES-OTHER PRGM.	22. 00	•	1, 386, 448			5. 00
5.00	COSTS APPRVD	22.00		1, 300, 440			3.00
6.00	ADULTS & PEDIATRICS	30.00		219, 518			6. 00
7.00	INTENSIVE CARE UNIT	31. 00		4, 178			7. 00
8.00	SURGICAL INTENSIVE CARE UNIT	34.00		6, 643			8. 00
9.00	NURSERY	43. 00		724			9. 00
10. 00	SKILLED NURSING FACILITY	44. 00		923			10.00
11. 00	OPERATING ROOM	50.00		3, 346			11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00		2, 500			12. 00
13.00	RADI OLOGY-DI AGNOSTI C	54.00		13, 742			13.00
14.00	RADI OLOGY-THERAPEUTI C	55. 00		11, 892			14. 00 15. 00
15. 00 16. 00	CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00		35, 530 5, 583			16. 00
17. 00	PHYSI CAL THERAPY	66.00		20, 518			17. 00
18. 00	ELECTROCARDI OLOGY	69.00		42, 062			18. 00
19. 00	ELECTROENCEPHALOGRAPHY	70. 00		768			19. 00
20. 00	CLINIC	90.00		2, 107			20. 00
21. 00	EMERGENCY	91.00		245, 480			21. 00
22. 00	ADMINISTRATIVE & GENERAL	5. 00	165, 138				22. 00
23. 00	OTHER NON REIMBURABLE	194. 05	<u>291, 1</u> 76				23. 00
	0		456, 314	2, 084, 659			
	X - OB SUPPORT						
1.00	ADULTS & PEDIATRICS	3000	116, 701				1.00
	U LATERN & RECURENT CALABY	ECLACC	116, 701	205			
1 00	Y - INTERN & RESIDENT SALARY RI	21. 00	774 710				1 00
1. 00	I &R SERVI CES-SALARY & FRI NGES APPRVD	21.00	774, 712	0			1. 00
	TOTALS	+	774, 712	— — <sub>ō</sub>			
	Z - COVI D-19- CONTRACT LABOR			<u> </u>			
1.00	ADULTS & PEDIATRICS	30.00	0	13, 408, 079			1.00
	TOTALS			13, 408, 079			
	AA - RESIDENT MALPRACTICE	<u> </u>					
1.00	I &R SERVICES-SALARY &	21. 00	0	71, 349			1.00
	FRI NGES APPRVD	+	+				
F00 0-	TOTALS		0	71, 349			
500.00	Grand Total: Increases		5, 116, 036	102, 678, 335			500. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 31-0041 Period:

From	01/01/2021		
To	12/31/2021	Date/Time	Prepared:
		5/24/2022	5: 22 pm

						5/24/2022	5: 22 pm
		Decreases				1	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
	A - MEDICAL SURGICAL SUPPLIES		_1		_		
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	219, 711			1. 00
2.00	MAINTENANCE & REPAIRS	6. 00	0	3, 993			2. 00
3.00	OPERATION OF PLANT	7. 00	0	317			3. 00
4.00	HOUSEKEEPI NG	9.00	0	58, 367			4. 00
5.00	DI ETARY	10.00	0	14, 036		1	5. 00
6.00	NURSING ADMINISTRATION	13.00	0	4, 382			6. 00
7. 00 8. 00	CENTRAL SERVICES & SUPPLY	14. 00 15. 00	0	997, 070		1	7. 00
9.00	PHARMACY MEDICAL RECORDS & LIBRARY	16. 00	0	66, 823	0	1	8. 00 9. 00
10. 00	ADULTS & PEDIATRICS	30.00	0	2, 059, 420		•	10.00
11. 00	INTENSIVE CARE UNIT	31. 00	0	1, 835, 332			11.00
12. 00	SURGICAL INTENSIVE CARE UNIT	34.00	0	150, 758		•	12.00
13. 00	SKILLED NURSING FACILITY	44. 00	o	64, 135		1	13. 00
14. 00	OPERATING ROOM	50.00	0	7, 114, 576			14. 00
15. 00	RECOVERY ROOM	51.00	0	63, 860		•	15. 00
16. 00	DELIVERY ROOM & LABOR ROOM	52. 00	Ö	335, 366			16. 00
17. 00	OP INFUSION	52. 01	Ö	52, 105		1	17. 00
18. 00	ANESTHESI OLOGY	53.00	o	424, 290			18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	660, 188		•	19. 00
20. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	34, 903			20. 00
21. 00	RADI OI SOTOPE	56.00	0	2, 642		•	21. 00
22. 00	CT SCAN	57. 00	o	134, 277		1	22. 00
23. 00	MRI	58.00	0	18, 156			23. 00
24. 00	CARDI AC CATHETERI ZATI ON	59.00	o	1, 442, 920		•	24. 00
25. 00	LABORATORY	60.00	0	7, 693			25. 00
26. 00	RESPIRATORY THERAPY	65. 00	0	350, 505		1	26. 00
27. 00	PHYSI CAL THERAPY	66.00	0	27, 504			27. 00
28. 00	SPEECH PATHOLOGY	68. 00	o	1, 412		•	28. 00
29. 00	ELECTROCARDI OLOGY	69. 00	o	69, 749		1	29. 00
30. 00	ELECTROENCEPHALOGRAPHY	70.00	o	27, 001	0	1	30.00
31. 00	CARDIAC REHABILITATION	76. 97	o	4, 187	0		31. 00
32.00	CLINIC	90.00	o	283, 031	0		32. 00
33. 00	EMERGENCY	91.00	o	1, 453, 972	0		33. 00
34.00	OBSERVATION BEDS-DISTINCT	92. 01	o	157, 193			34.00
	0 — — — — —		0				
	B - IMPLANTABLES	·					
1.00	CENTRAL SERVICES & SUPPLY	14. 00		4, 600	0		1. 00
2.00	ADULTS & PEDIATRICS	30.00		2, 420			2. 00
3.00	INTENSIVE CARE UNIT	31.00		6, 076	0		3. 00
4.00	SURGICAL INTENSIVE CARE UNIT	34. 00		6, 477	0		4. 00
5.00	OPERATING ROOM	50.00		9, 134, 908	0		5. 00
6.00	ANESTHESI OLOGY	53.00		10, 665			6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00		562, 363		•	7. 00
8. 00	CARDIAC CATHETERIZATION	59. 00		4, 409, 616		1	8. 00
9. 00	ELECTROCARDI OLOGY	69. 00		2, 277			9. 00
10. 00	CLINIC	90. 00		293, 457	0	•	10. 00
11. 00	EMERGENCY	<u>91.</u> 00	+	<u>3, 6</u> 55			11. 00
	0		0	14, 436, 514			
	C - DRUGS AND IV SOLUTIONS	5 00	-			I	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	4, 927, 519		1	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	5, 288			2.00
3.00	PHARMACY	15.00	0	36, 765, 812			3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	372, 583		•	4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	292, 091		•	5. 00
6.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	120, 892		1	6. 00
7.00	SKILLED NURSING FACILITY	44.00	0	2, 105			7. 00
8. 00 9. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	204, 693 8, 540		1	8. 00
9. 00 10. 00	•	51. 00 52. 00	0			1	9.00
11. 00	DELIVERY ROOM & LABOR ROOM OP INFUSION	52. 00 52. 01	0	47, 574 65, 616		1	10. 00 11. 00
	1	53. 00	0			1	1
12. 00 13. 00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	54.00	0	23, 883 84, 969			12. 00 13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	55.00	ol Ol	84, 969 295		1	14.00
15. 00	RADI OLOGI - THERAPEUTI C	56. 00	0	976			15. 00
16. 00	CT SCAN	57. 00	0	2, 338		1	16. 00
17. 00	MRI	58. 00	0	2, 330 743			17. 00
18. 00	CARDIAC CATHETERIZATION	59. 00	ol	26, 725		•	18.00
19. 00	LABORATORY	60.00	o	1, 757, 353		l .	19. 00
20. 00	RESPIRATORY THERAPY	65. 00	0	38, 918		•	20.00
21. 00	PHYSI CAL THERAPY	66. 00	0	75		1	21.00
22. 00	ELECTROCARDI OLOGY	69.00	o	255, 202		•	22.00
23. 00	ELECTROENCEPHALOGRAPHY	70.00	o	394		•	23. 00
24. 00	CLI NI C	90.00	o	334		•	24. 00
00	1	70.00	9	337		I .	1 21.00

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/24/2022 5:22 pm

		Doorsoos				5/24/2022 5:	22 pm
	Cost Center	Decreases Li ne #	Sal ary	Other	     Wkst. A-7 Ref.		
	6.00	7.00	8. 00	9, 00	10.00		
25. 00	EMERGENCY	91.00	0.00	559, 318			25. 00
26.00	OBSERVATION BEDS-DISTINCT	92. 01	0	45, 564	l .		26. 00
				45, 609, 800			
	D - BLOOD						
1.00	ADULTS & PEDIATRICS	30.00		4, 945			1. 00
2.00	INTENSIVE CARE UNIT	31.00		6, 450			2. 00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00		3, 375	l 1		3. 00
4.00	OPERATING ROOM	50.00		10, 210			4. 00
5.00	OP INFUSION	52. 01		4, 500	l 1		5. 00
6.00	LABORATORY	60.00		2,099,841	0		6. 00
	O E ANTEREST EXPENSE		0	2, 129, 321			
4 00	E - INTEREST EXPENSE	440.00	ما	0.0/0.004	4.4		4 00
1.00	INTEREST EXPENSE	113.00	0	3, 863, 981			1.00
2. 00			0	0			2. 00
	F - PROPERTY INSURANCE		U	3, 863, 981			-
1. 00	ADMINISTRATIVE & GENERAL	5.00	0	227, 067	12		1. 00
2. 00	ADWINISTRATIVE & GENERAL	0.00	0	227,067	l		2. 00
2.00					— — <sup>'2</sup>		2.00
	G - RADI OLOGY RNS		Ο <sub>Ι</sub>	221,001			
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	384, 394	10, 182	0		1.00
2. 00	I WE GEOGLE BY NOW COLL O	0.00	0	0	l .		2. 00
2.00			384, 394	10, 182			2.00
	H - DIETARY		001,071	10, 102			
1.00	DI ETARY	10.00	594, 131	434, 148	0		1. 00
	0 = = = =		594, 131	434, 148			
	J - LINEN	'			'		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	6, 142	0		1. 00
2.00	OPERATION OF PLANT	7.00	0	861	0		2. 00
3.00	HOUSEKEEPI NG	9.00	0	8, 098			3. 00
4.00	DI ETARY	10.00	0	17, 236			4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	99	l .		5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	28, 576			6. 00
7.00	PHARMACY	15. 00	0	1, 542			7. 00
8. 00	I &R SERVICES-OTHER PRGM.	22. 00	0	2, 942	0		8. 00
0.00	COSTS APPRVD	20.00		000 000			0.00
9.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	282, 322	0		9. 00 10. 00
10. 00 11. 00	SURGICAL INTENSIVE CARE UNIT	34.00	0	216, 791 17, 611			11. 00
12. 00	SKILLED NURSING FACILITY	44. 00	0	17, 611	1		12. 00
13. 00	OPERATING ROOM	50.00	0	60, 785			13. 00
14. 00	RECOVERY ROOM	51.00	o	11, 992			14. 00
15. 00	DELIVERY ROOM & LABOR ROOM	52. 00	Ö	32, 997	0		15. 00
16. 00	OP INFUSION	52. 01	Ö	10, 558	I - I		16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	39, 546			17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55.00	0	92	l 1		18. 00
19.00	RADI OI SOTOPE	56.00	O	8, 497	o		19. 00
	MRI	58.00	0	7, 930	0		20. 00
21.00	CARDIAC CATHETERIZATION	59.00	0	8, 913	0		21. 00
22.00	LABORATORY	60.00	0	1, 631			22. 00
	PHYSI CAL THERAPY	66.00	0	8, 834			23. 00
24. 00	ELECTROCARDI OLOGY	69. 00	0	9, 184			24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00	0	6, 094			25. 00
26. 00	HYPERBARI C OXYGEN THERAPY	76. 98	0	13, 875	l 1		26. 00
	EMERGENCY	91.00	0	218, 156	l 1		27. 00
28. 00	OBSERVATI ON BEDS-DISTINCT	92.01	•	31, 596			28. 00
	U MOTHED DADY		0	1, 070, 546			
1. 00	K - MOTHER BABY ADULTS & PEDIATRICS	30.00	1, 575, 579	251, 532			1.00
1.00	ADULIS & PEDIATRICS		1, 575, 579	251, 532 251, 532			1.00
	M - MALPRACTICE		1, 373, 377	231, 332			
1. 00	ADMINISTRATIVE & GENERAL	5.00	0	65, 104	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	0.00	o	03, 104			2. 00
3. 00		0.00	Ö	0	o		3. 00
4. 00		0.00	Ö	0	o		4. 00
5. 00		0.00	ol	0	o		5. 00
6. 00		0.00	ol	0	Ö		6. 00
7. 00		0.00	o	0	Ö		7. 00
8. 00		0.00	o	0	o		8. 00
9.00		0.00	o	0	o		9. 00
10.00		0.00	o	0	o		10.00
11. 00	<u> </u>	0.00	0	0_	0		11. 00
	0	Ι Τ	0	65, 104			

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Provider CCN: 31-0041 Date/Time Prepared: 5/24/2022 5:22 pm

		D				5/24/2022 5	ZZ pili
		Decreases				1	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	N - BENEFITS DIRECTLY ASSIGNE	:D					
1.00	I &R SERVICES-OTHER PRGM.	22. 00		392, 216	0		1.00
	COSTS APPRVD			,			
2.00	ADULTS & PEDIATRICS	30.00		51, 197	0		2. 00
3. 00		44.00					3. 00
	SKILLED NURSING FACILITY			367, 729			4
4.00	EMERGENCY	<u> </u>	+	<u> </u>			4. 00
	0		0	836, 708			
	Q - TRANSPORT						
1.00	ADMINISTRATIVE & GENERAL	5. 00	1, 144, 013	25, 322	0		1. 00
2.00		0.00		. 0			2. 00
3.00		0.00	0	0			3. 00
			0				1
4.00		0.00	0	0			4. 00
5.00		0.00	0	0	-		5. 00
6. 00		0.00	0	0	0		6. 00
7.00		0.00	0	0	0		7. 00
8.00		0.00	0	0	o		8. 00
9. 00		0.00		0	0		9. 00
10.00			0	0	1		1
		0.00	U	U	U		10.00
11. 00	L	0.00	0	0	0		11. 00
	0		1, 144, 013	25, 322			_
	R - PHARMACY RESIDENTS						
1.00	PHARMACY	15. 00	70, 192	13, 941	0		1.00
			70, 192	13, 941			
	W - WAGE INDEX		70, 172	10, 711			_
1 00		12.00	0 211				1 1 00
1.00	NURSING ADMINISTRATION	13. 00	8, 311		0		1. 00
2.00	PHARMACY	15. 00	7, 918		0		2. 00
3.00	MEDICAL RECORDS & LIBRARY	16. 00	65, 166		0		3. 00
4.00	SOCI AL SERVI CE	17. 00	1, 302		0		4. 00
5.00	I &R SERVICES-OTHER PRGM.	22. 00	1, 386, 448		0		5. 00
	COSTS APPRVD		.,,		1		1
6. 00	ADULTS & PEDIATRICS	30.00	219, 518		0		6. 00
							1
7.00	INTENSIVE CARE UNIT	31. 00	4, 178		0		7. 00
8. 00	SURGICAL INTENSIVE CARE UNIT	34.00	6, 643		0		8. 00
9.00	NURSERY	43. 00	724		0		9. 00
10.00	SKILLED NURSING FACILITY	44.00	923		0		10.00
11. 00	OPERATING ROOM	50.00	3, 346		0		11. 00
12. 00	DELIVERY ROOM & LABOR ROOM	52.00	2, 500		o		12. 00
							1
13. 00	RADI OLOGY-DI AGNOSTI C	54. 00	13, 742		0		13. 00
14. 00	RADI OLOGY-THERAPEUTI C	55. 00	11, 892		0		14. 00
15.00	CARDIAC CATHETERIZATION	59. 00	35, 530		0		15. 00
16.00	LABORATORY	60.00	5, 583		o		16. 00
17. 00	PHYSI CAL THERAPY	66.00	20, 518		0		17. 00
18. 00	ELECTROCARDI OLOGY	69.00	42, 062		0		18. 00
19. 00	ELECTROENCEPHALOGRAPHY	70.00	768		0		19. 00
20.00	CLINIC	90.00	2, 107		0		20. 00
21.00	EMERGENCY	91.00	245, 480		0		21. 00
22.00	ADMINISTRATIVE & GENERAL	5.00		165, 138	0		22. 00
23.00	OTHER NON REIMBURABLE	194. 05		291, 176			23. 00
20.00	0	— — 1711.03	2, 084, 659	456, 314			23.00
	V OR CURRORT		2, 004, 009	430, 314			-
	X - OB SUPPORT						4
1. 00	DELIVERY ROOM & LABOR ROOM	52.00	11 <u>6, 7</u> 01	205	0		1. 00
	0		116, 701	205			
	Y - INTERN & RESIDENT SALARY	RECLASS					
1.00	I &R SERVI CES-OTHER PRGM.	22.00	774, 712	0	0		1.00
1. 50	COSTS APPRVD	22.00	, , , , , , , , ,	0			'. 55
		+	774, 712	— — — ō	<del> </del>		
	TOTALS		114,112	0			_
	Z - COVID-19- CONTRACT LABOR						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0_	<u>13, 408, 0</u> 79			1. 00
	TOTALS	- — T		13, 408, 079			
	AA - RESIDENT MALPRACTICE						
1.00	ADMI NI STRATI VE & GENERAL	5.00	ما	71, 349	0		1.00
1.00			— — ₩				1.00
-05	TOTALS		0	71, 349			
500.00	Grand Total: Decreases		6, 744, 381	101, 049, 990			500.00

					-rom 01/01/2021 Го 12/31/2021	Part I Date/Time Pre 5/24/2022 5:2	
				Acqui si ti ons		372472022 3.2	Z piii
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	198, 713	0	(	0	0	1. 00
2.00	Land Improvements	2, 567, 723	0	(	0	0	2. 00
3.00	Buildings and Fixtures	695, 396, 707	34, 064, 052	(	34, 064, 052	3, 195, 667	3. 00
4.00	Building Improvements	5, 183, 612	0	(	0	0	4. 00
5.00	Fixed Equipment	77, 147, 012	0	(	0	0	5. 00
6.00	Movable Equipment	131, 962, 147	6, 581, 061	(	6, 581, 061	3, 168, 007	6. 00
7.00	HIT designated Assets	0	0	(	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	912, 455, 914	40, 645, 113	(	40, 645, 113	6, 363, 674	8. 00
9.00	Reconciling Items	0	0	(	0	0	9. 00
10. 00	Total (line 8 minus line 9)	912, 455, 914	40, 645, 113	(	40, 645, 113	6, 363, 674	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
		( 00	Assets				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	6.00	7. 00				
1 00			1 (20 150				1 00
1.00	Land	198, 713	1, 628, 159				1.00
2.00	Land Improvements	2, 567, 723	49, 963, 117				2.00
3.00	Buildings and Fixtures	726, 265, 092	4, 520, 732				3.00
4.00	Building Improvements	5, 183, 612	58, 663, 067				4.00
5.00	Fi xed Equipment	77, 147, 012	74 000 (50				5. 00
6.00	Movable Equipment	135, 375, 201	74, 898, 653				6. 00
7.00	HIT designated Assets	044 727 252	100 (72 720				7. 00
8.00	Subtotal (sum of lines 1-7)	946, 737, 353	189, 673, 728				8. 00
9.00	Reconciling Items	044 727 252	100 (72 720				9.00
10. 00	Total (line 8 minus line 9)	946, 737, 353	189, 673, 728				10. 00

Heal th	Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 31-0041	Peri od:	Worksheet A-7	
					From 01/01/2021	Part II	
					To 12/31/2021	Date/Time Pre	
						5/24/2022 5:2	2 pm
			SL	JMMARY OF CAP	'I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	9, 007, 331	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7, 705, 137	0	1	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	16, 712, 468	0	1	0 0	0	3. 00
		SUMMARY O	F CAPITAL		<u>'</u>		
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	` ' '				
		d Costs (see	through 14)				
		instructions)	cin ough in				
		14.00	15. 00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	13E1 71, 33E0W	9, 007, 331				1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	7, 705, 137	1			2.00
2.00	Total (sum of lines 1.2)	0	1, 700, 107				2.00

0 0 0

9, 007, 331 7, 705, 137 16, 712, 468

1. 00 2. 00 3. 00

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

Heal th	n Financial Systems	COMMUNITY MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Pre 5/24/2022 5:22	pared:
		COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FLXT	811, 362, 151		0 , 0 0 = ,			
2.00	CAP REL COSTS-MVBLE EQUIP	135, 375, 201	l .	135, 375, 20			
3.00	Total (sum of lines 1-2)	946, 737, 352		946, 737, 35			3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL BESCHOLLLATION OF SARITAL SOCTO OF	6.00	7. 00	8. 00	9. 00	10. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS O		ı	0 007 221	0	1 00
1.00	CAP REL COSTS-BLDG & FIXI	ı	1		0 9, 007, 331	0	1.00
2. 00 3. 00		0			0 7, 705, 137		2. 00 3. 00
3.00	Total (sum of lines 1-2)	0	<u> </u>	JMMARY OF CAPI	0 16, 712, 468	U	3.00
			30	DIVINART OF CAPT	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)			
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COCTO OF	11. 00	12.00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS 1, 756, 750	129, 561	1	0 0	10 002 (42	1. 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXI	1, 756, 750		1	0 0	10, 893, 642 9, 305, 419	
3.00	Total (sum of lines 1-2)	3, 259, 526		1	0 0		1
3.00	Total (Sum Of Titles 1-2)	3, 237, 320	221,001	I	υ <sub> </sub> υ	20, 177, 001	J 3.00

					o 12/31/2021	Date/Time Prep 5/24/2022 5: 22	
				Expense Classification on		3/24/2022 3. 2.	Z piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FLXT (chapter 2)	В	-325, 776	CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	В	-278, 679	CAP REL COSTS-MVBLE EQUIP	2.00	11	2. 00
3.00	Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	В	107 027	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
7.00	stations excluded) (chapter 21)	В	-107,037	ADMINISTRATIVE & GENERAL	3.00	0	7.00
8. 00	Television and radio service (chapter 21)	В		OPERATION OF PLANT	7. 00	0	
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	B A-8-2	-35, 606 -6, 864, 134	MAINTENANCE & REPAIRS	6. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-18, 298, 756			0	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-807. 192	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee and others		0		0. 00	0	
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	-323	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	Λ	PHYSI CAL THERAPY	66. 00		24. 00
00	therapy costs in excess of limitation (chapter 14)		O		03.00		
25. 00	Utilization (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
o	(chapter 21)			0.40 0.51 0.0050 51.55 1 51.55			
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1. 00	0	
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	O O	30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest MED & DENTAL STAFF OTHER REV	В	-169, 450	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
	1 2 22 THE STATE OF THE REV		.37, 130	, SENERAL		· <u> </u>	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 31-0041 

					5 12/31/2021	Date/lime Prep 5/24/2022 5:22	
				Expense Classification on	Worksheet A	372472022 3.22	z piii
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00.01	LY DAY CODY FEEC	1.00	2.00	3.00	4. 00	5. 00	00.01
33. 01	X-RAY COPY FEES	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
33. 02 33. 03	GARNISHEE SERVICE CHARGE REV	B B		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 02
33. 03	OUTREACH LAB	В		LABORATORY	60.00	0	33. 03 33. 04
33. 04	OTHER MI SCELLANEOUS REVENUE OTHER MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE & GENERAL CENTRAL SERVICES & SUPPLY	5. 00 14. 00	0	33. 05
33. 06	OTHER MI SCELLANEOUS REVENUE	В	· ·	PHARMACY	15. 00	0	33. 06
33. 07	OTHER MI SCELLANEOUS REVENUE	В		SKILLED NURSING FACILITY	44. 00	0	33. 07
33. 08	OTHER MI SCELLANEOUS REVENUE	В	·	OPERATING ROOM	50. 00	0	33. 08
33. 09	OTHER MI SCELLANEOUS REVENUE	B		LABORATORY	60.00	0	33. 09
33. 10	OTHER MI SCELLANEOUS REVENUE	В		CLINIC	90.00	ő	33. 10
33. 11	EMPLOYEE - HEALTH PAYMENTS	B		ADULTS & PEDIATRICS	30.00	0	33. 11
33. 12	EMPLOYEE - HEALTH PAYMENTS	В		INTENSIVE CARE UNIT	31. 00	0	33. 12
33. 13	EMPLOYEE - HEALTH PAYMENTS	В		SURGICAL INTENSIVE CARE UNIT	34. 00	0	33. 13
33. 14	EMPLOYEE - HEALTH PAYMENTS	В		SKILLED NURSING FACILITY	44.00	0	33. 14
33. 15	EMPLOYEE - HEALTH PAYMENTS	В	-3, 983	OPERATING ROOM	50.00	0	33. 15
33. 16	EMPLOYEE - HEALTH PAYMENTS	В	-766	RECOVERY ROOM	51.00	0	33. 16
33. 17	EMPLOYEE - HEALTH PAYMENTS	В	-1, 632	DELIVERY ROOM & LABOR ROOM	52.00	0	33. 17
33. 18	EMPLOYEE - HEALTH PAYMENTS	В	-244	OP INFUSION	52. 01	0	33. 18
33. 19	EMPLOYEE - HEALTH PAYMENTS	В	-490	ANESTHESI OLOGY	53.00	0	33. 19
33. 20	EMPLOYEE - HEALTH PAYMENTS	В	-5, 473	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 20
33. 21	EMPLOYEE - HEALTH PAYMENTS	В	-2, 635	RADI OLOGY-THERAPEUTI C	55. 00	0	33. 21
33. 22	EMPLOYEE - HEALTH PAYMENTS	В	-233	RADI OI SOTOPE	56. 00	0	33. 22
33. 23	EMPLOYEE - HEALTH PAYMENTS	В	-2, 015	1	58. 00	0	33. 23
33. 24	EMPLOYEE - HEALTH PAYMENTS	В		CARDI AC CATHETERI ZATI ON	59. 00	0	33. 24
33. 25	EMPLOYEE - HEALTH PAYMENTS	В	,	LABORATORY	60.00	0	33. 25
33. 26	EMPLOYEE - HEALTH PAYMENTS	В		RESPIRATORY THERAPY	65.00	0	33. 26
33. 27	EMPLOYEE - HEALTH PAYMENTS	В		PHYSI CAL THERAPY	66.00	0	33. 27
33. 28	EMPLOYEE - HEALTH PAYMENTS	В		OCCUPATI ONAL THERAPY	67.00	0	33. 28
33. 29	EMPLOYEE - HEALTH PAYMENTS	В		SPEECH PATHOLOGY	68.00	0	33. 29
33. 30	EMPLOYEE - HEALTH PAYMENTS	B B	· ·	ELECTROCARDI OLOGY	69.00	0	33. 30
33. 31 33. 32	EMPLOYEE - HEALTH PAYMENTS EMPLOYEE - HEALTH PAYMENTS	В		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO	70.00	0	33. 31 33. 32
33. 32	EMPLOTEE - HEALTH PATMENTS	D	-070	PATIENT	71. 00	U	33. 32
33. 33	EMPLOYEE - HEALTH PAYMENTS	В	-793	IMPL. DEV. CHARGED TO	72.00	0	33. 33
00.00	LIMI ESTEE HEAETH TATMENTS			PATI ENTS	72.00	Ŭ	00.00
33. 34	EMPLOYEE - HEALTH PAYMENTS	В		DRUGS CHARGED TO PATIENTS	73.00	0	33. 34
33. 35	EMPLOYEE - HEALTH PAYMENTS	В		CARDIAC REHABILITATION	76. 97	0	33. 35
33. 36	EMPLOYEE - HEALTH PAYMENTS	В		CLINIC	90.00	0	33. 36
33. 37	EMPLOYEE - HEALTH PAYMENTS	В	-6, 935	EMERGENCY	91.00	0	33. 37
33. 38	EMPLOYEE - HEALTH PAYMENTS	В	-40	ADULTS & PEDIATRICS	30.00	0	33. 38
33. 39	EMPLOYEE - HEALTH PAYMENTS	В		OBSERVATION BEDS-DISTINCT	92. 01	0	33. 39
33. 40	RENTAL I NCOME	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 40
33. 41	FOUNDATION SUBSIDY	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 41
33. 42	FOUNDATION SUBSIDY	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 43	FOUNDATION SUBSIDY	В	·	OPERATION OF PLANT	7. 00	0	33. 43
33. 44	FOUNDATION SUBSIDY	В	,	DI ETARY	10.00	0	33. 44
33. 45	FOUNDATION SUBSIDY	В		NURSING ADMINISTRATION	13.00	0	33. 45
33. 46	FOUNDATION SUBSIDY	В		PHARMACY	15.00	0	33. 46 33. 47
33. 47	FOUNDATION SUBSIDY	B B		MEDICAL RECORDS & LIBRARY	16.00	0	33. 4 <i>7</i> 33. 48
33. 48	FOUNDATION SUBSIDY	<sup>p</sup>	-110	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22. 00	ا	აა. 48
33. 49	FOUNDATION SUBSIDY	В	-11 N38	ADULTS & PEDIATRICS	30.00	0	33. 49
33. 50	FOUNDATION SUBSIDY	В	·	INTENSIVE CARE UNIT	31.00	0	33. 50
33. 51	FOUNDATION SUBSIDY	В	,	SURGICAL INTENSIVE CARE UNIT	34. 00	0	33. 50
33. 52	FOUNDATION SUBSIDY	В		NURSERY	43. 00	0	33. 52
33. 53	FOUNDATION SUBSIDY	В		SKILLED NURSING FACILITY	44.00	o	33. 53
33. 54	FOUNDATION SUBSIDY	В		OPERATING ROOM	50.00	0	33. 54
33. 55	FOUNDATION SUBSIDY	В	,	DELIVERY ROOM & LABOR ROOM	52. 00	Ö	33. 55
33. 56	FOUNDATION SUBSIDY	В		OP INFUSION	52. 01	0	33. 56
33. 57	FOUNDATION SUBSIDY	В		RADI OLOGY-THERAPEUTI C	55.00	0	33. 57
33. 58	FOUNDATION SUBSIDY	В	-1, 823	CARDIAC CATHETERIZATION	59.00	0	33. 58
33. 59	FOUNDATION SUBSIDY	В	-13, 094	PHYSICAL THERAPY	66.00	0	33. 59
33. 60	FOUNDATION SUBSIDY	В		ELECTROENCEPHALOGRAPHY	70.00	0	33. 60
33. 61	FOUNDATION SUBSIDY	В		CLINIC	90.00	0	33. 61
33. 62	INTERCOMPANY RENTAL INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 62
33. 63	NON ALLOWABLE ENTERTAINMENT	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 63
33. 64	NON ALLOWABLE ENTERTALINMENT	A		OPERATION OF PLANT	7. 00	0	33. 64
33. 65	NON ALLOWABLE ENTERTALIMENT	A		HOUSEKEEPI NG	9.00	0	33. 65
33. 66	NON ALLOWABLE ENTERTAINMENT	A	-2, 562	DI ETARY	10. 00	0	33. 66

From 01/01/2021 | Not Ksheet A-5 | Worksheet A-5 | To 12/31/2021 | Date/Time Prepared:

	To 12/31/2021					Date/Time Prepared: 5/24/2022 5:22 pm	
	·			Expense Classification on	Worksheet A	072172022 0.2.	2 p
				To/From Which the Amount is			
				To the mineral the mineral to	to be haj astea		
	Cost Center Description	Pasis/Codo (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2. 00	3. 00	4. 00	5. 00	
33. 67	NON ALLOWABLE ENTERTALNMENT	1.00 A		NURSI NG ADMI NI STRATI ON	13. 00	5.00	33, 67
					15. 00		
33. 68	NON ALLOWABLE ENTERTALINMENT	A		PHARMACY	0	33. 68	
33. 69	NON ALLOWABLE ENTERTAINMENT	A	•	MEDICAL RECORDS & LIBRARY	0	33. 69	
33. 70	NON ALLOWABLE ENTERTAINMENT	A		SOCI AL SERVI CE	17. 00	0	33. 70
33. 71	NON ALLOWABLE ENTERTAINMENT	A		I&R SERVICES-OTHER PRGM.	22. 00	0	33. 71
				COSTS APPRVD			
33. 72	NON ALLOWABLE ENTERTAINMENT	A		PARAMED ED PRGM-(SPECIFY)	23. 00	0	00.72
33. 73	NON ALLOWABLE ENTERTAINMENT	A		ADULTS & PEDIATRICS	30. 00	0	33. 73
33. 74	NON ALLOWABLE ENTERTAINMENT	A		INTENSIVE CARE UNIT	31. 00	0	33. 74
33. 75	NON ALLOWABLE ENTERTAINMENT	A		OPERATING ROOM	50.00	0	33. 75
33. 76	NON ALLOWABLE ENTERTAINMENT	A	-37	DELIVERY ROOM & LABOR ROOM	52.00	0	33. 76
33. 77	NON ALLOWABLE ENTERTAINMENT	A	-892	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 77
33. 78	NON ALLOWABLE ENTERTAINMENT	A	-215	RADI OLOGY-THERAPEUTI C	55.00	0	33. 78
33. 79	NON ALLOWABLE ENTERTAINMENT	A	-392	CARDIAC CATHETERIZATION	59.00	0	33. 79
33. 80	NON ALLOWABLE ENTERTAINMENT	A	-303	RESPIRATORY THERAPY	65.00	0	33. 80
33. 81	NON ALLOWABLE ENTERTAINMENT	l A	-1, 086	PHYSI CAL THERAPY	66. 00	0	33. 81
33. 82	NON ALLOWABLE ENTERTAINMENT	A		7 EMERGENCY 91.00		0	33. 82
33. 83	NON ALLOWABLE ENTERTAINMENT	A	-669	9 OBSERVATION BEDS-DISTINCT 92.01		0	33. 83
33. 84	FINES	A		DSKILLED NURSING FACILITY 44.00		0	33. 84
33. 85	FQHC	A		DADMINISTRATIVE & GENERAL 5.00		0	33. 85
33. 86	LOBBYI NG EXPENSE	A		9ADMI NI STRATI VE & GENERAL 5.00		0	33. 86
33. 87	BHMG/MMG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 87
33. 88	ADDITIONAL CAPTIVE PHYS	A	-2, 486, 040		91. 00	0	33. 88
33.00	PRACTICE	A	-2, 400, 040	EWERGENCT	91.00	U	33.00
33. 89	ADDITIONAL CAPTIVE PHYS	A	1 410 050	ADULTS & PEDIATRICS	30.00	0	33. 89
33. 09	PRACTICE	A	-1,019,039	ADULIS & PEDIATRICS	30.00	U	33. 69
33. 90	NURSE PRACTIONERS (INCLUDES	A	2 470	ADMINISTRATIVE & CENEDAL	F 00	0	33. 90
33. 90	FRINGES)	A	-3, 479	ADMINISTRATIVE & GENERAL	5. 00	U	33. 90
22 01	NURSE PRACTIONERS (INCLUDES		00 747	NURSING ADMINISTRATION	12 00	0	22 01
33. 91	`	A	-89, 747	NURSTING ADMINISTRATION	13. 00	U	33. 91
22 02	FRI NGES)		2 205	ADULTO A DEDLATRICO	20.00	0	22 02
33. 92	NURSE PRACTIONERS (INCLUDES	A	-2, 205	ADULTS & PEDIATRICS	30. 00	0	33. 92
22 02	FRINGES)		272 072	EMDLOVEE DENEELTS DEDARTMENT	4 00	0	22 02
33. 93	PENSION ADMINISTRATION COSTS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	33. 93
50. 00	TOTAL (sum of lines 1 thru 49)		-56, 943, 183				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)			ONC D 1 45 4			

<sup>(1)</sup> 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.

