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 EXPI RES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 31-0041 Period: Worksheet S From 01/01/2024 Parts I-III AND SETTLEMENT SUMMARY 12/31/2024 Date/Time Prepared: 5/28/2025 10:36 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/28/2025 Time: 10:36 am] Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor]Cost Report Status 11. Contractor's Vendor Code: (1) As Submitted use only (2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [O] If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [N] Final Report for this Provider CCN number of times reopened = 0-9.

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY MEDICAL CENTER (31-0041) for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Richa	rd Henwood	ı	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 chard Henwood			2
3	Signatory Title	VP CORP REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-4, 118, 367	3, 471, 525	0	-1, 877, 224	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	481	0		0	7. 00
200.00	TOTAL	0	-4, 117, 886	3, 471, 525	0	-1, 877, 224	200.00
Tho of	nove amounts represent "due to" or "due from"	the applicable	program for t	he element of	the above compl	ov indicated	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0041 Peri od: Worksheet S-2 From 01/01/2024 Part I Date/Time Prepared: 12/31/2024 5/28/2025 10:36 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 99 ROUTE 37S 1.00 PO Box: 1.00 State: NJ Zip Code: 08755-6423 County: OCEAN 2.00 City: TOMS RIVER 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY MEDICAL 310041 35154 07/01/1967 N 3.00 CENTER Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - 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 Hospital -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital -Based Health Clinic - RHC 15.00 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) 12/31/2024 20.00 01/01/2024 21.00 Type of Control (see instructions) 21.00 2 1.00 3.00 2.00 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. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 for the portion of the cost reporting period occurring prior to October

1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν N 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic redesignation from urban to rural Ν Ν Ν 22.03 as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015 or FY2025? Enter in column 1. "Y" for yes or 'N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas

23.00

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

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

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.

ves or "N" for no.

In Lieu of Form CMS-2552-10 COMMUNITY MEDICAL CENTER Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0041 Worksheet S-2 Peri od: From 01/01/2024 Part I Date/Time Prepared: 12/31/2024 5/28/2025 10:36 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days Medi cai d Medi cai d el i gi bl e days paid days el i gi bl e unpai d days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 827 53 11, 378 315 24.00 2 420 6 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26 00 cost reporting period. Enter "1" for urban or "2" for rural Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38 00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates Y/N Y/N 2.00 1.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume Ν 39.00 N hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for 40.00 Ν N no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For 56.00 Υ 56.00 cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Υ 57.00 is this the first cost reporting period during which residents in approved 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. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of

which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0041 Peri od: Worksheet S-2 From 01/01/2024 Part I Date/Time Prepared: 12/31/2024 5/28/2025 10: 36 am 1. 00 2.00 3.00 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. Ν 58.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60 00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 1 instructions) Y/N LME Direct GME IME Direct GME 1. 00 2. 00 3. 00 4.00 5. 00 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in Ν 0 00 o od 61.00 column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 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 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	COMMUNI	ITY MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 01/01/2024	Worksheet S-2 Part I	pared:
			Unwei ghted		Ratio (col. 1/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te 1.00	2.00	3. 00	
Section 5504 of the ACA Base Yea	ar FTE Residents in N	onprovider Settings				
period that begins on or after of the following seriod that begins on or after of the following seriod that the base year period, the number of the following seriod that the following seriod the following seriod the following seriod that the following seriod the following seriod the following seriod that the following seriod that the following seriod that the following seriod tha	s yes, or your facili aber of unweighted non stations occurring in a 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
of (column 1 divided by (column	1 + column 2)). (see Program Name	instructions) Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	
	11 ogi dili Nalic	Trogram code	FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
(5.00 5.1	1. 00	2. 00	3.00	4.00	5. 00	45.00
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)			Unweighted		Ratio (col. 1/	65. 00
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	nospi tai	2))	
Section 5504 of the ACA Current	Voor ETE Docidonts i	n Nonnrovidor Sotting	1.00	2.00	3. 00	
periods beginning on or after Ju		ii Noripi ovi dei Setti lig	SEITECTIVE I			
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 +	occurring in all nonpo unweighted non-prima cal. Enter in column (column 2)). (see in	rovider settings. ry care resident 3 the ratio of structions)	1. 80			66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00 Entent	1.00	2.00	3.00	4.00	5. 00	(7.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	INTERNAL MEDICINE	1400	0. 71	34. 86	0. 019961	67.00

COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10 Health Financial Systems Worksheet S-2 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0041 From 01/01/2024 Part I Date/Time Prepared: 12/31/2024 5/28/2025 10:36 am 1. 00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 0 71.00 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 0 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1. 00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 87.00 N Approved for Number of Permanent Approved Adjustment Permanent (Y/N)Adjustments 1. 00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν 0 88.00 "Y" for yes or "N" for no. If yes, complete col. 2 and line amount per discharge? Enter 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Wkst. A Line Effective Date Approved No. Permanent Adjustment Amount Per Di scharge 1.00 2.00 3. 00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 89.00 0.00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. ٧/ XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν 90.00 yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in Ν 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.

Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν 94.00 applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. 95.00 0.00 10.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 5.80 97.00

	Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-	-2552-10
HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTIFICATION DATA	Provi der C	F	eriod: rom 01/01/2024 o 12/31/2024	Date/Time Pro	epared:
					V	5/28/2025 10 XI X	. 30 alli
08.00	Does title V or XIX follow Medicare	(title VVIII) for the i	ntorns and ros	sidents post	1. 00 N	2. 00 Y	98.00
	stepdown adjustments on Wkst. B, Pt column 1 for title V, and in column	. I, col. 25? Enter "Y" 2 for title XIX.	for yes or "N'	'for no in		·	
98. 01	Does title V or XIX follow Medicare C, Pt. I? Enter "Y" for yes or "N" title XIX.				N	Y	98. 01
98. 02	Does title V or XIX follow Medicare bed costs on Wkst. D-1, Pt. IV, lin for title V, and in column 2 for ti	e 89? Enter "Y" for yes			N	Y	98. 02
98. 03	Does title V or XIX follow Medicare reimbursed 101% of inpatient service for title V, and in column 2 for ti	e (title XVIII) for a cri es cost? Enter "Y" for y			N	N	98. 03
98. 04	Does title V or XIX follow Medicare outpatient services cost? Enter "Y"		N	N	98. 04		
98. 05	in column 2 for title XIX. Does title V or XIX follow Medicare Wkst. C, Pt. I, col. 4? Enter "Y" f	N	Y	98. 05			
98. 06	column 2 for title XIX. Does title V or XIX follow Medicare Pts. I through IV? Enter "Y" for ye column 2 for title XIX.				N	Y	98. 06
	Rural Providers					I	Ī
	Does this hospital qualify as a CAH If this facility qualifies as a CAH for outpatient services? (see instr	l, has it elected the all	-inclusive met	thod of payment	N		105. 00 106. 00
107. 00	Column 1: If line 105 is Y, is this training programs? Enter "Y" for ye Column 2: If column 1 is Y and lin approved medical education program	s or "N" for no in colum ne 70 or line 75 is Y, do	n 1. (see ins you train L&F	structions) Rs in an			107. 00
107. 01	Enter "Y" for yes or "N" for no in If this facility is a REH (line 3, reimbursement for I&R training prog	column 2. (see instruct column 4, is "12"), is i	ions) teligible for	cost			107. 01
108. 00	instructions) Is this a rural hospital qualifying CFR Section §412.113(c). Enter "Y"		CRNA fee sche	edul e? See 42	N		108. 00
			Physi cal	Occupati onal	Speech 3,00	Respiratory	
109. 00	If this hospital qualifies as a CAH therapy services provided by outsid for yes or "N" for no for each ther	le supplier? Enter "Y"	1.00	Occupati onal 2. 00	Speech 3. 00	Respiratory 4.00	109. 00
109.00	If this hospital qualifies as a CAH therapy services provided by outsid	le supplier? Enter "Y"	1.00			4.00	109.00
	If this hospital qualifies as a CAH therapy services provided by outsid	le supplier? Enter "Y" apy. le Rural Community Hospit reporting period? Enter	al Demonstrati	on project (§4	3.00 10A f yes,		109.00
	If this hospital qualifies as a CAH therapy services provided by outsid for yes or "N" for no for each ther Did this hospital participate in th Demonstration)for the current cost complete Worksheet E, Part A, lines	le supplier? Enter "Y" apy. le Rural Community Hospit reporting period? Enter	al Demonstrati	on project (§4	3.00 10A f yes, gh 215, as	1. 00 N	
110.00	If this hospital qualifies as a CAH therapy services provided by outsid for yes or "N" for no for each ther Did this hospital participate in th Demonstration)for the current cost complete Worksheet E, Part A, lines	le supplier? Enter "Y" lapy. le Rural Community Hospit reporting period? Enter 200 through 218, and Wo l, did it participate in demonstration for this c 1. If the response to c in which this CAH is pa	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in	on project (§4-"N" for no. I ines 200 throu	3.00 10A f yes,	1.00	
110.00	lif this hospital qualifies as a CAH therapy services provided by outsid for yes or "N" for no for each there points and the period of this hospital participate in the Demonstration) for the current cost complete Worksheet E, Part A, lines applicable. If this facility qualifies as a CAH Health Integration Project (FCHIP) "Y" for yes or "N" for no in column integration prong of the FCHIP demo Enter all that apply: "A" for Ambul	le supplier? Enter "Y" lapy. le Rural Community Hospit reporting period? Enter 200 through 218, and Wo l, did it participate in demonstration for this c 1. If the response to c in which this CAH is pa	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in	on project (§4 "N" for no. I ines 200 throu Community period? Enter enter the n column 2. s; and/or "C"	3.00 10A f yes, gh 215, as 1.00 N	1. 00 N	110.00
110.00	If this hospital qualifies as a CAH therapy services provided by outsid for yes or "N" for no for each ther Did this hospital participate in the Demonstration) for the current cost complete Worksheet E, Part A, lines applicable. If this facility qualifies as a CAH Health Integration Project (FCHIP) "Y" for yes or "N" for no in column integration prong of the FCHIP demo Enter all that apply: "A" for Ambul for tele-health services. Did this hospital participate in the (PARHM) demonstration for any portiperiod? Enter "Y" for yes or "N" for "Y", enter in column 2, the date the demonstration. In column 3, enter participation in the demonstration,	le supplier? Enter "Y" rapy. le Rural Community Hospit reporting period? Enter 200 through 218, and Wo I, did it participate in demonstration for this c 1. If the response to c 1. If the response to c 2. In which this CAH is pa ance services; "B" for a le Pennsylvania Rural Hea on of the current cost r for no in column 1. If c 1. If c 1. If c 2. In the column 1. If c 3. In the date the hospital ce 3. In the current cost r 3. In the current cost r 4. In the current cost r 6. In the current	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds Ith Model eporting olumn 1 is pating in the	on project (§4-"N" for no. I ines 200 throu	3.00 10A f yes, gh 215, as	1. 00 N	110.00
110.00	lif this hospital qualifies as a CAH therapy services provided by outsid for yes or "N" for no for each there in the period of this hospital participate in the Demonstration) for the current cost complete Worksheet E, Part A, lines applicable. If this facility qualifies as a CAH Health Integration Project (FCHIP) "Y" for yes or "N" for no in column integration prong of the FCHIP demo Enter all that apply: "A" for Ambul for tele-health services. Did this hospital participate in the (PARHM) demonstration for any portiperiod? Enter "Y" for yes or "N" for y	le supplier? Enter "Y" lapy. le Rural Community Hospit reporting period? Enter 200 through 218, and Wo I, did it participate in demonstration for this c 1. If the response to c 1. If the response	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting ol umn 1 is Y, rticipating ir dditional beds I th Model eporting ol umn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes	on project (§4 "N" for no. I i nes 200 throu Community period? Enter enter the n column 2. s; and/or "C"	3.00 10A f yes, gh 215, as 1.00 N	1. 00 N	110.00
110.00	lif this hospital qualifies as a CAH therapy services provided by outsid for yes or "N" for no for each ther Demonstration) for the current cost complete Worksheet E, Part A, lines applicable. If this facility qualifies as a CAH Health Integration Project (FCHIP) "Y" for yes or "N" for no in column integration prong of the FCHIP demo Enter all that apply: "A" for Ambul for tele-health services. Did this hospital participate in the (PARHM) demonstration for any portiperiod? Enter "Y" for yes or "N" f"Y", enter in column 2, the date the demonstration. In column 3, enter participation in the demonstration, Miscellaneous Cost Reporting Inform is this an all-inclusive rate provi in column 1. If column 1 is yes, en in column 2. If column 2 is "E", en for short term hospital or "98" per psychiatric, rehabilitation and lon	le supplier? Enter "Y" lapy. le Rural Community Hospit reporting period? Enter 200 through 218, and Wo I, did it participate in demonstration for this c 1. If the response to c 1. If the response	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on	on project (§4-"N" for no. I i nes 200 throu	3.00 10A f yes, gh 215, as 1.00 N	1. 00 N	111.00
110. 00 111. 00 112. 00 116. 00	Did this hospital participate in the complete Worksheet E, Part A, lines applicable. If this facility qualifies as a CAH Demonstration) for the current cost complete Worksheet E, Part A, lines applicable. If this facility qualifies as a CAH Health Integration Project (FCHIP) "Y" for yes or "N" for no in column integration prong of the FCHIP demo Enter all that apply: "A" for Ambul for tele-health services. Did this hospital participate in the (PARHM) demonstration for any portiperiod? Enter "Y" for yes or "N" f"Y", enter in column 2, the date the demonstration. In column 3, enter participation in the demonstration, Miscellaneous Cost Reporting Inform Is this an all-inclusive rate proviin column 1. If column 1 is yes, en in column 2. If column 2 is "E", en for short term hospital or "98" per psychiatric, rehabilitation and lon the definition in CMS Pub. 15-1, chals this facility classified as a re	de supplier? Enter "Y" rapy. De Rural Community Hospit reporting period? Enter 200 through 218, and Wo I, did it participate in demonstration for this co 1. If the response to co 1. If the participate in 1. If the participate in 1. If the control in the current cost re 1. If the control in the current cost re 1. If the control in the current cost re 1. If the control in the current cost re 1. If the control in the current cost re 1. If the control in the current cost re 1. If the cost report in the current cost re 1. If the cost report in the current cost re 1. If the cost report in the current cost re 1. If the cost report in the current cost re 1. If the response to co 1. If the resp	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on	on project (\$4 - "N" for no. I i nes 200 throu Community period? Enter enter the n column 2. s; and/or "C"	3.00 10A f yes, gh 215, as 1.00 N	1. 00 N	110.00