	Li ne No.	Cost Center	Expense I tems	Amount of	Amount			
				Allowable Cost	Included in			
					Wks. A, column			
					5			
	1. 00	2.00	3. 00	4. 00	5. 00			
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED							
	HOME OFFICE COSTS:					l		
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	44, 243, 175	62, 567, 149	1.00		
2.00	0.00			0	ol	2. 00		
3.00	5. 00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL AUXILIA	23, 648	23, 648	3. 00		
3. 01	5. 00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL FOUND	68, 048	68, 048	3. 01		
3.02	5. 00	ADMINISTRATIVE & GENERAL	ST BARNABAS CORP	528, 758	528, 758	3. 02		
3.03	95. 00	AMBULANCE SERVICES	AMBULANCE ADD ON	25, 218	l ol	3. 03		
4.00	0.00			0	l ol	4. 00		
5.00	TOTALS (sum of lines 1-4).			44, 888, 847	63, 187, 603	5. 00		
	Transfer column 6, line 5 to					l		
	Worksheet A-8, column 2,					l		
	line 12.					l		
* The	* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A. column 6. Lines as							

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

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

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

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

6.00	A	0.00 RWJ BARNABAS HEALTH 100.00	6.00
7.00		0.00	7. 00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
	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 organization.
- $\hbox{E. Individual is director, of ficer, administrator, or key person of provider and related organization.}\\$
- 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	COMMUNITY ME	DICAL CENTER	In Lie	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOM	E Provider CCN: 31-0041	Peri od:	Worksheet A-8	3-1
OFFI CE	COSTS				From 01/01/2021	5	
					To 12/31/2021	Date/Time Pro 5/24/2022 5:2	
	Net	Wkst. A-7 Ref.				3/24/2022 3.2	ZZ PIII
	Adjustments	WKSt. A 7 KCI.					
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO	STS:					
1.00	-18, 323, 974	C					1. 00
2.00	0	C					2. 00
3.00	0	C					3. 00
3.01	0	C					3. 01
3.02	0	C					3. 02
3.03	25, 218	C	)				3. 03
4 00	l o	1 0	ما ا				1 1 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

5.00

nas not	been posted to worksheet A,	cordining 1 and/or 2, the amount arrowable should be find cated in cordinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	. Comont undor the tro Attiti		
6.00	HEALTHCARE		6. 00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
10. 00 100. 00		10	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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

-18, 298, 756

Provider CCN: 31-0041

| Period: | From 01/01/2021 | To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: | 5/24/2022 5: 22 pm

						12/31/2021	5/24/2022 5: 2	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE &	5, 151, 417	5, 115, 442	35, 975	211, 500	851	1. 00
2. 00	10.00	GENERAL AGGREGATE-DI ETARY	13, 871	13, 871	0	0	0	2. 00
3. 00		AGGREGATE-MEDICAL RECORDS &	24, 901	24, 901	0	0	0	3. 00
		LI BRARY	·					
4. 00	22. 00	AGGREGATE-I&R SERVICES-OTHER	1, 416, 063	0	1, 416, 063	211, 500	9, 172	4. 00
5. 00	30.00	PRGM. C AGGREGATE-ADULTS &	16, 190	48	16, 142	197, 500	120	5. 00
		PEDI ATRI CS				,		
6. 00		AGGREGATE-OPERATING ROOM	2, 690	2, 690	0	0	0	6. 00
7. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	512, 842	512, 842	0	0	0	7. 00
8. 00	55. 00	AGGREGATE-RADI OLOGY-THERAPEU	69, 375	69, 375	0	0	0	8. 00
	50.00	TIC	70.04	70.04/				
9. 00	59.00	AGGREGATE-CARDI AC CATHETERI ZATI ON	72, 216	72, 216	0	0	0	9. 00
10.00	60.00	AGGREGATE - LABORATORY	40, 530	40, 530	0	0	0	10.00
11. 00	65. 00	AGGREGATE-RESPI RATORY	49, 987	49, 987	0	0	0	11. 00
12. 00	60.00	THERAPY AGGREGATE-ELECTROCARDI OLOGY	96, 456	45, 586	50, 870	211, 500	208	12. 00
13. 00		AGGREGATE-ELECTROEARDI OLOGI AGGREGATE-ELECTROENCEPHALOGR	244, 985		0 30,870	211,300	0	13. 00
		APHY		·				
14.00		AGGREGATE-SLEEP LAB AGGREGATE-EMERGENCY	6, 358		0	0	0	14. 00
15. 00 200. 00	91.00	AGGREGATE-EMERGENCY	171, 138 7, 889, 019		0 1, 519, 050	0	0 10, 351	15. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE		Component	of Mal practice	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	5. 00	AGGREGATE-ADMINISTRATIVE &	86, 532	4, 327	0	0	139, 085	1. 00
2. 00	10.00	GENERAL AGGREGATE-DI ETARY	_	0	0		0	2. 00
3. 00		AGGREGATE-BLETARY AGGREGATE-MEDICAL RECORDS &		0	0	0	3, 897	3. 00
		LI BRARY	_		_	_		
4.00	22. 00	AGGREGATE-I&R SERVICES-OTHER	932, 634	46, 632	0	0	15, 029	4. 00
5. 00	30.00	PRGM. C AGGREGATE-ADULTS &	11, 394	570	0	0	2, 534	5. 00
0.00	00.00	PEDI ATRI CS	, .,	0,0			2,00.	0.00
6.00		AGGREGATE - OPERATING ROOM	0	0	0	0	421	6. 00
7. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST I C	0	0	0	0	344	7. 00
8.00	55. 00	AGGREGATE-RADI OLOGY-THERAPEU	0	0	0	0	10, 817	8. 00
		TIC	_	_	_	_		
9. 00	59.00	AGGREGATE-CARDI AC CATHETERI ZATI ON	0	0	0	0	5, 741	9. 00
10.00	60. 00	AGGREGATE-LABORATORY	О	0	0	0	0	10. 00
11. 00	65. 00	AGGREGATE-RESPI RATORY	0	0	0	0	7, 822	11. 00
12. 00	40.00	THERAPY AGGREGATE-ELECTROCARDI OLOGY	21, 150	1, 058	0	0	11, 713	12. 00
13. 00		AGGREGATE-ELECTROEARDI OLOGI AGGREGATE-ELECTROENCEPHALOGR	21, 130	1,038	0	_	5, 791	13. 00
		APHY						
14. 00 15. 00		AGGREGATE-SLEEP LAB AGGREGATE-EMERGENCY	0	0	0	0	995	14. 00 15. 00
200.00	91.00	AGGREGATE - EMERGENCT	1, 051, 710	52, 587	0	0	204, 189	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col. 14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 00	AGGREGATE-ADMINISTRATIVE & GENERAL	971	87, 503	0	5, 115, 442		1. 00
2. 00	10.00	AGGREGATE-DI ETARY	0	0	0	13, 871		2. 00
3. 00		AGGREGATE-MEDICAL RECORDS &	Ö	Ö	ő	24, 901		3. 00
4 00	20	LI BRARY	45 000	0.47	4/0 /	4/0 /		4 60
4. 00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM. C	15, 029	947, 663	468, 400	468, 400		4. 00
5. 00	30.00	AGGREGATE-ADULTS &	2, 526	13, 920	2, 222	2, 270		5. 00
,		PEDI ATRI CS						
6. 00 7. 00		AGGREGATE-OPERATING ROOM AGGREGATE-RADIOLOGY-DIAGNOST	0	0	0	2, 690 512, 842		6. 00 7. 00
7.00	34.00	I C				512,042		7.00
8. 00	55. 00	AGGREGATE-RADI OLOGY-THERAPEU	0	0	0	69, 375		8. 00
		TIC	l					

Heal th F	inancial Syste	ems	COMMUNITY ME	EDICAL CENTER		In Li€	eu of Form CMS-	2552-10
PROVI DEI	R BASED PHYSIC	AN ADJUSTMENT		Provi der (		Peri od: From 01/01/2021	Worksheet A-8	3-2
						To 12/31/2021	Date/Time Pro 5/24/2022 5:2	
\	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			

							5/24/2022 5: 2	22 pm
	Wkst. A Line #	J	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
9.00	59. 00	AGGREGATE-CARDI AC	0	0	0	72, 216		9. 00
		CATHETERI ZATI ON						
10.00	60.00	AGGREGATE-LABORATORY	0	0	0	40, 530		10.00
11. 00	65. 00	AGGREGATE-RESPI RATORY	0	0	0	49, 987		11. 00
		THERAPY						
12.00	69. 00	AGGREGATE-ELECTROCARDI OLOGY	6, 177	27, 327	23, 543	69, 129		12.00
13.00	70.00	AGGREGATE-ELECTROENCEPHALOGR	0	0	0	244, 985		13. 00
		APHY						
14.00	70. 01	AGGREGATE-SLEEP LAB	0	0	0	6, 358		14. 00
15.00	91.00	AGGREGATE-EMERGENCY	0	0	0	171, 138		15. 00
200.00			24, 703	1, 076, 413	494, 165	6, 864, 134		200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0041 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/24/2022 5: 22 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 10, 893, 642 00100 CAP REL COSTS-BLDG & FLXT 10, 893, 642 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 9, 305, 419 9, 305, 419 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 32, 722, 513 112, 464 32, 834, 977 4.00 00500 ADMINISTRATIVE & GENERAL 61, 822, 804 1, 953, 110 66, 951, 924 5 00 560, 153 2, 615, 857 5 00 6.00 00600 MAINTENANCE & REPAIRS 746,002 34, 615 8, 516 47, 229 836, 362 6.00 7.00 00700 OPERATION OF PLANT 10, 582, 305 173, 118 425, 718 719, 288 11, 900, 429 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1,070,546 1,070,546 8.00 C 00900 HOUSEKEEPI NG 127, 034 8, 772 905, 784 6, 692, 729 9 00 5, 651, 139 9 00 4, 462, 863 10.00 01000 DI ETARY 225, 552 44,662 551, 169 5, 284, 246 10.00 01100 CAFETERI A 221, 087 187, 710 542, 926 11.00 7, 850 126, 279 11.00 01300 NURSING ADMINISTRATION 5, 418, 222 91, 815 1, 045, 010 7, 211, 711 13.00 13.00 656, 664 01400 CENTRAL SERVICES & SUPPLY 3, 350, 474 14.00 431, 495 253, 688 382, 649 4, 418, 306 14 00 15.00 01500 PHARMACY 6,079,854 112, 651 61, 130 1, 120, 624 7, 374, 259 15.00 01600 MEDICAL RECORDS & LIBRARY 4, 202, 357 16.00 3, 457, 042 167, 061 24 578, 230 16.00 4, 680, 622 01700 SOCIAL SERVICE 4, 119, 728 17.00 0 0 560.894 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 846,061 C 0 164, 660 1, 010, 721 21 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 1, 534, 311 0 69, 295 1, 603, 606 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 255, 439 47, 937 303, 376 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 47, 235, 411 2, 327, 887 78.502 6, 320, 422 55, 962, 222 30.00 23, 205, 150 03100 INTENSIVE CARE UNIT 1, 281, 914 102, 234 4, 565, 826 29, 155, 124 31.00 31.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 3,005,299 98, 851 12, 178 583, 632 3, 699, 960 34.00 04300 NURSERY 43.00 2, 821, 157 139, 023 13, 550 545, 805 3, 519, 535 43.00 04400 SKILLED NURSING FACILITY 44.00 2, 367, 178 179, 675 2,022 309, 343 2, 858, 218 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10, 617, 993 708, 918 2, 105, 336 1, 497, 436 14, 929, 683 50.00 05100 RECOVERY ROOM 101, 161 302, 540 1, 870, 998 51.00 1, 436, 739 30, 558 51.00 05200 DELIVERY ROOM & LABOR ROOM 3, 392, 577 325, 755 679, 644 4, 440, 068 52.00 42,092 52.00 52.01 03190 OP INFUSION 1, 569, 495 174, 014 312, 277 2, 055, 786 52.01 05300 ANESTHESI OLOGY 133, 724 20, 815 5.011 53 00 16,820 176, 370 53.00 7, 281, 215 9, 598, 600 54.00 05400 RADI OLOGY-DI AGNOSTI C 451, 603 782, 033 1, 083, 749 54.00 05500 RADI OLOGY-THERAPEUTI C 301, 901 739, 098 8, 771, 983 55.00 7, 283, 456 447, 528 55.00 05600 RADI OI SOTOPE 10, 408 101, 726 1, 674, 263 56.00 1, 374, 041 188,088 56.00 05700 CT SCAN 2, 051, 109 2, 338, 351 57.00 15, 611 271, 631 57.00 58.00 05800 MRI 899, 397 61, 737 364, 955 147, 541 1, 473, 630 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 626, 581 439, 322 375, 592 589, 491 5, 030, 986 59.00 06000 LABORATORY 13, 967 15, 635, 036 60 00 14, 273, 470 266 557 1, 081, 042 60 00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 2, 129, 321 10, 408 2, 139, 729 63.00 65.00 06500 RESPIRATORY THERAPY 3, 166, 701 39, 174 170, 198 581, 597 3, 957, 670 65.00 06600 PHYSI CAL THERAPY 66.00 3, 289, 005 111, 464 24, 222 656, 633 4, 081, 324 66.00 06700 OCCUPATIONAL THERAPY 199, 002 1, 140, 903 67 00 936 323 5. 578 67 00 68.00 06800 SPEECH PATHOLOGY 229, 581 17, 443 2, 130 48,064 297, 218 68.00 06900 ELECTROCARDI OLOGY 92, 523 55, 707 457, 850 3, 374, 714 69.00 2.768.634 69.00 111, 911 70.00 07000 ELECTROENCEPHALOGRAPHY 959, 036 193, 163 132, 930 1, 397, 040 70.00 70.01 07001 SLEEP LAB 1, 105 -164 C 0 941 70 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 18, 138, 715 0 0 0 18, 138, 715 71.00 14, 435, 721 07200 IMPL. DEV. CHARGED TO PATIENTS 0 14, 435, 721 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 45, 607, 293 45, 607, 293 73.00 0 0 73.00 07697 CARDIAC REHABILITATION 50, 914 76.97 325, 947 1.903 66, 907 445, 671 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 300, 746 54, 119 354, 865 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 1,010,758 11, 542 88.333 1, 110, 633 90.00 91.00 09100 EMERGENCY 13, 764, 495 1, 190, 036 213, 648 2, 477, 029 17, 645, 208 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 3, <u>85</u>5, 168 09201 OBSERVATION BEDS-DISTINCT 92.01 3, 250, 857 0 604, 311 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 997, 103 0 0 0 997, 103 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 406, 423, 515 10, 893, 642 9, 237, 788 32, 733, 942 406, 254, 849 118. 00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 0 0 0 194. 00 194. 01 07951 PUBLIC RELATIONS 551 194, 01 551 0 0 0 194. 03 07952 LI GHTHOUSE 50, 960 0 0 9, 243 60, 203 194. 03 194.04 07953 KIDS & FAMILY 834 0 0 834 194. 04 194. 05 07954 OTHER NON REIMBURABLE 0 57, 487 91, 792 291, 334 194. 05 142,055 10, 694 194. 06 194. 06 07955 GRANTS/TRI ALS 550 0 10, 144 0 194. 07 07956 RETAIL PHARMACY 0 0 194. 07

Health Financial Systems	COMMUNITY MED	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 31-0041		Peri od:	Worksheet B			
				From 01/01/2021 To 12/31/2021	Part     Date/Time Pre	nared.		
					5/24/2022 5: 2	2 pm		
		CAPI TAL REI	_ATED COSTS					
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal			
	for Cost Allocation			DEPARTMENT				
	(from Wkst A			DEPARTMENT				
	col. 7)							
	0	1. 00	2.00	4. 00	4A			
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)	406, 618, 465	10, 893, 642	9, 305, 41	9 32, 834, 977	406, 618, 465	202. 00		

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/24/2022 5:22 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 66, 951, 924 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 164, 856 1,001,218 6.00 00700 OPERATION OF PLANT 2, 345, 705 7.00 17,016 14, 263, 150 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 211, 016 1, 281, 562 8.00 8, 205, 376 00900 HOUSEKEEPI NG 1, 319, 211 180.950 9.00 12, 486 9 00 10.00 01000 DI ETARY 1,041,583 22, 169 321, 280 12, 357 49, 430 10.00 11.00 01100 CAFETERI A 107, 017 18, 450 267, 378 41, 414 11.00 01300 NURSING ADMINISTRATION 1, 421, 508 9, 024 130, 783 13 00 13 00 0 0 14.00 01400 CENTRAL SERVICES & SUPPLY 870, 897 42, 411 614, 631 14, 487 141, 610 14.00 15.00 01500 PHARMACY 1, 453, 548 11, 072 160, 462 0 44,086 15.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 828.331 237, 966 16, 420 0 0 16,00 01700 SOCIAL SERVICE 0 0 17.00 922, 602 C 0 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 199, 224 0 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 22.00 316,088 0 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 59, 799 0 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 11, 030, 680 228, 810 3, 315, 899 350, 750 3, 791, 414 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 746, 796 125, 999 1, 825, 985 270, 498 758, 817 31.00 03400 SURGICAL INTENSIVE CARE UNIT 9, 716 34.00 729.303 140, 805 22, 173 142.946 34.00 43.00 04300 NURSERY 693, 739 13,665 198, 028 14, 695 43.00 44.00 04400 SKILLED NURSING FACILITY 563, 386 17,660 255, 933 22, 217 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 942, 805 69, 679 1,009,798 76,057 173, 673 50.00 51.00 05100 RECOVERY ROOM 368, 794 9, 943 144, 096 15,098 51.00 05200 DELIVERY ROOM & LABOR ROOM 32, 018 39, 395 52.00 875, 186 464, 012 273, 869 52.00 03190 OP INFUSION 17, 104 247.869 13. 293 52.01 405, 218 557,089 52.01 05300 ANESTHESI OLOGY 53.00 34, 764 2, 046 29, 649 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 891, 990 44, 388 643, 272 48, 101 154, 970 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 1, 729, 054 29, 674 430, 034 69, 469 55.00 56 00 05600 RADI OI SOTOPE 330 016 1 023 14 825 10.698 37, 406 56 00 57.00 05700 CT SCAN 460, 915 1, 534 22, 237 56, 110 57.00 05800 MRI 290, 469 87, 940 9, 984 217, 759 58.00 6,068 58.00 59.00 05900 CARDIAC CATHETERIZATION 991, 663 43, 181 625, 779 11, 222 431, 510 59.00 06000 LABORATORY 379, 690 60.00 3, 081, 838 26, 200 2,054 84, 165 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS 421, 764 1,023 14,825 0 63.00 06500 RESPIRATORY THERAPY 65.00 780, 100 3,850 55, 800 18, 703 65.00 66 00 06600 PHYSI CAL THERAPY 804 474 10, 956 158 772 12, 811 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 224, 885 548 7, 946 0 67.00 06800 SPEECH PATHOLOGY 58, 585 1, 714 24, 846 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 665, 193 9,094 131, 791 11, 330 69.00 0 07000 ELECTROENCEPHALOGRAPHY 275, 146 70 00 275, 372 18, 986 70 00 7,672 0 70.01 07001 SLEEP LAB 185 0 0 0 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 575, 340 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 2.845.439 0 0 0 0 07300 DRUGS CHARGED TO PATIENTS 8, 989, 699 0 0 73.00 C 0 73.00 76. 97 07697 CARDIAC REHABILITATION 87,847 5,004 72, 522 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 76.98 69, 948 5, 319 77,088 17, 469 0 76.98 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90 00 218, 918 0 90 00 91.00 09100 EMERGENCY 116, 968 1, 695, 113 313, 896 1, 146, 241 91.00 3, 478, 065 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09201 OBSERVATION BEDS-DISTINCT 759.896 92.01 0 0 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 196, 540 0 0 95.00 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 66, 880, 251 14, 263, 150 8, 205, 376 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,001,218 1, 281, 562 NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 0 194, 00 0 0 0 194. 01 07951 PUBLIC RELATIONS 0 0 109 0 0 194, 01 194. 03 07952 LI GHTHOUSE 0 0 0 194. 03 11,867 0 0 194.04 07953 KIDS & FAMILY 0 0 194. 04 164 194. 05 07954 OTHER NON REIMBURABLE 0 0 194, 05 57.425 0 0 194.06 194. 06 07955 GRANTS/TRI ALS 2, 108 0 0 194. 07 07956 RETAIL PHARMACY 0 0 194. 07 0 0 Cross Foot Adjustments 200.00 200.00 Negative Cost Centers 0 201.00 201.00 202.00 TOTAL (sum lines 118 through 201) 66, 951, 924 1,001,218 14, 263, 150 1, 281, 562 8, 205, 376 202. 00

Provider CCN: 31-0041

			10	12/31/2021	Date/lime Pre   5/24/2022 5:2	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	, p
			ADMI NI STRATI ON	SERVI CES & SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00   00600 MAINTENANCE & REPAIRS						6.00
7.00 O0700 OPERATION OF PLANT						7.00
8.00   00800 LAUNDRY & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY	6, 731, 065					10.00
11. 00   01100   CAFETERI A	0	977, 185				11. 00
13. 00 01300 NURSING ADMINISTRATION	0	24, 389				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	21, 266		6, 123, 608	0 404 004	14.00
15. 00   01500   PHARMACY	0	34, 707		26, 067	9, 104, 201	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	0	25, 744		0	0	16. 00 17. 00
21. 00   01700   SOCIAL SERVICE 21. 00   02100   I&R SERVICES-SALARY & FRINGES APPRVD	0	17, 086 7, 625		0	0	21.00
22. 00   02200   &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	2, 108		0	0	22.00
23. 00   02300   PARAMED ED   PRGM- (SPECIFY)	0	2, 212	l o	ol	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		•		-,		
30. 00 03000 ADULTS & PEDIATRICS	3, 811, 001	229, 620	3, 039, 083	60, 827	0	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 563, 271	153, 081	2, 049, 035	54, 363	0	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	194, 541	17, 220		3, 787	0	34. 00
43. 00   04300   NURSERY	0	14, 516		0	0	43. 00
44. 00 O4400 SKILLED NURSING FACILITY	162, 252	10, 171	100, 987	2, 693	0	44. 00
ANCILLARY SERVICE COST CENTERS	0	44.070	(27.040	22 5/5	0	 
50. 00   05000   0PERATI NG ROOM 51. 00   05100   RECOVERY ROOM	0	44, 860		33, 565	0	50. 00 51. 00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	7, 218 20, 318		487 8, 511	0	52.00
52. 01   03190   OP   I NFUSI ON	0	10, 184		2, 264	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	1, 045		13	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	38, 996		8, 262	0	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0	21, 710		416	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0	2, 437	0	275	0	56.00
57. 00   05700   CT   SCAN	0	9, 011	0	0	0	57. 00
58. 00   05800   MRI	0	4, 636		0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	14, 813		7, 306	0	59. 00
60. 00 06000 LABORATORY	0	46, 634		10, 093	0	60.00
63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00   06500   RESPI RATORY THERAPY	0	10 222	0	823	0	63. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY	0	18, 332 23, 484		195	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	5, 280		173	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	1, 513		ol	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	o	18, 022		1, 339	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	4, 673		10, 289	0	70.00
70. 01   07001   SLEEP LAB	0	0	0	0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3, 179, 058	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 644, 204	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	9, 104, 201	73.00
76. 97   O7697   CARDI AC   REHABI LI TATI ON 76. 98   O7698   HYPERBARI C   OXYGEN   THERAPY	0	1, 817	34, 688	140	0	76. 97
OUTPATIENT SERVICE COST CENTERS	UU		l O	<u> </u>	0	76. 98
90. 00   09000   CLI NI C	0	2, 133	21, 777	859	0	90.00
91. 00   09100   EMERGENCY	0	94, 355		59, 587	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	Ĭ	, ,, 000	, 55, 515	07,007	ū	92.00
92. 01 09201 OBSERVATION BEDS-DISTINCT	0	21, 041	266, 434	7, 996	0	92. 01
OTHER REIMBURSABLE COST CENTERS	<u> </u>			· .		ĺ
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 731, 065	972, 257	8, 797, 375	6, 123, 419	9, 104, 201	118. 00
NONREI MBURSABLE COST CENTERS				al		
194. 00 07950 MI SCELLANEOUS	0	0	0	0		194. 00
194. 01 07951 PUBLI C RELATI ONS	0	240	0	U O		194. 01
194. 03 07952 LI GHTHOUSE 194. 04 07953 KI DS & FAMI LY		249 4, 679		O A		194. 03 194. 04
194. 05 07954 OTHER NON REIMBURABLE	0	4, 0/9 ∩	0	189		194. 04
194. 06 07955 GRANTS/TRI ALS		0	40	0		194. 06
194. 07 07956 RETAIL PHARMACY		0	0	ől		194. 07
200.00 Cross Foot Adjustments		0		Ĭ	Ü	200. 00
201.00 Negative Cost Centers	0	0	0	o		201.00
202.00 TOTAL (sum lines 118 through 201)	6, 731, 065	977, 185	8, 797, 415	6, 123, 608	9, 104, 201	202. 00
	·		·	·		

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/24/2022 5: 22 pm INTERNS & RESIDENTS SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER PARAMED ED MEDI CAL Cost Center Description RECORDS & Y & FRINGES PRGM. COSTS **PRGM** LI BRARY 22.00 23.00 16.00 17.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 418, 251 16.00 01700 SOCIAL SERVICE 17.00 5, 862, 937 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21 00 0 1 217 570 21 00 22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 0 C 1, 921, 802 22.00 02300 PARAMED ED PRGM-(SPECIFY) 365, 387 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 30 00 1,837,329 1, 574, 197 633.364 999 695 0 31.00 03100 INTENSIVE CARE UNIT 137,082 866, 874 132, 971 209, 881 0 31.00 03400 SURGICAL INTENSIVE CARE UNIT 110, 532 34.00 66, 846 0 34.00 124, 078 43.00 04300 NURSERY 94, 013 0 o 0 43.00 04400 SKILLED NURSING FACILITY 121, 503 0 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 479, 395 50.00 05000 OPERATING ROOM 811,654 0 0 0 05100 RECOVERY ROOM 51.00 68. 409 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 220, 287 15.814 24, 961 52.00 122, 452 0 52.00 52.01 03190 OP INFUSION 117, 674 18,640 29, 422 0 52.01 05300 ANESTHESI OLOGY 53 00 0 14,076 40, 914 64, 579 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 305, 389 0 0 54.00 0 05500 RADI OLOGY-THERAPEUTI C 0 0 55 00 204, 156 0 0 55.00 7, 038 05600 RADI OI SOTOPE 0 0 56.00 56.00 0 57.00 05700 CT SCAN 0 0 10, 557 0 57.00 05800 MRI 0 58.00 41.749 0 58.00 0 05900 CARDIAC CATHETERIZATION 0 0 59.00 297, 085 0 59.00 60.00 06000 LABORATORY 0 180, 255 0 0 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 7.038 63.00 06500 RESPIRATORY THERAPY 15, 074 65.00 26, 491 23, 792 Λ 65.00 75, 376 66.00 06600 PHYSI CAL THERAPY 0000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 3, 772 0 67.00 0 11, 796 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 62, 567 38, 223 60, 330 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 130, 624 70.00 07001 SLEEP LAB 0 0 70.01 70.01 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71 00 C Ω 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 365, 387 73.00 73.00 07697 CARDIAC REHABILITATION 76.97 34, 429 0 76.97 0 07698 HYPERBARIC OXYGEN THERAPY 76. 98 36, 597 0 0 76. 98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 245, 656 26, 379 41, 636 0 90.00 91 00 09100 EMERGENCY 1 029 468 804.744 296 191 467 506 91 00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 09201 OBSERVATION BEDS-DISTINCT 92.01 92.01 0 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95 00 0 0 0 0 0 95 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS\_(SUM OF LINES 1 through 117) 118.00 5, 418, 251 5, 862, 937 1, 217, 570 1, 921, 802 365, 387 118. 00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 0 0 194. 00 C 0 194. 01 194. 01 07951 PUBLIC RELATIONS 0 0 0 0 0 194. 03 07952 LI GHTHOUSE 0 0 0 194. 03 0 194.04 07953 KIDS & FAMILY 0 0 0 0 194, 04 194. 05 07954 OTHER NON REIMBURABLE 0 0 0 194. 05 0 0 194. 06 07955 GRANTS/TRI ALS 0 0 0 194.06 0 194. 07 07956 RETAIL PHARMACY 0 194. 07 C 0 200.00 Cross Foot Adjustments 0 0 200.00 201.00 Negative Cost Centers 0 0 201.00

Health Financial Systems	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/24/2022 5:2		
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE		RESIDENTS  RSERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM		
	16.00	17. 00	21. 00	22.00	23. 00		
202.00 TOTAL (sum lines 118 through 201)	5, 418, 251	5, 862, 937	1, 217, 570	1, 921, 802	365, 387	202. 00	

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/24/2022 5:22 pm	Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0041

					1	5/24/2022 5:2	
		Cost Center Description	Subtotal	Intern &	Total		
				Residents Cost			
				& Post			
				Stepdown Adjustments			
			24. 00	25. 00	26. 00		
	GENER	AL SERVICE COST CENTERS	21100	20100	20.00		
1.00		CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	1	ADMINISTRATIVE & GENERAL					5. 00
6.00		MAINTENANCE & REPAIRS					6. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	1	HOUSEKEEPI NG					9. 00
10. 00		DI ETARY					10.00
11. 00	1	CAFETERI A					11. 00
13.00	1	NURSING ADMINISTRATION					13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY					14. 00
15. 00	1	PHARMACY					15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY					16. 00
17. 00	1	SOCIAL SERVICE					17. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM. COSTS APPRVD					21. 00 22. 00
22. 00 23. 00		PARAMED ED PRGM-(SPECIFY)					23. 00
23.00		IENT ROUTINE SERVICE COST CENTERS					23.00
30. 00		ADULTS & PEDIATRICS	86, 864, 891	0	86, 864, 891		30.00
31.00	1	INTENSIVE CARE UNIT	44, 049, 777	0	44, 049, 777		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5, 445, 522	0	5, 445, 522		34.00
43.00		NURSERY	4, 784, 408	0	4, 784, 408		43. 00
44. 00		SKILLED NURSING FACILITY	4, 115, 020	0	4, 115, 020		44. 00
F0 00		LARY SERVICE COST CENTERS	04 000 047	ما	04 000 047		
50.00		OPERATING ROOM	21, 209, 017	0	21, 209, 017		50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	2, 647, 695 6, 881, 388	0	2, 647, 695 6, 881, 388		51. 00 52. 00
52. 00	1	OP INFUSION	3, 605, 394	0	3, 605, 394		52. 00
53. 00		ANESTHESI OLOGY	363, 456	0	363, 456		53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	12, 822, 854	0	12, 822, 854		54.00
55.00	05500	RADI OLOGY-THERAPEUTI C	11, 338, 995	0	11, 338, 995		55. 00
56.00		RADI OI SOTOPE	2, 077, 981	0	2, 077, 981		56. 00
57. 00	1	CT SCAN	2, 898, 715	0	2, 898, 715		57. 00
58. 00	05800	1	2, 132, 235	0	2, 132, 235		58. 00
59.00	1	CARDI AC CATHETERI ZATI ON	7, 663, 613	0	7, 663, 613		59.00
60. 00 63. 00	1	LABORATORY BLOOD STORING, PROCESSING & TRANS.	19, 446, 229 2, 584, 379	0	19, 446, 229 2, 584, 379		60. 00 63. 00
65. 00	1	RESPIRATORY THERAPY	4, 900, 635	0	4, 900, 635		65. 00
66. 00	1	PHYSI CAL THERAPY	5, 167, 392	0	5, 167, 392		66. 00
67. 00		OCCUPATI ONAL THERAPY	1, 383, 334	0	1, 383, 334		67. 00
68.00	06800	SPEECH PATHOLOGY	395, 672	0	395, 672		68. 00
69. 00		ELECTROCARDI OLOGY	4, 464, 956	0	4, 464, 956		69. 00
70. 00		ELECTROENCEPHALOGRAPHY	2, 121, 720	0			70. 00
		SLEEP LAB	1, 126	0	1, 126		70. 01
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	24, 893, 113	0	24, 893, 113		71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	19, 925, 364 64, 066, 580	0	19, 925, 364 64, 066, 580		72. 00 73. 00
76. 97		CARDI AC REHABI LI TATI ON	682, 118	0	682, 118		76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	561, 286	0	561, 286		76. 98
		TIENT SERVICE COST CENTERS	22., 200				1
90.00	09000	CLINIC	2, 667, 991	0	2, 667, 991		90. 00
91. 00	1	EMERGENCY	27, 910, 985	0	27, 910, 985		91. 00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
92. 01		OBSERVATI ON BEDS-DI STI NCT	4, 910, 535	0	4, 910, 535	L	92. 01
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	1 102 442	٥	1 102 442		95. 00
95.00		AL PURPOSE COST CENTERS	1, 193, 643	0	1, 193, 643		95.00
113 00		INTEREST EXPENSE					113. 00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	406, 178, 019	0	406, 178, 019		118. 00
		IMBURSABLE COST CENTERS	., -, -, -, -,	<u> </u>			1
194.00	07950	MI SCELLANEOUS	0	0	0		194. 00
		PUBLIC RELATIONS	660	0	660		194. 01
	1	LI GHTHOUSE	72, 319	0	72, 319		194. 03
		KIDS & FAMILY	5, 677	0	5, 677		194. 04
		OTHER NON REIMBURABLE	348, 948	0	348, 948		194. 05
		GRANTS/TRIALS RETAIL PHARMACY	12, 842	0	12, 842 0		194. 06 194. 07
200.00		Cross Foot Adjustments	0	0	0		200. 00
200.00	1	Negative Cost Centers	0	0			201.00
	1	1 -3	9	۷۱		·	

Health Financial Systems	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 31-0041	Peri od: From 01/01/2021 To 12/31/2021		
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24. 00	25. 00	26.00			
202.00 TOTAL (sum lines 118 through 201)	406, 618, 465	0	406, 618, 4	65	202	2. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Part | I | Prepared: | From 12/31/2021 | Pre Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0041

Country   Discription   Disc						То	12/31/2021	Date/Time Prep 5/24/2022 5: 2:	
COLUMN   C					CAPI TAL REI	LATED COSTS			
Column   C			Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
Belland Stray of Cost Chitese   1.00			· ·	Assigned New					
								DEPARIMENT	
1.00					1.00	2.00	2A	4. 00	
2.00	1 00								1 00
5.00   000000 ADM INSTRATIVE & CEMERAL   163,779   560,155   2,615,807   3,339,789   6,600   5.00   000000 ADM INSTRATIVE & CEMENAL   163,779   17,711   184,5718   435,718   643,670   7,466   7,000   10,000   1	2.00	00200	CAP REL COSTS-MVBLE EQUIP						
0.00   0.00		1	l e e e e e e e e e e e e e e e e e e e	-					
2.00   007000   PERATI NO 0   PLANT   54,834   173,118   425,718   633,670   2,464   2,00   1,00   0,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00   0,00   1,00				163, 779					
9.00   00000   DIETREY N	7.00	00700	OPERATION OF PLANT	54, 834	173, 118	425, 718	653, 670	2, 464	7. 00
10.00   010000   IETARY		1		0	_	-	-	-	
11.00 0 10100 CAFETERIA									
14.00   01400  CENTRAL SERVICES & SUPPLY   129, 304   431, 495   253, 688   814, 487   1, 311   14, 00   10.00   10.00   MEDICAL RECORDS & LIBRARY   7, 992   107, 001   24   177, 007   1, 991   10, 00   10.00   1	11. 00	01100	CAFETERI A	0	187, 710	7, 850	195, 560	433	11. 00
15.00   01500				1					
16. 00   01-600   MERICAL RECORDS & LIBRARY   9,082   167,061   24   177,067   1,981   16,00   170.00				1					
21.00   0.0100   IAR SERVICES-SALARY & FRINGES APPRIVD   0   0   0   0   0   22.550   564   21.00   20.00	16.00	01600	MEDICAL RECORDS & LIBRARY	1					16. 00
22.00				0	-	- 1	-		
23.00   0.300   PARAMED ED PROM. (SPECIFY)   0   0   0   0   64   23.00				22, 250					
30.00   3000   ADULTS & PEDIATRICS   24, 741   2, 327, 887   78, 502   2, 431, 130   21, 646   30.00   31.00   310.00		02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		
31.0 0 3100 (INTENSIVE CARE UNIT 1 15,759 1,281,914 102,234 1,399,907 15,639 31.00 43.0 0 3400 (SURGICAL INTENSIVE CARE UNIT 1 3,423 99,851 12,175 114,452 1,199 34.0 0 43.0 0 3400 (SURGICAL INTENSIVE CARE UNIT 1 3,423 99,851 12,175 114,452 1,199 34.0 0 43.0 0 3400 (SURGICAL INTENSIVE CARE UNIT 1 88 179,675 2,02 181,765 1,600 44.0 0 4400 (SURLIED NURSING FACILITY 88 179,675 2,02 181,765 1,600 44.0 0 4400 (SURLIED NURSING FACILITY 88 1,000 64.0 0 44.	20.00			24 741	2 227 007	79 502	2 421 120	21 646	20 00
34. 00   03400   NURSERY   0   139,023   13,550   152,573   1,869   43. 00		03000	INTENSIVE CARE UNIT	1					
44. 00   04400   SKILLED NURSING FACILITY   88   179, 675   2, 022   181, 785   1, 606   44, 00	34.00	03400	SURGICAL INTENSIVE CARE UNIT	3, 423	98, 851	12, 178		1, 999	
MOST   LLARY SERVICE COST CENTERS   50. 00   50.00   05000   PERATING ROOM   2.30, 990   708, 918   2,105, 336   3.045, 244   5.129   50. 01   51. 00   05100   PERATING ROOM   2.253   101, 161   30, 558   133, 972   1.036   51. 00   52. 01   03790   DELIVERY ROOM & LABOR ROOM   5.900   325, 755   42,092   373, 747   2.328   52. 00   52. 01   03790   DELIVERY ROOM & LABOR ROOM   5.900   325, 755   42,092   373, 747   2.328   52. 00   52. 01   03790   DELIVERY ROOM & LABOR ROOM   5.018   174, 014   0   204, 199   1.070   52. 01   53. 00   05300   ARESTHESI OLGGY   729   20, 815   5.011   2.65, 555   58   53. 01   54. 00   05400   RADIOLOGY-DIAGNOSTIC   30, 118   451, 603   782, 033   1, 263, 754   3, 712   54. 00   55. 00   05500   RADIOLOGY-THERAPEUTIC   8.238   301, 901   447, 528   757, 667   2, 532   55. 00   55. 00   05500   RADIOLOGY-THERAPEUTIC   8.238   301, 901   447, 528   757, 667   2, 532   55. 00   55. 00   05500   RADIOLOGY-THERAPEUTIC   8.238   301, 901   447, 528   757, 667   2, 532   55. 00   55. 00   05500   RADIOLOGY-THERAPEUTIC   8.388   301, 901   447, 528   757, 667   2, 532   55. 00   55. 00   05500   RADIOLOGY-THERAPEUTIC   8.388   301, 901   447, 528   757, 667   2, 532   55. 00   55. 00   05500   RADIOLOGY-THERAPEUTIC   8.388   301, 901   447, 528   757, 667   2, 532   55. 00   55. 00   05500   RADIOLOGY-THERAPEUTIC   8.388   301, 901   447, 561   40, 900   60. 00   06000   LABORATORY   8.34   40, 93, 322   375, 592   832, 748   2, 101   590   60. 00   06000   LABORATORY   8.34   40, 40, 93, 322   375, 592   832, 748   2, 101   590   60. 00   05000   RESPIRATION   FIREPAPY   9.515   111, 464   24, 222   145, 501   60. 00   05000   PHYSICAL THERAPY   9.515   111, 464   24, 222   145, 501   60. 00   05000   PHYSICAL THERAPY   9.515   111, 464   24, 222   145, 501   60. 00   05000   PHYSICAL THERAPY   9.515   111, 464   24, 222   145, 501   60. 00   05000   PHYSICAL THERAPY   9.515   111, 464   24, 222   141, 501   60. 00   05000   PHYSICAL THERAPY   9.515   111, 464   24, 222   141, 501				1					
50.00	44.00	ANCI L	LARY SERVICE COST CENTERS	00	179, 075	2, 022	161, 760	1,000	44.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   5,000   325,755   42,002   373,747   2,328   52.00   53.00   05300   ANESTHESIOLOGY   729   20,815   5,011   26,555   58   53.00   54.00   05400   RADIOLOGY-THERAPEUTIC   8,238   301,901   447,528   757,667   2,532   55.00   05500   RADIOLOGY-THERAPEUTIC   8,238   301,901   447,528   757,667   2,532   55.00   05500   RADIOLOGY-THERAPEUTIC   8,238   301,901   447,528   757,667   2,532   55.00   05500   RADIOLOGY-THERAPEUTIC   8,238   301,901   447,528   757,667   2,532   55.00   05700   CT SCAN   6,494   15,611   0   22,105   930   57.00   05700   CT SCAN   6,494   15,611   0   22,105   930   57.00   05900   CADURITORY   60,438   439,322   375,592   823,748   2,019   89.00   05900   CADURITORY   60,438   439,322   375,592   823,748   2,019   89.00   05900   CADURITORY   70,408   439,432   439,322   375,592   823,748   2,019   89.00   05900   CADURITORY   70,408									
52 01   03190   OP INFUSION   30,1815   174,014   0   204,199   1,070   52,015   54,00   05400   ARDIDLOGY - DIAGNOSTIC   30,118   451,603   782,033   1,263,754   3,712   54,00   50,00   05500   ARDIDLOGY - PIRRAPEUTIC   8,238   301,901   447,528   757,667   2,532   55,00   05500   ARDIDLOGY - PIRRAPEUTIC   8,238   301,901   447,528   757,667   2,532   55,00   05500   ARDIDLOGY - PIRRAPEUTIC   8,238   301,901   447,528   757,667   2,532   55,00   05500   ARDIDLOGY - PIRRAPEUTIC   8,238   301,901   447,528   757,667   2,532   55,00   05500   ARDIDLOGY - PIRRAPEUTIC   8,238   301,901   447,528   757,667   2,532   55,00   05500   ARDIDLOGY - PIRRAPEUTIC   8,238   301,901   447,528   757,667   2,532   55,00   05500   ARDIDLOGY - PIRRAPEUTIC   1,470   10,408   188,088   199,966   348   56,00   05800   05800   MRI   0 0 0 1,410   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
54. 00   05400   RADI OLOGY-DI ACNOSTIC   30,118   451,603   782,033   1,263,754   3,712   54. 00   55. 00   05500   RADI OLOGY-DI ENCANSTIC   8,238   301,901   447,529   757,667   2,522   55. 00   56. 00   05600   RADI OLOGY-THERAPEUT C   1,470   10,408   188,088   199,966   348   56. 00   20,700   CT SCAN   6,494   15,611   0   22,105   93.0   57. 00   570,00   CT SCAN   6,494   15,611   0   22,105   93.0   57. 00   570,00   CT SCAN   6,494   15,611   0   0   22,105   93.0   57. 00   570,00   CT SCAN   6,494   15,611   0   0   22,105   93.0   57. 00   570,00   CT SCAN   6,494   15,611   0   0   22,105   93.0   57. 00   570,00   CT SCAN   6,494   15,611   0   0   22,105   93.0   57. 00   570,00   CARDI AC CATHETERI ZATI ON   8,834   439,322   823,748   2,019   59.00   63.00   06800   CABDIA ATORY   GARDIAR ATORY   16,742   266,557   13,967   441,266   3,703   60.00   63.00   06800   CABDIA ATORY   HERRAPY   30,608   39,174   170,198   239,980   1,922   65.00   66.00   66.00   06800   CESPI RATORY   HERRAPY   9,515   111,464   24,222   145,201   2,249   66.00   66.00   06600   COCUMATI ONAL   HERRAPY   0   5,578   682   67.00   67									
55 00   05500   RADIO LOGY-THERAPEUTIC   8,238   301, 901   447,528   757,667   2,522   55 00		1	l e e e e e e e e e e e e e e e e e e e	1					
56.00   05-00   05-00   05-00   CADDIO I SOTOPE   1.470   1.470   1.408   188, 088   199, 966   348   56.00   57.00   157-00									
58.00   05800   MR    0   05900   CARDIA C CATHETERIZATION   8.834   439, 22   375, 592   823, 748   2, 019   59, 00									
59. 00         05900 CARDIAC CATHETERI ZATION         8,834         439,322         375,592         823,748         2,019 59,00         60.00           60. 00         06000 LABORATORY         160,742         266,557         13,967         441,266         3,703 60.00           63. 00         06500 BLOOD STORING, PROCESSING & TRANS.         0         10,408         0         10,408         0         10,408         0         63.00           65. 00         06500 RESEPIRATORY THERAPY         30,608         39,174         170,198         239,980         1,992 65.00         66.00           67. 00         06700 OCCUPATIONAL THERAPY         9,515         111,464         24,222         145,201         2,249 66.00         66.00           69. 00         06900 ELECTROCARDIOLOCY         0         17,443         2,130         19,573         165 68.00         68.00           69. 00         06900 ELECTROCARDIOLOCY         10,067         92,523         55,707         158,297         1,568 69.00         69.00           70. 01         170.01         170.01         15,578         0         0         0         0         0         0         1,558         69.00         0           70. 01         170.01         170.01         170.01<		1		6, 494					
60.00   06000   LABORATORY   160,742   266,557   13,967   441,266   3,703   60.00		1		0 8 834					
65.00   06500   RESPI RATORY THERAPY   30,608   39,174   170,198   239,980   1,992   65.00				1					
66.00   06600   PHYSI CAL THERAPY   9,515   111, 464   24,222   145,201   2,249   66.00   67.00   06700   OCCUPATI ONAL THERAPY   0   5,578   0   5,578   682   67.00   68.00   06800   SPEECH PATHOLOGY   0   17,443   2,130   19,573   165   68.00   69.00   06800   SPEECH PATHOLOGY   10,067   92,523   55,707   158,297   1,568   69.00   69.00   06900   ELECTROCARDI OLOGY   10,067   92,523   55,707   158,297   1,568   69.00   70.00   70700   ELECTROCRECEPHALGGRAPHY   120   193,163   111,111   305,194   455   70.00   70.01   07001   SLEEP LAB   0   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   74.97   07697   CARDIA CR EHABIL LITATION   5,679   50,914   1,903   58,496   229   76.97   76.98   07698   HYPERBARI C OXYGEN THERAPY   0   54,119   0   54,119   0   76.98   79.00   07000   CLINIC C   0   0   0   11,542   11,542   303   90.00   79.00   07000   CLINIC C   0   0   0   11,542   11,542   303   90.00   79.00   07000   DESERVATION BEDS ON SERVATION SEDS ON SERVATION SEDS ON SUBJECT OF SERVATION SEDS ON SUBJECT O				0				-	
67 00   06700   05CUPATI ONAL THERAPY   0   5,578   0   5,578   682   67. 00				1					
69.00   06900   ELECTROCARDIOLOGY   10,067   92,523   55,707   158,297   1,568   69.00				1 _1					
70. 00   07000   ELECTROENCEPHALOGRAPHY   120   193, 163   111, 911   305, 194   455   70. 00   0   0   0   0   0   0   0   0				0					
70. 01   0700   SLEEP LAB									
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   73. 00   73.00   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   73. 00				0	0	0	0		
73. 00		1		0	0	0	0	-	
76. 97   07697   CARDI AC REHABI LI TATI ON   5, 679   50, 914   1, 903   58, 496   229   76. 97   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   54, 119   0   54, 119   0   76. 98   00   00   00   00   00   00   00				0	0	0	0	-	
OUTPATI ENT SERVI CE COST CENTERS   O   O   11, 542   11, 542   303   90.00		07697	CARDIAC REHABILITATION	5, 679	50, 914	1, 903	58, 496		
90. 00	76. 98		I.	0	54, 119	0	54, 119	0	76. 98
91. 00	90. 00			O	0	11. 542	11. 542	303	90. 00
92. 01	91.00	09100	EMERGENCY	67, 652					91. 00
95. 00 OTHER REIMBURSABLE COST CENTERS  95. 00 OF OF ON				2.7/0	0		0	2 070	
95. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   0   0   95. 00	92.01		l.	2, 709	0	l o	2, 709	2,070	92.01
113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 057, 729 10, 893, 642 9, 237, 788 21, 189, 159 112, 118 118.00 NONREI MBURSABLE COST CENTERS  194. 00 07950 MI SCELLANEOUS 0 0 0 0 0 0 0 194. 00 194. 01 194. 01 07951 PUBLI C RELATIONS 0 0 0 0 0 0 0 194. 01 194. 03 07952 LI GHTHOUSE 0 0 0 0 0 0 0 32 194. 01 194. 04 07953 KI DS & FAMILY 194. 05 07954 OTHER NON REI MBURABLE 0 0 0 57, 487 194. 06 07955 GRANTS/TRI ALS 0 0 0 10, 144 10, 144 0 194. 05 194. 07 07956 RETAI L PHARMACY 0 0 0 0 0 0 0 0 194. 07	95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95. 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   1,057,729   10,893,642   9,237,788   21,189,159   112,118   118.00	112 00								112 00
NONREI   MBURSABLE COST CENTERS   194. 00   07950   MI SCELLANEOUS   0   0   0   0   0   194. 00				1, 057, 729	10, 893. 642	9, 237, 788	21, 189, 159		
194. 01       07951       PUBLI C RELATIONS       0       0       0       0       194. 01         194. 03       07952       LI GHTHOUSE       0       0       0       0       0       32       194. 03         194. 04       07953       KI DS & FAMI LY       0       0       0       0       0       194. 04         194. 05       07954       OTHER NON REI MBURABLE       0       0       57, 487       57, 487       314       194. 05         194. 06       07955       GRANTS/TRI ALS       0       0       10, 144       10, 144       0       194. 06         194. 07       07956       RETAI L PHARMACY       0       0       0       0       0       0       194. 07		NONRE	MBURSABLE COST CENTERS		., ,	, , , , ,			
194. 03 07952 LI GHTHOUSE 0 0 0 0 0 32 194. 03 194. 04 07953 KI DS & FAMI LY 0 0 0 0 0 0 194. 04 194. 05 07954 OTHER NON REI MBURABLE 0 0 0 57, 487 57, 487 314 194. 05 194. 06 07955 GRANTS/TRI ALS 0 0 10, 144 10, 144 0 194. 06 194. 07 07956 RETAI L PHARMACY 0 0 0 0 0 0 194. 07							0		
194. 04     07953     KI DS & FAMI LY     0     0     0     0     194. 04       194. 05     07954     07HER NON REI MBURABLE     0     0     57, 487     57, 487     314     194. 05       194. 06     07955     GRANTS/TRI ALS     0     0     10, 144     10, 144     0     194. 06       194. 07     07956     RETAI L PHARMACY     0     0     0     0     0     194. 07					0		0	32	194. 03
194. 06   07955   GRANTS/TRI ALS   0   0   10, 144   10, 144   0   194. 06   194. 07   07956   RETAI L PHARMACY   0   0   0   0   194. 07	194. 04	07953	KIDS & FAMILY		0	0	o	0	194. 04
194. 07 07956 RETAIL PHARMACY 0 0 0 0 194. 07					0				
					0	10, 144			
200.00	200.00		Cross Foot Adjustments				o		200. 00

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part II   Date/Time Pre	nared·
				12/01/2021	5/24/2022 5: 2	2 pm
		CAPI TAL REI	_ATED COSTS			
	5	DI DO 4 FINT			5451 0V55	
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	1, 057, 729	10, 893, 642	9, 305, 41	9 21, 256, 790	112, 464	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/24/2022 5:22 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 5.00 9.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 3, 346, 479 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 8, 240 51, 533 6.00 00700 OPERATION OF PLANT 117, 243 7.00 876 774, 253 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 10, 547 10.547 8.00 219, 319 00900 HOUSEKEEPI NG 9.823 9.00 65.937 643 9 00 10.00 01000 DI ETARY 52,060 1, 141 17, 440 102 1, 321 10.00 11.00 01100 CAFETERI A 5, 349 950 14, 514 0 1, 107 11.00 01300 NURSING ADMINISTRATION 13.00 71,050 7.099 13 00 464 0 0 14.00 01400 CENTRAL SERVICES & SUPPLY 43, 529 2, 183 33, 364 119 3, 785 14.00 15.00 01500 PHARMACY 72,651 570 8,710 0 1, 178 15.00 01600 MEDICAL RECORDS & LIBRARY 41, 402 12, 918 0 16, 00 845 0 16,00 01700 SOCIAL SERVICE 46, 113 17.00 C 0 0 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 9, 958 0 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 15, 799 22.00 22 00 0 0 02300 PARAMED ED PRGM-(SPECIFY) 2, 989 23.00 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 551, 425 179, 998 2,889 101, 339 30.00 11, 777 30.00 03100 INTENSIVE CARE UNIT 31.00 287, 236 6, 485 99, 121 2, 226 20, 282 31.00 03400 SURGICAL INTENSIVE CARE UNIT 7,643 3, 821 34.00 36, 452 500 182 34.00 43.00 04300 NURSERY 34,674 703 10, 750 0 393 43.00 44.00 04400 SKILLED NURSING FACILITY 28, 159 909 13, 893 183 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 147.087 3, 586 54, 815 626 4,642 50.00 51.00 05100 RECOVERY ROOM 18, 433 512 7,822 124 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 43, 744 52.00 1,648 25, 188 324 7, 320 52.00 14, 890 03190 OP INFUSION 20. 254 880 13, 455 109 52.01 52.01 05300 ANESTHESI OLOGY 53.00 1,738 105 1.609 0 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 94, 565 2, 285 34, 919 396 4, 142 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 86, 422 1, 527 23, 344 0 1,857 55.00 56 00 05600 RADI OI SOTOPE 16 495 53 805 88 1 000 56 00 05700 CT SCAN 57.00 23,037 79 1, 207 0 1,500 57.00 58.00 05800 MRI 14, 518 312 4,774 82 5, 820 58.00 59.00 05900 CARDIAC CATHETERIZATION 49, 565 2.223 33.969 92 11, 534 59.00 154, 036 06000 LABORATORY 60.00 1, 349 20, 611 17 2, 250 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS 21,081 53 805 0 0 63.00 06500 RESPIRATORY THERAPY 65.00 38, 991 198 3,029 0 500 65.00 66 00 06600 PHYSI CAL THERAPY 40, 209 105 66 00 8.619 Ω 564 06700 OCCUPATIONAL THERAPY 67.00 11, 240 28 431 0 0 67.00 06800 SPEECH PATHOLOGY 2,928 1, 349 0 68.00 68.00 88 0 69.00 06900 ELECTROCARDI OLOGY 33, 248 468 7, 154 93 69.00 0 07000 ELECTROENCEPHALOGRAPHY 14, 936 70 00 63 70 00 13, 764 977 0 70.01 07001 SLEEP LAB C 0 0 0 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 178, 703 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 142, 221 0 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73 00 449, 323 C 0 76. 97 07697 CARDIAC REHABILITATION 4, 391 258 3, 937 0 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 76.98 3.496 274 4, 185 144 0 76.98 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 10 942 0 90 00 91.00 09100 EMERGENCY 6,020 92, 017 2, 583 30, 638 91.00 173, 841 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09201 OBSERVATION BEDS-DISTINCT 0 0 92.01 37, 981 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 9,823 0 0 95.00 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 342, 898 51, 533 774, 253 10, 547 219, 319 118. 00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 0 0 0 194, 00 0 194. 01 07951 PUBLIC RELATIONS 5 0 0 C 0 194, 01 194. 03 07952 LI GHTHOUSE 0 0 0 194. 03 593 0 0 194.04 07953 KIDS & FAMILY 0 0 194. 04 8 194. 05 07954 OTHER NON REIMBURABLE 0 0 194, 05 2.870 C 0 194. 06 0 194. 06 07955 GRANTS/TRI ALS 105 C 0 194. 07 07956 RETAIL PHARMACY 0 0 194. 07 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 3, 346, 479 51, 533 774, 253 10, 547 219, 319 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

				72/31/2021	5/24/2022 5: 2	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11. 00	13. 00	SUPPLY 14.00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					i	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					1	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL					1	5.00
6. 00 00600 MAI NTENANCE & REPAI RS					i	6.00
7.00 00700 OPERATION OF PLANT					i	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					1	8.00
9. 00 00900 HOUSEKEEPI NG					i	9.00
10. 00 01000 DI ETARY	355, 803				1	10.00
11. 00   01100   CAFETERI A	0	217, 913	1		i	11.00
13.00 01300 NURSING ADMINISTRATION	o	5, 439			1	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	o	4, 742	0	903, 520	i	14. 00
15. 00 01500 PHARMACY	o	7, 740	o	3, 846	275, 745	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	5, 741	10, 236	o	0	16. 00
17. 00 01700 SOCIAL SERVICE	o	3, 810	23, 118	o	0	17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	o	1, 700	o	o	0	21. 00
22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	o	470	o	o	0	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	o	493	o	ol	0	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	201, 449	51, 209	289, 571	8, 975	0	30.00
31.00 03100 INTENSIVE CARE UNIT	135, 494	34, 137	195, 237	8, 021	0	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	10, 283	3, 840	29, 318	559	0	34.00
43. 00   04300 NURSERY	o	3, 237	10, 685	o	0	43.00
44.00 04400 SKILLED NURSING FACILITY	8, 577	2, 268	9, 622	397	0	44. 00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM	0	10, 004	60, 776	4, 952	0	50.00
51.00   05100   RECOVERY ROOM	o	1, 610	15, 498	72	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	4, 531	32, 825	1, 256	0	52.00
52. 01 03190 OP INFUSION	o	2, 271		334	0	52. 01
53. 00 05300 ANESTHESI OLOGY	o	233		2	0	1
54. 00   05400 RADI OLOGY-DI AGNOSTI C	o	8, 696		1, 219	0	1
55. 00   05500 RADI OLOGY-THERAPEUTI C	o	4, 841		61	0	1
56. 00   05600 RADI OI SOTOPE	o	543		41	0	1
57. 00   05700 CT SCAN	o	2, 009		o	0	1
58. 00   05800   MRI	l ol	1, 034		ol	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	l ol	3, 303		1, 078	0	
60. 00   06000   LABORATORY	l ol	10, 399		1, 489	0	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	1
65. 00 06500 RESPI RATORY THERAPY	l ol	4, 088	o	121	0	
66. 00 06600 PHYSI CAL THERAPY	0	5, 237		29	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 177		0	0	
68. 00 06800 SPEECH PATHOLOGY	0	337		ol	0	
69. 00 06900 ELECTROCARDI OLOGY		4, 019		198	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		1, 042		1, 518	0	
70. 01   07001   SLEEP LAB		., 0.2	0	., 5.0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	l o	0	1	469, 065	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	l o	0	.1	390, 139	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0	1	0/0/10/	275, 745	•
76. 97 07697 CARDI AC REHABI LI TATI ON	l o	405	1	21	0	•
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0		0	Ö	
OUTPATIENT SERVICE COST CENTERS	<u> </u>		,	٥,	J	70.70
90. 00 09000 CLINIC	O	476	2, 075	127	0	90.00
91. 00 09100 EMERGENCY		21, 041		8, 792	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	]	= 1, 5 1.	,	-,		92.00
92. 01 09201 OBSERVATION BEDS-DISTINCT	0	4, 692	25, 386	1, 180	0	1
OTHER REIMBURSABLE COST CENTERS	<u>ا</u>	4, 072	25, 500	1, 100		/2.01
95. 00 09500 AMBULANCE SERVICES	ol	0	0	O	0	95. 00
SPECIAL PURPOSE COST CENTERS	١		,	<u> </u>		70.00
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	355, 803	216, 814	838, 236	903, 492	275, 745	
NONREI MBURSABLE COST CENTERS	000,000	210,011	000, 200	700, 172	270,710	1110.00
194. 00 07950 MI SCELLANEOUS	ol	0	o	ol	n	194. 00
194. 01 07951 PUBLIC RELATIONS		0		ő		194. 01
194. 03 07952  LI GHTHOUSE		56	1	٥		194. 01
194. 04 07953 KI DS & FAMI LY		1, 043	•	٥		194. 03
194. 05 07954 OTHER NON REI MBURABLE		1, 043		28		194. 04
194.06 07955 GRANTS/TRIALS		0		20 ^		194. 05
194. 07 07956 RETALL PHARMACY		0		٥		194. 00
200.00 Cross Foot Adjustments	١	U	7	٩	U	200.00
201.00 Negative Cost Centers		0			0	200.00
202.00 TOTAL (sum lines 118 through 201)	355, 803	217, 913	838, 240	903, 520		
202. 00    TOTAL (Sum Times The till ough 201)	1 333, 603	217, 713	. 330, 240	703, 320	275, 145	1-02.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0041

			1	0 12/31/2021	Date/lime Pre   5/24/2022 5:2	
		<b>'</b>	INTERNS &	RESI DENTS	7 07 2 17 2022 012	
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVI CES-OTHER PRGM. COSTS	PARAMED ED PRGM	
	16.00	17. 00	21.00	22.00	23. 00	
GENERAL SERVICE COST CENTERS   1.00						1. 00 2. 00 4. 00 5. 00 6. 00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE 21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRVD 22. 00 02200 L&R SERVICES-OTHER PRGM. COSTS APPRVD	250, 190 0 0	74, 962 0 0	34, 472	16, 506		7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 21. 00 22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) I NPATIENT ROUTINE SERVICE COST CENTERS	0	0		·	3, 646	1
30. 00	84, 840 6, 330 5, 104 5, 729 0	20, 125 11, 084 855 1, 202 1, 554				30. 00 31. 00 34. 00 43. 00 44. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM 51. 00   05100   RECOVERY ROOM	37, 478 0	6, 129 875				50. 00 51. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 52. 01   03190   OP   NFUSI ON 53. 00   05300   ANESTHESI OLOGY	5, 654 0 0	2, 817 1, 505 180				52. 00 52. 01 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C 56. 00   05600   RADI OI SOTOPE	0 0	3, 905 2, 610 90				54. 00 55. 00 56. 00
57. 00   05700 CT SCAN 58. 00   05800 MRI	0	135 534				57. 00 58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	0	3, 798 2, 305				59. 00 60. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS. 65. 00   06500   RESPIRATORY THERAPY 66. 00   06600   PHYSICAL THERAPY	0	90 339 964				63. 00 65. 00 66. 00
67.00 06700 OCCUPATIONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	48 151				67. 00 68. 00
69. 00   06900  ELECTROCARDI OLOGY 70. 00   07000  ELECTROENCEPHALOGRAPHY 70. 01   07001  SLEEP LAB	0 0	800 1, 670 0				69. 00 70. 00 70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				71.00
73.00   07300   DRUGS CHARGED TO PATIENTS 76.97   07697   CARDIAC REHABILITATION	0	0 440				73. 00 76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	468				76. 98
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	57, 519 47, 536	0 10, 289				90. 00 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.01 09201 OBSERVATION BEDS-DISTINCT	0	0				92. 00 92. 01
95. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0				95. 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	250, 190	74, 962	0	0	0	113. 00 118. 00
NONREI MBURSABLE COST CENTERS  194. 00 17950 MI SCELLANEOUS	0	0				194. 00
194. 01 07951 PUBLI C RELATI ONS 194. 03 07952 LI GHTHOUSE 194. 04 07953 KI DS & FAMI LY	0	0				194. 01 194. 03 194. 04
194. 05 07954 OTHER NON REI MBURABLE 194. 06 07955 GRANTS/TRI ALS	0	0				194. 04 194. 05 194. 06
194.07/07956 RETAIL PHARMACY 200.00 Cross Foot Adjustments	0	0	34, 472	16, 506		194. 07 200. 00
201.00 Negative Cost Centers	0	0	0	l o	0	201. 00

Health Financial Systems	COMMUNITY MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/24/2022 5:2	
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE		RESI DENTS  SERVI CES-OTHER PRGM. COSTS	PARAMED ED PRGM	
	16.00	17. 00	21.00	22. 00	23. 00	
202.00 TOTAL (sum lines 118 through 201)	250, 190	74, 962	34, 472	16, 506	3, 646	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0041

					To 12/31/2021	Date/Time Prepared: 5/24/2022 5:22 pm
	Cost Center Description	Subtotal	Intern &	Total		37 2 47 2022 3. 22 pm
			Residents Cost & Post			
			Stepdown			
		24. 00	Adjustments 25.00	26. 00	-	
_	GENERAL SERVICE COST CENTERS					
	DO100 CAP REL COSTS-BLDG & FLXT DO200 CAP REL COSTS-MVBLE EQUIP					1.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
	00600 MAINTENANCE & REPAIRS					6.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
1	00900 HOUSEKEEPI NG					9. 00
1	D1000 DI ETARY					10.00
1	D1100 CAFETERIA D1300 NURSING ADMINISTRATION					11. 00
	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	D1500 PHARMACY					15. 00
	01600 MEDICAL RECORDS & LIBRARY					16.00
	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD					17. 00 21. 00
1	D2200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD					22. 00
	D2300 PARAMED ED PRGM-(SPECIFY)					23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	3, 956, 373	O	3, 956, 37	2	30.00
	03100 INTENSIVE CARE UNIT	2, 221, 199		2, 221, 19		31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	215, 008	l	215, 00		34.00
	04300 NURSERY	221, 815		221, 81		43.00
	04400 SKILLED NURSING FACILITY NNCILLARY SERVICE COST CENTERS	248, 407	0	248, 40	/	44. 00
	D5000 OPERATING ROOM	3, 380, 468	0	3, 380, 46	8	50.00
4	D5100 RECOVERY ROOM	179, 954		179, 95		51.00
	D5200 DELIVERY ROOM & LABOR ROOM D3190 OP INFUSION	501, 382 271, 435	0	501, 38 271, 43		52. 00 52. 01
	D5300 ANESTHESI OLOGY	30, 480		30, 48		53. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	1, 426, 062	0	1, 426, 06		54. 00
1	D5500 RADI OLOGY-THERAPEUTI C	888, 722	0	888, 72		55. 00
	D5600 RADI 0I SOTOPE D5700 CT SCAN	219, 429 51, 002	0	219, 42 51, 00		56. 00 57. 00
1	05800 MRI	454, 271	0	454, 27		58. 00
1	D5900 CARDI AC CATHETERI ZATI ON	951, 345	0	951, 34		59. 00
	D6000 LABORATORY D6300 BLOOD STORING, PROCESSING & TRANS.	637, 450 32, 437	0	637, 45 32, 43		60.00
	06500 RESPIRATORY THERAPY	289, 238		289, 23		65. 00
	06600 PHYSI CAL THERAPY	203, 177	0	203, 17		66. 00
1	06700 OCCUPATI ONAL THERAPY	19, 184	0	19, 18		67. 00
1	D6800 SPEECH PATHOLOGY D6900 ELECTROCARDI OLOGY	24, 591 214, 645	0	24, 59 214, 64		68. 00 69. 00
4	07000 ELECTROENCEPHALOGRAPHY	339, 802	Ö	339, 80	_	70. 00
70. 01	07001 SLEEP LAB	13		1		70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	647, 768 532, 360		647, 76 532, 36		71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	725, 068		725, 06		73.00
76. 97	07697 CARDIAC REHABILITATION	71, 482	0	71, 48		76. 97
	D7698 HYPERBARIC OXYGEN THERAPY DUTPATIENT SERVICE COST CENTERS	62, 686	0	62, 68	6	76. 98
	09000 CLINIC	82, 984	O	82, 98	4	90.00
4	09100 EMERGENCY	1, 945, 339		1, 945, 33		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	74.070	0	74.07		92.00
	D9201 OBSERVATION BEDS-DISTINCT OTHER REIMBURSABLE COST CENTERS	74, 078	0	74, 07	8	92. 01
	09500 AMBULANCE SERVICES	9, 823	0	9, 82	3	95. 00
	SPECIAL PURPOSE COST CENTERS					
113. 00 1 118. 00	I1300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	21 120 477	0	21 120 47	7	113. 00 118. 00
<u> </u>	NONREI MBURSABLE COST CENTERS	21, 129, 477	U <sub>I</sub>	21, 129, 47	/	118.00
194.00	07950 MI SCELLANEOUS	0	0		0	194. 00
	07951 PUBLIC RELATIONS	5	0		5	194. 01
	D7952 LI GHTHOUSE D7953 KI DS & FAMI LY	681 1, 051	0	68 1, 05		194. 03 194. 04
1	07955 KTD3 & FAMILET 07954 OTHER NON REIMBURABLE	60, 699	o	60, 69		194. 04
194.06	07955 GRANTS/TRI ALS	10, 253	0	10, 25	3	194. 06
	07956 RETAIL PHARMACY	0 E4 424	0		0	194. 07
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	54, 624 0		54, 62	0	200. 00 201. 00
	1.109421.10 0001 00111010		·		-1	1201.00

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/24/2022 5:2	
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24. 00	25. 00	26. 00			
202.00   TOTAL (sum lines 118 through 201)	21, 256, 790	0	21, 256, 79	0		202. 00

	Financial Systems	COMMUNITY MEL		011 04 0044		eu of Form CMS-	
COST	ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre	pared:
						5/24/2022 5: 2	
		CAPITAL RE	LATED COSTS				
		DI DO A FILVE	I 10/01 5 50/11 5				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
		(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
				DEPARTMENT		(ACCUM COST)	
				(GROSS			
		1.00	2.00	SALARI ES)	ГА	F 00	
	CENEDAL CEDALCE COCT CENTEDO	1.00	2. 00	4. 00	5A	5. 00	
1 00	GENERAL SERVICE COST CENTERS	F22 2FF					1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT	523, 355	l				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	F 400	7, 864, 458				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 403	1		1	220 /// 541	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	26, 911	1 ' '				5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	1, 663 8, 317				836, 362 11, 900, 429	1
8. 00	00800 LAUNDRY & LINEN SERVICE	0, 317	1	1		1	1
9. 00	00900 HOUSEKEEPING	6, 103	1				1
10.00	01000 DI ETARY	10, 836					
11. 00	01100 CAFETERI A	9, 018			1		
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 411	1		1		1
14. 00	01400 CENTRAL SERVICES & SUPPLY	20, 730	1		1		1
15. 00	01500 PHARMACY	5, 412					
		8, 026	1	1			
17. 00	01700 SOCIAL SERVICE	0,020	l		1	l	
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD		_	774, 71	1	l	
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD		1	1	1		1
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			1	1		
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		,	220,01	٥,	000,070	20.00
30. 00	03000 ADULTS & PEDI ATRI CS	111, 837	66, 346	29, 736, 94	2 0	55, 962, 222	30.00
31. 00	03100   NTENSI VE CARE UNI T	61, 586	1				1
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	4, 749	1		1		1
43. 00	04300 NURSERY	6, 679	1		1		
44. 00	04400 SKILLED NURSING FACILITY	8, 632	1				•
	ANCILLARY SERVICE COST CENTERS	2,000	.,	17 1227 12	-1		1
50.00	05000 OPERATI NG ROOM	34, 058	1, 779, 322	7, 045, 30	0 0	14, 929, 683	50.00
51.00	05100 RECOVERY ROOM	4, 860		1	1		•
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 650	1		1		
52. 01	03190 OP INFUSION	8, 360		1	1		
53. 00	05300 ANESTHESI OLOGY	1,000				1	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 696	1		1		
55.00	05500 RADI OLOGY-THERAPEUTI C	14, 504	1		1	1	1
56.00	05600 RADI 0I SOTOPE	500	1		1		1
57.00	05700 CT SCAN	750		1		l	
58.00	05800 MRI	2, 966	308, 441	694, 16	3 0	l	
59.00	05900 CARDI AC CATHETERI ZATI ON	21, 106	317, 431	2, 773, 50	o o	5, 030, 986	59.00
60.00	06000 LABORATORY	12, 806	11, 804	5, 086, 20	4 0	15, 635, 036	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	500	0	)	o o	2, 139, 729	63.00
65.00	06500 RESPI RATORY THERAPY	1, 882	143, 843	2, 736, 36	2 0	3, 957, 670	65.00
66.00	06600 PHYSI CAL THERAPY	5, 355	20, 471	3, 089, 39	3 0	4, 081, 324	66.00
67.00	06700 OCCUPATI ONAL THERAPY	268	0	936, 28	3 0		
68.00	06800 SPEECH PATHOLOGY	838	1, 800	226, 13	5 0	297, 218	68. 00
69.00	06900 ELECTROCARDI OLOGY	4, 445	47, 081	2, 154, 14	0	3, 374, 714	
70.00	07000 ELECTROENCEPHALOGRAPHY	9, 280	94, 581	625, 42	3 0	1, 397, 040	70.00
70. 01	07001  SLEEP LAB	0	0	5, 19	9 0	941	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	18, 138, 715	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	14, 435, 721	•
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	45, 607, 293	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 446		314, 78	9 0	445, 671	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 600	0	1	0	354, 865	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	9, 755	415, 60	1 0	1, 110, 633	90.00
91. 00	09100 EMERGENCY	57, 172	180, 564	11, 654, 19	4 0	17, 645, 208	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	0	0	2, 843, 22	3 0	3, 855, 168	92. 01
	OTHER REIMBURSABLE COST CENTERS	1	1	1	1		
95. 00	09500 AMBULANCE SERVICES	0	0		0	997, 103	95. 00
	SPECIAL PURPOSE COST CENTERS	ı	1	1	1		l
	11300 I NTEREST EXPENSE	500.055	7 007 000	454.040.40			113. 00
118.00	, ,	523, 355	7, 807, 300	154, 010, 13	-66, 951, 924	339, 302, 925	1118.00
104 5	NONREI MBURSABLE COST CENTERS	-			-1	-	104 22
	07950 MI SCELLANEOUS	0	<u> </u>	1	0	l e	194. 00
	07951 PUBLI C RELATIONS	0	<u> </u>		)  -  -		194. 01
	3 07952 LI GHTHOUSE	0	<u>0</u>	43, 48	0	l	194. 03
	07953 KIDS & FAMILY		0	404.07			194. 04
	07954 OTHER NON REIMBURABLE		48, 585		1	291, 334	
	07955 GRANTS/TRI ALS	0			0		194.06
194.07	07956 RETAIL PHARMACY	0	0	"	0	1 0	194. 07

Health Fina	ancial Systems	COMMUNITY MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
					From 01/01/2021 Fo 12/31/2021	Date/Time Pre 5/24/2022 5:2	
		CAPITAL REL	_ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
				(GROSS SALARI ES)		(Accom cost)	
		1. 00	2.00	4.00	5A	5. 00	
200.00	Cross Foot Adjustments					l	200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	10, 893, 642	9, 305, 419	32, 834, 97	7	66, 951, 924	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	20. 815015	1. 183224	0. 21254	1	0. 197111	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			112, 46	1	3, 346, 479	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0.00072	3	0. 009852	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

Provider CCN: 31-0041

				1	0 12/31/2021	Date/lime Pre 5/24/2022 5:2	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DIETARY (MEALS SERVED)	
		6. 00	7. 00	8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA	489, 378 8, 317 0 6, 103 10, 836 9, 018	481, 061 0 6, 103 10, 836	18, 299	6, 142	407, 965 0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
13. 00 14. 00 15. 00 16. 00 17. 00 21. 00 22. 00 23. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVI CE 02100 I &R SERVI CES-SALARY & FRINGES APPRVD 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY)	4, 411 20, 730 5, 412 8, 026 0 0	4, 411	0 21, 454 0 0 0 0 0	0	0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 21. 00 22. 00 23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		-				
30. 00 31. 00 34. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04300 NURSERY 04400 SKILLED NURSING FACILITY	111, 837 61, 586 4, 749 6, 679 8, 632	4, 749	32, 836 0	568	230, 982 155, 358 11, 791 0 9, 834	
50. 00 51. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05100 RECOVERY ROOM	34, 058 4, 860 15, 650	4, 860	22, 359	0	0 0	50.00 51.00
52. 00 52. 01 53. 00 54. 00	O5200   DELI VERY ROOM & LABOR ROOM   O3190   OP I NFUSI ON   O5300   ANESTHESI OLOGY   O5400   RADI OLOGY - DI AGNOSTI C	8, 360 1, 000 21, 696	8, 360	19, 685 0	417 0	0	52. 00 52. 01 53. 00 54. 00
55. 00 56. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN	14, 504 500 750	14, 504 500 750	0 15, 843 0	52 28 42	0 0 0	55. 00 56. 00 57. 00
58. 00 59. 00 60. 00 63. 00 65. 00	O5800   MRI   O5900   CARDI AC   CATHETERI ZATI ON   O6000   LABORATORY   O6300   BLOOD   STORI NG,   PROCESSI NG & TRANS.   O6500   RESPI RATORY   THERAPY	2, 966 21, 106 12, 806 500 1, 882	21, 106 12, 806 500 1, 882	16, 619 3, 042 0 0		0 0 0 0	58. 00 59. 00 60. 00 63. 00 65. 00
66. 00 67. 00 68. 00 69. 00 70. 00	O6600  PHYSI CAL THERAPY   O6700  OCCUPATI ONAL THERAPY   O6800  SPEECH PATHOLOGY   O6900  ELECTROCARDI OLOGY   O7000  ELECTROENCEPHALOGRAPHY	5, 355 268 838 4, 445 9, 280	268 838 4, 445	0 0 16, 779	0 0 0	0 0 0 0	66. 00 67. 00 68. 00 69. 00 70. 00
70. 01	07001 SLEEP LAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0	l		_	0 0	
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	2, 446 2, 600				0	76. 97 76. 98
90. 00 91. 00 92. 00 92. 01	O9000   CLINI C   O9100   EMERGENCY   O9200   OBSERVATION BEDS (NON-DISTINCT PART   O9201   OBSERVATION BEDS-DISTINCT   OTHER REIMBURSABLE COST CENTERS	0 57, 172 0		0 464, 848 0	0 858 0	0	
95. 00	O9500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	95. 00
113. 00 118. 00	11300 INTEREST EXPENSE	489, 378	481, 061	1, 897, 864	6, 142	407, 965	113. 00 118. 00
194. 01 194. 03 194. 04	07950 MI SCELLANEOUS 07951 PUBLI C RELATI ONS 07952 LI GHTHOUSE 07953 KI DS & FAMI LY 07954 OTHER NON REIMBURABLE	0 0 0 0	l	0 0 0 0	0 0 0 0	0 0 0	194. 00 194. 01 194. 03 194. 04 194. 05
194.06	07955 GRANTS/TRIALS 07956 RETAIL PHARMACY Cross Foot Adjustments	0	0	0	0	0	194. 05 194. 06 194. 07 200. 00 201. 00