SCRETAL AND HOODETAL HEALTH CARE COMPLEY IDENTIFICATION DATA	CAL CENTER	N 04 0044			u of Form CMS	
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	JN: 31-0041	Peri From To	n 01/01/2024 12/31/2024	Worksheet S Part I Date/Time P	
		Premi ums		Lacasa	5/28/2025 1	0:36 am
		Pi eiiii uiiis		Losses	Insurance	
		1.00		2. 00	3. 00	
18.01 List amounts of malpractice premiums and paid losses:			0	0		80 118. C
				1 00	0.00	
18.02 Are malpractice premiums and paid losses reported in a cost of	center other	than the		1. 00 N	2. 00	118. 0
Administrative and General? If yes, submit supporting scheduland amounts contained therein.				IV		
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendment	column 1, "Y alifies for t	" for yes or he Outpatien		N	N	119. C
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	ntable device	s charged to		Υ		121. (
22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1				N		122. 0
the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) pure services, e.g., legal, accounting, tax preparation, bookkeepi management/consulting services, from an unrelated organization for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from a located in a CBSA outside of the main hospital CBSA? In column	ng, payroll, on? In column greater than unrelated org	and/or 1, enter "Y 50% of total anizations		Υ	N	123. (
"N" for no. 24.00 Did the hospital incur cost, either directly or through a cor supplier, to establish and maintain access to no less than a one or more essential medicines according to 42 CFR 412.113(g"N" for no. Certified Transplant Center Information	6-month buff	er stock of				124.
25.00 Does this facility operate a Medicare-certified transplant co		"Y" for yes		N		125. (
and "N" for no. If yes, enter certification date(s) (mm/dd/y 26.00 f this is a Medicare-certified kidney transplant program, er in column 1 and termination date, if applicable, in column 2.	nter the cert	ification da	te			126.
27.00 f this is a Medicare-certified heart transplant program, entire in column 1 and termination date, if applicable, in column 2.	ter the certi					127.
28.00 f this is a Medicare-certified liver transplant program, enting in column 1 and termination date, if applicable, in column 2.29.00 f this is a Medicare-certified lung transplant program, ento			9			128. 129.
in column 1 and termination date, if applicable, in column 2. 0.00 lf this is a Medicare-certified pancreas transplant program,	enter the ce					130.
date in column 1 and termination date, if applicable, in column 1 and termination date	n, enter the	certi fi cati o	ו			131.
2.00 If this is a Medicare-certified islet transplant program, en in column 1 and termination date, if applicable, in column 2.	ter the certi	fication date	9			132.
 3.00 Removed and reserved 4.00 If this is a hospital-based organ procurement organization ((in column 1 and termination date, if applicable, in column 2. 		he OPO numbe	-			133. 134.
All Providers 0.00 Are there any related organization or home office costs as dechapter 10? Enter "Y" for yes or "N" for no in column 1. If yer are claimed, enter in column 2 the home office chain number.	yes, and home	office costs	6	Υ	H53560	140.
1.00 2.00	, sss institut			3. 00		
If this facility is part of a chain organization, enter on I			name		of the	
home office and enter the home office contractor name and co			o m!	Number 1999	\1	141
.1.00 Name: RWJBARNABAS HEALTH Contractor's Name: NOVI .2.00 Street: 95 OLD SHORT HILLS ROAD PO Box:	TAS SULUTION	s Contract	or s	Number: 1200) I	141. 142.
13. 00 City: WEST ORANGE State: NJ		Zi p Code	:	0705	i2	143.
is sojs, c _j . Heat divinoe jatato. No		₁ 2. p code		0,00	<u>-</u>	1,45.

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	COMMUNITY MED X IDENTIFICATION DATA	Provi der CO	CN: 31-0041		i od:	worksheet S-	
				Fror To	m 01/01/2024 12/31/2024	Date/Time Pr	
						5/28/2025 10	D: 36 am
					1. 00	2. 00	
45.00 f costs for renal services are clinpatient services only? Enter "Y' no, does the dialysis facility inc	' for yes or "N" for no ir	n column 1. If	column 1 i				145. (
period? Enter "Y" for yes or "N"	for no in column 2.			,			
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	column 1. (See CMS Pub.			lf	N		146. (
						1. 00	
47.00Was there a change in the statisti	cal basis? Enter "Y" for	yes or "N" for	no.			N N	147.
48.00 Was there a change in the order of						N	148.
49.00 Was there a change to the simplifi	ed cost finding method? E				Title V	N Title XIX	149.
		Part A 1.00	Part 2.00		3.00	4.00	\dashv
Does this facility contain a provi	der that qualifies for a						
costs or charges? Enter "Y" for yo §413.13)	es or "N" for no for each	component for	Part A and	d Part	B. (See 42	CFR	
55. 00 Hospi tal		N	N N		N	N	155.
56.00 Subprovi der - IPF 57.00 Subprovi der - IRF		N N	N N		N N	N N	156. 157.
58. 00 SUBPROVI DER		IN IN	i iv		IN	IN	158.
59. 00 SNF		N	N		N	N	159.
60.00 HOME HEALTH AGENCY		N	N		N	N	160.
61. 00 CMHC			N N		N	N	161.
le con						1. 00	
Multicampus 65.00 s this hospital part of a Multica	ampus hospital that has or	ne or more camp	uses in di	fferen	t CBSAs?	N	165.
Enter "Y" for yes or "N" for no.				71 0		FTF (0	
	Name O	County 1.00	2. 00	Zi p Co 3. 00		FTE/Campus 5.00	+
66.00 fline 165 is yes, for each			2.00	0.00	7 11 00		00 166.
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					Act	N.	
67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10 reasonable cost incurred for the P	05 is "Y") and is a meanir	ngful user (lin			nter the	N	167. 168.
68.01 If this provider is a CAH and is m	not a meaningful user, doe	es this provide			hardshi p		168.
exception under §413.70(a)(6)(ii)′ 69.00 f this provider is a meaningful u	? Enter "Y" for yes or "N" user (line 167 is "Y") and	for no. (see	instruction (line 105	ons) is "N"`). enter the	0.0	00169.
transition factor. (see instruction			(11110 100	,			30.07.
					Begi nni ng	Endi ng	4
70.00 Enter in columns 1 and 2 the EHR I	peginning date and ending	date for the r	eporti ng		1. 00	2. 00	170.
period respectively (mm/dd/yyyy)							
					1. 00	2. 00	
 	ildan haya any daya for in	adi vi dual a seesa	llodin		N N	2.00	0171.

COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10 Health Financial Systems Worksheet S-2 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 31-0041 From 01/01/2024 Part II Date/Time Prepared: 12/31/2024 5/28/2025 10:36 am Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entitles (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1 00 2 00 3 00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Υ 04/01/2025 4.00 Α or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper 2 00 1 00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 Ν the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 7.00 N Were nursing programs and/or allied health programs approved and/or renewed during the 8.00 N 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 9.00 program in the current cost report? If yes, see instructions.

Was an approved Intern and Resident GME program initiated or renewed in the current Ν 10.00 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Υ 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see 14 00 Ν 14 00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Ν 15.00 Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Ν Ν 16.00 If either column 1 or 3 is yes, in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions) 17.00 Was the cost report prepared using the PS&R Report for 04/01/2025 Υ 04/01/2025 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν 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. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

HUJFI I	Financial Systems COMMUNITY MED AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 31-0041	Peri od: From 01/01/2024 To 12/31/2024	w of Form CM Worksheet S Part II Date/Time F 5/28/2025 1	5-2 Prepared:
			iption	Y/N	Y/N	
	Transfer of the second of the		0	1.00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)	·		
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see					22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprai	sais made du	ring the cost		23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost r	eporting period?		24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see		25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost ropert	ing period?	If yes soo		26. 00
20.00	instructions.	ne cost report	ing perrou?	ii yes, see		20.00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	f yes, submit		27. 00
28. 00	<pre>Interest Expense Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.</pre>	ntered into du	ring the cos	t reporting		28. 00
29. 00	Did the provider have a funded depreciation account and/or		ebt Service	Reserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see insti Has existing debt been replaced prior to its scheduled matu		deht? If ve	s see		30.00
	instructions.	,	,			
31.00	Has debt been recalled before scheduled maturity without is instructions. Purchased Services	SSuance of new	debt? IT ye	s, see		31.00
32. 00	Have changes or new agreements occurred in patient care ser		ed through c	ontractual		32. 00
33. 00	arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 approximately, see instructions.		ng to compet	itive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an a lf yes, see instructions.	arrangement wi	th provider-	oased physicians?		34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35. 00
	physicians during the cost reporting period? If yes, see in	nstructi ons.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs				00	
36. 00	Were home office costs claimed on the cost report?					36.00
	If line 36 is yes, has a home office cost statement been pu	repared by the	home office	?		37. 00
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of			f		38. 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			5,		39. 00
				1		1
	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00
39. 00	see instructions.					40. 00
39. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.		If yes, see	2.	00	40.00
39. 00 40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position			HENWOOD	00	40.00
39. 00 40. 00 41. 00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	1.	00		00	41.00
39. 00 40. 00 41. 00 42. 00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	1.	00			

Heal th	Financial Systems COMMUNI	TY MED	DICAL CENTER	In Li	eu of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	RE	Provider CCN: 31-0041	Period: From 01/01/202		
				To 12/31/202	4 Date/Time Pre 5/28/2025 10:	
			3. 00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	n	VP OF CORPORATE			41.00
	held by the cost report preparer in columns 1, 2, and	I 3,	REI MBURSEMENT			
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the c	ost				43.00
	report preparer in columns 1 and 2, respectively.					1

| Period: | Worksheet S-3 | From 01/01/2024 | Part | To 12/31/2024 | Date/Time Prepared: Provi der CCN: 31-0041

					7	To 12/31/2024	Date/Time Pre 5/28/2025 10:	
							I/P Days / 0/P	JU alli
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH/REH Hours	Title V	
	36pariant	Li ne No.		o. Bous	Avai I abl e	oran near o		
		1. 00		2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		253	92, 598	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	6. 00
7.00	Total Adults and Peds. (exclude observation			253	92, 598	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		165	60, 390	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, 392	0.00	0	
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	
14.00	Total (see instructions)			430	157, 380	0.00	0	14.00
15. 00	CAH visits						0	15. 00
15. 10	REH hours and visits					0.00	0	15. 10
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, 150		0	19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27.00	Total (sum of lines 14-26)			455				27. 00
28. 00	Observation Bed Days						0	28. 00
29.00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF			0	,			31.00
32.00	Labor & delivery days (see instructions)			Ü)		32.00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33. 00
33. 00	LTCH fion-covered days LTCH si te neutral days and discharges							33. 00
	Temporary Expansion COVID-19 PHE Acute Care							34. 00
51.00	1. Simportary Expansion Covid 17 The Moute Care	1	1		I	I	I	1 3 1. 33

Provi der CCN: 31-0041

| Period: | Worksheet S-3 | From 01/01/2024 | Part | To 12/31/2024 | Date/Time Prepared:

				'	0 12/31/2024	5/28/2025 10:	
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA		'				
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	45, 608	1, 198	66, 261			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)	37, 827	10, 688				2.00
3. 00	HMO IPF Subprovider	0,,02,	0				3.00
4. 00	HMO IRF Subprovider	o	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	Ö	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	o l	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	45, 608	1, 198	66, 261			7.00
7.00	beds) (see instructions)	43, 000	1, 170	00, 201			7.00
8. 00	INTENSIVE CARE UNIT	2, 907	975	45, 965			8.00
9. 00	CORONARY CARE UNIT	2, 707	773	43, 703			9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	1, 556	o	3, 574			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	1, 330	o _l	3, 374			12.00
13. 00	NURSERY		2, 116	4, 236			13.00
14. 00	Total (see instructions)	50, 071	4, 289	120, 036		2, 007. 96	
15. 00	CAH visits	50, 071	4, 209	120, 030		2,007.90	15.00
15. 10	REH hours and visits	0	0	0			15. 10
16. 00	SUBPROVI DER - I PF	o _l	U U	C			16.00
17. 00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	4, 056	0	6, 859	0.00	36. 78	
20. 00	NURSING FACILITY	4,030	U U	0, 037	0.00	30.70	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)			0			24.00
25. 00	CMHC - CMHC			U			25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)	U	U U	C	93. 01	2.044.74	
28. 00	Observation Bed Days		0	83		2,044.74	28.00
29. 00	Ambulance Trips	0	U U	03			29.00
30.00	Employee discount days (see instruction)	U		1, 165			30.00
31. 00	Employee discount days (see Histruction)			1, 103			31.00
32. 00	Labor & delivery days (see instructions)	0	22	1, 059			32.00
32. 00	Total ancillary labor & delivery room	۷	22	1, 059			32.00
32.01	outpatient days (see instructions)			U			32.01
33. 00	LTCH non-covered days	0					33.00
33. 00	LTCH site neutral days and discharges	0					33.00
	Temporary Expansi on COVID-19 PHE Acute Care	٥					34.00
54.00	Tomporary Expansion Covid-19 File Acute Care	ı l	l		I	I	1 34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 31-0041
From 01/01/2024
To 12/31/2024
Date/Time Prepared:

				To	12/31/2024	Date/Time Pre 5/28/2025 10::	
		Full Time		Di sch	arges	3/20/2023 10.	JU alli
		Equi val ents			. 5		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13. 00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(8, 282	527	24, 295	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			, ,,,,,	0 570		0.00
2.00	HMO and other (see instructions)			6, 280	3, 570		2.00
3.00	HMO IPF Subprovider				0		3.00
4. 00 5. 00	HMO IRF Subprovider				Ч		4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	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	(8, 282	527	24, 295	14.00
15.00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
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	0.00					26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					26. 25 27. 00
28.00	Total (sum of lines 14-26) Observation Bed Days	0.00					28.00
29.00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see l'istruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
02.01	outpatient days (see instructions)						-2.0.
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Period: Worksheet S-3 From 01/01/2024 Part II To 12/31/2024 Date/Time Prepared: Provi der CCN: 31-0041

					T	o 12/31/2024	Date/Time Prep 5/28/2025 10:3	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	30 alli
				A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	196, 762, 298	-3, 081, 535	193, 680, 763	4, 253, 065. 82	45. 54	1. 00
2. 00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2. 00
3. 00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
4. 00	Physician-Part A -		154, 394	0	154, 394	312. 00	494. 85	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0 2, 041, 779	0	_	0. 00 20, 950. 00		4. 01 5. 00
6. 00	Physician-Part B 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	21. 00	0	7, 754, 845	7, 754, 845	216, 866. 53	35. 76	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0.00	0.00	7. 01
8. 00	residents (in an approved programs) Home office and/or related		0	0	0	0.00	0.00	8. 00
	organi zati on personnel			40.070				
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44.00	4, 048, 922 341, 072			l '		9. 00 10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		6, 993, 017	I 0	6, 993, 017	59, 819. 00	116. 90	11. 00
	Care							
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	О	0	0.00	0.00	14.00
14. 01	Home office salaries		34, 646, 465	О	34, 646, 465	492, 857. 45	70. 30	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	1	0			14. 02 15. 00
15.00	- Administrative		0			0.00	0.00	15.00
15. 01	Home office Physicians Part A - Administrative		0	0	0	0.00	0.00	15. 01
15. 02	Home office contract Physicians Part A - Administrative		0	0	0	0.00	0.00	15. 02
16. 00	Home office and Contract		0	О	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 Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		51, 878, 288	0	51, 878, 288			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19.00	Excluded areas		1, 200, 292	0	1, 200, 292			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		1 121	0	1 121			21.00
22. 00	Physician Part A - Administrative		1, 121		1, 121			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		111, 240	0	111, 240			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0 779, 411	0 0	779, 411			24. 00 25. 00
25. 50	approved program) Home office wage-related		7, 630, 301	0				25. 50
20.00	(core)		7, 000, 001		,, 550, 501			

Period: Worksheet S-3 From 01/01/2024 Part II To 12/31/2024 Date/Time Prepared:

					T	12/31/2024	Date/Time Pre 5/28/2025 10:	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
			,	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4	00.1.07	
		1.00	2.00	3.00	4.00	5. 00	6. 00	
25. 51	Related organization		0	0	0			25. 51
	wage-related (core)							
25.52	Home office: Physician Part A		0	0	0			25. 52
	- Administrative -							
	wage-related (core)							
25.53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4. 00	451, 514		451, 514	•		
27.00	Administrative & General	5. 00	13, 286, 588	-1, 931, 659				
28.00	Administrative & General under		2, 430, 831	0	2, 430, 831	9, 798. 00	248. 09	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	279, 530		279, 530	•		29. 00
30.00	Operation of Plant	7. 00	4, 529, 802	0	4, 529, 802	147, 717. 16		30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	3, 363, 188	0	3, 363, 188	169, 946. 71		
33.00	Housekeeping under contract		0	0	0	0. 00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	3, 874, 356	-807, 549	3, 066, 807	129, 287. 09		34.00
35.00	Dietary under contract (see		0	0	0	0. 00	0.00	35.00
	instructions)							
36.00		11. 00	0	807, 549	807, 549			36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00		37. 00
38.00	Nursing Administration	13. 00	4, 488, 878	· ·		•		
39.00	Central Services and Supply	14. 00	2, 191, 007		2, 191, 007	77, 554. 43		
40.00	Pharmacy	15. 00	6, 578, 326	-30, 503	6, 547, 823			
41.00	Medical Records & Medical	16. 00	0	0	0	0. 00	0.00	41. 00
	Records Li brary	47.00	0 474 500		0 474 500			
	Soci al Servi ce	17. 00	3, 174, 530	0	3, 174, 530			42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 31-0041	Period: Worksheet S-3 From 01/01/2024 Part III

					10) 12/31/2024	5/28/2025 10:	
	·	Wasalsalaa a A	A +-	DI: 6:+:	A -1: +1	Detal Harris		
		Worksheet A		Reclassi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		197, 151, 350	-10, 836, 380	186, 314, 970	4, 025, 047. 29	46. 29	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 389, 994	379, 346	4, 769, 340	94, 587. 54	50. 42	2.00
	instructions)							
3.00	Subtotal salaries (line 1		192, 761, 356	-11, 215, 726	181, 545, 630	3, 930, 459. 75	46. 19	3.00
	minus line 2)							
4.00	Subtotal other wages & related		41, 639, 482	0	41, 639, 482	552, 676. 45	75. 34	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		59, 509, 710	0	59, 509, 710	0.00	32. 78	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		293, 910, 548	-11, 215, 726	282, 694, 822	4, 483, 136. 20	63.06	6.00
7.00	Total overhead cost (see		44, 648, 550	-1, 971, 604	42, 676, 946	1, 045, 196. 08	40. 83	7.00
	instructions)		, ,					
	1			1	ı		1	

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10	
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 31-0041	Period: Worksheet S-3 From 01/01/2024 Part IV To 12/31/2024 Date/Time Prepared:	

	To 12/31/2024	Date/Time Pre 5/28/2025 10:	pared: 36 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	7, 471, 799	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	358, 135	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1, 254, 973	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-Pensi on Plan	1, 881, 164	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)	24, 988, 006	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	418, 021	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	156, 206	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)	833, 825	13.00
14.00		338, 403	14.00
15.00	'Workers' Compensation Insurance	1, 247, 851	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumulative portion)]
	TAXES		
17.00		14, 125, 102	
18.00	Medicare Taxes - Employers Portion Only	0	
19.00		326, 456	
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00		0	21.00
	instructions))		
22.00	Day Care Cost and Allowances	0	
23.00		570, 413	1
24.00		53, 970, 354	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Heal th	Financial Systems	COMMUNITY MEDICA	AL CENTER	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet S-3 Part V Date/Time Pre 5/28/2025 10:	pared:
	Cost Center Description			Contract Labor	Benefit Cost 2.00	
	PART V - Contract Labor and Benefit Cost			1.00	2. 00	
	Hospital and Hospital-Based Component Identi	fi cati on:				
1.00	Total facility's contract labor and benefit			6, 993, 017	53, 970, 353	1.00
2.00	Hospi tal			6, 993, 017	53, 970, 353	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	SKILLED NURSING FACILITY			0	0	8. 00
9.00	NURSING FACILITY					9. 00
10.00	OTHER LONG TERM CARE I					10.00
11.00	Hospital-Based HHA					11. 00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I					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
	RENAL DIALYSIS I					17. 00
18.00	Other			0	0	18. 00