Health Fina	ancial Systems	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCA	ATION - STATISTICAL BASIS		Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre 5/24/2022 5:2	pared:	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DIETARY (MEALS SERVED)		
		6. 00	7. 00	8. 00	9. 00	10.00		
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 001, 218	14, 263, 150	1, 281, 56	2 8, 205, 376	6, 731, 065	202. 00	
203.00	Unit cost multiplier (Wkst. B, Part I)	2. 045899	29. 649358	0. 67526	5 1, 335. 945295	16. 499124	203. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	51, 533	774, 253	10, 54	7 219, 319	355, 803	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 105303	1. 609469	0. 00555	7 35. 708076	0. 872141	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	

	LLOCATION - STATISTICAL BASIS	COMMONTTT MEE	Provider CC	CN: 31-0041 Pe	eri od:	Worksheet B-1	
					om 01/01/2021	Date/Time Pre 5/24/2022 5:2	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Z pili
	·	(FTES)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			(DIRECT NRSING	SUPPLY (COSTED	REQUIS.)	LIBRARY (TIME SPENT)	
			HRS)	REQUIS.)		(TIME SPENT)	
		11.00	13.00	14. 00	15. 00	16. 00	
1 00	GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FIXT						1 00
1. 00 2. 00	00200 CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	4/0.005					10.00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	160, 825 4, 014					11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	3, 500		36, 789, 307			14. 00
15. 00	01500 PHARMACY	5, 712		156, 606	45, 609, 863		15. 00
	01600 MEDI CAL RECORDS & LI BRARY	4, 237		0	0	•	16.00
	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	2, 812 1, 255		0	0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	347	1	0	o	0	1
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	364	0	0	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	37, 791	461, 098	365, 434	ol	3, 391	30.00
	03100 INTENSIVE CARE UNIT	25, 194			0	253	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	2, 834	46, 684	22, 753	О	204	
	04300 NURSERY	2, 389			0	229	
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	1, 674	15, 322	16, 178	0	0	44.00
50.00	05000 OPERATI NG ROOM	7, 383	96, 776	201, 649	0	1, 498	50.00
51. 00	05100 RECOVERY ROOM	1, 188			0	0	
52. 00 52. 01	05200 DELIVERY ROOM & LABOR ROOM 03190 OP INFUSION	3, 344 1, 676			0	226 0	1
	05300 ANESTHESI OLOGY	172		13, 377	o	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 418			0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	3, 573		2, 498	0	0	
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	401 1, 483		1, 650 0	0	0	
58. 00	05800 MRI	763		0	Ö	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 438		43, 894	0	0	59.00
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	7, 675		60, 639 0	0	0	
65. 00	06500 RESPIRATORY THERAPY	3, 017	1	4, 946	Ö	0	1
66. 00	06600 PHYSI CAL THERAPY	3, 865		1, 169	0	0	
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	869 249		0	0	0	1
69. 00	06900 ELECTROCARDI OLOGY	2, 966		8, 044	0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	769		61, 811	0	0	1
70. 01	07001 SLEEP LAB	C	0	0	0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS			19, 099, 122 15, 885, 781	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	C	o o	0	45, 609, 863	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	299		840	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	C	0	0	0	0	76. 98
90. 00	09000 CLINIC	351	3, 304	5, 158	0	2, 299	90.00
91. 00	09100 EMERGENCY	15, 529		357, 987	O	1, 900	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.4/2	40 424	40.027		0	92.00
92. 01	O9201   OBSERVATION   BEDS-DISTINCT     OTHER REIMBURSABLE COST CENTERS	3, 463	8 40, 424	48, 037	0	0	92. 01
95.00	09500 AMBULANCE SERVICES	C	0	0	0	0	95. 00
110.00	SPECIAL PURPOSE COST CENTERS		T T		T		1112 00
113.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	160, 014	1, 334, 761	36, 788, 170	45, 609, 863	10 000	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	100,014	1,334,701	30, 700, 170	+3, 007, 003	10,000	1110.00
	07950 MI SCELLANEOUS	C	0	0	0		194. 00
	07951 PUBLI C RELATI ONS 07952 LI GHTHOUSE	C 41	1	0	0		194. 01 194. 03
	07952 LIGHTHOUSE 07953 KIDS & FAMILY	770		0	ol Ol		194. 03
	07954 OTHER NON REI MBURABLE	,,,		1, 137	ő	0	194. 05
	07955 GRANTS/TRI ALS	C	6	0	О	0	194. 06
194. 07 200. 00	07956 RETAIL PHARMACY Cross Foot Adjustments	C	9	0	0	0	194. 07 200. 00
200.00							201. 00
	· -		'	'	'		

Heal th Fi	nancial Systems	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLO	OCATION - STATISTICAL BASIS		Provi der CO	CN: 31-0041	Peri od:	Worksheet B-1		
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 5:2		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		(FTES)	ADMI NI STRATI ON		(COSTED	RECORDS &		
				SUPPLY	REQUIS.)	LI BRARY		
			(DIRECT NRSING	(COSTED		(TIME SPENT)		
			HRS)	REQUIS.)				
		11. 00	13. 00	14. 00	15. 00	16. 00		
202. 00	Cost to be allocated (per Wkst. B, Part I)	977, 185	8, 797, 415	6, 123, 60	9, 104, 201	5, 418, 251	202. 00	
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 076076	6. 590974	0. 16645	0. 199610	541. 825100	203. 00	
204.00	Cost to be allocated (per Wkst. B, Part II)	217, 913	838, 240	903, 52	275, 745	250, 190	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part II)	1. 354970	0. 628005	0. 02455	0. 006046	25. 019000	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	

	FINANCIAI SYSTEMS	COMMUNITY MED		CN 21 0041 F		W
COST P	LLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2021	Worksheet B-1
					To 12/31/2021	Date/Time Prepared:
						5/24/2022 5: 22 pm
			I NTERNS &	RESI DENTS		
	Cost Center Description	SOCIAL SERVICE	CEDVICES SALAD	DEEDVI CES OTHER	PARAMED ED	
	cost center bescription	SOCIAL SERVICE	Y & FRINGES	PRGM. COSTS	PRGM	
		(SQUARE FEET)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		(SQS/IKE TEET)	TIME)	TIME)	TIME)	
		17. 00	21.00	22.00	23.00	
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FLXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL					5. 00
6.00	00600 MAI NTENANCE & REPAI RS					6.00
7.00	00700 OPERATION OF PLANT					7. 00 8. 00
8. 00 9. 00	OO8OO  LAUNDRY & LINEN SERVICE   OO9OO  HOUSEKEEPING					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17.00	01700 SOCIAL SERVICE	416, 525				17. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	36, 187	'		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0		36, 187	7	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0			1, 141	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS	111, 837	18, 824		1	30.00
31.00	03100   NTENSI VE CARE UNI T	61, 586	3, 952			31.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	4, 749	0			34.00
43.00	04300 NURSERY	6, 679	0	1		43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	8, 632	0	) (	0	44. 00
50. 00	05000 OPERATING ROOM	34, 058	0		o	50.00
51. 00	05100 RECOVERY ROOM	4, 860	0	1		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	15, 650	470			52. 00
52. 01	03190 OP INFUSION	8, 360	554		1	52. 01
53. 00	05300 ANESTHESI OLOGY	1,000	1, 216		1	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	21, 696	0	) .,	-	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	14, 504	Ö			55. 00
56. 00	05600 RADI OI SOTOPE	500	0			56.00
57. 00	05700 CT SCAN	750	O	1	1	57. 00
58.00	05800  MRI	2, 966	0		ol ol	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	21, 106	0	)	0	59. 00
60.00	06000 LABORATORY	12, 806	0			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	500	0	) (	1	63. 00
65. 00	06500 RESPI RATORY THERAPY	1, 882	448	1		65. 00
	06600 PHYSI CAL THERAPY	5, 355	0	) (	0	66. 00
	06700 OCCUPATI ONAL THERAPY	268	0		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	838	0	) (		68.00
69. 00	06900 ELECTROCARDI OLOGY	4, 445	1, 136	1, 136		69.00
70. 00 70. 01	07000  ELECTROENCEPHALOGRAPHY   07001  SLEEP LAB	9, 280	0			70. 00 70. 01
70. 01	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		-	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	, o	0		1, 141	73. 00
	07697 CARDI AC REHABI LI TATI ON	2, 446	0		.,	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	2, 600	0			76. 98
	OUTPATIENT SERVICE COST CENTERS			•	'	
90.00	09000 CLI NI C	0	784	. 784	1 0	90.00
91.00	09100 EMERGENCY	57, 172	8, 803	8, 803	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	0	0	)	0	92. 01
	OTHER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVICES	0	0	)  (	0	95. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE	417 505	2/ 107	2/ 10	, , , , ,	113.00
118.00		416, 525	36, 187	36, 187	7 1, 141	118. 00
104 00	NONREI MBURSABLE COST CENTERS 07950 MI SCELLANEOUS	0			0	194. 00
	07950 MI SCELLANEOUS 07951 PUBLI C RELATI ONS		0		1	194. 00
	07952 LI GHTHOUSE					194. 03
	07953 KIDS & FAMILY					194. 04
	07954 OTHER NON REIMBURABLE	0	) n		-	194. 05
	07955 GRANTS/TRI ALS	l ő	Ö		-	194. 06
	07956 RETAIL PHARMACY	0	Ö		ol ol	194. 07
200.00						200. 00
		<u>'</u>			<u>'</u>	·

Heal th	Financial Systems	COMMUNITY MED	OLCAL CENTER		In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 5:2	
			INTERNS &	RESI DENTS			
	Cost Center Description	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHE PRGM. COSTS	R PARAMED ED PRGM		
		(SQUARE FEET)		(ASSI GNED	(ASSI GNED		
		(040/11/2 1221)	TIME)	TIME)	TIME)		
		17. 00	21.00	22. 00	23. 00		
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 862, 937	1, 217, 570	1, 921, 80	2 365, 387		202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	14. 075835	33. 646613	53. 10752	5 320. 234005		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	74, 962	34, 472	16, 50	6 3, 646		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 179970	0. 952607	0. 45613	3. 195443		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000		207. 00

				o 12/31/2021	Date/Time Pre 5/24/2022 5:2	pared:
		Title	XVIII	Hospi tal	PPS	Ζ μιιι
		11110	XVIII	Costs	113	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
555t 5511t61 55551 pt 1511	(from Wkst. B,	Adj.	1014. 00010	Di sal I owance	.014. 00010	
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	86, 864, 891		86, 864, 891	2, 222	86, 867, 113	30. 00
31.00 03100 INTENSIVE CARE UNIT	44, 049, 777		44, 049, 777	o	44, 049, 777	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	5, 445, 522		5, 445, 522	. 0	5, 445, 522	34.00
43. 00   04300   NURSERY	4, 784, 408		4, 784, 408	0	4, 784, 408	43.00
44.00 O4400 SKILLED NURSING FACILITY	4, 115, 020		4, 115, 020	0	4, 115, 020	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	21, 209, 017		21, 209, 017	0	21, 209, 017	50.00
51.00   05100   RECOVERY ROOM	2, 647, 695		2, 647, 695	0	2, 647, 695	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	6, 881, 388		6, 881, 388	0	6, 881, 388	52. 00
52.01   03190   OP   INFUSION	3, 605, 394		3, 605, 394	0	3, 605, 394	52. 01
53. 00   05300   ANESTHESI OLOGY	363, 456		363, 456		363, 456	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	12, 822, 854		12, 822, 854	I I	12, 822, 854	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	11, 338, 995		11, 338, 995		11, 338, 995	55. 00
56. 00   05600   RADI 0I SOTOPE	2, 077, 981		2, 077, 981		2, 077, 981	56. 00
57.00   05700   CT   SCAN	2, 898, 715		2, 898, 715	I I	2, 898, 715	57. 00
58. 00   05800   MRI	2, 132, 235		2, 132, 235		2, 132, 235	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	7, 663, 613		7, 663, 613		7, 663, 613	59. 00
60. 00   06000   LABORATORY	19, 446, 229		19, 446, 229	I I	19, 446, 229	60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 584, 379		2, 584, 379	I I	2, 584, 379	1
65. 00   06500   RESPI RATORY THERAPY	4, 900, 635	0	.,	I	4, 900, 635	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 167, 392	0			5, 167, 392	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 383, 334	0	,		1, 383, 334	67. 00
68. 00 06800 SPEECH PATHOLOGY	395, 672	0	395, 672	I .	395, 672	68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 464, 956		4, 464, 956		4, 488, 499	
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 121, 720		2, 121, 720	I I	2, 121, 720	1
70. 01   07001   SLEEP LAB	1, 126		1, 126		1, 126	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 893, 113		24, 893, 113	· •	24, 893, 113	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	19, 925, 364		19, 925, 364		19, 925, 364	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	64, 066, 580		64, 066, 580	I I	64, 066, 580	
76. 97 07697 CARDI AC REHABI LI TATI ON	682, 118		682, 118	1	682, 118	1
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	561, 286		561, 286	0	561, 286	76. 98
OUTPATIENT SERVICE COST CENTERS	2 //7 001		2 //7 001		2 //7 001	00.00
90. 00   09000  CLI NI C 91. 00   09100  EMERGENCY	2, 667, 991		2, 667, 991		2, 667, 991	90.00
	27, 910, 985		27, 910, 985	I I	27, 910, 985	1
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART 92.01   09201   OBSERVATION BEDS-DISTINCT	372, 410		372, 410		372, 410	
OTHER REIMBURSABLE COST CENTERS	4, 910, 535		4, 910, 535	ıj U	4, 910, 535	92. 01
95. 00 09500 AMBULANCE SERVI CES	1, 193, 643		1, 193, 643	l	1, 193, 643	95. 00
SPECIAL PURPOSE COST CENTERS	1, 193, 043		1, 193, 043	ı U	1, 193, 043	95.00
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	406, 550, 429	0	406, 550, 429	25, 765	406, 576, 194	
201. 00 Less Observation Beds	372, 410	0	372, 410	1	372, 410	1
202.00 Total (see instructions)	406, 178, 019	0			406, 203, 784	
232. 33	100, 170, 017	0	100, 170, 017	20, 700	100, 200, 104	1232.00

					-rom 01/01/2021 Го 12/31/2021	Part I Date/Time Pre 5/24/2022 5:2	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1 4/0 /00 /4	<b>-</b> I		
30.00	03000 ADULTS & PEDIATRICS	468, 622, 647		468, 622, 64			30.00
31. 00	03100 INTENSIVE CARE UNIT	389, 348, 300		389, 348, 30			31. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	36, 778, 200		36, 778, 20			34. 00
43. 00	04300 NURSERY	22, 284, 514		22, 284, 51			43. 00
44. 00	04400 SKILLED NURSING FACILITY	9, 463, 184		9, 463, 18	4		44. 00
FO 00	ANCILLARY SERVICE COST CENTERS	27 200 525	25 070 270	72 250 00	0.202141	0.000000	F0 00
50.00	05000 OPERATI NG ROOM	36, 380, 535	35, 970, 370			0.000000	
51.00	05100 RECOVERY ROOM	6, 903, 851	9, 068, 927			0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM 03190 OP INFUSION	20, 924, 634	7, 219, 619			0.000000	
52. 01	05300 ANESTHESI OLOGY	45, 544	13, 306, 251			0.000000	
53. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 210, 766	5, 543, 469			0. 000000 0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	29, 281, 624	38, 499, 201			0. 000000	
56. 00	05600 RADI OI SOTOPE	2, 276, 338	76, 325, 246			0. 000000	1
57. 00	05700 CT SCAN	2, 568, 641 52, 037, 334	3, 779, 815 51, 508, 747			0.00000	
58. 00	05800 MRI	15, 408, 589	12, 927, 658			0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	28, 292, 208	30, 775, 699			0.000000	
60.00	06000 LABORATORY	116, 786, 097	99, 698, 919			0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	13, 500, 723	3, 490, 864			0.000000	
65. 00	06500 RESPIRATORY THERAPY	25, 149, 197	1, 758, 517			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	14, 004, 723	7, 305, 517			0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	8, 124, 210	1, 691, 037			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	1, 643, 771	506, 739			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	22, 553, 670	41, 097, 195			0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 145, 003	6, 774, 962			0. 000000	
70. 01	07001 SLEEP LAB	2, 110, 000	0, 7, 1, 702		0. 000000	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 405, 355	8, 528, 849			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 042, 526	11, 608, 706			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	43, 538, 384	57, 275, 937			0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	2, 832, 637			0. 000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	3, 369, 774			0. 000000	
	OUTPATIENT SERVICE COST CENTERS	, -,					
90.00	09000 CLI NI C	90, 534	10, 409, 829	10, 500, 36	0. 254086	0.000000	90. 00
91.00	09100 EMERGENCY	93, 017, 140	136, 062, 600	229, 079, 74	0. 121840	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	975, 600	900, 050	1, 875, 65	0. 198550	0.000000	92. 00
92. 01	09201 OBSERVATION BEDS-DISTINCT	31, 401, 150	60, 590, 550	91, 991, 70	0. 053380	0.000000	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	120, 280	120, 28	9. 923869	0.000000	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
200.00	,	1, 519, 204, 992	738, 947, 997	2, 258, 152, 98	9		200. 00
201.00	1						201. 00
202.00	Total (see instructions)	1, 519, 204, 992	738, 947, 997	2, 258, 152, 98	9		202. 00

Heal th Financial Systems COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

			10 12/31/2021	5/24/2022 5: 22 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · · ·	
·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
43. 00   04300   NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCI LLARY SERVI CE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 293141			50.00
51.00   05100   RECOVERY ROOM	0. 165763			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 244504			52. 00
52.01  03190   OP   NFUSI ON	0. 270031			52. 01
53. 00   05300   ANESTHESI OLOGY	0. 041518			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 189181			54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 144259			55.00
56. 00   05600   RADI 0I SOTOPE	0. 327321			56. 00
57. 00  05700   CT   SCAN	0. 027994			57.00
58. 00   05800   MRI	0. 075248			58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 129742			59. 00
60. 00  06000   LABORATORY	0. 089827			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 152098			63. 00
65. 00  06500 RESPI RATORY THERAPY	0. 182128			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 242484			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 140937			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 183990			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 070517			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 237862			70.00
70. 01   07001   SLEEP LAB	0. 000000			70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 388024			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 808291			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 635491			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 240807			76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0. 166565			76. 98
OUTPATIENT SERVICE COST CENTERS	0.254004			00.00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	0. 254086			90.00
	0. 121840			91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	0. 198550			92. 00
92. 01 09201 OBSERVATI ON BEDS-DI STI NCT	0. 053380			92. 01
OTHER REIMBURSABLE COST CENTERS  95. 00   O9500   AMBULANCE SERVI CES	9. 923869			95. 00
SPECIAL PURPOSE COST CENTERS	7. 723009			95.00
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
202.00   10101 (300 111311 0011 0113)	ı			1202.00

				o 12/31/2021	Date/Time Pre 5/24/2022 5:2	epared:
		Ti tl	e XIX	Hospi tal	TEFRA	.z piii
		11 61	O ALX	Costs	TETTO	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
555t 5511t61 55551 pt 1511	(from Wkst. B,	Adj.	1014. 00010	Di sal I owance	.014. 00010	
	Part I, col.					
	26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	86, 864, 891		86, 864, 891	2, 222	86, 867, 113	30.00
31.00 03100 INTENSIVE CARE UNIT	44, 049, 777		44, 049, 777	O	44, 049, 777	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	5, 445, 522		5, 445, 522	el o	5, 445, 522	34.00
43. 00   04300 NURSERY	4, 784, 408		4, 784, 408	o	4, 784, 408	43.00
44.00 04400 SKILLED NURSING FACILITY	4, 115, 020		4, 115, 020	o	4, 115, 020	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	21, 209, 017		21, 209, 017	0	21, 209, 017	50. 00
51.00   05100   RECOVERY ROOM	2, 647, 695		2, 647, 695	0	2, 647, 695	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	6, 881, 388		6, 881, 388	0	6, 881, 388	52. 00
52. 01  03190 OP INFUSION	3, 605, 394		3, 605, 394	. 0	3, 605, 394	52. 01
53. 00   05300   ANESTHESI OLOGY	363, 456		363, 456	0	363, 456	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	12, 822, 854		12, 822, 854	0	12, 822, 854	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	11, 338, 995		11, 338, 995	0	11, 338, 995	55. 00
56. 00   05600   RADI 0I SOTOPE	2, 077, 981		2, 077, 981	0	2, 077, 981	56. 00
57. 00  05700 CT SCAN	2, 898, 715		2, 898, 715	0	2, 898, 715	57. 00
58. 00   05800   MRI	2, 132, 235		2, 132, 235	0	2, 132, 235	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	7, 663, 613		7, 663, 613	0	7, 663, 613	59. 00
60. 00  06000  LABORATORY	19, 446, 229		19, 446, 229	0	19, 446, 229	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 584, 379		2, 584, 379	0	2, 584, 379	63. 00
65. 00 06500 RESPIRATORY THERAPY	4, 900, 635	0	4, 900, 635	0	4, 900, 635	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 167, 392	0	5, 167, 392	0	5, 167, 392	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	1, 383, 334	0	1, 383, 334	0	1, 383, 334	67. 00
68.00  06800  SPEECH PATHOLOGY	395, 672	0	395, 672	0	395, 672	68. 00
69. 00  06900  ELECTROCARDI OLOGY	4, 464, 956		4, 464, 956	23, 543	4, 488, 499	69. 00
70. 00  07000  ELECTROENCEPHALOGRAPHY	2, 121, 720		2, 121, 720	0	2, 121, 720	70. 00
70. 01  07001   SLEEP LAB	1, 126		1, 126		1, 126	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 893, 113		24, 893, 113	0	24, 893, 113	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 925, 364		19, 925, 364	I I	19, 925, 364	1
73.00 07300 DRUGS CHARGED TO PATIENTS	64, 066, 580		64, 066, 580	0	64, 066, 580	73. 00
76. 97   07697   CARDIAC REHABILITATION	682, 118		682, 118	0	682, 118	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	561, 286		561, 286	0	561, 286	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	2, 667, 991		2, 667, 991	l l	2, 667, 991	1
91. 00   09100   EMERGENCY	27, 910, 985		27, 910, 985	1	27, 910, 985	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	372, 410		372, 410		372, 410	
92. 01 09201 OBSERVATION BEDS-DISTINCT	4, 910, 535		4, 910, 535	0	4, 910, 535	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	1, 193, 643		1, 193, 643	0	1, 193, 643	95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	406, 550, 429	0			406, 576, 194	
201.00 Less Observation Beds	372, 410	_	372, 410		372, 410	1
202.00   Total (see instructions)	406, 178, 019	0	406, 178, 019	25, 765	406, 203, 784	202.00

Date/Time Prepared: 12/31/2021 5/24/2022 5: 22 pm Title XIX Hospi tal TEFRA Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 468, 622, 647 468, 622, 647 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 389, 348, 300 389, 348, 300 31.00 03400 SURGICAL INTENSIVE CARE UNIT 36, 778, 200 36, 778, 200 34.00 34.00 43.00 04300 NURSERY 22, 284, 514 22, 284, 514 43.00 04400 SKILLED NURSING FACILITY 44.00 9, 463, 184 9, 463, 184 44.00 ANCILLARY SERVICE COST CENTERS 36, 380, 535 50 00 05000 OPERATING ROOM 35, 970, 370 72, 350, 905 0 293141 0 293141 50.00 05100 RECOVERY ROOM 6.903.851 9.068.927 15, 972, 778 0.165763 0.165763 51.00 51.00 7, 219, 619 05200 DELIVERY ROOM & LABOR ROOM 20, 924, 634 52.00 28, 144, 253 0.244504 0.244504 52 00 52.01 03190 OP INFUSION 45, 544 13, 306, 251 13, 351, 795 0.270031 0.270031 52.01 53.00 05300 ANESTHESI OLOGY 3, 210, 766 5, 543, 469 8, 754, 235 0.041518 0.041518 53.00 29, 281, 624 0. 189181 05400 RADI OLOGY-DI AGNOSTI C 38, 499, 201 67, 780, 825 0.189181 54.00 54.00 |05500| RADI OLOGY-THERAPEUTI C 55.00 2, 276, 338 76, 325, 246 78, 601, 584 0.144259 0.144259 55.00 56, 00 05600 RADI 0I SOTOPE 3, 779, 815 6, 348, 456 0.327321 0.327321 2, 568, 641 56.00 57.00 05700 CT SCAN 52, 037, 334 51, 508, 747 103, 546, 081 0.027994 0.027994 57.00 05800 MRI 15, 408, 589 12, 927, 658 28, 336, 247 0.075248 0.075248 58 00 58 00 59.00 05900 CARDIAC CATHETERIZATION 28, 292, 208 30, 775, 699 59, 067, 907 0. 129742 0.129742 59.00 06000 LABORATORY 116, 786, 097 99, 698, 919 216, 485, 016 0.089827 0.089827 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 13, 500, 723 3, 490, 864 16, 991, 587 0. 152098 0.152098 63.00 63.00 26, 907, 714 06500 RESPIRATORY THERAPY 65.00 25, 149, 197 1, 758, 517 0. 182128 0.182128 65.00 66.00 06600 PHYSI CAL THERAPY 14,004,723 7, 305, 550 21, 310, 273 0.242484 0.242484 66.00 06700 OCCUPATIONAL THERAPY 67.00 8, 124, 210 1, 691, 037 9, 815, 247 0.140937 0.140937 67.00 68 00 06800 SPEECH PATHOLOGY 1 643 771 506, 739 2 150 510 0 183990 0 183990 68 00 69.00 06900 ELECTROCARDI OLOGY 22, 553, 670 41, 097, 195 63, 650, 865 0.070148 0.070148 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 145, 003 6, 774, 962 8, 919, 965 0. 237862 0.237862 70.00 70.01 07001 SLEEP LAB 0.000000 0.000000 70.01 9, 405, 355 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 8, 528, 849 17, 934, 204 1.388024 1.388024 71.00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 13, 042, 526 11, 608, 706 24, 651, 232 0.808291 0.808291 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 43, 538, 384 57, 275, 937 100, 814, 321 0.635491 0.635491 73.00 76 97 07697 CARDIAC REHABILITATION 2 832 637 2 832 637 0 240807 0 240807 76 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 3, 369, 774 3, 369, 774 0.166565 0.166565 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90, 534 10, 409, 829 10, 500, 363 0. 254086 0. 254086 90.00 229, 079, 740 91 00 09100 EMERGENCY 93, 017, 140 0. 121840 0 121840 91 00 136, 062, 600 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 975,600 900, 050 1, 875, 650 0.198550 0.198550 92.00 09201 OBSERVATION BEDS-DISTINCT 60, 590, 550 91, 991, 700 0.053380 0.053380 92. 01 31, 401, 150 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 9. 923869 9. 923869 95.00 0 120, 280 120, 280 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 738, 947, 997 2, 258, 152, 989 200.00 Subtotal (see instructions) 1, 519, 204, 992 200. 00

1, 519, 204, 992

738, 947, 997 2, 258, 152, 989

201. 00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041 From 01/01/2021 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/24/2022 5:22 pm

					5/24/2022 5: 22 pm
			Title XIX	Hospi tal	TEFRA
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDIATRICS				30.00
31. 00	03100 INTENSIVE CARE UNIT				31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
43. 00	04300 NURSERY				43.00
44. 00	04400 SKILLED NURSING FACILITY				44.00
Í	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
50.00	05000 OPERATING ROOM	0. 000000			50.00
51. 00	05100 RECOVERY ROOM	0. 000000			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
	03190 OP INFUSION	0. 000000			52. 01
	05300 ANESTHESI OLOGY	0. 000000			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
	05600 RADI OI SOTOPE	0. 000000			56. 00
	05700 CT SCAN	0. 000000			57. 00
	05800 MRI	0. 000000			58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
	06000 LABORATORY	0. 000000			60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
	06500 RESPIRATORY THERAPY	0. 000000			65. 00
	06600 PHYSI CAL THERAPY	0. 000000			66. 00
	06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
	06800 SPEECH PATHOLOGY	0. 000000			68. 00
	06900 ELECTROCARDI OLOGY	0. 000000			69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
	07000 SLEEP LAB	0. 000000			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	07697 CARDI AC REHABILITATION	0. 000000			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
	OUTPATIENT SERVICE COST CENTERS	0.000000			70. 70
	09000 CLINIC	0. 000000			90.00
	09100 EMERGENCY	0. 000000			91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
	09201 OBSERVATION BEDS-DISTINCT PART	0. 000000			92.00
	OTHER REIMBURSABLE COST CENTERS	0.000000			92.01
	09500 AMBULANCE SERVICES	0.000000			95. 00
		0. 000000			95.00
	SPECIAL PURPOSE COST CENTERS 11300   INTEREST EXPENSE				113. 00
	· · · · · · · · · · · · · · · · · · ·				
200.00	Subtotal (see instructions)				200. 00
201.00					201. 00
202.00	Total (see instructions)				202. 00

REDUCT	TIONS FOR MEDICALD ONLY				To 12/31/2021		pared: 2 pm
			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -	-	Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	21, 209, 017	3, 380, 468				
51.00	05100 RECOVERY ROOM	2, 647, 695	179, 954	2, 467, 74	17, 995	143, 129	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 881, 388	501, 382	6, 380, 006	50, 138	370, 040	52.00
52. 01	03190 OP INFUSION	3, 605, 394	271, 435	3, 333, 959	27, 144	193, 370	52. 01
53.00	05300 ANESTHESI OLOGY	363, 456	30, 480	332, 976	3, 048	19, 313	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 822, 854	1, 426, 062	11, 396, 792	142, 606	661, 014	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	11, 338, 995	888, 722	10, 450, 273	88, 872	606, 116	55. 00
56.00	05600 RADI OI SOTOPE	2, 077, 981	219, 429	1, 858, 552	21, 943	107, 796	56.00
57.00	05700 CT SCAN	2, 898, 715	51, 002	2, 847, 713	5, 100	165, 167	57.00
58.00	05800 MRI	2, 132, 235		1, 677, 964	45, 427	97, 322	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	7, 663, 613	951, 345				59.00
60.00	06000 LABORATORY	19, 446, 229	637, 450	18, 808, 779	63, 745	1, 090, 909	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 584, 379					63.00
65. 00	06500 RESPI RATORY THERAPY	4, 900, 635					65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 167, 392					66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 383, 334	19, 184	· · ·			67. 00
68. 00	06800 SPEECH PATHOLOGY	395, 672	24, 591				68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 464, 956		·			
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 121, 720		· · ·			70.00
70. 01	07001 SLEEP LAB	1, 126	13			65	ı
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 893, 113	647, 768				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	19, 925, 364	532, 360	· · ·	· ·		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	64, 066, 580					1
76. 97	07697 CARDI AC REHABI LI TATI ON	682, 118					76. 97
76. <del>9</del> 7	07698 HYPERBARI C OXYGEN THERAPY	561, 286		·			76. 98
70. 90	OUTPATIENT SERVICE COST CENTERS	301, 200	02,000	490,000	0, 209	20, 919	70.90
90. 00	09000 CLINIC	2, 667, 991	82, 984	2, 585, 00	8. 298	149, 930	90.00
91.00	09100 EMERGENCY	27, 910, 985					91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	372, 410					91.00
	09201 OBSERVATION BEDS-DISTINCT PART	4, 910, 535					
92.01		4, 910, 535	74, 078	4, 836, 457	7, 408	280, 515	92.01
05 00	OTHER REIMBURSABLE COST CENTERS	1 100 (40	0.000	1 102 020	000	(0.772	05 00
95. 00	O9500   AMBULANCE   SERVI CES   SPECI AL   PURPOSE   COST   CENTERS	1, 193, 643	9, 823	1, 183, 820	982	68, 662	95. 00
112 00	11300 INTEREST EXPENSE	1		I	T	T	112 00
200.00		241 200 011	14 202 424	247 007 17	1 420 244	14 224 410	113.00
200.00		261, 290, 811	14, 283, 636				
201.00		372, 410 260, 918, 401		·			
202.00	p protai (fine 200 minus fine 201)	200, 918, 401	14, 266, 675	240, 001, 720	1, 426, 668	14, 305, 802	1202.00

Health Financial Systems	COMMUNITY MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST	TO CHARGE RATIOS NET OF	Provider CCN: 31-0041	From 01/01/2021	Worksheet C Part II Date/Time Prepared:

					10 12/31/2021	5/24/2022 5:	
			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent	•		
	<b>'</b>	Capital and	(Worksheet C,		e		
			Part I, column				
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	19, 836, 914	72, 350, 905	0. 27417	5		50.00
51.00	05100 RECOVERY ROOM	2, 486, 571					51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 461, 210	28, 144, 253	0. 22957!	5		52. 00
	03190 OP INFUSION	3, 384, 880					52. 01
53.00	05300 ANESTHESI OLOGY	341, 095			3		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 019, 234			5		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	10, 644, 007					55. 00
56. 00	05600 RADI 0I SOTOPE	1, 948, 242					56. 00
57. 00	05700 CT SCAN	2, 728, 448		0. 026350			57. 00
58. 00	05800 MRI	1, 989, 486					58. 00
	05900 CARDI AC CATHETERI ZATI ON	7, 179, 166		0. 12154 <sup>-</sup>			59. 00
60. 00	06000 LABORATORY	18, 291, 575					60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	2, 433, 122					63. 00
	06500 RESPI RATORY THERAPY	4, 604, 250					65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 859, 150					66. 00
	06700 OCCUPATI ONAL THERAPY	1, 302, 295					67. 00
	06800 SPEECH PATHOLOGY	371, 690					68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 196, 973					69. 00
	07000 ELECTROENCEPHALOGRAPHY	1, 984, 389					70.00
	07001 SLEEP LAB	1,060		0. 000000			70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 422, 106		1. 306002			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	18, 747, 334		0. 760503			72. 00
	07300 DRUGS CHARGED TO PATIENTS	60, 320, 265		0. 598330			73.00
	07697 CARDI AC REHABI LI TATI ON	639, 553					76. 97
	07698 HYPERBARI C OXYGEN THERAPY	526, 098		0. 156123			76. 98
70.70	OUTPATIENT SERVICE COST CENTERS	020,070	0,00,777	0. 10012	<u>- 1</u>		1 70. 70
90.00	09000 CLINIC	2, 509, 763	10, 500, 363	0. 23901	7		90.00
	09100 EMERGENCY	26, 210, 444					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	350, 098					92.00
	09201 OBSERVATI ON BEDS-DI STI NCT	4, 622, 612					92. 01
72.01	OTHER REIMBURSABLE COST CENTERS	1,022,012	71, 771, 700	0.00020	21		72.01
95. 00	09500 AMBULANCE SERVI CES	1, 123, 999	120, 280	9. 344854	1		95. 00
70.00	SPECIAL PURPOSE COST CENTERS	1,120,777	120, 200	7. 0 1 100	•		70.00
113 00	11300   I NTEREST EXPENSE						113. 00
200.00		245 536 029	1, 331, 656, 144				200. 00
201.00		350, 098					201.00
202.00			1, 331, 656, 144				202. 00
_52.00	1.500. (	5, 155, 751	, ., 55., 555, 144	ı	1		1-02.00

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	TAL COSTS	Provi der C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/24/2022 5:2	pared: 2 pm
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 956, 373	l e	0,,00,0,0	•	61. 23	
31.00   INTENSIVE CARE UNIT	2, 221, 199	l e	2, 221, 199			31.00
34.00 SURGICAL INTENSIVE CARE UNIT	215, 008		215, 008			34.00
43. 00 NURSERY	221, 815		221, 815	4, 846		43.00
44.00 SKILLED NURSING FACILITY	248, 407		248, 407	2, 770		
200.00 Total (lines 30 through 199)	6, 862, 802		6, 862, 802	119, 455		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	47, 475					30. 00
31.00 INTENSIVE CARE UNIT	4, 397	222, 576				31.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	)			34.00
43. 00 NURSERY	0	0	)			43.00
44.00 SKILLED NURSING FACILITY	1, 992					44.00
200.00 Total (lines 30 through 199)	53, 864	3, 308, 113				200. 00

	Financial Systems	COMMUNITY MED		CN 21 0041		u of Form CMS-2	2552-10
APPORT	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/24/2022 5:2	pared: 2 pm
			Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	•	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.			column 4)	
		Part II, col.	8)	2)	Ŭ	ŕ	
		26)	,	,			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	•	•				
50.00	05000 OPERATI NG ROOM	3, 380, 468	72, 350, 905	0. 04672	20, 424, 639	954, 300	50.00
51.00	05100 RECOVERY ROOM	179, 954	15, 972, 778	0. 01126	6 3, 674, 454	41, 396	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	501, 382	28, 144, 253	0. 01781	5 25, 718	458	52.00
52. 01	03190 OP INFUSION	271, 435	13, 351, 795	0. 02032	.9	0	52. 01
53. 00	05300 ANESTHESI OLOGY	30, 480				4, 608	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 426, 062				212, 841	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	888, 722			1, 156, 048	13, 071	55.00
56. 00	05600 RADI OI SOTOPE	219, 429	6, 348, 456	0. 03456	1, 086, 060	37, 539	56.00
57.00	05700 CT SCAN	51, 002	103, 546, 081	0.00049	23, 940, 694	11, 803	57.00
58. 00	05800 MRI	454, 271				107, 486	
59. 00	05900 CARDI AC CATHETERI ZATI ON	951, 345				88, 859	59.00
60.00	06000 LABORATORY	637, 450	216, 485, 016	0. 00294			60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	32, 437	16, 991, 587	0.00190	6, 377, 902	12, 175	63.00
65. 00	06500 RESPIRATORY THERAPY	289, 238	26, 907, 714	0. 01074	9 10, 355, 679	111, 313	65.00
66. 00	06600 PHYSI CAL THERAPY	203, 177				72, 030	
67. 00	06700 OCCUPATI ONAL THERAPY	19, 184				8, 096	67.00
68. 00	06800 SPEECH PATHOLOGY	24, 591					
69. 00	06900 ELECTROCARDI OLOGY	214, 645					69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	339, 802	8, 919, 965	0. 03809	1, 029, 727	39, 227	70.00
70. 01	07001 SLEEP LAB	13		1		0	70.01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	647, 768	17, 934, 204	0. 03611	9 3, 652, 394	131, 921	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	532, 360				128, 705	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	725, 068				172, 455	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	71, 482				0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	62, 686			0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS	•		•	•		1
90.00	09000 CLI NI C	82, 984	10, 500, 363	0.00790	2, 265	18	90.00
91. 00	09100 EMERGENCY	1, 945, 339					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 961	•			4, 545	92.00
92. 01	09201 OBSERVATION BEDS-DISTINCT	74, 078				7, 201	92. 01
	OTHER REIMBURSABLE COST CENTERS						]
95. 00	09500 AMBULANCE SERVI CES						95.00

14, 273, 813 1, 331, 535, 864

240, 123, 445

2, 584, 482 200. 00

95. 00 | 09500 | AMBULANCE SERVICES | Total (lines 50 through 199)

Health Financial Systems	COMMUNITY MEDI	CAL CENTER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COST			Period: From 01/01/2021 To 12/31/2021	5/24/2022 5: 2	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS   30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   INTENSIVE CARE UNIT   34. 00   03400   SURGICAL   INTENSIVE CARE UNIT   43. 00   04300   NURSERY	0 0	0 0 0		0 0 0	1, 633, 059 342, 852 0	31. 00 34. 00
44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	0	0		0 0	1, 975, 911	44. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 34. 00   03400   SURGICAL INTENSIVE CARE UNIT 43. 00   04300   NURSERY 44. 00   04400   SKILLED NURSING FACILITY	0	1, 633, 059 342, 852 0 0 0		7. 81 7. 0. 00 6 0. 00	4, 397 0 0	31. 00 34. 00 43. 00
200.00 Total (lines 30 through 199)		1, 975, 911	119, 45	5	53, 864	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT	1, 199, 693 34, 341					30. 00 31. 00 34. 00
34. 00   03400   SURGI CAL INTENSIVE CARE UNIT 43. 00   04300   NURSERY 44. 00   04400   SKILLED NURSING FACILITY 200. 00   Total (lines 30 through 199)	0 0 0 1, 234, 034					34. 00 43. 00 44. 00 200. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 31	
THROUGH COSTS		From 01/01/2021   Part IV

THROU	GH CUSIS				To 12/31/2021		
			Ti tl e	e XVIII	Hospi tal	PPS	<u> p</u>
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCI LLARY SERVI CE COST CENTERS		1			1	
50. 00		0	0	)	0	0	1 00.00
51. 00		0	0	)	0	0	51. 00
52. 00		0	0	)	0	0	52. 00
52. 01		0	0	)	0	0	52. 01
53. 00		0	0	)	0	0	53. 00
54. 00		0	0	)	0	0	54. 00
55. 00		0	0	)	0	0	55. 00
56.00		0	0	)	0	0	56. 00
57. 00		0	0	)	0	0	57. 00
58. 00		0	0	)	0	0	58. 00
59. 00		0	0	)	0	0	59. 00
60.00		0	0	)	0	0	60.00
63. 00	· ·	0	0	)	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	)	0	0	65. 00
66. 00		0	0	)	0	0	66. 00
67. 00		0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	)	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
70. 01	07001 SLEEP LAB	0	0		0	0	70. 01
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	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	365, 387	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	O	)	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
92. 01	09201 OBSERVATION BEDS-DISTINCT	0	0		0 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.0	0 Total (lines 50 through 199)	0	o c	)	0	365, 387	200.00

APPOR	n Financial Systems FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER GH COSTS	COMMUNITY MED VICE OTHER PASS			In Lie Period: From 01/01/2021 Fo 12/31/2021	worksheet D Part IV Date/Time Pre 5/24/2022 5:23	
			Title	XVIII	Hospi tal	PPS	<u>_ p</u>
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		72, 350, 905		
51. 00	05100 RECOVERY ROOM	0	0		15, 972, 778		
52.00	05200 DELIVERY ROOM & LABOR ROOM	40, 775					
52. 01	03190 OP INFUSION	48, 062					
53.00	05300 ANESTHESI OLOGY	105, 493	105, 493	105, 49			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		67, 780, 825		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		78, 601, 584		
56.00	05600 RADI OI SOTOPE	0	0		6, 348, 456	0.000000	
57.00	05700 CT SCAN	0	0		103, 546, 081	0.000000	57. 00
58.00	05800 MRI	0	0		28, 336, 247	0.000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		59, 067, 907	0.000000	59. 00
60.00	06000 LABORATORY	0	0		216, 485, 016	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		16, 991, 587	0.000000	63. 00
65.00	06500 RESPI RATORY THERAPY	38, 866	38, 866	38, 86	6 26, 907, 714	0. 001444	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		21, 310, 273	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		9, 815, 247	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		2, 150, 510	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	98, 553	98, 553	98, 55	63, 650, 865	0. 001548	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		8, 919, 965	0.000000	70.00
70. 01	07001 SLEEP LAB	0	0		0	0.000000	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		17, 934, 204	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	24, 651, 232	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	365, 387	365, 38	7 100, 814, 321	0. 003624	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	(	2, 832, 637	0.000000	76. 97
		1 -	1 -	i .	-1	1'	1

68, 015

763, 697

1, 170, 462

7, 001

68, 015

7, 001

763, 697

1, 535, 849

3, 369, 774

10, 500, 363

229, 079, 740

1, 875, 650 91, 991, 700

68, 015

763, 697

7, 001

1, 535, 849 1, 331, 535, 864

76. 98

90.00

91.00

92.00

92.01

95.00

200. 00

0.000000

0.006477

0.003334

0.003733

0.000000

76. 98

90.00

92.00

92. 01

200.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

91. 00 09100 EMERGENCY

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS-DISTINCT OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	COMMUNITY MEDI		°N. 21 0041   F	eriod:	eu of Form CMS-2 Worksheet D	ZDDZ- I
	TOUMENT OF IMPAILENT/OUTPAILENT ANCILLARY SEI H COSTS	RVICE UTHER PASS	Provider Co	F	rom 01/01/2021 o 12/31/2021	Part IV Date/Time Pre	pared: 2 pm
			Title	XVIII	Hospi tal	PPS	_ p
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS	<u>.                                      </u>					
0. 00	05000 OPERATING ROOM	0. 000000	20, 424, 639	C	13, 018, 370	0	50.0
1. 00	05100 RECOVERY ROOM	0. 000000	3, 674, 454	C	2, 785, 841	0	51. (
2. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 001449	25, 718	37	3, 066	4	52. (
2. 01	03190 OP INFUSION	0. 003600	0	C	0	0	52. (
3. 00	05300 ANESTHESI OLOGY	0. 012051	1, 323, 506	15, 950	1, 471, 634	17, 735	53.
1. 00	05400   RADI OLOGY-DI AGNOSTI C	0. 000000	10, 116, 478	C	7, 409, 735	0	54.
5. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 156, 048	C	37, 341, 442	0	55.
5. 00	05600 RADI OI SOTOPE	0. 000000	1, 086, 060	C	1, 113, 229	0	56.
7. 00	05700  CT SCAN	0. 000000	23, 940, 694		16, 277, 475	0	57.
3. 00	05800  MRI	0. 000000	6, 704, 911	C	4, 039, 610	0	58.
9. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	5, 517, 138	C	8, 338, 046	0	59.
0. 00	06000 LABORATORY	0. 000000	55, 116, 999		14, 802, 585	0	60.
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	6, 377, 902	C		0	63.
5. 00	06500 RESPI RATORY THERAPY	0. 001444	10, 355, 679	14, 954	1, 374, 424	1, 985	65.
6. 00	06600 PHYSI CAL THERAPY	0. 000000	7, 555, 110	C	172, 073	0	66.
7. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	4, 141, 131	C	13, 829	0	67.
3. 00	06800 SPEECH PATHOLOGY	0. 000000	928, 139	C	4, 169	0	68.
9. 00	06900 ELECTROCARDI OLOGY	0. 001548	13, 254, 865			27, 224	69.
0. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 029, 727	C	1, 804, 931	0	
). 01	07001  SLEEP LAB	0. 000000	0		_	0	70. (
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	3, 652, 394		2, 698, 128	0	71.
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 959, 659		.,	0	72.
3. 00	07300 DRUGS CHARGED TO PATIENTS	0. 003624	23, 978, 714	86, 899	34, 823, 035	126, 199	73. (
5. 97	O7697   CARDI AC REHABI LI TATI ON	0. 000000	0	C	1, 363, 484	0	
5. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	C	0	0	76.
	OUTPATIENT SERVICE COST CENTERS						
0. 00	09000 CLI NI C	0. 006477	2, 265			1, 033	
. 00	09100 EMERGENCY	0. 003334	24, 353, 133				
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 003733	502, 558		·	852	
2. 01	09201 OBSERVATION BEDS-DISTINCT	0. 000000	8, 945, 524	C	19, 860, 167	0	92. (
	OTHER REIMBURSABLE COST CENTERS						
00	109500 AMBULANCE SERVICES			I		I	95

240, 123, 445

221, 443

224, 088, 644

95.00

281, 415 200. 00

95. 00 | 09500 | AMBULANCE SERVICES | 200. 00 | Total (Lines 50 through 199)

Health Financial Systems	COMMUNITY MED	DICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 31-0041 F	Peri od:	Worksheet D	
				rom 01/01/2021	Part V	
				o 12/31/2021	Date/Time Pre	pared:
		Ti +Lo	xVIII	Hooni tal	5/24/2022 5: 2 PPS	2 pm
		11116	Charges	Hospi tal	Costs	
Cost Center Description	Cost to Chargo	PPS Reimbursed		Cost	PPS Services	
cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(366 11131.)	
	Part I, col. 9		Subject To	Subject To		
	1 41 1 7 661. 7		Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATING ROOM	0. 293141	13, 018, 370		0	3, 816, 218	50.00
51. 00 05100 RECOVERY ROOM	0. 165763		1 0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 244504			0	750	52. 00
52. 01 03190 OP INFUSION	0. 270031			0	0	52. 01
53. 00 05300 ANESTHESI OLOGY	0. 041518	1, 471, 634	1	0	61, 099	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 189181			0	1, 401, 781	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 144259				5, 386, 839	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 327321			0	364, 383	56. 00
57. 00 05700 CT SCAN	0. 027994			0	455, 672	57.00
58. 00 05800 MRI	0. 075248	4, 039, 610		0	303, 973	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 129742			0	1, 081, 795	1
60. 00 06000 LABORATORY	0. 089827			0	1, 329, 672	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 152098	1, 298, 368	1 0	0	197, 479	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 182128	1, 374, 424	1 0	0	250, 321	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 242484	172, 073	1 0	0	41, 725	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 140937	13, 829	1	0	1, 949	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 183990	4, 169	1 0	0	767	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 070148	17, 586, 672	(	0	1, 233, 670	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 237862	1, 804, 931	(	0	429, 324	70. 00
70. 01  07001  SLEEP LAB	0. 000000	0		0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 388024	2, 698, 128	(	0	3, 745, 066	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 808291	4, 191, 999		0	3, 388, 355	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 635491	34, 823, 035	(	71, 202	22, 129, 725	73. 00
76. 97   07697 CARDIAC REHABILITATION	0. 240807	1, 363, 484	(	0	328, 336	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 166565	0	C	0	0	76. 98
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLI NI C	0. 254086	159, 511	C	0	40, 530	90. 00
91. 00   09100   EMERGENCY	0. 121840	31, 908, 543	15, 800	0	3, 887, 737	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 198550	228, 278	C	0	45, 325	92. 00
92. 01 09201 OBSERVATION BEDS-DISTINCT	0. 053380	19, 860, 167	C	0	1, 060, 136	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	9. 923869		(	)		95. 00
200.00 Subtotal (see instructions)		224, 088, 644	15, 800	71, 202	51, 444, 416	
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		224, 088, 644	15, 800	71, 202	51, 444, 416	202. 00

				10 12/31/2021	5/24/2022 5: 22	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
· ·	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
51.00   05100   RECOVERY ROOM	o	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0				52.00
52. 01 03190 OP INFUSION	o	0				52. 01
53. 00   05300   ANESTHESI OLOGY	l ol	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	أم	0				55. 00
56. 00   05600   RADI OI SOTOPE		0				56. 00
57. 00   05700 CT SCAN		0				57. 00
58. 00   05800   MRI		0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0				59. 00
60. 00   06000   LABORATORY		0				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0				63. 00
65. 00 06500 RESPIRATORY THERAPY		0				65. 00
66. 00   06600 PHYSI CAL THERAPY		0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0				67. 00
68. 00 06800 SPEECH PATHOLOGY		0				68. 00
69. 00   06900   ELECTROCARDI OLOGY		0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0				70.00
70. 01   07001   SLEEP LAB		0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0				70.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0				71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	0	45, 248				72.00
76. 97 07697 CARDIAC REHABILITATION	0	45, 246	•			76. 97
	0					76. 97 76. 98
76. 98 07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	ı u	0				70. 98
90. 00   09000   CLINIC	0	0				90. 00
91. 00   09100   EMERGENCY	1, 925	0				91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	1, 923	0				91.00
· · · · · · · · · · · · · · · · · · ·	0					
92. 01   09201   0BSERVATI ON BEDS-DI STI NCT	<u> </u>	0				92. 01
OTHER REIMBURSABLE COST CENTERS						05 00
95. 00 09500 AMBULANCE SERVICES	1 025	45 240				95. 00
200.00 Subtotal (see instructions)	1, 925	45, 248				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges (Line 200 Line 201)	1 005	4E 240				202.00
202.00   Net Charges (line 200 - line 201)	1, 925	45, 248	I		ı	202. 00

		·			5/24/2022 5: 2	2 pm
		Title	: XVIII	Skilled Nursing	PPS	
				Facility		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
· ·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	,	
	Part I, col. 9	,	Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	0. 293141	0		0 0	0	50.00
· · · · · · · · · · · · · · · · · · ·	1 I	0		0 0	_	
51. 00   05100   RECOVERY ROOM	0. 165763	0			0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 244504	0		0	0	
52. 01 03190 OP INFUSION	0. 270031	0		0	0	52. 01
53. 00   05300   ANESTHESI OLOGY	0. 041518	0		0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 189181	0		0	0	54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 144259	0		0	0	55. 00
56. 00   05600   RADI 01 SOTOPE	0. 327321	0		0 0	0	56. 00
57. 00 05700 CT SCAN	0. 027994	0		0 0	0	57.00
58. 00   05800   MRI	0. 075248	0		0 0	0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 129742	0	•	0 0	0	59.00
60. 00   06000   LABORATORY	0. 089827	0		0 0	0	60.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.	0. 084827	0		0 0	0	63.00
		-			0	
65. 00 06500 RESPI RATORY THERAPY	0. 182128	0		0	0	
66. 00   06600   PHYSI CAL THERAPY	0. 242484	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 140937	0		0	0	1 07.00
68. 00   06800   SPEECH PATHOLOGY	0. 183990	0		0	0	68. 00
69. 00  06900  ELECTROCARDI OLOGY	0. 070148	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 237862	0		0	0	70. 00
70. 01 07001 SLEEP LAB	0. 000000	0		0 0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 388024	0		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 808291	0		0 0	n	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 635491	0		0 4, 381	0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 240807	0		0 4,381	0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 166565	0	l .	0 0	0	1
	0. 100000	0		0 0	U	76. 98
OUTPATIENT SERVICE COST CENTERS	0.054004					
90. 00 09000 CLI NI C	0. 254086	0		0	0	1 ,0.00
91. 00   09100   EMERGENCY	0. 121840	0		0	0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 198550	0		0	0	1 /2.00
92. 01 09201 OBSERVATI ON BEDS-DI STI NCT	0. 053380	0		0 0	0	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	9. 923869			0		95. 00
200.00 Subtotal (see instructions)		0		0 4, 381	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1	0		0 4, 381	n	202. 00
		O	1	-1 ., 551		1-32. 00

Health Financial Systems	COMMUNITY MEDIC		In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider CO		Peri od: From 01/01/2021 To 12/31/2021		
		Title	e XVIII	Skilled Nursing Facility	PPS	•
	Costs	;				

			Title	e XVIII	Skilled Nursing Facility	PPS	
		Cos	:ts		Facility		
	Cost Center Description	Cost	Cost	-			
	oost outtor bescription	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0				50. 00
51. 00	05100 RECOVERY ROOM	0	0	)			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)			52. 00
52. 01	03190 OP INFUSION	0	0	1			52. 01
	05300 ANESTHESI OLOGY	0	0	1			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1			55. 00
56. 00	05600 RADI OI SOTOPE	0	0	1			56.00
57. 00	05700 CT SCAN	0	0	1			57.00
58. 00	05800 MRI	0	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	0	0				60.00
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	0	0				63.00
66.00	06600 PHYSI CAL THERAPY	0	0				65. 00 66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	0				67.00
68. 00	06800 SPEECH PATHOLOGY	0	0				68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07001 SLEEP LAB	0	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 784				73.00
	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
	OUTPATIENT SERVICE COST CENTERS	,		'			
90.00	09000 CLI NI C	0	0	)			90.00
91.00	09100 EMERGENCY	0	0	)			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	)			92.00
92. 01	09201 OBSERVATION BEDS-DISTINCT	0	0	)			92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0					95. 00
200.00		0	2, 784				200. 00
201.00		0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	2, 784	1			202. 00

Health Financial Systems	COMMUNITY MED	OLCAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prep 5/24/2022 5:22	
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Pati ent		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B, Part II, col.		Related Cost (col. 1 - col			
	26)		2)	•		
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	3, 956, 373	0	3, 956, 37	3 64, 612	61. 23	30. 00
31. 00 INTENSIVE CARE UNIT	2, 221, 199		2, 221, 19			31. 00
34.00 SURGICAL INTENSIVE CARE UNIT	215, 008		215, 00	3, 347	64. 24	34.00
43. 00 NURSERY	221, 815		221, 81	5 4, 846	45. 77	43.00
44.00 SKILLED NURSING FACILITY	248, 407		248, 40	2, 770	89. 68	44.00
200.00 Total (lines 30 through 199)	6, 862, 802		6, 862, 80	2 119, 455		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	6. 00	6) 7. 00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	681	41, 698				30. 00
31. 00 INTENSIVE CARE UNIT	695					31. 00
34. 00 SURGICAL INTENSIVE CARE UNIT	58					34. 00
43. 00 NURSERY	2, 235					43.00
44.00 SKILLED NURSING FACILITY	0		1			44. 00
200.00 Total (lines 30 through 199)	3, 669	182, 901				200. 00

Heal th	Financial Systems	COMMUNITY MED	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C	CN: 31-0041	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/24/2022 5:2	nared:
			Ti tI	e XIX	Hospi tal	TEFRA	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)		,	
		26)	,	,			
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 380, 468	72, 350, 905	0. 04672	3 219, 900	10, 274	50.00
51.00	05100 RECOVERY ROOM	179, 954	15, 972, 778	0. 01126	6 45, 214	509	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	501, 382	28, 144, 253	0. 01781	5 1, 117, 566	19, 909	52. 00
52. 01	03190 OP INFUSION	271, 435	13, 351, 795	0. 02032	9 0	0	52. 01
53.00	05300 ANESTHESI OLOGY	30, 480	8, 754, 235	0. 00348	21, 992	77	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 426, 062			9 368, 505	7, 753	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	888, 722				161	55. 00
56.00	05600 RADI OI SOTOPE	219, 429				1, 154	56. 00
57.00	05700 CT SCAN	51, 002	103, 546, 081	0.00049	3 555, 507	274	57.00
58.00	05800 MRI	454, 271	28, 336, 247	0. 01603	1 151, 507	2, 429	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	951, 345		0. 01610		5, 673	59. 00
60.00	06000 LABORATORY	637, 450	216, 485, 016	0. 00294	5 1, 624, 471	4, 784	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	32, 437				256	63.00
65.00	06500 RESPIRATORY THERAPY	289, 238	26, 907, 714	0. 01074	9 261, 750	2, 814	65. 00
66.00	06600 PHYSI CAL THERAPY	203, 177	21, 310, 273	0.00953	4 68, 372	652	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	19, 184				87	67. 00
68. 00	06800 SPEECH PATHOLOGY	24, 591				223	68. 00
69.00	06900 ELECTROCARDI OLOGY	214, 645	63, 650, 865	0.00337	2 230, 520	777	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	339, 802	8, 919, 965	0. 03809	5 17, 072	650	70. 00
70. 01	07001 SLEEP LAB	13	O	0.00000	0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	647, 768	17, 934, 204	0. 03611	9 103, 867	3, 752	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	532, 360				1, 283	1
73.00	07300 DRUGS CHARGED TO PATIENTS	725, 068	100, 814, 321	0.00719	339, 631	2, 443	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	71, 482				0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	62, 686			2 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS				*	,	1
90.00	09000 CLI NI C	82, 984	10, 500, 363	0.00790	3, 412	27	90. 00
91.00	09100 EMERGENCY	1, 945, 339	229, 079, 740	0.00849	2 618, 841	5, 255	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 961	1, 875, 650	0. 00904	3 0	0	92. 00
92. 01	09201 OBSERVATION BEDS-DISTINCT	74, 078	91, 991, 700	0. 00080	94, 906	76	92. 01
	OTHER REIMBURSABLE COST CENTERS						1

14, 273, 813 1, 331, 535, 864

95.00

71, 292 200. 00

6, 500, 358

09201 OBSERVATION BEDS-DISTINCT
OTHER REIMBURSABLE COST CENTERS

95. 00 | 09500 | AMBULANCE SERVICES | Total (lines 50 through 199)

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	COMMUNITY MED		CN: 31_00/1	In Lie	eu of Form CMS- Worksheet D	<u>2552-10</u>
AFFORTIONMENT OF INFAITENT ROOTINE SERVICE OTHER FA	ASS THROUGH COST			From 01/01/2021 To 12/31/2021	Part III	epared: 2 pm
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Healt Post-Stepdow Adjustments	h Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   INTENSI VE CARE UNI T 34. 00   03400   SURGI CAL   INTENSI VE CARE UNI T 43. 00   04300   NURSERY	0 0	0 0 0 0		0 0 0 0 0 0	1, 633, 059 342, 852 0 0	31. 00 34. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	j	0 0		44. 00
200.00 Total (lines 30 through 199)	0	0		0 0	1, 975, 911	200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6, 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	1, 633, 059	64, 61	2 25. 27	681	30. 00
31.00 03100 INTENSIVE CARE UNIT		342, 852				
34. 00 03400 SURGICAL INTENSIVE CARE UNIT		0	-, -			
43. 00   04300   NURSERY		0	4, 84			
44.00 04400 SKILLED NURSING FACILITY		1 075 011	2, 77			1
200.00   Total (lines 30 through 199)  Cost Center Description	I npati ent	1, 975, 911	119, 45	05	3, 669	200. 00
Cost Center Description	Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   INTENSI VE CARE UNI T	17, 209 5, 428					30.00
34.00   03400   SURGI CAL INTENSI VE CARE UNIT 43.00   04300   NURSERY	0					34. 00 43. 00
44. 00   04400   SKI LLED   NURSI NG   FACI LI TY						44. 00
200.00 Total (lines 30 through 199)	22, 637					200.00

Heal th Financial	Systems		COMMUNI TY	MEDICA	AL CENTER		In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE OTHER	PASS	Provider CCN	: 31-0041	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared:

Cost Center Description	THROUG	SH COSTS				To 12/31/2021	Date/Time Pre 5/24/2022 5:2	pared:
Non Physician   Anesthetist   Cost   Center Description   Non Physician   Anesthetist   Cost   Program				Ti tl	e XIX	Hospi tal		2 pm
Adj ustments		Cost Center Description		Nursi ng	Nursi ng	Allied Health	Allied Health	
Adjustments					Program			
NACILLARY SERVICE COST CENTERS			Cost			Adjustments		
ANCI LLARY SERVICE COST CENTERS			1.00		2.00	2.4	2.00	
50.00		ANCILLADY SERVICE COST CENTERS	1.00		2.00	3A	3.00	
51.00   05100 RECOVERY ROOM	50 00				ı		0	50.00
52.00   05200   DELI VERY ROOM & LABOR ROOM   0   0   0   0   0   0   52.00			_	_		0	ľ	
52. 01   03190   OP   INFUSI ON			0			0	ľ	
53.00   05300   ANESTHESI OLOGY   0   0   0   0   0   0   53.00			0			0	1 0	
54.00   05400   RADI OLOGY-DI AGNOSTIC   0 0 0 0 0 0 0 0 0 0 55.00			0			0 0	1 0	
55. 00   05500   RADI OLOGY_THERAPEUTI C			0			0 0	i o	
56. 00   05600   RADI OI SOTOPE   0   0   0   0   0   0   56. 00			0			0 0	l o	1
57.00   05700   CT SCAN   0   0   0   0   0   0   57.00			0	0		0 0	l ő	
S8.00   O5800   MRI   O   O   O   O   O   O   O   O   O			0	0		0 0	0	
59.00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0			0	0	,	0	0	
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0			0	Ō	j	o o	l o	
65. 00	60.00	I I	0	0		0 0	0	60.00
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   70. 01   07001   SLEEP LAB   0   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   0   0   0   0   0   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   79. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0   70. 00   07500   AMBULANCE SERVI CES   95. 00	63. 00	I I	0	0		0 0	0	63. 00
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   67. 00   68. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0	65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65. 00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0	66.00	06600 PHYSI CAL THERAPY	0	0	1	0 0	0	66. 00
69. 00   06900   ELECTROCARDI OLOGY   0 0 0 0 0 0 0 69. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 01 70. 00 70. 00 70. 01 70. 00	67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   70. 00   70. 00   70. 01   70. 01   70. 01   70. 01   70. 01   70. 01   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   74. 07   73. 00   74. 07   74.	68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
70. 01   07001   SLEEP LAB   0   0   0   0   0   0   70. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   73. 00   07300   ROUGH CHARGED TO PATIENTS   0   0   0   0   0   0   365, 387   73. 00   07300   ROUGH CHARGED TO PATIENTS   0   0   0   0   0   0   0   76. 97   07697   CARDI AC REHABI LITATI ON   0   0   0   0   0   0   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   0   76. 98   00   09000   CLI NI C   0   0   0   0   0   0   76. 98   09000   CLI NI C   0   0   0   0   0   0   76. 98   09000   CLI NI C   0   0   0   0   0   76. 98   09100   EMERGENCY   0   0   0   0   0   76. 98   09100   EMERGENCY   0   0   0   0   76. 98   09100   DESERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0   76. 98   09100   OSSERVATI ON BEDS -DI STI NCT   0   0   0   76. 99   09200   OSSERVATI ON BEDS -DI STI NCT   0   0   0   76. 99   09500   AMBULANCE SERVI CES   95. 00	69.00	06900 ELECTROCARDI OLOGY	0	0	)	0	0	69. 00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   71. 00   72. 00   72. 00   72. 00   72. 00   1MPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   365, 387   73. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   0   0   76. 97   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   0   0   0	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   365, 387   73. 00   76. 97   07697   CARDIAC REHABILITATION   0   0   0   0   0   0   0   76. 97   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   0   0   0	70. 01	07001 SLEEP LAB	0	0		0 0	0	70. 01
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   365, 387   73. 00   76. 97   76. 97   76. 98   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   0   76. 97   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   0   76. 98   0000000000000000000000000000000000	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0	0	71. 00
76. 97 76. 98 07698   HYPERBARI C OXYGEN THERAPY			0	0	1	0	0	
76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   76. 98			0	0	)	0	365, 387	73. 00
OUTPATI ENT SERVICE COST CENTERS   O			_	_		0	-	
90. 00   09000   CLI NI C   0   0   0   0   0   90. 00   91. 00   91. 00   92. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0   0   92. 00   92. 01   09201   0BSERVATI ON BEDS-DI STI NCT   0   0   0   0   0   92. 01   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00   95. 0	76. 98		0	0		0 0	0	76. 98
91. 00   09100   EMERGENCY   0   0   0   0   0   91. 00   92. 00   92. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0   0   0   0   0   0   92. 00   92. 01   09201   OBSERVATION BEDS-DISTINCT   0   0   0   0   0   92. 01   0000   00								
92. 00   09200   085ERVATION BEDS (NON-DISTINCT PART   0   0   0   0   92. 00   92. 01   09201   085ERVATION BEDS-DISTINCT   0   0   0   0   92. 01   075ER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   95. 00			-	_		0	1	
92. 01   09201   085ERVATI ON BEDS-DI STI NCT			-	_		0	0	
OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 95. 00			-	1		0	0	
95. 00   09500   AMBULANCE SERVI CES   95. 00	92. 01		0	0	1	0 0	0	92. 01
	05.00		ı	1	ı			05.00
200.00    Total (Tines 50 through 199)   0  0  0  0  365, 387 (200.00				_			2/5 227	
	200.00	p   Total (Times 50 through 199)	1	ıl O	1	υ <sub> </sub> 0	365, 387	J∠UU. UU

Heal th	Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS	S Provider Co	F	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/24/2022 5:2	pared:
			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols.	Total Outpatient Cost (sum of cols. 2, 3,	Total Charges (from Wkst. C,	Ratio of Cost	
				and 4)		(see instructions)	
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(	72, 350, 905	0.000000	
	05100 RECOVERY ROOM	0	0	(	15, 972, 778	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	40, 775	40, 775	40, 775	28, 144, 253	0. 001449	52.00
	03190 OP INFUSION	48, 062	48, 062	48, 062	13, 351, 795	0.003600	52. 01
53.00	05300 ANESTHESI OLOGY	105, 493	105, 493	105, 493			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	67, 780, 825	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	78, 601, 584	0.000000	55.00
56.00	05600 RADI OI SOTOPE	0	0	(	6, 348, 456	0.000000	56.00
57.00	05700 CT SCAN	0	0	C	103, 546, 081	0.000000	57.00
58.00	05800 MRI	0	0	C	28, 336, 247	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	C	59, 067, 907	0.000000	59.00
60.00	06000 LABORATORY	0	0		216, 485, 016	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		16, 991, 587	0.000000	63.00
65.00	06500 RESPI RATORY THERAPY	38, 866	38, 866	38, 866	26, 907, 714	0. 001444	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		21, 310, 273	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		9, 815, 247	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		2, 150, 510	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	98, 553	98, 553	98, 553	63, 650, 865	0. 001548	69. 00

0

0

0

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68, 015

7, 001

763, 697

1, 170, 462

365, 387

68, 015

763, 697

1, 535, 849

7, 001

8, 919, 965

17, 934, 204

24, 651, 232

2, 832, 637

3, 369, 774

10, 500, 363

1, 875, 650

91, 991, 700

229, 079, 740

100, 814, 321

0

365, 387

68, 015

763, 697

7,001

1, 535, 849 1, 331, 535, 864

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70.00

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72.00

73.00

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76. 98

90.00

91.00

92.00

92.01

95.00

200.00

70. 00 07000 ELECTROENCEPHALOGRAPHY

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

07200 I MPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

09201 OBSERVATION BEDS-DISTINCT

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

07697 CARDIAC REHABILITATION

07001 SLEEP LAB

09000 CLI NI C

09100 EMERGENCY

70. 01

71.00

72. 00 73. 00

76.97

76. 98

90.00

91.00

92.00

92.01

95.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	COMMUNITY MEDI EVICE OTHER PASS	Provi der CO	-	Period: From 01/01/2021 Fo 12/31/2021	Date/Time Pre 5/24/2022 5:2	pared:
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8		Outpatient Program Pass-Through Costs (col. 9	
	9.00	10. 00	x col. 10) 11.00	12.00	x col . 12) 13.00	
ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATI NG ROOM	0. 000000	219, 900	(	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	45, 214		0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 001449	1, 117, 566	1, 619	9 0	0	52.00
52. 01   03190   OP   I NFUSI ON	0. 003600	0	(	0	0	52. 01
53. 00   05300   ANESTHESI OLOGY	0. 012051	21, 992	26!	5 0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	368, 505	(	0	0	54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 000000	14, 255	(	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000	33, 392		0	0	56. 00
57. 00  05700   CT SCAN	0. 000000	555, 507		-	0	57. 00
58. 00   05800   MRI	0. 000000	151, 507		-	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000	352, 259		-	0	59. 00
60. 00   06000   LABORATORY	0. 000000	1, 624, 471		-	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	134, 250			0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0. 001444	261, 750			0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	68, 372		-	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 000000	44, 282		-	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	19, 486			0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 001548	230, 520		7 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	17, 072	(	0	0	70. 00
70. 01  07001   SLEEP LAB	0. 000000	0		0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	103, 867		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	59, 401		-	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 003624	339, 631	1, 23		0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	(		0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	(	0	0	76. 98

0. 006477

0.003334

0.003733

0. 000000

3, 412

618, 841

94, 906

6, 500, 358

22

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2, 063

5, 935

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0 92.00

0 92. 01

90.00

95.00

0 200. 00

OUTPATIENT SERVICE COST CENTERS
09000 CLINIC

09201 OBSERVATION BEDS-DISTINCT OTHER REIMBURSABLE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

90.00

91.00

92. 01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-0041 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/24/2022 5: 22 pm Title XIX Hospi tal TEFRA Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 274176 40, 054 0 50.00 51.00 05100 RECOVERY ROOM 0.155676 10, 548 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 229575 511, 074 52 00 0 52 00 0 03190 OP INFUSION 52.01 0.253515 0 5, 631 0 52.01 53. 00 05300 ANESTHESI OLOGY 0.038963 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.177325 0 188.790 54.00 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.135417 93, 130 0 55.00 56.00 05600 RADI OI SOTOPE 0.306884 11, 287 0 56.00 05700 CT SCAN 57.00 0.026350 0 202, 359 0 57.00 05800 MRI 0 58 00 58 00 0.070210 0 74, 626 59.00 05900 CARDIAC CATHETERIZATION 0. 121541 0 0 59.00 06000 LABORATORY 0.084493 75, 877 0 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.143196 63.00 301 0 63.00 06500 RESPIRATORY THERAPY 65.00 0 2, 116 0.171113 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 228019 0 11,020 0 66.00 06700 OCCUPATI ONAL THERAPY 3, 459 67.00 0. 132681 67.00 06800 SPEECH PATHOLOGY 0 3, 543 68.00 0.172838 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69 00 0.065937 64, 340 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 222466 2, 028 0 70.00 07001 SLEEP LAB 0.000000 70.01 70.01 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1. 306002 0 9, 162 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0.760503 978 Ω 72.00 07300 DRUGS CHARGED TO PATIENTS 0.598330 0 0 73.00 73.00 65, 662 07697 CARDIAC REHABILITATION 76. 97 0. 225780 0 0 76. 97 C Ō 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 76. 98 0.156123 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 239017 0 90.00 3,657 0 0 91.00 09100 EMERGENCY 0. 114416 0 1, 422, 257 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.186654 10, 788 0 92.00 92.00 0 Λ 92.01 09201 OBSERVATION BEDS-DISTINCT 0.050250 391, 819 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 89. 710 95.00 9.344854 200.00 Subtotal (see instructions) Ω 3, 294, 216 0 0 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 201. 00

0

3, 294, 216

0

0 202.00

Only Charges

Net Charges (line 200 - line 201)

| Peri od: | Worksheet D | Part V | To | 12/31/2021 | Date/Time Prepared: | Part V |