near th	Financial Systems COMMUNITY MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024		pared:
				1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA			1. 00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1
1. 00	Cost to charge ratio (see instructions)			0. 176082	1.00
1.00	Medicaid (see instructions for each line)			0. 170002	1.00
2.00	Net revenue from Medicaid			44, 282, 794	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments	ents from Medio	cai d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medic			3, 239, 484	5.00
6.00	Medi cai d charges			333, 689, 828	6.00
7.00	Medicaid cost (line 1 times line 6)			58, 756, 772	7.00
8.00	Difference between net revenue and costs for Medicaid program (see ins	tructions)		11, 234, 494	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each I	i ne)			
9. 00	Net revenue from stand-alone CHIP			0	
10.00	Stand-al one CHIP charges			0	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	
12.00	Difference between net revenue and costs for stand-alone CHIP (see ins		`	0	12. 00
	Other state or local government indigent care program (see instructions			242 (22	
13.00	Net revenue from state or local indigent care program (Not included on			313, 632	1
14.00	Charges for patients covered under state or local indigent care program 10)	n (Not Included	d in lines 6 or	4, 860, 338	14. 00
15. 00	State or local indigent care program cost (line 1 times line 14)			855, 818	15. 00
16.00	Difference between net revenue and costs for state or local indigent care	are program (se	e instructions)	542, 186	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and s			· · · · · · · · · · · · · · · · · · ·	1 .0.00
	instructions for each line)		g pg		
17.00	Private grants, donations, or endowment income restricted to funding cl	nari ty care		0	17. 00
18.00	Government grants, appropriations or transfers for support of hospital	operati ons		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indige	nt care program	ms (sum of lines	11, 776, 680	19.00
	8, 12 and 16)	1			
		Uni nsured		Total (col. 1	
		patients 1.00	pati ents	+ col . 2)	
	Uncompensated care cost (see instructions for each line)	1.00	2. 00	3. 00	
20.00	Charity care charges and uninsured discounts (see instructions)	74, 568, 6	21 799, 570	75, 368, 191	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see				
21.00	instructions)	10, 100, 1	72 777,070	10,727,702	21.00
22.00	Payments received from patients for amounts previously written off as		0 0	0	22. 00
	charity care				
23.00	Cost of charity care (see instructions)	13, 130, 1	92 799, 570	13, 929, 762	23.00
				1. 00	
24.00	Does the amount on line 20 col. 2, include charges for patient days be		of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care program				
	If line 24 is yes, enter the charges for patient days beyond the indig	ent care progra	am's length of	0	25. 00
25. 00	! ! +				
	stay limit				25 01
25. 01	Charges for insured patients' liability (see instructions)			20 202 519	
25. 00 25. 01 26. 00 27. 00				0 20, 293, 518 1, 348, 757	26. 00