Cost   Cost   Cost   Cost   Cost   Reimbursed   Services   Servi						10 12/31/2021	5/24/2022 5: 2	epared: 22 nm
Cost   Cost   Cost   Cost   Rel inbursed   Servi ces Not   Subject To   Ded. & Coin   Servi ces Not   Subject To   Ded. & Coin				Ti tl	e XIX	Hospi tal		<u> </u>
Cost   Center Description   Cost   Reinbursed   Services   Subject To   Ded. & Coins.   Subject To   Ded. & Coins.   See inst.   Ded. & Coin			Cos					
Rel imbursed   Services   Subject To   Ded. & Coins.		Cost Center Description			1			
Services   Subject To   Ded. & Coins   Subject   Ded. & Coins   Ded. &								
Subject To   Ded & Coins.   Subject To   Ded & Coins.   See inst.)   Subject To   Ded & Coins.   See inst.)   Subject To   Ded & Coins.   See inst.)   Subject To   Subject To Subject To   Subject To   Subject To   Subject To   Subject To   Subject To   Subject To   Subject To   Subject To   Subject To   Subject To   Subject To   Subject To   Subject To   Subject To								
Bed. & Colins.   See Inst.								
See Inst.   See			_					
NANCILLARY SERVICE COST CENTERS								
ANCILLARY SERVICE COST CENTERS   50.00   50.								
50.00     05000   05000   05000   05000   051.00   051.00   051.00   051.00   051.00   051.00   051.00   051.00   052.00   052.00   052.00   052.00   052.00   052.00   052.00   052.00   052.00   052.00   052.00   052.00   052.00   052.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   055.00   050.		ANCILLARY SERVICE COST CENTERS			1			
51.00   05100   RECOVERY ROOM   1.642   0   05200   DELIVERY ROOM & LABOR ROOM   117, 330   0   05200   DELIVERY ROOM & LABOR ROOM   117, 330   0   0   0   0   0   0   0   0   0	50.00		10, 982	0				50.00
S2. 00   05200   05200   05210   VELIVERY ROOM & LABOR ROOM   117, 330   0   0710   07100								51.00
52. 01   03190   P INFUSI ON   1,428   0   52. 01			1	l	1			1
53. 00   05300   AMESTHESI OLOGY   0   0   0   0   0   0   0   0   0			1	l				
54.00   05400   RADI OLOGY-DI AGNOSTI C   33,477   0   55.00   05500   RADI OLOGY-THERAPEUTI C   12,611   0   55.00   05600   RADI OLOGY-THERAPEUTI C   12,611   0   55.00   05600   RADI OLOGY-THERAPEUTI C   12,611   0   55.00   05600   RADI OLOGY-THERAPEUTI C   55.00   05700   CT SCAN   5,332   0   57.00   05800   MRI   5,239   0   58.00   05800   MRI   5,239   0   0   05900   CARDIAC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0			1		1			1
55. 00   05500   RADI OLOGY—THERAPEUTI C   12, 611   0   0560   00   05600   RADI OLOGY—THERAPEUTI C   3, 464   0   0   0560   05600   RADI OLOGY—THERAPEUTI C   3, 464   0   0   0   0   0   0   0   0   0		1 1	· -	-	1			
56. 00   05600   RADI OI SOTOPE   3, 464   0   57. 00   5700   CT SCAN   5, 332   0   57. 00   57. 00   5700   CT SCAN   5, 332   0   58. 00   60. 00   60		I I	1		1			1
57. 00   05700   CT SCAN   5,332   0   58. 00   580   MRI   5,239   0   58. 00   58. 00   580   MRI   5,239   0   0   58. 00   58. 00   60.0				1	•			
58.00         05800 MRI         5,239         0         58.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         65.00         65.00         66.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></td<>								1
59.00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0		I I			1			1
60. 00   06000   LABORATORY   6, 411   0   63. 00   63. 00   63. 00   63. 00   63. 00   63. 00   63. 00   63. 00   63. 00   65. 00   65. 00   65. 00   65. 00   66. 0								
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   43   0   0   05500   RESPIRATORY THERAPY   362   0   0   06500   RESPIRATORY THERAPY   2,513   0   0   06700   0   0   0   0   0   0   0   0   0			· -	1	1			1
65. 00   06500   RESPI RATORY THERAPY   362   0   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   67. 00   67. 00   66. 00   67. 00   67. 00   67. 00   67. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   69. 00				-				
66. 00			1	1	1			
67. 00		I I	1		1			
68. 00 06800 SPEECH PATHOLOGY 612 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 4, 242 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 451 0 70. 00 70. 01 07001 SLEEP LAB 0 0 70. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 11, 966 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 744 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 39, 288 0 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 7698 HYPERBARI C OXYGEN THERAPY 0 0 0 0UTPATI ENT SERVI CE COST CENTERS  90. 00 09100 EMERGENCY 162, 729 0 91. 00 91. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART 2, 014 0 92. 00 92. 01 09201 OSSERVATI ON BEDS-DI STI NCT PART 2, 014 0 92. 00 92. 01 07697 DARBULANCE SERVI CES 838, 327 095. 00 Subtotal (see instructions) 1, 282, 229 0 9200 00 Subtotal (see instructions) 1, 282, 229 0 9200 00  68. 00 69. 00 69. 00 69. 00 69. 00 70. 00			1		1			
69. 00					1			
70. 00				-				
70. 01		i i			1			1
71. 00			451		1			
72. 00	70. 01		0	0				
73. 00 76. 97 76. 97 76. 98 07697 CARDI AC REHABILITATION 0 0 0 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 00 00 00 00 00 00 00 00 00 00 00		07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 966	0				
76. 97   07697   CARDI AC REHABILITATI ON   0   0   0   0   76. 97   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0    90. 00   0000   CLI NI C   874   0   90. 00    91. 00   09200   08ERGENCY   162, 729   0   91. 00    92. 00   09200   08ERVATI ON BEDS (NON-DISTINCT PART   2, 014   0   92. 00    92. 01   09201   08ERVATI ON BEDS-DISTINCT   19, 689   0   92. 01    07HER REI MBURSABLE COST CENTERS   838, 327   95. 00    90. 00   Subtotal (see instructions)   1, 282, 229   0   200. 00	72. 00							72. 00
76. 98   07698   HYPERBARI C 0XYGEN THERAPY   0   0   0   0    90. 00   0UTPATI ENT   SERVI CE   COST   CENTERS   90. 00   91. 00   91. 00   91. 00    91. 00   09100   EMERGENCY   162, 729   0   91. 00    92. 00   09200   0BSERVATI ON   BEDS   (NON-DI STI NCT   PART   2, 014   0   92. 00    92. 01   09201   0BSERVATI ON   BEDS-DI STI NCT   19, 689   0   92. 01    95. 00   0THER   REI   MBURSABLE   COST   CENTERS   09500   AMBULANCE   SERVI CES   838, 327   95. 00    200. 00   Subtotal   (see instructions)   1, 282, 229   0   200. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	39, 288	0				73. 00
OUTPATIENT SERVICE COST CENTERS   90. 00   O9700   CLINIC   874   0   90. 00   O9700   CLINIC   162,729   0   91. 00   O9700   OBSERVATION BEDS (NON-DISTINCT PART   2,014   0   92. 00   O9701   OBSERVATION BEDS-DISTINCT   19,689   0   O71HER REIMBURSABLE COST CENTERS   O9500   AMBULANCE SERVICES   838,327   O9500   AMBULANCE SERVICES   838,327   O9500   Subtotal (see instructions)   1,282,229   O   200. 00   O9700	76. 97	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
90. 00   09000   CLINIC   874   0   90. 00   91. 00   91. 00   92. 00   92. 00   92. 00   92. 00   92. 01   92.	76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
91. 00   09100   EMERGENCY   162,729   0   91. 00   92. 00   09200   09SERVATI ON BEDS (NON-DI STI NCT PART   2,014   0   92. 00   09201   09SERVATI ON BEDS-DI STI NCT   19,689   0   92. 01   07HER REI MBURSABLE COST CENTERS   095. 00   09500   AMBULANCE SERVI CES   838,327   95. 00   200. 00   Subtotal (see instructions)   1,282,229   0   200. 00								
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   2, 014   0   92. 00   09201   0BSERVATI ON BEDS-DISTINCT   19, 689   0   92. 01   00201   0DTHER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   838, 327   95. 00   200. 00   Subtotal (see instructions)   1, 282, 229   0   200. 00	90.00	09000 CLI NI C	874	0				90. 00
92. 01   09201   0BSERVATI ON BEDS-DISTINCT   19, 689   0   92. 01	91.00	09100 EMERGENCY	162, 729	0				91. 00
95. 00   07500   MBULANCE SERVICES   838, 327   95. 00   200. 00   Subtotal (see instructions)   1, 282, 229   0   200. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 014	0				92.00
95. 00 09500 AMBULANCE SERVICES 838, 327 95. 00 200. 00 Subtotal (see instructions) 1, 282, 229 0 200. 00	92. 01	09201 OBSERVATION BEDS-DISTINCT	19, 689	0				92. 01
200.00 Subtotal (see instructions) 1,282,229 0 200.00		OTHER REIMBURSABLE COST CENTERS						
	95.00	09500 AMBULANCE SERVICES	838, 327					95. 00
201 00 less PRP Clinic Lab Services-Program   0	200.00	Subtotal (see instructions)	1, 282, 229	0				200.00
201.00     LC33 FBI OFFITO LCB. 30 VICO3-110yFalli   0	201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges		Only Charges						
202.00   Net Charges (line 200 - line 201)   1,282,229   0   202.00	202.00	Net Charges (line 200 - line 201)	1, 282, 229	0				202. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 31-0041	Peri od: From 01/01/2021	Worksheet D-1	
		To 12/31/2021	Date/Time Pre 5/24/2022 5:2	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		Title XVIII	Hospi tal	5/24/2022 5: 2 PPS	2 pm	
	Cost Center Description	THE AVIII	позрі саі	113		
	DART I ALL DROWLDED COMPONENTS			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		64, 612	1. 00	
2.00	Inpatient days (including private room days, excluding swing-			64, 612	2.00	
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pri	vate room days,	0	3. 00	
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		64, 335	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	5. 00	
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	om days) after December (	21 of the cost	0	6. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at tel becember .	of the cost	0	0.00	
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00	
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 2	1 of the cost	0	8. 00	
6.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilibei s	i or the cost	0	0.00	
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	47, 475	9. 00	
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	alv (i naludi na privata r	nom dave)	0	10.00	
10.00	through December 31 of the cost reporting period (see instructions)		Joili days)	0	10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private ro	oom days) after	0	11. 00	
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		o room days)	0	12. 00	
12.00	through December 31 of the cost reporting period	Comy (including private	e room days)	0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX		0	13. 00		
14 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra		0	14. 00		
14. 00 15. 00	Total nursery days (title V or XIX only)	0	15. 00			
16. 00	Nursery days (title V or XIX only)	0	16. 00			
47.00	SWING BED ADJUSTMENT			47.00		
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	17. 00			
18. 00	Medicare rate for swing-bed SNF services applicable to service	0.00	18. 00			
40.00	reporting period		40.00			
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	19. 00			
20. 00	Medicaid rate for swing-bed NF services applicable to services	0.00	20.00			
	reporting period	`		0, 0,7 440		
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	86, 867, 113 0	21. 00 22. 00	
22.00	5 x line 17)	si 31 di the cost reporti	riig perroa (irrie		22.00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00	
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reportion	na period (line	0	24. 00	
24.00	7 x line 19)	or the cost reportin	ig perrod (Triic		24.00	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
26. 00	x line 20)  Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		86, 867, 113		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			_		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	28. 00 29. 00	
30. 00	Semi -private room charges (excluding swing-bed charges)			Ö	ł	
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000		
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00		
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0. 00 0. 00	1	
35. 00	Average per diem private room cost differential (line 34 x lin	0.00				
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00			
37. 00						
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 344. 44		
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			63, 827, 289 0	39. 00 40. 00	
	Total Program general inpatient routine service cost (line 39)			63, 827, 289	ł	
				•		

Heal th	Financial Systems	COMMUNITY MEDI	CAL CENTER		In lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 31-0041	Peri od:	Worksheet D-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	nared:
						5/24/2022 5: 2	
	Cost Contor Description	Total	Ti tl e	Average Per	Hospital Program Days	PPS Program Cost	
	Cost Center Description	Inpatient Cost				(col. 3 x col.	
				col . 2)		4)	
10.00	MIDGEDY (1) II WA WW. I Y	1.00	2.00	3.00	4. 00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	44, 049, 777	43, 880	1, 003. 8	37 4, 397	4, 414, 016	43. 00
44.00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT		45. 00				
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	46. 00 47. 00				
111.00	Cost Center Description	· · · · · · · · · · · · · · · · · · ·		•	<b>'</b>		
	1-					1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			unc)		51, 227, 472 119, 468, 777	•
49.00	PASS THROUGH COST ADJUSTMENTS	41 (111 Ough 46) (8	see mstructro	115)		119, 400, 777	49.00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sur	of Parts I and	4, 363, 504	50. 00
E4 00					6.5	0 005 005	E4 00
51. 00	Pass through costs applicable to Program inpland IV)	attent ancillary	services (Tr	OM WKST. D, S	sum or Parts II	2, 805, 925	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				7, 169, 429	52. 00
53. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	etist, and	112, 299, 348	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00						0	54. 00
55.00	Target amount per discharge					0.00	55. 00
56.00	, ,				1. 50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	11ne 53)	0	57. 00 58. 00			
59. 00	Lesser of lines 53/54 or 55 from the cost re		59. 00				
	market basket						,,,,,,,
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						01100
	amount (line 56), otherwise enter zero (see instructions)						
62. 00 63. 00	62.00   Relief payment (see instructions) 63.00   Allowable Inpatient cost plus incentive payment (see instructions)						
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	5111 (300 111311 40	211 0113)				63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	or 31 of the c	ost reporting	neriod (See	0	65. 00
00.00	instructions)(title XVIII only)	to di tei becembe	51	ost roporting	, perred (see		00.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost re	norting period	0	67. 00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 + line	. 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NI						07.00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applications		(line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	lorksheet B, F	Part II, column		75. 00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78.00	Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces				nus line 79)		79. 00 80. 00
81. 00							81.00
82. 00	Inpatient routine service cost limitation (						82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (		S)				83. 00 84. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84.00
86. 00							86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			1, 344. 44	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•	· · · /			372, 410	•

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/24/2022 5: 2:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	3, 956, 373	86, 867, 113	0. 04554	5 372, 410	16, 961	90. 00
91.00 Nursing Program cost	0	86, 867, 113	0.00000	0 372, 410	0	91.00
92.00 Allied health cost	0	86, 867, 113	0.00000	0 372, 410	0	92. 00
93.00 All other Medical Education	1, 633, 059	86, 867, 113	0. 01880	372, 410	7, 001	93. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 31-0041	Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 31-5490		
	Title XVIII	Skilled Nursing	PPS
		Eoci Li +v	

		litle XVIII	Facility	PPS	
	Cost Center Description		1 40.11.		
	DADT I ALL DOOM DED COMPONIENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 770	1.00
2.00	Inpatient days (including private room days, excluding swing-	ped and newborn days)		2, 770	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only p	rivate room days,	0	3. 00
4 00	do not complete this line.			0.770	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	2, 770 0	ı
3.00	reporting period	om days) trii odgir becemb	ci si di the cost	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	m days) through Decembe	r 31 or the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	m davs) after December	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 7			
9.00	Total inpatient days including private room days applicable to	o the Program (excludin	g swing-bed and	1, 992	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private	room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	tions)	1 doil days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private	room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	x only (including priva	te room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	X only (including priva	te room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost	0. 00	17. 00
18. 00	reporting period	oo often December 21 of	the cost	0.00	10.00
16.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es aitei beceiibei si oi	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 o	f the cost	0. 00	19. 00
20. 00	reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost				20. 00
20.00	reporting period	s arter becember 31 or	the cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			4, 115, 020	1
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost repor	ting period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na period (line 6	0	23. 00
	x line 18)		3		
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost report	ing period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reportin	g period (line 8	0	25. 00
	x line 20)		9	_	
26. 00	Total swing-bed cost (see instructions)	(1.1 04 1 1.1 07)		0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 115, 020	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed c	harges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instru	ctions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x line	ne 31)		0. 00	•
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost d	ifforential (line	0 4, 115, 020	36. 00 37. 00
57.00	27 minus line 36)	and private room cost d	in erential (IIIIe	4, 115, 020	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line				38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra				40.00
	Total Program general inpatient routine service cost (line 39				41. 00

	Financial Systems TATION OF INPATIENT OPERATING COST	COMMUNITY MEDIC	Provider C	N: 31 0041	Period:	u of Form CMS- Worksheet D-1	
WPUI	ATION OF INPATIENT OPERATING COST			CCN: 31-5490	From 01/01/2021 To 12/31/2021	Date/Time Pre	epare
			Title	XVIII	Skilled Nursing	5/24/2022 5: 2 PPS	22 piii
	Cost Center Description	Total	Total	Average Per	Facility Program Days	Program Cost	
	oost deliter bescription	Inpatient Cost I		Diem (col. 1		(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	3.00	42.
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43
. 00	BURN INTENSIVE CARE UNIT						45
00	SURGICAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1. 00	-
00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			1.00	48
00				ns)			49
	PASS THROUGH COST ADJUSTMENTS						١
00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, su	m of Parts I and		50
00	Pass through costs applicable to Program inp	atient ancillarv	services (fr	om Wkst. D,	sum of Parts II		51
	and IV)	,	- (	•			
00	Total Program excludable cost (sum of lines	,	a+aal ======1	ololon !!	hotiot cod		52
00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ateu, non-phy	sician anest	netist, and		53
	TARGET AMOUNT AND LIMIT COMPUTATION	/					
	Program di scharges						54
00	Target amount per discharge Target amount (line 54 x line 55)						55
00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)		57
00	Bonus payment (see instructions)	<b>J</b>	,		,		58
00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996, u	pdated and c	ompounded by the		59
00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	ated by the m	arket hasket			60
. 00	If line 53/54 is less than the lower of line						61
	which operating costs (line 53) are less tha	n expected costs					
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)					62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)				63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	1	ts through Decem	per 31 of the	cost report	ing period (See		64
00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	r 31 of the c	ost reportin	a period (See		65
	instructions)(title XVIII only)				5   1		
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For		66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost r	eporting period		67
	(line 12 x line 19)				5 1		
00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period		68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (L	ne 67 + line	68)			69
	PART III - SKILLED NURSING FACILITY, OTHER N						
00	3 3				)	4, 115, 020	
00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ie /U ÷ line	۷)		1, 485. 57 2, 959, 255	
00	,	•	(line 14 x li	ne 35)		2, 434, 233	
00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)	•		2, 959, 255	74
00	Capital -related cost allocated to inpatient	routine service	costs (from W	orksheet B,	Part II, column	0	75
00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	ne 2)				0.00	76
00	Program capital-related costs (line 9 x line	76)				O	77
00	Inpatient routine service cost (line 74 minu		and da '	۵)		0	
00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus lina 70)	0	
00	Inpatient routine service costs for comp		st iimitatiON	(TITIE /O IIII	1143 1116 /7)	0. 00	
00	Inpatient routine service cost limitation (I	ine 9 x line 81)				0	82
. 00	Reasonable inpatient routine service costs (		)			2, 959, 255	
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)			517, 741	84   85
	Total Program inpatient operating costs (sum					3, 476, 996	
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
. 00	Total observation bed days (see instructions	•				0. 00	1 -
00	Adjusted general inpatient routine cost per	diam (lina 27	line 2)				

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 31-0041	Peri od:	Worksheet D-1	
		Component (	CCN: 31-5490	From 01/01/2021 To 12/31/2021	Date/Time Prep 5/24/2022 5: 2:	
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
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	0	0	0. 00000	0 0	0	90. 00
91.00 Nursing Program cost	0	0	0.00000	0 0	0	91.00
92.00 Allied health cost	0	0	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	O	0. 00000	0	0	93. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0041	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Preps/24/2022 5: 23	
	Title XIX	Hospi tal	TEFRA	
Cost Center Description				
			1 00	

PART 1 - ALL PROVIDER COMPONENTS   1.00
PART 1 - ALL PROVIDER COMPONENTS   NATION   NA
MPATEENT DAYS   1.00   Inpate int days (including private room days and swing-bed days, excluding newborn)   64,612   2.00   1   1   1   1   1   1   1   1   1
Inpatient days (including private room days, excluding swing-bed adn enwborn days)   64,612   2.00
Private room days (excluding swing-bed and observation bed days). If you have only private room days.  4.00 do not complete this line.  5.01 Total saving-bed SNT type inpatient days (including private room days) through December 31 of the cost reporting period (it saving-bed SNT type inpatient days (including private room days) after December 31 of the cost reporting period (if cale dard ryear, enter 0 on this line)  7.00 Total saving-bed SNT type inpatient days (including private room days) after December 31 of the cost reporting period (if cale dard ryear, enter 0 on this line)  7.00 Total saving-bed SNT type inpatient days (including private room days) after December 31 of the cost reporting period (if cale dard ryear, enter 0 on this line)  7.00 Total inpatient days including private room days after December 31 of the cost reporting period (if cale dard ryear, enter 0 on this line)  7.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days)  8.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  8.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (ic alendar year, enter 0 on this line)  8.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (ic alendar year, enter 0 on this line)  8.01 Swing-bed SNT type inpatient days applicable to titles V or XIX only (including private room days)  8.01 Swing-bed SNT type inpatient days applicable to titles V or XIX only (including private room days)  8.02 Swing-bed SNT type inpatient days applicable to services through December 31 of the cost reporting period (in a swing-bed SNT services applicable to services through December 31 of the cost reporting period (in a swing-bed SNT services applicable to services after December 31 of the cos
do not complete this line.  4. 00 Semi-private room days (excluding swing-bed and observation bed days)  5. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Swing-bed SNF type institut days applicable to title XVIII only (including private room days)  9. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  11. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  12. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  13. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  14. 00 Medically incessary private room days applicable to title XVIII only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Medically incessary private room days applicable to the Program (excluding swing-bed days)  17. 00 Medically incessary private room days applicable to the Program (excluding swing-bed days)  18. 00 Medically incessary private room days applicable
Semi-private room days (excluding swing-bed and observation bed days)   Semi-private room days swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   7.00
reporting period  6. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days apit cable to the Program (excluding swing-bed and newborn days) (see Instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see Instructions)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see Instructions)  12. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days)  14. 00 Medically inecessary private room days applicable to title V or XIX only (including private room days)  15. 00 Introduction of the cost reporting period (if calendar year, enter 0 on this line)  16. 00 Inversery days (title V or XIX only)  17. 00 Medically inecessary private room days applicable to the Program (excluding swing-bed days)  18. 00 Medical rocessary private room days applicable to services through December 31 of the cost  18. 00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost  19. 00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical care for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical rate for swing-bed SNF serv
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total inpatient days including private room days) after December 31 of the cost reporting period (see instructions)   Total inpatient days applicable to title XVIII only (including private room days)   Total inpatient days applicable to title XVIII only (including private room days)   Total through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total through December 31 of the cost   Total through 3 (title V or XIX only)   Total through 3 (title Y or XIX only)   Total through
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 14. 00 Medical (all y necessary private room days applicable to titles V or XIX only (including private room days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Inversery days (title V or XIX only) 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including year) 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost period (including year) 19. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost period (including year) 19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost period (including year) 19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost period (including year) 19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost period (including year) 19. 00 Medicare rate for swing-bed SNF servic
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   10.00   10.0
reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) and through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on 12.00 through December 31 of the cost reporting period (see instructions)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) on 13.00 after December 31 of the cost reporting period (see instructions)  15.00 Total nursery days (title V or XIX only)  16.00 No India nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (see instructions)  18.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (see instructions)  18.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (see instructions)  19.00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (see instructions)  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (line 6
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)   10.00
through December 31 of the cost reporting period (see instructions)  11.00  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00  Modically necember 31 of the cost reporting period (if calendar year, enter 0 on this line)  15.00  16.00  17.00  18.0
through December 31 of the cost reporting period (see instructions)  11. 00 Sung-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)  12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Period Medicare for swing-bed SNF services after December 31 of the cost reporti
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00  15.00 Total nursery days (title V or XIX only) 4,846 15.00  17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (modicar rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (modicar rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (modicar rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (modicar rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (modicar rate for swing-bed NF services applicable to services after December 31 of the cost of seporting period (modicar rate for swing-bed NF services applicable to services after December 31 of the cost of second reporting period (modicar rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x line 17)  18.00 Total general inpatient routine service cost (see instructions) 86,864,891 (2).00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Total swing-bed cost applicable to NF type ser
12.00   Swing-bed NF type inpatient days applicable to titles v or XIX only (including private room days)   12.00   through December 31 of the cost reporting period   13.00   3xing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   37 the cost reporting period (if calendar year, enter 0 on this line)   14.00   15.00   16.00   17.00   17.00   18.00   1
through December 31 of the cost reporting period  3,00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  4,00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  6,00 Total nursery days (title V or XIX only)  7,00 Nursery days (title V or XIX only)  8,00 Nursery days (title V or XIX only)  8,00 Nursery days (title V or XIX only)  9,00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  10,00 Nursery days (title V or XIX only)  11,00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  12,00 Nursery days (title V or XIX only)  13,00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  14,00 Nursery days (title V or XIX only)  15,00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost on the cost reporting period  16,00 Nursery days (title V or XIX only)  17,00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost on the cost reporting period (line for sung-bed SNF services applicable to services after December 31 of the cost reporting period (line for X I line 18)  18,00 Nursery days (title V or XIX only)  19,00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line for NF type services after December 31 of the cost reporting period (line for X I line 18)  20,00 Nursery days (title V or XIX only)  21,00 Nursery days (title V or XIX only)  22,00 Nursery days (title V or XIX only)  23,00 Nursery days (title V or XIX only)  24,00 Nursery days (title V or XIX only)  25,00 Nursery days (title V or XIX only)  26,00 Nursery days (title V or XIX only)  27,00 Nursery days (title V or XIX only)  28,00 Nursery days (title V or XIX only)  29,00 Nursery days
Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  Total nursery days (title V or XIX only)  Nursery days (title Vor XIX only)  Nursery days (the text for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 0 2 2.00 2.00 2.00 2.00 2.00 2.00 2.0
15.00 Total nursery days (title V or XIX only)  Nursery days (title V or XIX only)  SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicair rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)
16.00   Nursery days (title V or XIX only)   2,235   16.00   SWING BED ADJUSTMENT   17.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18.00   18.00   18.00   19.00
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 10.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 10.00 Total general inpatient routine service cost (see instructions) 10.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 10.00 Swing
reporting period  18.00 Medicaire rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Total general inpatient routine service cost (see instructions)  21.00 Total general inpatient routine services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  25.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  29.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  20.00 Occount after the cost reporting period (line 8 to 20 conditions)
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  25.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Document of the cost reporting period (line 8 to 2 25.00 to 25.00 to 26.00
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)
reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  1.00 Total general inpatient routine service cost (see instructions)  2.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  2.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  2.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  2.00 Total swing-bed cost (see instructions)  2.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  2.00 PRIVATE ROOM DIFFERNIAL ADJUSTMENT  2.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  3.00 Semi-private room charges (excluding swing-bed charges)  3.00 Semi-private room charges (excluding swing-bed charges)  3.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  3.00 Condotted the cost reporting period (line 28)  3.00 Condotted the cost reporting period (line 8)  3.00 Condotted the cost reporting period (line 8)  3.00 Condotted the cost reporting period (line 8)  3.00 Semi-private room charges (excluding swing-bed and observation bed charges)  3.00 General inpatient routine service cost/charges (line 21 minus line 26)  3.00 Condotted the cost reporting period (line 8)  3.00 Cond
reporting period  Total general inpatient routine service cost (see instructions)  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0 23.00 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 0 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 0 25.00 x line 20)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  O 26.00 Semi-private room charges (excluding swing-bed charges)  O 27.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  O 0.000000 31.00
Total general inpatient routine service cost (see instructions)  21.00  22.00  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Pri vate room charges (excluding swing-bed charges)  Semi-pri vate room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  O.0000000  31.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Occupancy (line 21 minus line 26)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Conditions (line 20)  32.00 December 31 of the cost reporting period (line 8 occupance 24.00 occupance
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 Swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Occupancy for the cost reporting period (line 8 occupancy 24.00 occupancy 25.00 occupancy 25.00 occupancy 25.00 occupancy 26.00 occupancy 26.00 occupancy 26.00 occupancy 27.00 occupancy 27.00 occupancy 27.00 occupancy 28.00 occupancy 28.00 occupancy 28.00 occupancy 28.00 occupancy 29.00 oc
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  29.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  0.0000000 31.00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  25.00 26.00  26.00 27.00  27.00 28.00  28.00 29.00  30.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 31.00
x line 20)  26.00 Total swing-bed cost (see instructions)  Conceral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  86,864,891  27.00  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  0.0000000 31.00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28. 00 Private room charges (excluding swing-bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  27. 00  28. 00  29. 00  30. 00  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30. 00  31. 00
PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  28.00  29.00  30.00  31.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  28.00  29.00  30.00  31.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00
32.00   Average private room per diem charge (line 29 ÷ line 3) 0.00   32.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33.00
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  0.00 34.00
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  0.00 35.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 86,864,891 37.00
27 minus line 36)
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,344.41 38.00
39.00 Program general inpatient routine service cost (line 9 x line 38) 915,543 39.00
40.00   Medically necessary private room cost applicable to the Program (line 14 x line 35)
715,00   10 tal 11 ogram general impatrent routine service cost (inne 37 + 1111e 40)

Heal th	Financial Systems COMMUNITY MEDICAL CENTER In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST  Provider CCN: 31-0041   Period: From 01/01/2021	Worksheet D-1	
	To 12/31/2021	Date/Time Prep 5/24/2022 5: 2:	
	Title XIX Hospital	TEFRA	<u> </u>
	Cost Center Description   Total   Total   Average Per   Program Days   Inpatient Cost   Inpatient Days   Diem (col. 1 ÷	Program Cost (col. 3 x col.	
		4)	
42. 00	1. 00 2. 00 3. 00 4. 00 NURSERY (title V & XIX only) 4, 784, 408 4, 846 987. 29 2, 235	5. 00 2, 206, 593	42. 00
	Intensive Care Type Inpatient Hospital Units		
43. 00 44. 00	INTENSIVE CARE UNIT 44,049,777 43,880 1,003.87 695	697, 690	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT		45. 00
46. 00 47. 00	SURGI CAL   INTENSI VE CARE UNI T   5, 445, 522   3, 347   1, 626. 99   58   OTHER SPECI AL CARE (SPECI FY)	94, 365	46. 00 47. 00
	Cost Center Description		
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1. 00 1, 251, 471	48. 00
	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5, 165, 662	
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	205, 538	50. 00
	III)		
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	77, 227	51. 00
52. 00	Total Program excludable cost (sum of lines 50 and 51)	282, 765	
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4, 882, 897	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54. 00 55. 00		459 4, 284. 54	
56. 00	Target amount (line 54 x line 55)	1, 966, 604	56. 00
57. 00 58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	-2, 916, 293 0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62.00	Relief payment (see instructions)	196, 660	
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	2, 446, 029	63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
	CAH (see instructions)		
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled pursing facility/other pursing facility/ICF/IID routing service cost (line 27)		70.00
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost per dreim frim tatron Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)		83. 00 84. 00
85.00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00	Total observation bed days (see instructions)	277	87. 00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 344. 41 372, 402	
07.00	Jobbon Valion Dea Goot (Title of A Title oo) (See Thati delibilis)	372, 402	07.00

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 5: 2	
		Ti tl	e XIX	Hospi tal	TEFRA	
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	3, 956, 373	86, 864, 891	0. 04554	6 372, 402	16, 961	90. 00
91.00 Nursing Program cost	0	86, 864, 891	0.00000	0 372, 402	0	91.00
92.00 Allied health cost	0	86, 864, 891	0.00000	0 372, 402	0	92. 00
93.00 All other Medical Education	1, 633, 059	86, 864, 891	0. 01880	0 372, 402	7, 001	93. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od: From 01/01/2021	Worksheet D-3	
			To 12/31/2021	Date/Time Pre 5/24/2022 5:2	pared: 2 pm
	Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	0// //0 700		
30. 00   03000   ADULTS & PEDI ATRI CS			364, 448, 738		30.00
31. 00   03100   NTENSI VE CARE UNI T			75, 170, 300		31.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM		0.2021	11 20 424 420	5, 987, 299	FO 00
50. 00   05000   OPERATING ROOM 51. 00   05100   RECOVERY ROOM		0. 29314			
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 16576		609, 089	
52. 00   03200   DELI VERY ROOM & LABOR ROOM   52. 01   03190   OP   INFUSION		0. 24450 0. 27003		6, 288 0	52.00
53. 00   05300   ANESTHESI OLOGY		0. 27003		54, 949	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 0413			
55. 00   05500   RADI OLOGY - THERAPEUTI C		0. 14425			
56. 00   05600   RADI OI SOTOPE		0. 14423		355, 490	
57. 00   05700 CT SCAN		0. 02799		670, 196	
58. 00   05800 MRI		0.02773		504, 531	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 12974			
60. 00   06000   LABORATORY		0. 08982			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 15209		970, 066	
65. 00 06500 RESPIRATORY THERAPY		0. 18212			
66. 00 06600 PHYSI CAL THERAPY		0. 24248			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 14093		583, 639	
68. 00 06800 SPEECH PATHOLOGY		0. 18399		170, 768	
69. 00 06900 ELECTROCARDI OLOGY		0. 07051		934, 693	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 23786		244, 933	
70. 01   07001   SLEEP LAB		0.00000		0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 38802		5, 069, 611	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 80829		4, 817, 139	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 63549		15, 238, 257	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 24080		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 16656		0	76. 98
OUTPATIENT SERVICE COST CENTERS			•		1
90. 00 09000 CLI NI C		0. 25408	36 2, 265	576	90.00
91. 00   09100   EMERGENCY		0. 12184	24, 353, 133	2, 967, 186	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 19855		99, 783	
92. 01 09201 OBSERVATION BEDS-DISTINCT		0. 05338	8, 945, 524	477, 512	92. 01
OTHER RELMBURSABLE COST CENTERS					I

240, 123, 445

240, 123, 445

95.00

202. 00

51, 227, 472 200. 00 201. 00

OTHER REIMBURSABLE COST CENTERS

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

09500 AMBULANCE SERVICES

95.00

200. 00 201. 00

	Financial Systems COMMUNITY MEDIC NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 31-0041	Peri od:	w of Form CMS-3 Worksheet D-3	
		Component	CCN: 31-5490	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 5:2	
		Titl€	e XVIII	Skilled Nursing Facility	PPS	<u> 2 piii</u>
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS					
	D3000 ADULTS & PEDI ATRI CS					30.00
	03100   NTENSIVE CARE UNIT					31.00
	03400 SURGICAL INTENSIVE CARE UNIT					34. 0
	04300 NURSERY					43.00
	ANCI LLARY SERVI CE COST CENTERS		0.0004	44		
- 1	D5000 OPERATING ROOM D5100 RECOVERY ROOM		0. 29314		0	
	D5200 DELIVERY ROOM & LABOR ROOM		0. 16576 0. 24456		0	
	03190 OP INFUSION		0. 24430		0	
4	05300 ANESTHESI OLOGY		0. 2700.		0	1
	D5400 RADI OLOGY-DI AGNOSTI C		0. 18918		550	
	D5500 RADI OLOGY-THERAPEUTI C		0. 1442!		0	
4	D5600 RADI OI SOTOPE		0. 32732		994	
	05700 CT SCAN		0. 02799		0	1
58. 00 C	05800 MRI		0. 07524	48 0	0	58.0
59. 00 C	D5900 CARDI AC CATHETERI ZATI ON		0. 12974	42 0	0	59.0
	D6000 LABORATORY		0. 08982	27 415, 407	37, 315	60.0
	D6300 BLOOD STORING, PROCESSING & TRANS.		0. 1520		0	
1	06500 RESPI RATORY THERAPY		0. 18212		937	
	06600 PHYSI CAL THERAPY		0. 24248		241, 976	
	06700 OCCUPATI ONAL THERAPY		0. 14093		107, 634	
	06800 SPEECH PATHOLOGY		0. 18399	·	1, 179	
	06900  ELECTROCARDI OLOGY 07000  ELECTROENCEPHALOGRAPHY		0. 0705° 0. 23786		259 0	1
	07000 ELECTROENCEPHALOGRAPHY		0. 23780		0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 38802		139	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 80829		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 63549		126, 758	
	07697 CARDI AC REHABI LI TATI ON		0. 24080		0	
- 1	07698 HYPERBARI C OXYGEN THERAPY		0. 16656		0	76. 9
O	OUTPATIENT SERVICE COST CENTERS		•			1
90.00	09000 CLI NI C		0. 25408	86 0	0	90.0
	09100 EMERGENCY		0. 12184		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1985		0	1
	09201 OBSERVATI ON BEDS-DI STI NCT		0. 05338	80 0	0	92. 0
	OTHER REIMBURSABLE COST CENTERS		1			4 _
4	09500 AMBULANCE SERVICES			0.007:-		95. 0
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(1)		2, 397, 743	517, 741	
201.00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0 207 740		201. 0
202. 00	Net charges (line 200 minus line 201)		1	2, 397, 743	1	202. C

Health Financial Systems	COMMUNITY MEDICAL	CENTER		In lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT				Period: From 01/01/2021 To 12/31/2021	Worksheet D-3  Date/Time Pre 5/24/2022 5:2	pared:
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description			Ratio of Cost		Inpati ent	
·			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS				4, 599, 735		30.00
31.00 03100 INTENSIVE CARE UNIT				6, 614, 016		31. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				522, 033		34.00
43. 00 04300 NURSERY				1, 609, 910		43. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM			0. 29314			
51.00   05100   RECOVERY ROOM			0. 16576			
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 24450		273, 249	
52.01 03190 OP INFUSION			0. 27003			52. 01
53. 00 05300 ANESTHESI OLOGY			0. 04151		913	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C			0. 18918			54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C			0. 14425			
56. 00   05600   RADI OI SOTOPE			0. 32732			
57. 00  05700   CT SCAN			0. 02799			
58. 00   05800   MRI			0. 07524			
59. 00   05900   CARDI AC   CATHETERI ZATI ON			0. 12974			
60. 00   06000   LABORATORY			0. 08982		145, 921	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 15209			
65. 00   06500   RESPI RATORY THERAPY			0. 18212			
66. 00 06600 PHYSI CAL THERAPY			0. 24248		16, 579	
67. 00 06700 OCCUPATI ONAL THERAPY			0. 14093		6, 241	67. 00
68. 00   06800   SPEECH PATHOLOGY			0. 18399		3, 585	68. 00
69. 00 06900 ELECTROCARDI OLOGY			0. 07014			
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 23786		4, 061	
70. 01  07001   SLEEP LAB			0.00000		0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			1. 38802		144, 170	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 80829		48, 013	
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 63549		215, 832	
76. 97 07697 CARDIAC REHABILITATION			0. 24080			76. 97
74 OO O74OO UVDEDDADLC OVVCEN THEDADY			0 1//5/	El O	۸ .	7/ 00

0. 254086

0. 121840

0. 198550

0. 053380

3, 412

618, 841

94, 906

6, 500, 358

6, 500, 358

76. 98

90.00

91.00

92.00

92.01

95.00

201. 00

202. 00

0

867

0

1, 251, 471 200. 00

75, 400

5, 066

76. 98 07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS

09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS-DISTINCT

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

OTHER REIMBURSABLE COST CENTERS

09000 CLI NI C

09100 EMERGENCY

90.00

91.00

92.00

92.01

95.00

200.00

201.00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/24/2022 5: 22 pm

				5/24/2022 5: 2	2 pm
		Title XVIII	Hospi tal	PPS	
				1 00	
	DADT A LANDATIENT HOCDITAL CEDVICES LINDED LDDS			1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring	prior to October 1 (s	see	70, 156, 405	1. 00
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see				1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for d	ischarges occurring p	orior to October	0	1. 03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for d	ischarges occurring o	on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions			0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (see			427, 978	1
2.04	Outlier payments for discharges occurring on or after October 1 (	see instructions)		229, 932	2. 04
3.00	Managed Care Simulated Payments			48, 740, 496	1
4. 00	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment	g period (see instrud	ctions)	412. 24	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most re- or before 12/31/1996. (see instructions)	cent cost reporting p	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the c new programs in accordance with 42 CFR 413.79(e)	riteria for an add-or	n to the cap for	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified unde			0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions.	CFR §412.105(f)(1)(IN	/)(B)(2) If the	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) 1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots report straddles July 1, 2011, see instructions.	under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital		0. 00	8. 02	
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)			0. 00	9. 00
	FTE count for allopathic and osteopathic programs in the current	year from your record	ls	0.00	•
	FTE count for residents in dental and podiatric programs.				11. 00
	Current year allowable FTE (see instructions)				12. 00
13. 00	Total allowable FTE count for the prior year.			0. 00	•
14. 00	Total allowable FTE count for the penultimate year if that year electric otherwise enter zero.	nded on or after Sept	ember 30, 1997,	0. 00	14. 00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16.00	Adjustment for residents in initial years of the program			12. 14	16. 00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17. 00
18.00	Adjusted rolling average FTE count			12. 14	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0. 029449	19. 00
20.00	Prior year resident to bed ratio (see instructions)			0. 029449	20. 00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 029449	21. 00
	IME payment adjustment (see instructions)			1, 484, 958	
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of	the MMA		777, 996	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$ .		R 412. 105	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
	If the amount on line 24 is greater than -0-, then enter the lowe instructions)	r of line 23 or line	24 (see	0. 00	ı
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
	IME payments adjustment factor. (see instructions)			0. 000000	1
	IME add-on adjustment amount (see instructions)			0.000000	28. 00
	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			1, 484, 958	•
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			777, 996	•
30. 00	Percentage of SSI recipient patient days to Medicare Part A patie	nt days (see instruct	i ons)	2.44	30. 00
	Percentage of Medicaid patient days (see instructions)	30,0 (000 111011 00)	,	12. 23	1
	Sum of lines 30 and 31			14. 67	1
	Allowable disproportionate share percentage (see instructions)			0.00	ı
	Disproportionate share adjustment (see instructions)				34. 00
			'		

	Financial Systems COMMUNITY MEDIC ATION OF REIMBURSEMENT SETTLEMENT		In Lie	u of Form CMS-2 Worksheet E	2552-10
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0041	From 01/01/2021	Part A	
			To 12/31/2021	Date/Time Prep 5/24/2022 5: 2:	
		Title XVIII	Hospi tal	PPS	<u> </u>
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		8, 290, 014, 521	7, 192, 008, 710	35. 00
35. 01	Factor 3 (see instructions)		0. 000291743	0. 000600364	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se	е 0	0	35. 02
35. 03	instructions) Pro rata share of the hospital uncompensated care payment amounts and the second control of the second care payment amounts are second care payment.	ount (coo i netrusti one)	0	0	35. 03
36. 00	1		0	U	36.00
	Additional payment for high percentage of ESRD beneficiary di				
40. 00	Total Medicare discharges (see instructions)		0		40. 00
41.00	Total ESRD Medicare discharges (see instructions)	ti ana)	0		41.00
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see instruct Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		41. 01 42. 00
43.00	Total Medicare ESRD inpatient days (see instructions)	ry ron adjustment)	0.00		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44. 00
	days)				45.00
45.00	Average weekly cost for dialysis treatments (see instructions		0.00		45. 00 46. 00
46.00	Total additional payment (line 45 times line 44 times line 41 Subtotal (see instructions)	1.01)	95, 173, 679		46.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48. 00
	only. (see instructions)	·			
				Amount	
49. 00	Total payment for inpatient operating costs (see instructions	2)		1. 00 95, 951, 675	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			7, 361, 326	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li		0	52. 00	
53. 00	Nursing and Allied Health Managed Care payment			30, 899	
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			983, 035 0	54. 00 54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line &	59)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see intr			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. I	•	hrough 35).	1, 234, 034	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		221, 443	
59. 00	Total (sum of amounts on lines 49 through 58)			105, 782, 412	59.00
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	Line 60)		17, 465 105, 764, 947	60. 00 61. 00
62. 00	Deductibles billed to program beneficiaries	s Title 00)		8, 629, 852	
63. 00	Coinsurance billed to program beneficiaries			493, 783	63. 00
64.00	Allowable bad debts (see instructions)			1, 867, 799	64. 00
65.00	Adjusted reimbursable bad debts (see instructions)			1, 214, 069	1
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		462, 673	1
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS DBCs (s	oo instructions)	97, 855, 381 0	67. 00 68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	, , ,	· .	0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(101 301 300 That do thon	3)	0	70.00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)	tructions)		0	70. 88
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	tructions)		0	70. 89 70. 90
70. 90	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 93	HVBP payment adjustment amount (see instructions)			-747, 226	70. 93
70. 94	HRR adjustment amount (see instructions)			-1, 011, 213	
	Recovery of accelerated depreciation				70. 95

Health Financial Systems COM	MUNITY MEDICAL CENTED		In Lie	u of Form CMS 1	DEE2 10
Health Financial Systems CON CALCULATION OF REIMBURSEMENT SETTLEMENT	MUNITY MEDICAL CENTER	CN: 31-0041	Peri od:	u of Form CMS-2 Worksheet E	2552-10
CALCULATION OF REINIBURSEMENT SETTLEMENT	Pi ovi dei C		From 01/01/2021	Part A	
			To 12/31/2021	Date/Time Pre	pared:
- <u></u>				5/24/2022 5: 2	2 pm
	Ti tl e	e XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (y			0	0	70. 96
the corresponding federal year for the period pri				0	70.07
70. 97 Low volume adjustment for federal fiscal year (yy			0	0	70. 97
the corresponding federal year for the period end	aring on or arter 1071)			0	70.00
70.98 Low Volume Payment-3 70.99 HAC adjustment amount (see instructions)				254 000	70. 98 70. 99
	(minus lines (0 % 70)			254, 800	
71.00 Amount due provider (line 67 minus lines 68 plus, 71.01 Seguestration adjustment (see instructions)	/IIII nus Titles 69 & 70)			95, 842, 142	71. 00 71. 01
, , , , , , , , , , , , , , , , , , , ,	ww.cotrotion			0	
71. 02 Demonstration payment adjustment amount after sec	questration			Ü	71. 02
71.03   Sequestration adjustment-PARHM pass-throughs 72.00   Interim payments				99, 430, 576	71. 03 72. 00
				99, 430, 576	72.00
				0	
73.00   Tentative settlement (for contractor use only) 73.01   Tentative settlement-PARHM (for contractor use on	21.4)			Ü	73.00
74.00 Balance due provider/program (line 71 minus lines	3,			-3, 588, 434	
74. 00 Barance due provider/program (Title 71 millius Titles	5 /1.01, /1.02, /2, and			-3, 300, 434	74.00
74.01 Balance due provider/program-PARHM (see instructi	one)				74. 01
75. 00 Protested amounts (nonallowable cost report items				8, 641, 420	
CMS Pub. 15-2, chapter 1, §115.2	3) I'll accordance with			0, 041, 420	73.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 9	26)				
90.00 Operating outlier amount from Wkst. E, Pt. A, Iir				0	90. 00
plus 2.04 (see instructions)	,			_	
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92.00 Operating outlier reconciliation adjustment amoun	nt (see instructions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount				0	93.00
94.00 The rate used to calculate the time value of mone	ey (see instructions)			0.00	94.00
95.00 Time value of money for operating expenses (see i	,			0	95. 00
96.00 Time value of money for capital related expenses				0	96. 00
	•		Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment					
101.00 HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	1
102.00 HVBP adjustment amount for HSP bonus payment (see	e instructions)		0	0	102. 00
HRR Adjustment for HSP Bonus Payment					
103.00 HRR adjustment factor (see instructions)			0.0000	0.0000	l
104.00 HRR adjustment amount for HSP bonus payment (see	instructions)		0	0	104.00

	1.00	2.00	
HSP Bonus Payment Amount			
00.00 HSP bonus amount (see instructions)	0	0	100. (
HVBP Adjustment for HSP Bonus Payment			
01.00 HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101. (
02.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. (
HRR Adjustment for HSP Bonus Payment			
03.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103. (
04.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. (
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
00.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 0
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. (
02.00 Medicare discharges (see instructions)			202. (
03.00 Case-mix adjustment factor (see instructions)			203. (
Computation of Demonstration Target Amount Limitation (N/A in first year of the curren	t 5-year demonst	rati on	
peri od)			
04.00 Medicare target amount			204. 0
05.00 Case-mix adjusted target amount (line 203 times line 204)			205. (
06.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. (
Adjustment to Medicare Part A Inpatient Reimbursement			
07.00 Program reimbursement under the §410A Demonstration (see instructions)			207. (
08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.
09.00 Adjustment to Medicare IPPS payments (see instructions)			209.
10.00 Reserved for future use			210.
11.00 Total adjustment to Medicare IPPS payments (see instructions)			211.
Comparision of PPS versus Cost Reimbursement			
12.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. (
13.00 Low-volume adjustment (see instructions)			213. (
18.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. (
(line 212 minus line 213) (see instructions)			

| Period: | Worksheet E | From 01/01/2021 | Part A Exhibit 4 | Date/Time Prepared: | 5/24/2022 5:22 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 31-0041

						0 12/31/2021	5/24/2022 5: 22	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	1.00	1.00	2. 00	3.00	4. 00	5. 00	1. 00
1.00	payments	1.00	U	0	0	U	ď	1.00
1. 01	DRG amounts other than outlier	1. 01	70, 156, 405	0	70, 156, 405		70, 156, 405	1. 01
	payments for discharges		.,,				,	
	occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	22, 874, 406	0		22, 874, 406	22, 874, 406	1. 02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	0	0	0		0	1. 03
	operating payment for Model 4	1.00	١	· ·			Ĭ	00
	BPCI occurring prior to							
	October 1							
1. 04	DRG for Federal specific	1. 04	0	0		0	0	1. 04
	operating payment for Model 4 BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 00
	discharges (see instructions)							
2.01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
	discharges for Model 4 BPCI	0.00	407.070				407.070	
2. 02	Outlier payments for	2. 03	427, 978	0	427, 978		427, 978	2. 02
	discharges occurring prior to October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	229, 932	0		229, 932	229, 932	2. 03
	discharges occurring on or			·		,,,,	,	
	after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation	3. 00	10 710 104	0	24 250 100	12 400 204	10 710 104	4. 00
4.00	Managed care simulated payments	3.00	48, 740, 496	U	36, 250, 100	12, 490, 396	48, 740, 496	4.00
	Indirect Medical Education Adj	ustment						
5.00	Amount from Worksheet E, Part	21.00	0. 029449	0. 029449	0. 029449	0. 029449		5. 00
	A, line 21 (see instructions)							
6. 00	IME payment adjustment (see	22. 00	1, 484, 958	0	1, 119, 837	365, 121	1, 484, 958	6. 00
4 01	instructions)	22. 01	777, 996	0	E70 404	100 272	777 004	4 01
6. 01	IME payment adjustment for managed care (see	22.01	111, 990	Ü	578, 624	199, 372	777, 996	6. 01
	instructions)							
	Indirect Medical Education Adj	ustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0.000000	0. 000000		7.00
	(see instructions)		_	_	_	_	_	
8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
0.01	for managed care (see	20.01	U	Ü	0	O	ď	0. 01
	instructions)							
9.00	Total IME payment (sum of	29. 00	1, 484, 958	0	1, 119, 837	365, 121	1, 484, 958	9. 00
	lines 6 and 8)							
9. 01	Total IME payment for managed	29. 01	777, 996	0	578, 624	199, 372	777, 996	9. 01
	care (sum of lines 6.01 and 8.01)							
	Disproportionate Share Adjustm	ent			1			
10.00	Allowable disproportionate	33.00	0. 0000	0.0000	0.0000	0. 0000		10.00
	share percentage (see							
	instructions)							
11. 00	Disproportionate share adjustment (see instructions)	34.00	이	0	0	0	0	11. 00
11. 01	Uncompensated care payments	36.00	0	0	0	0	0	11. 01
11.01	Additional payment for high pe		D beneficiary (			<u> </u>	Ü	11.01
12. 00	Total ESRD additional payment	46.00	0	0	0	0	0	12. 00
	(see instructions)							
13. 00	Subtotal (see instructions)	47. 00	95, 173, 679	0	71, 704, 220	23, 469, 459	95, 173, 679	
14. 00	Hospital specific payments	48. 00	이	0	0	0	0	14. 00
	(completed by SCH and MDH,							
	small rural hospitals only.) (see instructions)							
15. 00	Total payment for inpatient	49. 00	95, 951, 675	0	72, 282, 844	23, 668, 831	95, 951, 675	15. 00
2.00	operating costs (see			0	_, _32, 311	2, 220, 001	2, 12., 570	50
	instructions)							
16. 00	Payment for inpatient program	50.00	7, 361, 326	0	5, 553, 003	1, 808, 323	7, 361, 326	16. 00
	capital (from Wkst. L, Pt. I,							
	ifapplicable)	I	ı l		I	ı l	I	

						rom 01/01/2021 o 12/31/2021	Date/Time Pre	pared:
				Title	xVIII	Hospi tal	5/24/2022 5: 2 PPS	2 piii
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54.00	983, 035	0	756, 064	226, 970	983, 034	17. 00
17. 01	Net organ aquisition cost		_	_		_	_	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	(	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	(	0	0	18. 00
19. 00	,			0	78, 591, 911	25, 704, 124	104, 296, 035	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2. 00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	7, 049, 849	0	5, 320, 512	1, 729, 337	7, 049, 849	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(	0	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	21, 024	0	13, 287	7, 737	21, 024	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	(	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0111	0. 0111	0. 0111	0. 0111		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	78, 253	0	59, 057	19, 196	78, 253	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0301	0. 0301	0. 0301	0. 0301		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	212, 200	0	160, 147	52, 053	212, 200	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	7, 361, 326	0	5, 553, 003	1, 808, 323	7, 361, 326	26. 00
		W/S E, Part A						
		line	Part A)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.000000	0. 000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				)	0	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	О	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100. 00
	ladjustments to WKST. E, PT. A.	I	I I		I	I	I	I

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION		TION EXHIBIT 5	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/24/2022 5:2	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	70, 156, 405	70, 156, 40!	5	70, 156, 405	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	22, 874, 406		22, 874, 406	22, 874, 406	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	(		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	(	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	427, 978	427, 978	3	427, 978	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	229, 932		229, 932	229, 932	2. 03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0 48, 740, 496	36, 250, 100	0 12, 490, 396	0 48, 740, 496	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 029449	0. 02944	9 0. 029449		5. 00
6.00	(see instructions)  IME payment adjustment (see instructions)	22.00	1, 484, 958			1, 484, 958	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	777, 996		199, 372	777, 996	6. 01
7. 00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	27.00	0. 000000	0. 00000	0.00000		7. 00
7.00	instructions)	27.00	0.00000	0.00000	0.000000		7.00
8.00	IME adjustment (see instructions)	28. 00	0	(	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	(	J O	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	1, 484, 958	1, 119, 83	7 365, 121	1, 484, 958	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	777, 996	578, 624	199, 372	777, 996	9. 01
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33. 00	0,0000	0.000	0.0000		10.00
10.00	(see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	0	(	0	0	11. 00
11. 01	Uncompensated care payments Additional payment for high percentage of ESR	36.00	di scharges	(	0	0	11. 01
12. 00		46. 00	0	(	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	95, 173, 679	71, 704, 220	23, 469, 459	95, 173, 679	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	(	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	95, 951, 675	72, 282, 84	23, 668, 831	95, 951, 675	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	7, 361, 326	5, 553, 003	1, 808, 323	7, 361, 326	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	983, 035	756, 06!	226, 970	983, 035	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	(	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	(	0	0	
19. 00	SUBTOTAL			78, 591, 912	25, 704, 124	104, 296, 036	19. 00

Heal th	Financial Systems	COMMUNITY MED	DICAL CENTER		In lie	u of Form CMS-:	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULAT			Provi der C	Provi der CCN: 31-0041		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2022 5:22 pm	
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	7, 049, 849	5, 320, 512	1, 729, 337	7, 049, 849	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21.00	Capital DRG outlier payments	2.00	21, 024	13, 287	7, 737	21, 024	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0111	0. 0111	0. 0111		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	78, 253	59, 057	19, 196	78, 253	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0301	0. 0301	0. 0301		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	212, 200	160, 147	52, 053	212, 200	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	7, 361, 326	5, 553, 003	1, 808, 323	7, 361, 326	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	(		0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-747, 226	-747, 226	0	-747, 226	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-1, 011, 213	-787, 128	-224, 085	-1, 011, 213	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0		0	0	31. 01

0

70. 99

1.00

Υ

0

2.00

254, 800

3.00

(Amt. to Wkst. E, Pt. A)

4.00

254, 800

32. 00

100. 00

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	Peri od: Worksheet E From 01/01/2021 Part B To 12/31/2021 Date/Time Prepared:

		T' II WILL II	5/24/2022 5: 2	2 pm
Medical and other services (see instructions)		Title XVIII Hospital	PPS	
Medical and other services (see instructions)			1, 00	
Medical and other services relianureed under DPPS (see Instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES		
0.00   Or   Designation   1.00   0.		1		
0.00   1.00		,		
0.000   0.00				
Inter the hospital specific payment to cost ratio (see instructions)			1	
Line 2 Times   Line 5		1		
2.00   Ancillary service other pass through costs from Wist. D. Pt. IV. col. 13, line 200   2.00			0.000	
9.00   Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200   281,415   9.00   10.00   Total cost (sun of lines 1 and 10) (see instructions)   47,173   11.00   200,000   200,			0.00	
10.00   Organ acquisitions   0   10.00	8.00	Transitional corridor payment (see instructions)	0	8. 00
1.00   Total cost (sum of lines 1 and 10) (see instructions)	9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	281, 415	9. 00
Computation of FISSER of COST OR CHARGES   Reasonable charges   Reasonable charges   Reasonable charges   Reasonable charges   Reasonable charges   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable charges (20 ml of 11 ms 12 and 13)   Reasonable (20 ml of 12 ml of			1	
Reusemble charges	11. 00		47, 173	11. 00
2.00   Ancil lary service charges   87,002   12.00   13.00   Organ acquisition charges (from West. D.4, Pt. 111, col. 4, line 69)   97,002   14.00   1018   reasonable charges (gui of lines 12 and 13)   15.00   Aggregate enount actually collected from patients liable for payment for services on a chargebasis   15.00   Aggregate enount actually collected from patients liable for payment for services on a chargebasis   15.00   Aggregate enount actually collected from patients liable for payment for services on a chargebasis   15.00   15.				
13.00   Organ acquisition charges (From West, D-4, Pt. III. col. 4, line 69)   0.13.00	12 00		87 002	12 00
14. 00   Total reasonable charges (sum of lines 12 and 13)				
Customary charges   Cust				
16. 00   Amounts that would have been real ized from patients liable for payment for services on a chargebasis   0   16. 00   Natio of line 15 to line 16 (not to exceed 1,000000)   07.00				
had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   17.00	15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
17.00   Ratio of   Info   15 to   Ine   16 (not to exceed   1.000000)	16. 00		0	16. 00
18. 00   Total customary charges (see instructions)   87,002   18. 00   10   10   10   10   10   10   10	47.00			47.00
19.00   Excess of customary Charges over reasonable cost (complete only if line 18 exceeds line 11) (see   39, 929   19.00			1	
Instructions		,		
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00	19.00		39, 029	19.00
Instructions   47,173   21.00	20. 00		0	20. 00
22.00   Interns and residents (see instructions)   0.22.00   22.00   22.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   47, 201,597   24.00   26				
23.00   Cost of physicians' services in a teaching hospital (see instructions)   47, 201,597   24.00	21. 00	Lesser of cost or charges (see instructions)	47, 173	21. 00
24.00   Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9)   47, 201, 597   24.00				
COMPUTATION OF REIMBURSEMENT SETTLEMENT   S. 00   Deductibles and coinsurance amounts (for CAH, see instructions)   3, 160   25, 00   Deductible sand coinsurance amounts (for CAH, see instructions)   7, 291, 266   26, 00   Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   7, 291, 266   26, 00   Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   7, 291, 266   26, 00   Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   28, 00   Deductible sand coinsurance amounts (from Wkst. E-4, line 36)   28, 00   29, 00   Seb direct medical education costs (from Wkst. E-4, line 36)   30, 954, 344   30, 00   30, 00   Subtotal (sum of lines 27 through 29)   39, 954, 344   30, 00   30, 00   Subtotal (sum of lines 27 through 29)   39, 954, 344   30, 00   30, 00   Subtotal (line 30 minus line 31)   32, 00   33, 00   34, 00   Alj usated reimbursable bad debts (see instructions)   728, 69   34, 00   35, 00   36, 00   Alj usated reimbursable bad debts (see instructions)   728, 69   34, 00   37, 00   39, 00   30, 00   Subtotal (see instructions)   40, 401, 510   37, 00   39, 00   39, 50   39,		, , ,	1	
25. 00   Deductible sand coinsurance amounts (For CAH, see instructions)   3. 160   25. 00   20. 00   Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see   39, 954, 344   27. 00   27. 00   27. 00   28. 00   29. 00   28. 00   29. 00	24. 00		47, 201, 597	24. 00
26. 00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   7, 291, 266   26. 00	25 00		2 140	25 00
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   39,954,344   27.00				
Instructions				
28.00   Direct graduate medical education payments (From Wkst. E-4, line 50)   0   28.00   0   0   0   0   0   0   0   0   0				
30.00   Subtotal (sum of lines 27 through 29)   39,954,344   30.00   26,486   31.00   31.00   Primary payer payments   26,486   31.00   32.00   Subtotal (line 30 minus line 31)   39,927,858   32.00   Subtotal (line 30 minus line 31)   0.00   34.00   AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   728,696   34.00   33.00   Allowable bad debts (see instructions)   728,696   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   282,108   36.00   37.00   Subtotal (see instructions)   282,108   36.00   37.00   Subtotal (see instructions)   40.401,510   37.00   39.00   39.00   39.50   ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0.39,00   39.50   70 loneer ACO demonstration payment adjustment (see instructions)   39.90	28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
32.00			1	
32.00   Subtotal (line 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   728,696   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   473,652   35.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   282,108   36.00   37.00   Subtotal (see instructions)   40,401,510   37.00   39.00   MSP-LCC reconciliation amount from PS&R   -1,914   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97   9.97   Demonstration payment adjustment (see instructions)   0   39.97   39.98   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   40,403,424   40.00   40.01   Sequestration adjustment (see instructions)   40,403,424   40.00   40.01   Sequestration adjustment (see instructions)   40,03   40.01   Sequestration adjustment (see instructions)   40,02   Demonstration payment adjustment amount after sequestration   40,03   40.01   40.02   40.02   40.02   40.03		,		
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33. 00   33. 00   Composite rate ESRD (from Wkst. I-5, I ine 11)   0   33. 00   34. 00   All lowable bad debts (see instructions)   728,696   34. 00   35. 00   Adjusted reimbursable bad debts (see instructions)   282,108   36. 00   37. 00   38. 00   All lowable bad debts for dual etilgible beneficiaries (see instructions)   282,108   36. 00   37. 00   Subtotal (see instructions)   40, 401,510   37. 00   38. 00   MSP-LCC reconcilitation amount from PS&R   40, 401,510   37. 00   39. 00   MSP-LCC reconcilitation amount from PS&R   40, 401,510   37. 00   39. 00   MSP-LCC reconcilitation amount from PS&R   40, 401,510   37. 00   39. 00   MSP-LCC reconcilitation amount from PS&R   40, 401,510   37. 00   39. 90   MSP-LCC reconcilitation amount from PS&R   40, 401,510   37. 00   39. 90   MSP-LCC reconcilitation amount from PS&R   40, 401,510   37. 00   39. 90   MSP-LCC reconcilitation amount from PS&R   41, 401,401   41,401   4		3,3,1,3		
33.00   Composite rate ESRD (from Wist. 1-5, line 11)   33.00   34.0	32.00		39, 927, 858	32.00
34. 00   All owable bad debts (see instructions)   728,696   34. 00   35. 00   Adjusted reimbursable bad debts (see instructions)   473,652   35. 00   36. 00   All owable bad debts for dual eligible beneficiaries (see instructions)   282,108   36. 00   37. 00   Subtotal (see instructions)   40,401,510   37. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   -1,914   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39. 00   39. 50   Ploneer ACO demonstration payment adjustment (see instructions)   39. 50   Ploneer ACO demonstration payment adjustment (see instructions)   39. 50   99. Partial or full credits received from manufacturers for replaced devices (see instructions)   39. 97   99. Partial or full credits received from manufacturers for replaced devices (see instructions)   39. 99   40. 00   Subtotal (see instructions)   40. 40. 40. 40. 40. 40. 40. 40. 40. 40.	33 00		1 0	33 00
35.00   Adjusted reimbursable bad debts (see instructions)   282, 108   36.00   30.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   282, 108   36.00   37.00   Subtotal (see instructions)   40,401,510   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -1,914   38.00   39.00   OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   39.97   Pioneer ACO demonstration payment adjustment amount before sequestration   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.99   40.00   Subtotal (see instructions)   40,403,424   40.00   40.01   40.00   40.0				
36. 00   Al Towable bad debts for dual eligible beneficiaries (see instructions)   282, 108   36. 00   37. 00   39. 00				
38. 00   MSP-LCC reconciliation amount from PS&R   -1, 914   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 39. 00   39. 00   39. 90   39. 50   91   oneer ACO demonstration payment adjustment amount before sequestration   0 39. 97   39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39. 98   39. 99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39. 98   39. 99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39. 98   39. 99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 40. 02   Partial credits received from manufacturers for replaced devices (see instructions)   0 40. 02   Partial credits received from manufacturers for replaced devices (see instructions)   0 40. 02   Partial credits received from manufacturers for replaced devices (see instructions)   0 40. 02   Partial credits received from manufacturers for replaced devices (see instructions)   0 40. 02   Partial credits received from manufacturers for replaced devices (see instructions)   0 40. 02   Partial credits received from manufacturers for replaced devices (see instructions)   0 40. 02   Partial credits received from manufacturers for replaced devices (see instructions)   0 40. 02   Partial credits received from manufacturers for replaced devices (see instructions)   0 40. 02   Partial credits received from manufacturers for replaced devices (see instructions)   1 40. 02   Partial credits received from manufactur	36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	282, 108	36.00
39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       39. 00         39. 50       Pioneer ACO demonstration payment adjustment (see instructions)       39. 57         39. 97       Demonstration payment adjustment amount before sequestration       0 39. 97         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0 39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0 39. 99         40. 00       Subtotal (see instructions)       40. 403, 424       40. 00         40. 01       Sequestration adjustment (see instructions)       0 40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0 40. 01         40. 03       Sequestration adjustment-PARHM pass-throughs       0 40. 02         41. 00       Interim payments-PARHM       39, 609, 140       41. 00         41. 01       Interim payments-PARHM       41. 00       42. 00         42. 01       Tentative settlement (for contractors use only)       42. 01         43. 01       Bal ance due provider/program-PARHM (see instructions)       794, 284       43. 01         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 10. 01       44. 00         415. 15.       2       70. 02       70. 02				
39.50   Pi oneer ACO demonstration payment adjustment (see instructions)   39.50	38. 00	MSP-LCC reconciliation amount from PS&R	-1, 914	38. 00
39.97   Demonstration payment adjustment amount before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   40,403,424   40.00   40.01   Sequestration adjustment (see instructions)   40.01   Demonstration payment adjustment amount after sequestration   0   40.02   40.03   Sequestration adjustment-PARHM pass-throughs   41.00   Interim payments   39,609,140   41.00   41.01   Interim payments-PARHM   41.01   Interim payments-PARHM (for contractors use only)   42.01   Tentative settlement (for contractor use only)   42.01   Tentative settlement (for contractor use only)   42.01   Bal ance due provider/program (see instructions)   794,284   43.00   43.01   Bal ance due provider/program (see instructions)   43.01   Bal ance due provider/program (see instructions)   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   9   44.00   45.01   45			0	
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39.98 RECOVERY OF ACCELERATED DEPRECIATION  40.00 Subtotal (see instructions)  40.403, 424  40.00  40.01 Sequestration adjustment (see instructions)  40.02 Demonstration payment adjustment amount after sequestration  5 Sequestration adjustment-PARHM pass-throughs  41.00 Interim payments  41.01 Interim payments-PARHM  42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement (for contractor use only)  43.00 Bal ance due provider/program (see instructions)  43.01 Bal ance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5 Do Do Outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 The rate used to calculate the Time Value of Money  92.00 Time Value of Money (see instructions)  93.99  39.99  40.03  40.40  40.00  40.01  40.01  40.02  40.03  41.00  41.00  42.00  42.00  42.00  42.01  43.01  44.00  44.00  45.01  46.00  47.01  47.01  47.01  48.00  49.00  49.00  49.00  49.00  49.00  49.00  49.00  49.00  49.00  49.00  49.00  49.00  49.00  49.00			_	
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99				
40.00       Subtotal (see instructions)       40, 403, 424       40.00         40.01       Sequestration adjustment (see instructions)       0 40.01         40.02       Demonstration payment adjustment amount after sequestration       0 40.02         40.03       Sequestration adjustment-PARHM pass-throughs       39,609,140       41.00         41.01       Interim payments       39,609,140       41.01         42.00       Interim payments-PARHM       41.01         42.01       Tentative settlement (for contractors use only)       0 42.00         43.01       Bal ance due provider/program (see instructions)       794,284         43.01       43.00         43.01       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00       44.00         90.00       Original outlier amount (see instructions)       0 90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0 91.00         92.00       The rate used to calculate the Time Value of Money (see instructions)       0 93.00				
40. 01 Sequestration adjustment (see instructions)  40. 02 Demonstration payment adjustment amount after sequestration  Sequestration adjustment -PARHM pass-throughs  1 Interim payments  1 Interim payments-PARHM  1 Interim payments-PARHM  1 Interim payments-PARHM  1 Interim payments-PARHM  2 Interim payments-PARHM  2 Interim payments-PARHM  3 (00 payments)  4 (10 payments)  4 (			1	
40. 02 Demonstration payment adjustment amount after sequestration  40. 03 Sequestration adjustment-PARHM pass-throughs  41. 00 Interim payments  41. 01 Interim payments-PARHM  42. 00 Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM (for contractor use only)  43. 00 Balance due provider/program (see instructions)  43. 01 Balance due provider/program-PARHM (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 \$\frac{1}{5}\$115. 2  \text{TO BE COMPLETED BY CONTRACTOR}  90. 00 Outlier reconciliation adjustment amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  93. 00 Time Value of Money (see instructions)  0 40. 02  40. 03  41. 00  41. 00  41. 01  42. 01  42. 01  43. 00  43. 01  44. 00  45. 01  47. 02  47. 02  48. 00  49. 00  90. 00  91. 00  91. 00  91. 00  92. 00  93. 00  93. 00  93. 00			1	
40. 03   Sequestration adjustment-PARHM pass-throughs   40. 03   41. 00   1nterim payments   41. 00   41. 01   1nterim payments   42. 00   42. 00   42. 00   42. 00   43. 00   43. 01   43. 00   8al ance due provider/program (see instructions)   43. 00   8al ance due provider/program PARHM (see instructions)   43. 01   44. 00				
41.00   Interim payments   39,609,140   41.00   41.01   1nterim payments-PARHM   41.01   1nterim payments-PARHM   41.01   42.00   Tentative settlement (for contractor use only)   0   42.00   42.01   1nterim payments-PARHM (for contractor use only)   0   42.00   43.00   8al ance due provider/program (see instructions)   794,284   43.00   43.01   8al ance due provider/program-PARHM (see instructions)   43.01   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   15.2				
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 42.00 42.00 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 43.00 42.01 43.00 43.01 44.00 91.01 90.02 90.03 90.04 91.04 91.05 92.06 93.00		, ,	39, 609, 140	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions)	41.01	Interim payments-PARHM		41. 01
43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Og 93.00			0	
43.01  44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  §115.2  TO BE COMPLETED BY CONTRACTOR  90.00  Original outlier amount (see instructions)  91.00  Outlier reconciliation adjustment amount (see instructions)  92.00  The rate used to calculate the Time Value of Money  93.00  Time Value of Money (see instructions)  93.00				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0 93.00			794, 284	
\$115. 2 TO BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 93. 00 93. 00				
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00 93.00	44. 00		0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00 93.00				
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	90 00		0	90. 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00 93.00				
93.00 Time Value of Money (see instructions) 0 93.00		· · · · · · · · · · · · · · · · · · ·		
94.00   Total (sum of lines 91 and 93) 0   94.00	93. 00		0	93. 00
	94. 00	Total (sum of lines 91 and 93)	0	94. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	Peri od: From 01/01/2021	Worksheet E Part B
	Component CCN: 31-5490	To 12/31/2021	Date/Time Prepared: 5/24/2022 5:22 pm
	Title XVIII	Skilled Nursing	PPS