2, 075, 011 27. 01

3, 934, 205 17, 863, 967 29, 640, 647 31. 00

28.00

18, 218, 507

27.01 Medicare allowable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

	Financial Systems COMMUNITY MEDICAL CENT FAL UNCOMPENSATED AND INDIGENT CARE DATA Provid	ER ler CCN: 31-0	0041 F	eri od:	u of Form CMS-2 Worksheet S-1	
			F	rom 01/01/2024 o 12/31/2024	Parts I & II Date/Time Pre 5/28/2025 10:	pared
					1. 00	
	PART II - HOSPITAL DATA					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
. 00	Cost to charge ratio (see instructions)				0. 174383	1. C
	Medicaid (see instructions for each line)					, ,
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?					2. C
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental pa	vments from	Medi cai	d?		4.0
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Me	,	mour ou	.		5. 0
. 00	Medi cai d charges					6. (
. 00	Medicaid cost (line 1 times line 6)					7.0
. 00	Difference between net revenue and costs for Medicaid program (see i)			8.0
00	Children's Health Insurance Program (CHIP) (see instructions for each	h line)			Γ	
. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges					9. (10. (
1. 00	· ·					10. (
	Difference between net revenue and costs for stand-alone CHIP (see i	nstructions))			12. (
	Other state or local government indigent care program (see instructi					
3. 00	Net revenue from state or local indigent care program (Not included)		13.
4. 00	Charges for patients covered under state or local indigent care prog					14.
	10)					
5.00			/	! + + ! >		15.
6. 00	Difference between net revenue and costs for state or local indigent Grants, donations and total unreimbursed cost for Medicaid, CHIP and				ms (soo	16.
	instructions for each line)	3 ta te/ i ocai	i i i i i i i i i i	ent care progra	1113 (366	
7. 00	Private grants, donations, or endowment income restricted to funding	charity car	re			17.
8.00	Government grants, appropriations or transfers for support of hospit		nc			17.
						18.
	Total unreimbursed cost for Medicaid , CHIP and state and local indi			(sum of lines		18. (
		gent care pr	rograms		Total (col. 1	18. (
	Total unreimbursed cost for Medicaid , CHIP and state and local indi	gent care pr	rograms sured	Insured	Total (col. 1 + col. 2)	18. (19. (
	Total unreimbursed cost for Medicaid , CHIP and state and local indi	gent care pr Uning	rograms		Total (col. 1 + col. 2) 3.00	18. 0
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line)	gent care pr Uni ns pati 1.	sured ents 00	Insured patients 2.00	+ col . 2) 3.00	18. (19. (
0. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)	gent care pr Uning pati 1.	sured ents 00 568, 571	Insured patients 2.00	+ col . 2) 3.00 75,367,375	18. 19.
0. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (gent care pr Uning pati 1.	sured ents 00	Insured patients 2.00	+ col . 2) 3.00 75,367,375	18. 19.
9. 00 0. 00 1. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions)	gent care pr Uninspati 1. 74, see 13,	sured ents 00 568, 571 003, 491	Insured pati ents 2.00 798,804	+ col . 2) 3.00 75, 367, 375 13, 802, 295	18. 19. 20. 21.
9. 00 0. 00 1. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a	gent care pr Uninspati 1. 74, see 13,	sured ents 00 568, 571	Insured pati ents 2.00 798,804	+ col . 2) 3.00 75, 367, 375 13, 802, 295	18. 19. 20. 21.
9. 00 0. 00 1. 00 2. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care	gent care pr Uninspati 1. 74, see 13,	sured ents 00 568, 571 003, 491	I nsured pati ents 2.00 798,804 798,804	+ col. 2) 3.00 75,367,375 13,802,295	20. 21. 22.
9. 00 0. 00 1. 00 2. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care	gent care pr Uninspati 1. 74, see 13,	sured ents 00 568, 571 003, 491	I nsured pati ents 2.00 798,804 798,804	+ col . 2) 3.00 75,367,375 13,802,295	18. 19. 20. 21. 22.
9. 00 0. 00 1. 00 2. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions)	Uninspati	sured ents 00 568, 571 003, 491 003, 491	Insured pati ents 2.00 798,804 798,804 0 798,804	+ col . 2) 3.00 75,367,375 13,802,295 0 13,802,295	18. 19. 20. 21. 22.
9. 00 0. 00 1. 00 2. 00 3. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days	gent care pr Uni n: pati 1. 74, see 13, s 13, beyond a Ler	sured ents 00 568, 571 003, 491 003, 491	Insured pati ents 2.00 798,804 798,804 0 798,804	+ col. 2) 3.00 75,367,375 13,802,295 0 13,802,295	20. 21. 22.
9. 00 0. 00 1. 00 2. 00 3. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progr	gent care pr Uninspati 1. 74, see 13, s 13, beyond a leram?	sured ents 00 568,571 003,491 003,491	Insured patients 2.00 798,804 798,804 stay limit	+ col . 2) 3.00 75,367,375 13,802,295 0 13,802,295	20. (21. (22. (23. (24. (24. (24. (24. (24. (24. (24. (24
9. 00 0. 00 1. 00 2. 00 3. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the incompanies.	gent care pr Uninspati 1. 74, see 13, s 13, beyond a leram?	sured ents 00 568,571 003,491 003,491	Insured patients 2.00 798,804 798,804 stay limit	+ col . 2) 3.00 75,367,375 13,802,295 0 13,802,295	18. 19. 20. 21. 22. 23.
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the incistay limit	gent care pr Uninspati 1. 74, see 13, s 13, beyond a leram?	sured ents 00 568,571 003,491 003,491	Insured patients 2.00 798,804 798,804 stay limit	+ col. 2) 3.00 75, 367, 375 13, 802, 295 0 13, 802, 295 1.00 N	18. 19. 20. 21. 22. 23. 24.
9. 00 11. 00 22. 00 44. 00 45. 01	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the incomposed for insured patients' liability (see instructions)	gent care pr Uninspati 1. 74, see 13, s 13, beyond a leram?	sured ents 00 568,571 003,491 003,491	Insured patients 2.00 798,804 798,804 stay limit	+ col. 2) 3.00 75, 367, 375 13, 802, 295 0 13, 802, 295 1.00 N 0	20. 21. 22. 23. 24. 25.
3. 00 3. 00 1. 00 4. 00 4. 00 5. 01 6. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the incistay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)	gent care pr Uninspati 1. 74, see 13, s 13, beyond a leram?	sured ents 00 568,571 003,491 003,491	Insured patients 2.00 798,804 798,804 stay limit	+ col. 2) 3.00 75, 367, 375 13, 802, 295 0 13, 802, 295 1.00 N	20. 21. 22. 23. 24. 25. 26.
9. 00 3. 00 1. 00 1. 00 4. 00 5. 00 5. 01 6. 00 7. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the incistal limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)	gent care pr Uninspati 1. 74, see 13, s 13, beyond a leram?	sured ents 00 568,571 003,491 003,491	Insured patients 2.00 798,804 798,804 stay limit	+ col. 2) 3.00 75, 367, 375 13, 802, 295 0 13, 802, 295 1.00 N 0 20, 275, 052	20. 21. 22. 23. 24. 25. 26. 27.
9. 00 0. 00 11. 00 22. 00 44. 00 55. 00 55. 01 66. 00 77. 00 77. 01	Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the incistal limit (charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	gent care pr Uninspati 1. 74, see 13, s 13, beyond a leram?	sured ents 00 568,571 003,491 003,491	Insured patients 2.00 798,804 798,804 stay limit	+ col. 2) 3.00 75,367,375 13,802,295 0 13,802,295 1.00 N 0 20,275,052 1,348,757	20. 21. 22. 23. 24. 25. 26. 27. 27.
9. 00 0. 00 1. 00 2. 00 4. 00 5. 01 6. 00 7. 00 7. 01 8. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the incistay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts	gent care properties of the particular see and part	sured ents 00 568, 571 003, 491 ngth of program	Insured patients 2.00 798,804 798,804 stay limit	+ col. 2) 3.00 75, 367, 375 13, 802, 295 0 13, 802, 295 1.00 N 0 20, 275, 052 1, 348, 757 2, 075, 011 18, 200, 041 3, 900, 032	20. 21. 22. 23. 24. 25. 26. 27. 28. 29.
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 7. 00 7. 00 7. 00 9. 00 9. 00 0. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the inc stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts	gent care properties of the pating pating and pating and pating and pating and pating pating and pa	sured ents 00 568, 571 003, 491 ngth of program	Insured patients 2.00 798,804 798,804 stay limit	+ col. 2) 3.00 75, 367, 375 13, 802, 295 0 13, 802, 295 1.00 N 0 20, 275, 052 1, 348, 757 2, 075, 011 18, 200, 041	20. 21. 22. 23. 25. 26. 27. 28. 29. 30.

Heal th Finan	cial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
RECLASSI FI CA	ATION AND ADJUSTMENTS OF TRIAL BALANCE O)F EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 01/01/2024 To 12/31/2024	Date/Time Pre 5/28/2025 10:	
	0	0.1	011	T. I. I. (I (D I ! C' ! !		30 alli
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Reclassi fi cati	Reciassified	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
194. 07 07956	RETAIL PHARMACY	0	0)	0 0	0	194. 07
200. 00	TOTAL (SUM OF LINES 118 through 199)	196, 762, 298	347, 384, 822	544, 147, 12	0 0	544, 147, 120	200.00

 Heal th Financial
 Systems
 COMMUNITY I

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

		0 0 0 2002 . 0
041	Peri od:	Worksheet A
	From 01/01/2024	Worksheet A Date/Time Prepared: 5/28/2025 10:36 am
	10 12/31/2024	Date/IIme Prepared:
		15/28/2025 10:36 am