Medical and others send sets (see Instructions)			Title XVIII	Skilled Nursing Facility	PPS	
ART B				raciiity	1.00	
Medical and other services (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
3.00	1.00				2, 784	1. 00
0.01   Continer payment (see instructions)   4.00   Cottler reconcilitation amount (see instructions)   4.00   Cottler reconcilitation amount (see instructions)   4.00   Cottler reconcilitation amount (see instructions)   5.00   5.		· ·	i ons)		0	
4.01   Out   Fer reconcilitation amount (see instructions)   5.00   Enter the hospital specific payment to cost ratio (see instructions)   5.00   6.00   1.00   6.00						
Enter the hospit bill specific payment to cost ratio (see instructions)   5.00						
Line 2 Times   Line 5		, ,	ctions)			
3.00   Comparison   Corridor payment (see Instructions)   0. 8.00   0. 00			•			6. 00
9,00   Ancil lary service other pass through costs from West. D, Pt. IV, col. 13, line 200   0,00   0,00   0,00   0,00   0,000   0,00						
0.00   10.00		· ·	V col 12 line 200			
1.00   Total cost (sam of lines 1 and 10) (see instructions)   2,784   1.00			v, cor. 13, Title 200			
Reasonable charges		,				
12.00   Ancil lary service charges   4, 381   12.00   13.00   Organ acquist it on charges (from West. D4, Pt. 111, col. 4, line 69)   4, 381   14.00   13.00   Organ acquist it on charge (sum of lines 12 and 13)   4, 381   14.00   3.00						
13.00   Organ acquisition charges (From Wisks D-4, Pt. III, col. 4, line 69)	12.00				4 201	12 00
14.00		, , , , , , , , , , , , , , , , , , , ,	ne 69)			
Designation   Content			110 07)			
16.00   Amounts that would have been real ized from patients   iable for payment for services on a chargebasis   0   16.00   Nature payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000						
had such payment been made in accordance with 42 CFR \$413.13(e)		, 00 0	3			
17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00	16. 00			n a chargebasis	0	16. 00
18.00   Total customary charges (see instructions)   1.597   19.00   19.00   Excess of customary charges over reasonable cost (complete only	17. 00		·)		0. 000000	17. 00
instructions						18. 00
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00	19. 00		y if line 18 exceeds li	ne 11) (see	1, 597	19. 00
instructions   2,784   21.00     1.00   Interns and residents (see instructions)   0,20.00     22.00   Interns and residents (see instructions)   0,20.00     23.00   Cost of physicians' services in a teaching hospital (see instructions)   0,20.00     24.00   Total prospective payment (sum of lines 3, 4, 4,01, 8 and 9)   0,24.00     25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   0,25.00     26.00   Deductibles and coinsurance amounts (for CAH, see instructions)   0,25.00     27.00   Subtotal ([lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0,20.00     28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0,20.00     28.00   Direct graduate medical education costs (from Wkst. E-4, line 36)   0,20.00     29.00   ESRO direct medical education costs (from Wkst. E-4, line 36)   0,20.00     29.00   Subtotal (sum of lines 27 through 29)   2,784   30.00     30.00   Subtotal (sum of lines 27 through 29)   2,784   30.00     30.00   Subtotal (line 30 minus line 31)   2,784   30.00     30.00   Subtotal (line 30 minus line 31)   2,784   30.00     30.00   Composite rate ESRO (from Wkst. I-5, line 11)   0,30.00     30.00   Adjusted reimbursable bad debts (see instructions)   0,30.00     30.00   Adjusted reimbursable bad debts (see instructions)   0,30.00     30.00   Subtotal (see instructions)   0,30.00     30.00   Subtotal (see instructions)   0,30.00     30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0,30.00     30.00   Subtotal (see instructions)   0,30.00     30.00   OTHER ADJUSTMENTS (SEE Instructions)   0,30.00     30.00   OT	20.00		v if line 11 exceeds li	no 10) (coo		20.00
2.784   21.00	20.00		y II IIIle II exceeds II	116 10) (366	٥	20.00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   0.23.00   24.00   CoMPUTATION OF REIMBURSEMENT SETTLEMENT   0.24.00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   0.25.00   Deductible sand coinsurance amounts (for CAM, see instructions)   0.26.00   Deductible sand coinsurance amounts relating to amount on line 24 (for CAM, see instructions)   26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAM, see instructions)   26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAM, see instructions)   26.00   Distructions)   26.00   Distructions)   27.84   27.00   Distructions   27.84   27.00   Distructions   28.00   Distructi	21. 00				2, 784	21. 00
A		· · · · · · · · · · · · · · · · · · ·				
COMPUTATION OF RELIMBURSEMENT SETTLEMENT			ructions)			
25.00   Deductible sand col nsurance amounts (For CAH, see instructions)   26.00   26.00   Deductible sand Col nsurance amounts of line 24 (for CAH, see instructions)   26.00   27.00   Subtotal [(I] ins 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   2,784   27.00   1.00   27.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   29.00   28.00   29.00	24.00			<u> </u>	0	24.00
26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2.6.00	25. 00		5)		0	25. 00
Instructions		Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instr			
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28.00   0   29.00   29.00   SERD direct medical education costs (from Wkst. E-4, line 36)   0   29.00   30.00   30.00   Subtotal (sum of lines 27 through 29)   2,784   30.00   7	27. 00		olus the sum of lines 22	and 23] (see	2, 784	27. 00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   30.00   Subtotal (sum of lines 27 through 29)   30.00   31.00   7 marry payer payments   0.31.00   31.00   32.00   3	28 00		ne 50)		0	28 00
31.00   Subtotal (line 30 minus line 31)   2,784   32.00						
32.00   Subtortal (line 30 minus line 31)   2,784   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRO (from Wkst. 1-5, line 11)   0 33.00   34.00   Allowable bad debts (see instructions)   0 35.00   35.00   Allowable bad debts (see instructions)   0 35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 35.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 35.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 35.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 36.00   Subtotal (see instructions)   0 36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 39.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 39.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 39.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 39.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 39.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 39.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 39.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 39.00   39.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 39.00   39.00		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, I ine 11)   0   34.00   34.00   34.10 wable bad debts (see instructions)   0   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00   36.00   Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   2,784   37.00   38.00   MSP-LCC reconciliation amount from PS&R   38.00   MSP-LCC reconciliation amount from PS&R   38.00   MSP-LCT reconciliation amount before sequestrations   39.00   39.00   MSP-LCT reconciliation payment adjustment (see instructions)   39.90   MSP-LCT reconciliation payment adjustment sequestration   0   39.97   MSP-LCT reconciliation payment adjustment payment adjustment reconciliation adjustment (see instructions)   0   39.97   MSP-LCT reconciliation adjustment (see instructions)   0   40.01   40.01   MSP-LCT reconciliation adjustment amount after sequestration   0   40.01						
33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   34.00   All lowable bad debts (see instructions)   0   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   36.00   MI lowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   2,784   37.00   38.00   MSP-LCC reconciliation amount from PS&R   38.00   MSP-LCC reconciliation amount from PS&R   38.00   MSP-LCC reconciliation amount from PS&R   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Demonstration payment adjustment discount before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   39.99   RCCOVERY OF ACCELERATED EDEPRECIATION   0   39.99   40.00   Sequestration adjustment (see instructions)   2,784   40.00   40.01   Sequestration adjustment amount after sequestration   0   40.01   40.01   40.02   Demonstration payment adjustment amount after sequestration   0   40.02   40.03   40.01   40.02   40.03   40.01   40.02   40.03   40.01   40.02   40.03	32.00		EFS)		2, 784	32.00
35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00     36.00   Adjusted reimbursable bad debts (see instructions)   0   36.00     37.00   Subtotal (see instructions)   2,784     37.00   38.00   MSP-LCC reconciliation amount from PS&R   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50     39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50     39.97   Demonstration payment adjustment amount before sequestration   39.97     39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99     40.00   Subtotal (see instructions)   2,784   40.00     40.01   Sequestration adjustment (see instructions)   2,784   40.00     40.02   Demonstration payment adjustment amount after sequestration   40.02     40.03   Sequestration adjustment (see instructions)   40.02     40.04   Sequestration adjustment amount after sequestration   40.02     40.02   Demonstration payment adjustment amount after sequestration   40.02     40.03   Sequestration adjustment (see instructions)   40.02     40.04   Sequestration adjustment (for contractors use only)   40.02     40.05   Sequestration adjustment (for contractor use only)   40.02     40.06   Sequestration adjustment (for contractor use only)   40.02     40.07   Sequestration (for contractor use only)   40.01     40.08   Sequestration (for contractor use only)   40.01     40.09   Sequestration (for contractor use only)   40.01     40.00   Sequestration (for contractor use only)   40.01     40.01   Sequestration (for contractor use only)   40.01     40.01   Sequestration (for contractor use only)   40.01     40.02   Sequestration (for contractor use only)   40.01     40.01   Sequestration (for contractor use only)   40.01     40.02   Sequestration (for contractor use only)   40.01     40.03   Sequestration (for contractor use only)   40.01     40.04   Sequestration (for contractor use only)   40.01     40.05   Sequestration (for contractor use only)   40.01     40.06	33. 00				0	33. 00
36.00						
37. 00   Subtotal (see instructions)   2, 784   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   38. 00   MSP-LCC reconciliation amount from PS&R   38. 00   MSP-LCC reconciliation amount from PS&R   38. 00   39. 00		· · · · · · · · · · · · · · · · · · ·				
38. 00   MSP-LCC reconciliation amount from PS&R   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0.39. 00   0.39. 00   39. 00   39. 00   39. 00   39. 00   39. 97   39. 97   39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0.39. 98   39. 98   20. 00   39. 99   20. 00		,	uctions)			
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.00   39.00   39.00   39.50   50   50   50   50   50   50   50					2, 701	
39. 97 39. 98 39. 98 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 97 39. 98 39. 99 30. 00 30. 00 30. 00 30. 99 30. 99 30. 00 30. 00 30. 99 30. 99 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 90 30. 99 30. 99 30. 99 30. 99 30. 99 30. 99 30. 90 30	39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       2, 784       40. 00         40. 01       Demonstration adjustment (see instructions)       0       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 03         41. 01       Interim payments       4, 381       41. 00         42. 01       Tentative settlement (for contractors use only)       42. 00         42. 01       Tentative settlement-PARHM (for contractor use only)       42. 01         43. 00       Balance due provider/program (see instructions)       -1, 597       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00         90. 00       Original outlier amount (see instructions)       90. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       91. 00         92. 00       The rate used to calculate the Time Value of Money       93. 00		, , , , , , , , , , , , , , , , , , , ,	5)			
39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment—PARHM pass—throughs 41. 00 Interim payments 41. 01 Interim payments—PARHM 42. 00 Tentative settlement—PARHM (for contractors use only) 42. 01 Tentative settlement—PARHM (for contractor use only) 43. 00 Bal ance due provider/program (see instructions) 43. 01 Bal ance due provider/program—PARHM (see instructions) 43. 01 Bal ance due provider/program—PARHM (see instructions) 43. 01 Original outlier amount (see instructions) 44. 00 Tentative settlement—PARHM (see instructions) 45. 01 Tentative settlement—PARHM (see instructions) 46. 01 Tentative settlement—PARHM (see instructions) 47. 01 Tentative settlement—PARHM (see instructions) 48. 01 Tentative settlement—PARHM (see instructions) 49. 00 Tentative settlement—PARHM (see instructions) 40. 01 Tentative settlement—PARHM (see instructions) 40. 02 Tentative settlement—PARHM (see instructions) 41. 01 Tentative settlement—PARHM (see instructions) 42. 01 Tentative settlement—PARHM (see instructions) 43. 01 Tentative settlement—PARHM (see instructions) 44. 00 Tentative settlement—PARHM (see instructions) 45. 01 Tentative settlement—PARHM (see instructions) 46. 02 Tentative settlement—PARHM (see instructions) 47. 00 Tentative settlement—PARHM (see instructions) 48. 01 Tentative settlement—PARHM (see instructions) 49. 00 Tentative settlement—PARHM (see instructions) 40. 02 Tentative settlement—PARHM (see instructions) 41. 01 Tentative settlement—PARHM (see instructions) 42. 01 Tentative settlement—PARHM (see instructions) 43. 01 Tentative settlement—PARHM (see instructions) 44. 00 Tentative settlement—PARHM (see instructions) 45. 01 Tentative settlement—PARHM (see instructions) 46. 02 Tentative settlement—PARHM (see instructions) 47. 00 Tentative settlement—PARHM (see instructions) 48. 01 Tentative settlement—PARHM (see instructions) 49. 00 Tentative settlement—PARHM (see instructions			end devices (see instruc	tions)		
40.00 Subtotal (see instructions) 40.01 Sequestration adj ustment (see instructions) 40.02 Demonstration payment adj ustment amount after sequestration 40.03 Sequestration adj ustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 43.01 Protested amounts (see instructions) 44.00 Original outlier amount (see instructions) 45.01 Tentative settlement (for contractor use only) 46.00 Tentative settlement (for contractor use only) 47.00 Demonstration and use only and the payments of		· ·	devices (see instruc	(10113)		
40.02 Demonstration payment adjustment amount after sequestration  40.03 Sequestration adjustment-PARHM pass-throughs  41.00 Interim payments  41.01 Interim payments-PARHM  42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement (for contractor use only)  43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, one of the contractor of the contr					2, 784	
40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 4,381 41.00 41.01 Interim payments-PARHM Tentative settlement (for contractors use only) 42.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  To BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions) 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 79.00 The rate used to calculate the Time Value of Money 79.00 Time Value of Money (see instructions) 93.00		, , , , , , , , , , , , , , , , , , , ,				
41.00 Interim payments 4, 381 41.00 41.01 Interim payments-PARHM Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 597 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 590 Original outlier amount (see instructions) 591.00 Outlier reconciliation adjustment amount (see instructions) 792.00 The rate used to calculate the Time Value of Money 793.00 Time Value of Money (see instructions) 793.00					0	
41.01 Interim payments-PARHM  42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)  43.00 Bal ance due provider/program (see instructions)  43.01 Bal ance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00		, ,			4 381	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00		l			1, 001	
43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 First 15.2 To BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Pub. 15-2, chapter 1,		Tentative settlement (for contractors use only)			0	42. 00
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00					1 507	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\sqrt{115.2}}{\sqrt{10 BE COMPLETED BY CONTRACTOR}}\$  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00					-1, 597	
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00			nce with CMS Pub. 15-2.	chapter 1,	0	
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00		§115. 2		' '		
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 91.00 92.00 93.00	00.00					00.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 92.00 93.00						
93.00 Time Value of Money (see instructions) 93.00						
94.00   Iotal (sum of lines 91 and 93)   94.00						
	94. 00	lotal (sum of lines 91 and 93)			ļ	94. 00

| Period: | Worksheet E-1 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/24/2022 5:22 pm Health Financial Systems COMMANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 31-0041

					5/24/2022 5: 2	2 pm
			XVIII	Hospi tal	PPS	
		Inpatien	nt Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		98, 144, 482		39, 609, 140	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/29/2021	1, 546, 290		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	12/17/2021	260, 196		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		1, 286, 094		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		99, 430, 576		39, 609, 140	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		794, 284	6. 01
6.02	SETTLEMENT TO PROGRAM		3, 588, 434		0	6. 02
7.00	Total Medicare program liability (see instructions)		95, 842, 142		40, 403, 424	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	I		0	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Peri od: From 01/01/2021 To 12/31/2021 Part I To 12/31/2021 Date/Time Prepared: 5/24/2022 5: 22 pm Skilled Nursing PPS Provider CCN: 31-0041 Component CCN: 31-5490 Title XVIII

		Title	XVIII	Skilled Nursing Facility	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 363, 579	9	4, 381	1. 00
2.00	Interim payments payable on individual bills, either		(	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		(	O	0	3. 01
3.02				O	0	3. 02
3.03				O	0	3. 03
3. 04				0	0	3. 04
3. 05			(	0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM				0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51					0	3. 52
3. 53				Ď	Ö	3. 53
3. 54					Ö	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(	)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 363, 579	9	4, 381	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(	D	0	5. 01
5.02				D	0	5. 02
5. 03			(	<u> </u>	0	5. 03
E E0	Provider to Program TENTATIVE TO PROGRAM				0	E E0
5. 50 5. 51	TENTATIVE TO PROGRAM				0	5. 50 5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		(	0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 2/2 57		1, 597	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 363, 578	Contractor	2, 784 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	·				. '	

	Financial Systems COMMUNITY MEDIATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	Peri od:	u of Form CMS-2 Worksheet E-3	
CALCOL	ATTON OF RETWINDORSEMENT SETTLEMENT	11001461 6614. 31 6641	From 01/01/2021	Part VI	
		Component CCN: 31-5490	To 12/31/2021	Date/Time Pre 5/24/2022 5: 2	
		Title XVIII	Skilled Nursing Facility	PPS	
				1 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OT	HED HEALTH SERVICES FOR T	TITE YVIII DADT A	1. 00	
	SERVICES	TIER TIERETTI SERVICES FOR T	TILL AVIII IAKI A	TITS SINI	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				İ
. 00	Resource Utilization Group Payment (RUGS)			1, 387, 879	1.00
. 00	Routine service other pass through costs			0	2.00
. 00	Ancillary service other pass through costs			0	3.00
. 00	Subtotal (sum of lines 1 through 3)			1, 387, 879	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Medical and other services (Do not use this line as vaccine	costs are included in lin	e 1 of W/S E,		5. 00
00	Part B. This line is now shaded.)			0	, 00
00	Deducti bl e			0	
00	Coinsurance			24, 301	1
00	Allowable bad debts (see instructions) Reimbursable bad debts for dual eligible beneficiaries (see	instructions)		0	
0.00	Adjusted reimbursable bad debts (see instructions)	Tristi ucti oris)		0	10.00
1. 00	Utilization review			0	
2. 00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines	10 and 11)(see instruction	ns)	1, 363, 578	
3. 00	Inpatient primary payer payments		,	0	1
4. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.00
4. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	14. 50
4. 98	Recovery of accelerated depreciation.			0	14. 98
1. 99	Demonstration payment adjustment amount before sequestration			0	1 , ,
5. 00	Subtotal (see instructions			1, 363, 578	15. 00
5. 01	Sequestration adjustment (see instructions)			0	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration for non-claims based amounts (see instructions	)		0	
	Interim payments			1, 363, 579	
	Tentative settlement (for contractor use only)			0	
8. 00	Balance due provider/program (line 15 minus lines 15.01, 15.	02, 15.75, 16, and 17)		-1	18.00

18.00 Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)
19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,

§115. 2

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0041	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2022 5:22 pm

			To 12/31/2021	Date/Time Pre 5/24/2022 5: 2	
		Title XIX	Hospi tal	TEFRA	2 piii
		THE XIX	I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	VIOLO I OK TITLEO V OK AL	. 02 02.0		
1.00	Inpatient hospital/SNF/NF services		2, 446, 029		1.00
2. 00	Medical and other services		27 . 107 02 7	1, 282, 229	2. 00
3. 00	Organ acquisition (certified transplant centers only)		0	.,	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		2, 446, 029	1, 282, 229	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2, 446, 029	1, 282, 229	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8. 00
9.00	Ancillary service charges		6, 500, 358	3, 294, 216	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		6, 500, 358	3, 294, 216	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis			_	
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15 00	a charge basis had such payment been made in accordance with 4	2 CFR §413. 13(e)	0.000000	0.000000	15 00
15. 00 16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		0. 000000 6, 500, 358	0. 000000 3, 294, 216	1
17. 00	Excess of customary charges over reasonable cost (complete only	v if line 16 exceeds	4, 054, 329	2, 011, 987	17. 00
17.00	line 4) (see instructions)	y II IIIle 16 exceeds	4, 034, 329	2,011,907	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	vifline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y II IIIIc 4 cxcccd3 IIIIc		O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		2, 446, 029	1, 282, 229	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	,		2, 446, 029	1, 282, 229	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		_		
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2, 446, 029	1, 282, 229	
32.00	Deducti bl es		0	0	
33. 00			0	0	
34. 00	· · · · · · · · · · · · · · · · · · ·		0	0	34.00
35. 00 36. 00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	22)	2 444 020	1, 282, 229	35. 00 36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	2, 446, 029	1, 202, 229	37.00
	Subtotal (line 36 ± line 37)		2, 446, 029	1, 282, 229	1
	Direct graduate medical education payments (from Wkst. E-4)		2, 440, 029 O	1, 202, 227	39.00
40. 00			2, 446, 029	1, 282, 229	
41. 00	Interim payments		2, 766, 510	509, 680	
42. 00	Balance due provider/program (line 40 minus line 41)		-320, 481	772, 549	
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	0	772, 347	•
	chapter 1, §115.2			· ·	
	•		,		•

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	Peri od: From 01/01/2021	Worksheet E-3
	Component CCN: 31-5490		Date/Time Prepared: 5/24/2022 5:22 pm
	Title XIX	Skilled Nursing	Cost

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES  COMPUTATION OF NET COST OF COVERED SERVICES  1. 00 Inpatient hospital/SNF/NF services 2. 00 Medical and other services 3. 00 Organ acquisition (certified transplant centers only) 4. 00 Subtotal (sum of lines 1, 2 and 3)  Organ acquisition (certified transplant centers only)  Organ acquisition (certified transplant centers only)  Organ acquisition (certified transplant centers only)	0utpati ent 2.00 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1.00  PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES  COMPUTATION OF NET COST OF COVERED SERVICES  1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services 3.00 Organ acquisition (certified transplant centers only)  0	2.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES  COMPUTATION OF NET COST OF COVERED SERVICES  1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services 3.00 Organ acquisition (certified transplant centers only)  0	0 0	2. 00 3. 00 4. 00 5. 00 6. 00
COMPUTATION OF NET COST OF COVERED SERVICES  1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services 3.00 Organ acquisition (certified transplant centers only)  0	0	2. 00 3. 00 4. 00 5. 00 6. 00
1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services 3.00 Organ acquisition (certified transplant centers only) 0	0	2. 00 3. 00 4. 00 5. 00 6. 00
2.00 Medical and other services 3.00 Organ acquisition (certified transplant centers only)	0	2. 00 3. 00 4. 00 5. 00 6. 00
3.00 Organ acquisition (certified transplant centers only)	0	3. 00 4. 00 5. 00 6. 00
	0	4. 00 5. 00 6. 00
1. 00 Subtotal (Sum of 11105 1, 2 and 0)	0	5. 00 6. 00
5.00 Inpatient primary payer payments 0		6. 00
6.00 Outpatient primary payer payments		
7.00 Subtotal (line 4 less sum of lines 5 and 6)		,, 00
COMPUTATION OF LESSER OF COST OR CHARGES		
Reasonable Charges		
8. 00 Routi ne servi ce charges 0		8. 00
9.00 Ancillary service charges	0	9. 00
10.00 Organ acquisition charges, net of revenue	١	10. 00
11.00 Incentive from target amount computation		11. 00
12.00 Total reasonable charges (sum of lines 8 through 11)	0	
CUSTOMARY CHARGES	_	
13.00 Amount actually collected from patients liable for payment for services on a charge	0	13. 00
basis	-	
14.00 Amounts that would have been realized from patients liable for payment for services on 0	0	14.00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		
15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.0000000	0.000000	15. 00
16.00 Total customary charges (see instructions)	0	16. 00
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0	0	17. 00
line 4) (see instructions)		
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0	0	18.00
16) (see instructions)		
19.00   Interns and Residents (see instructions) 0	0	19. 00
20.00 Cost of physicians' services in a teaching hospital (see instructions)	0	20.00
21.00 Cost of covered services (enter the lesser of line 4 or line 16)	0	21. 00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.		
22.00 Other than outlier payments	0	22. 00
23.00 Outlier payments	0	23. 00
24.00 Program capital payments		24. 00
25.00 Capital exception payments (see instructions)		25. 00
26.00 Routine and Ancillary service other pass through costs	0	26. 00
27.00 Subtotal (sum of lines 22 through 26)	0	27. 00
28.00 Customary charges (title V or XIX PPS covered services only)	0	28. 00
29.00 Titles V or XIX (sum of lines 21 and 27)	0	29. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30.00 Excess of reasonable cost (from line 18)	0	
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	31. 00
32. 00   Deducti bl es   0	0	32. 00
33.00   Coinsurance   0	0	33. 00
34.00 Allowable bad debts (see instructions)	0	34.00
35.00 Utilization review 0		35. 00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	36. 00
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37. 00
38.00   Subtotal (line 36 ± line 37)   0	0	38. 00
39.00 Direct graduate medical education payments (from Wkst. E-4)		39. 00
40.00 Total amount payable to the provider (sum of lines 38 and 39)	0	40. 00
41.00   Interim payments 0	0	41. 00
42.00 Balance due provider/program (line 40 minus line 41)	0	42. 00
43.00 Protested anounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	43. 00
chapter 1, §115.2	ļ	

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT EDUCATION COSTS	Provi der Co	CN: 31-0041	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prep 5/24/2022 5:22	
		Title	XVIII	Hospi tal	PPS	- P
					1. 00	
	OMPUTATION OF TOTAL DIRECT GME AMOUNT					
	Jnweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.	orograms for	cost reporti	ng peri ods	0. 00	1. 00
	Jnweighted FTE resident cap add-on for new programs per 42 CFI	R 413.79(e)(	1) (see insti	ructions)	0. 00	2. 0
1	Amount of reduction to Direct GME cap under section 422 of MM/		0440 70 ( )		0.00	3. 0
	Direct GME cap reduction amount under ACA §5503 in accordance nstructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	9413.79 (m).	(see	0. 00	3. 0
. 00 A	,					4. 0
	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost roporti	na nori ode	0.00	4. 0
	straddling 7/1/2011)	uctions for	cost reporti	ng perrous	0.00	4. 0
. 02 A	ACA Section 5506 number of additional direct GME FTE cap slots	s (see inst	ructions for	cost reporting	0. 00	4. 0
	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plo	ıs or minus	line 4 nlus l	ines 4 01 and	0.00	5. 0
	4.02 plus applicable subscripts	as or illi rias	Time i prus i	Thes I. or and	0.00	0.00
	Unweighted resident FTE count for allopathic and osteopathic	orograms for	the current	year from your	0. 00	6. 0
1	records (see instructions) Enter the lesser of line 5 or line 6				0. 00	7. 00
			Primary Car		Total	
. 00 W	Weighted FTE count for physicians in an allopathic and osteopa	athi c	1.00	2.00	3. 00	8. 0
	program for the current year.	atili C	0.1	0.00	0.00	0. 0
	fline 6 is less than 5 enter the amount from line 8, otherwinultiply line 8 times the result of line 5 divided by the amou		0. (	0.00	0. 00	9. 0
-	). Noightad dontal and madiatria regident FTF count for the ourse	n+		0.00		10.0
	Veighted dental and podiatric resident FTE count for the curro Jnweighted dental and podiatric resident FTE count for the cu			0. 00 0. 00		10. 0 10. 0
1. 00 T	Total weighted FTE count	,	0.0	0.00		11. 0
	Fotal weighted resident FTE count for the prior cost reporting nstructions)	g year (see	0. (	0.00		12. 0
	Tistructions) Fotal weighted resident FTE count for the penultimate cost re	porting	0. (	0.00		13. 0
1	year (see instructions)	hv. 2)	0.0	0.00		14. 0
	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	by 3).	0.0			15. 0
5. 01 U	Jnweighted adjustment for residents in initial years of new pr		5. 8			15. 0
	Adjustment for residents displaced by program or hospital clos Unweighted adjustment for residents displaced by program or ho		0. (			16. 0 16. 0
	onwergnted adjustment for residents displaced by program of his closure	JSpi tai	0.1	0.00		10. 0
	Adjusted rolling average FTE count		0. (			17. 00
- 1	Per resident amount Approved amount for resident costs		0. (	0.00	0	18. 0 19. 0
7. 00   A	approved allount for resident costs			0 0	0	19.0
					1. 00	
	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	ceived under 42	0. 00	20. 0
1	Direct GME FTE unweighted resident count over cap (see instruc	ctions)			0. 00	21. 0
1	Allowable additional direct GME FTE Resident Count (see instru				0.00	
1	Enter the locality adjustment national average per resident an Multiply line 22 time line 23	mount (see i	nstructions)		0. 00 0	23. 0 24. 0
	Fotal direct GME amount (sum of lines 19 and 24)				0	25. 0
				rt Managed Care	Total	
			1. 00	2. 00	3. 00	
6. 00 T	OMPUTATION OF PROGRAM PATIENT LOAD  npatient Days (see instructions) (Title XIX - see S-2 Part I)	X, line	51, 8	72 28, 335		26. 00
- 1	3.02, column 2) Fotal Inpatient Days (see instructions)		112, 7	41 112, 741		27. 0
	Ratio of inpatient days to total inpatient days		0. 4600			28. 00
9. 00 P	Program direct GME amount			0 0	0	29. 0
1	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage			4. 07	0	29. 0° 30. 00
0.00 R						

Health Financial Systems COMMUNITY MEDICAL CENTER DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCI		Provider CCN: 31-0041	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2021 To 12/31/2021	Date/Time Prep 5/24/2022 5: 22	
		Title XVIII	Hospi tal	PPS	
				1 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	F XVIII ONLY (NURSING PR	OGRAM AND PARAMED	1. 00	
	EDUCATION COSTS)	LE XVIII ONE! (NONOTINO III	TOOTO IIII TIND I TIIV IIII EE	, ONE	
32.00					
	and 94)				
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	0	33.00
	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
	Medicare outpatient ESRD charges (see instructions)			0	35. 00 36. 00
36. 00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			123, 815, 911	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00
	Primary payer payments (see instructions)			17, 465	
41. 00					41. 00
	Part B Reasonable Cost			E4 404 070	
	Reasonable cost (see instructions)			51, 494, 373	
43. 00	Primary payer payments (see instructions)			26, 486	
	Total Part B reasonable cost (line 42 minus line 43)			51, 467, 887	
	Total reasonable cost (sum of lines 41 and 44)	44 11 45		175, 266, 333	
	Ratio of Part A reasonable cost to total reasonable cost (lin	,		0. 706345	
47.00	Ratio of Part B reasonable cost to total reasonable cost (lir ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 293655	47.00
10 00		KI B		0	48. 00
	Total program GME payment (line 31)	(and instructions)		0	48.00
	-				
5U. UU	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see mstructions)	ı	0	50.00

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

Worksheet G 21 21 Date/Time Prepared: 5/24/2022 5:22 pm

Offi y)					5/24/2022 5: 2	2 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS	T				
1.00	Cash on hand in banks	10, 025		0		1.00
2.00	Temporary investments	0	0	0		2.00
3. 00 4. 00	Notes recei vable	40 012 502	0	0	0	3. 00 4. 00
5.00	Accounts receivable Other receivable	60, 012, 583	0	0		5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-15, 734, 113	1	0	0	6.00
7. 00	Inventory	9, 646, 571	1	0	0	7. 00
8. 00	Prepaid expenses	3, 419, 050		0	Ö	8.00
9. 00	Other current assets	12, 046, 395		0	o o	9. 00
10.00	Due from other funds	386, 117, 146		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	455, 517, 657		0	0	11. 00
	FIXED ASSETS					
12.00	Land	198, 713	0	0	0	12. 00
13.00	Land improvements	2, 567, 723	0	0	0	13. 00
14.00	Accumulated depreciation	-2, 184, 051	0	0	0	14. 00
15. 00	Bui I di ngs	274, 635, 092	1	0		15. 00
16. 00	Accumulated depreciation	-128, 409, 547	1	0	0	16. 00
17. 00	Leasehold improvements	5, 183, 612	1	0	0	17. 00
18. 00	Accumulated depreciation	-5, 181, 987	1	0	0	18. 00
19. 00	Fi xed equipment	77, 147, 012		0	0	19. 00
20. 00	Accumul ated depreciation	-71, 426, 208	1	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation	105 075 004	0	0	0	22. 00
23. 00	Maj or movable equipment	135, 375, 201		0	0	23. 00
24. 00	Accumulated depreciation	-105, 903, 541	1	0	0	24. 00
25. 00	Mi nor equipment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation HIT designated Assets		0	0	0	26. 00 27. 00
27. 00 28. 00	Accumulated depreciation		0	0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e			0	l	29.00
30.00	Total fixed assets (sum of lines 12-29)	182, 002, 019		0		30.00
30.00	OTHER ASSETS	102,002,019	7 0	U	0	30.00
31. 00	Investments	500	0	0	0	31.00
32. 00	Deposits on Leases	0	0	0	1	32. 00
33. 00	Due from owners/officers	0	o o	0	0	33. 00
34.00	Other assets	26, 330, 242	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26, 330, 742		0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	663, 850, 418	0	0	0	36. 00
	CURRENT LI ABILITIES					
37. 00	Accounts payable	20, 947, 152	2 0	0		37. 00
38. 00	Salaries, wages, and fees payable	14, 574, 070	1	0		38. 00
39. 00	Payroll taxes payable	4, 336, 875	1	0	0	39. 00
40. 00	Notes and Loans payable (short term)	0	0	0	0	40. 00
41. 00	Deferred income	257, 376	0	0	0	41.00
42.00	Accel erated payments	0	)			42.00
43.00	Due to other funds	774, 120		0	0	43. 00
44. 00	Other current liabilities	71, 030, 432	1		0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	111, 920, 025	0	0	0	45. 00
46. 00	Mortgage payable	1	0	0	0	46. 00
47. 00	Notes payable		0	0	1	47. 00
48. 00	Unsecured Loans		o o	_	l	48. 00
49. 00	Other long term liabilities	157, 724, 369		0	l	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	157, 724, 369		-	l	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	269, 644, 394			l	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	394, 206, 024				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant		1		0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on		1			
59. 00	Total fund balances (sum of lines 52 thru 58)	394, 206, 024		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	663, 850, 418	0	0	0	60.00
	[59]	I	I			l

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 31-0041

Period: Worksheet G-1 From 01/01/2021

Date/Time Prepared: 5/24/2022 5:22 pm 12/31/2021 General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 394, 351, 605 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -4, 242, 231 2.00 3.00 Total (sum of line 1 and line 2) 390, 109, 374 0 3.00 4.00 OTHER 4, 441, 893 0 0 4.00 5.00 0 5.00 6.00 0 6.00 0 0 7.00 0 7.00 0 8.00 0 8.00 0 0 9.00 0 9. 00 10.00 Total additions (sum of line 4-9) 4, 441, 893 10.00 Subtotal (line 3 plus line 10) 394, 551, 267 0 11.00 11.00 12.00 NON-OPERATING REVENUE 345, 243 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 345, 243 18.00 Fund balance at end of period per balance 394, 206, 024 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 **OTHER** 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 NON-OPERATING REVENUE 0 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 0 18.00 18.00 Fund balance at end of period per balance 0 0 19.00 19.00 Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 31-0041

		10	12/31/2021	5/24/2022 5:22	
Cost Center Description		Inpatient	Outpati ent	Total	, p
		1.00	2. 00	3. 00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00 Hospi tal		496, 471, 665		496, 471, 665	1.00
2. 00 SUBPROVI DER - I PF					2.00
3. 00 SUBPROVI DER - I RF					3.00
4. 00 SUBPROVI DER					4. 00
5.00 Swing bed - SNF		0		0	5. 00
6.00 Swing bed - NF		0		0	6. 00
7.00 SKILLED NURSING FACILITY		9, 563, 244		9, 563, 244	7. 00
8. 00 NURSING FACILITY		1		.,,	8. 00
9. 00 OTHER LONG TERM CARE					9. 00
10.00 Total general inpatient care services (sum of lines 1-9	9)	506, 034, 909		506, 034, 909	10.00
Intensive Care Type Inpatient Hospital Services	′)	000,001,707		000, 001, 707	10.00
11. 00 INTENSIVE CARE UNIT		392, 947, 700		392, 947, 700	11. 00
12. 00 CORONARY CARE UNIT		072,717,700		072, 717, 700	12.00
13. 00 BURN INTENSIVE CARE UNIT					13. 00
14. 00 SURGICAL INTENSIVE CARE UNIT		37, 015, 900		37, 015, 900	14. 00
15. 00 OTHER SPECIAL CARE (SPECIFY)		37,013,700		37, 013, 700	15. 00
16.00 Total intensive care type inpatient hospital services (	cum of Lines	429, 963, 600		429, 963, 600	16. 00
11-15)	Sull of Titles	427, 703, 000		429, 903, 000	10.00
17.00 Total inpatient routine care services (sum of lines 10	and 16)	935, 998, 509		935, 998, 509	17. 00
18.00   Ancillary services	and 10)	473, 507, 138	550 221 525	1, 023, 738, 673	18. 00
19.00 Outpatient services		126, 573, 114	211, 857, 897	338, 431, 011	19. 00
		120, 573, 114	211,007,097	336, 431, 011	
		0	0	0	20.00
21. 00 FEDERALLY QUALIFIED HEALTH CENTER		0	U	U	21. 00
22. 00 HOME HEALTH AGENCY			0	0	22. 00
23. 00 AMBULANCE SERVICES		0	U	0	23. 00
24. 00 CMHC					24. 00
25. 00 AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26. 00 HOSPI CE					26. 00
27. 00 OTHER (SPECIFY)		0	0	0	27. 00
28.00 Total patient revenues (sum of lines 17-27) (transfer co	olumn 3 to Wkst.	1, 536, 078, 761	762, 089, 432	2, 298, 168, 193	28. 00
G-3, line 1)					
PART II - OPERATING EXPENSES		1	4/0 5/4 /40		00.00
29.00 Operating expenses (per Wkst. A, column 3, line 200)			463, 561, 648		29. 00
30. 00 ADD (SPECIFY)		0			30.00
31. 00		0			31.00
32. 00		0			32. 00
33. 00		0			33. 00
34. 00		0			34. 00
35. 00		0			35. 00
36.00 Total additions (sum of lines 30-35)			0		36. 00
37. 00 DEDUCT (SPECIFY)		0			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40. 00		0			40. 00
41. 00		0			41. 00
42.00 Total deductions (sum of lines 37-41)			0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus	line 42)(transfer		463, 561, 648		43.00
to Wkst. G-3, line 4)		1		l l	

111 4-	Figure 1 at Contains	COMMUNITY MEDICAL CENTED	1-11-	6 F OMC (	2552 40
	Financial Systems C ENT OF REVENUES AND EXPENSES	OMMUNITY MEDICAL CENTER  Provider CCN: 31-0041	Period:	u of Form CMS-2 Worksheet G-3	
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN. 31-0041	From 01/01/2021	WOLKSHEET G-3	
			To 12/31/2021		
				5/24/2022 5: 2	2 pm
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I,			2, 298, 168, 193	1. 00
2.00	Less contractual allowances and discounts on pa	iti ents' accounts		1, 854, 961, 793	2. 00
3.00	Net patient revenues (line 1 minus line 2)			443, 206, 400	3. 00
4.00	Less total operating expenses (from Wkst. G-2,			463, 561, 648	4. 00
5.00	Net income from service to patients (line 3 mir	nus line 4)		-20, 355, 248	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous	s communication services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking Lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and guests	5		0	14.00
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical suppl			0	16. 00
17. 00	Revenue from sale of drugs to other than patier	nts		0	17. 00
18. 00	Revenue from sale of medical records and abstra	ncts		0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc	c. )		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and	canteen		0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING REVENUE			3, 479, 209	24.00
24. 01	FEMA C-19			10, 132, 316	24. 01
24. 50	COVI D-19 PHE Funding			2, 501, 492	24. 50
25 00	Total other income (sum of lines 6.24)			16 112 017	25 00

16, 113, 017

-4, 242, 231

25.00

26.00 27. 00 28. 00 0 -4, 242, 231 29. 00

24. 50 COVID-19 PHE Funding
25. 00 Total other income (sum of lines 6-24)
26. 00 Total (line 5 plus line 25)
27. 00 OTHER EXPENSES (SPECIFY)
28. 00 Total other expenses (sum of line 27 and subscripts)
29. 00 Net income (or loss) for the period (line 26 minus line 28)

	<i>J</i>	TY MEDICAL CENTER		u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 31-0041	Peri od: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/24/2022 5:2	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			7, 049, 849	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			21, 024	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the	e cost reporting period (see inst	ructions)	312. 54	3. 00
4.00	Number of interns & residents (see instructions)			12. 14	4. 00
5.00	Indirect medical education percentage (see instruction			1. 11	5. 00
6. 00	Indirect medical education adjustment (multiply line 1.01) (see instructions)		78, 253		
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)				7. 00
8.00	Percentage of Medicaid patient days to total days (see instructions)			12. 23	
9.00				14. 67	9. 00
10.00				3. 01	
11.00	Disproportionate share adjustment (see instructions)			212, 200	
12.00	Total prospective capital payments (see instructions)	)		7, 361, 326	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructi			0	1. 00
2.00	Program inpatient ancillary capital cost (see instruc			0	
3.00	Total inpatient program capital cost (line 1 plus lin	ne 2)		0	
4. 00 5. 00	Capital cost payment factor (see instructions)	4)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line	4)		U	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2. 00 3. 00	Program inpatient capital costs for extraordinary cir Net program inpatient capital costs (line 1 minus lin			0	3.00
4.00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances	•		0.00	
7.00	Adjustment to capital minimum payment level for extra	aordinary circumstances (line 2 >	(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12,			0	
10.00	Current year comparison of capital minimum payment le			0	
11. 00	Carryover of accumulated capital minimum payment leve	el over capital payment (from pri	or year	0	11. 00
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to ca	anital nayments (line 10 plus lin	no 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive			0	
14. 00	Carryover of accumulated capital minimum payment leve			0	
50	(if line 12 is negative, enter the amount on this line				50
15. 00	3 .	•		0	15. 00
	Current year operating and capital costs (see instruc	ctions)		0	16. 00
	Current year exception offset amount (see instruction			0	