					10 12/31/2024	5/28/2025 10: 36 am
	Cost Center Description	Adjustments	Net Expenses		•	0, 20, 2020 10, 00 4
	·	(See A-8)	For Allocation			
		6. 00	7. 00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT	-49, 268	15, 362, 731			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-42, 653	13, 212, 879			2.00
3.00	00300 OTHER CAP REL COSTS	0	0			3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 817, 032	37, 740, 890			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-5, 389, 758	114, 273, 312			5.00
6.00	00600 MAINTENANCE & REPAIRS	-170, 408	575, 397			6.00
7.00	00700 OPERATION OF PLANT	-86, 135	13, 176, 783			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 410, 819			8.00
9.00	00900 HOUSEKEEPI NG	0	6, 236, 914			9.00
10.00	01000 DI ETARY	-72, 295	5, 961, 638			10.00
11.00	01100 CAFETERI A	-1, 508, 938	87, 469			11.00
13.00	01300 NURSING ADMINISTRATION	-28, 680	4, 966, 395			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-263, 430	4, 155, 914			14.00
15.00	01500 PHARMACY	-66, 352	6, 828, 075			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0			16.00
17.00	01700 SOCIAL SERVICE	-25, 674	5, 490, 157			17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	7, 754, 845			21.00
22.00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	-66, 855	4, 413, 136			22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	-4, 016	139, 519			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	-2, 976, 822	43, 638, 979			30.00
	03100 INTENSIVE CARE UNIT	-14, 804	29, 097, 896	1		31.00
	03400 SURGICAL INTENSIVE CARE UNIT	-703	3, 890, 683	1		34.00
	04300 NURSERY	-676	3, 439, 137			43. 00
	04400 SKILLED NURSING FACILITY	-43, 889	4, 558, 196			44. 00
11.00	ANCILLARY SERVICE COST CENTERS	10,007	1, 000, 170			11.00
50.00	05000 OPERATING ROOM	-300, 139	15, 006, 933			50.00
	05100 RECOVERY ROOM	-1, 756	1, 836, 849	1		51. 00
	05200 DELIVERY ROOM & LABOR ROOM	-20, 400	3, 990, 583	1		52.00
	03190 OP INFUSION	-942	1, 872, 889	1		52. 01
	05300 ANESTHESI OLOGY	-2, 124, 058	756, 081			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	-1, 892, 320	10, 204, 939			54.00
	05500 RADI OLOGY-THERAPEUTI C	-104, 436	5, 909, 113	1		55. 00
	05600 RADI OLOGI - THERAFLUTTO	-104, 430	1, 437, 902	1		56. 00
	05700 CT SCAN					l l
		-5, 133	3, 496, 349			57. 00 58. 00
	05800 MRI	-3, 167	1, 249, 614			
	05900 CARDI AC CATHETERI ZATI ON	-127, 537	4, 600, 264			59.00
	06000 LABORATORY	-625, 551	18, 938, 449	1		60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
	06500 RESPI RATORY THERAPY	-15, 298	4, 786, 001			65. 00
	06600 PHYSI CAL THERAPY	-1, 570	2, 265, 839			66.00
	06700 OCCUPATI ONAL THERAPY	-247	1, 354, 771			67. 00
	06800 SPEECH PATHOLOGY	-113	390, 825	1		68. 00
	06900 ELECTROCARDI OLOGY	-24, 755	3, 404, 844			69. 00
	07000 ELECTROENCEPHALOGRAPHY	-261, 206	1, 693, 222			70.00
	07001 SLEEP LAB	-58, 589	0			70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-1, 459	24, 573, 975			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	-1, 411	21, 513, 589	1		72.00
	07300 DRUGS CHARGED TO PATIENTS	-4, 704	47, 415, 628			73.00
	07697 CARDI AC REHABI LI TATI ON	-154	736, 581			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	265, 437			76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0			77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0			78. 00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	-74, 047	700, 971			90.00
91.00	09100 EMERGENCY	-705, 324	20, 015, 800			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	-2, 657	3, 339, 663			92. 01
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0			95.00
102. 00	10200 OPI OI D TREATMENT PROGRAM	0	0			102. 00
	SPECIAL PURPOSE COST CENTERS					
113. 00	11300 NTEREST EXPENSE	0	0			113. 00
118. 00		-15, 351, 687	528, 168, 875			118. 00
5. 20	NONREI MBURSABLE COST CENTERS	, , , , .	.,,,			
194 00	07950 MI SCELLANEOUS	O	0			194. 00
	07951 PUBLIC RELATIONS		546	1		194. 01
	07952 LI GHTHOUSE		56, 646	1		194. 03
	07953 KIDS & FAMILY		0, 040			194. 04
	07954 OTHER NON REIMBURABLE		562, 305	1		194. 04
	07955 GRANTS/TRIALS	0	7, 061			194. 06
	07956 RETAIL PHARMACY		7,001			194. 07
200. 00	1	15 251 407	-	ł		200. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-15, 351, 687	528, 795, 433	<u> </u>		<u> </u> 200.00

Peri od: From 01/01/2024 To 12/31/2024 Date/Ti me Prepared: 5/28/2025 10: 36 am Provi der CCN: 31-0041

		Increases			5/28/2025	10: 36 am
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
1 00	A - MEDICAL SURGICAL SUPPLIES			24 575 424		1.00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	24, 575, 434		1. 00
2.00		0. 00	O	0		2. 00
3. 00		0. 00	0	0		3. 00
4.00		0.00	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	0	0		7. 00
8. 00		0. 00	0	0		8. 00
9. 00		0. 00	0	0		9. 00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12.00		0.00	0	0		12.00
13.00		0. 00	0	0		13. 00
14.00		0. 00	0	0		14. 00
15.00		0. 00 0. 00	0	0		15.00
16. 00 17. 00		0.00	0	0		16. 00 17. 00
18. 00		0. 00	Ö	0		18. 00
19.00		0. 00	О	0		19. 00
20.00		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
23. 00		0.00	o	0		23. 00
24.00		0. 00	О	0		24. 00
25.00		0. 00	0	0		25. 00
26. 00 27. 00	1	0. 00 0. 00	0	0		26. 00 27. 00
28. 00		0. 00	0	Ö		28. 00
29. 00		0. 00	0	0		29. 00
30.00		0. 00 0. 00	0	0		30.00
31. 00			0	0 24, 575, 434		31.00
	B - IMPLANTABLES					
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	21, 515, 000		1.00
2. 00	PATI ENTS	0. 00	o	0		2. 00
3. 00		0. 00	Ö	0		3. 00
4.00		0. 00	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	0	0		7. 00
8.00		0. 00	O	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12.00		0. 00	o	0		12. 00
13.00		0. 00	0	0		13.00
14. 00		0.00	0	0 21, 515, 000		14. 00
	C - DRUGS AND IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	47, 420, 332		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0.00	0	0		4. 00
5.00			О	0		5. 00
6.00			0	0		6.00
7. 00 8. 00			0	0		7. 00 8. 00
9. 00			o	0		9. 00
10.00			0	0		10.00
11. 00		+	0	0 47, 420, 332		11. 00
	D - BLOOD					
1.00	LABORATORY	60. 00		225, 597		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0.00	0	0		4. 00
5.00		0. 00	0	0		5. 00
6.00		0.00	0	0		6.00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0. 00	Ö	Ö		9. 00
		•	•	•		

Peri od: From 01/01/2024 To 12/31/2024 Date/Ti me Prepared: Provi der CCN: 31-0041

					5/28/2025 10: 36 a	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
	U		0	225, 597		
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	o	2, 089, 814	1	. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	1, 809, 239	1	. 00
2.00	0	— — 		3, 899, 053		. 00
	F - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00		221, 902		. 00
2. 00	CAP REL COSTS-MVBLE EQUIP			104, 840		. 00
	O DADLOLOGY DNC		0	326, 742		
1. 00	G - RADI OLOGY RNS RADI OLOGY-THERAPEUTI C	55. 00	666, 939	0	1	. 00
2. 00	RADI OI SOTOPE	56. 00	68, 771	0	1	. 00
	0		735, 710	<u> </u>		
	H - DIETARY					
1. 00	CAFETERI A	1100	<u>807, 5</u> 49	78 <u>8, 8</u> 58		. 00
	0		807, 549	788, 858		
1. 00	J - LINEN LAUNDRY & LINEN SERVICE	8. 00		1, 410, 819	1	. 00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00		134, 866		. 00
3. 00	SERVINCE SERVINCES & SOLVE	0.00	0	0		. 00
4.00		0.00	0	0	I	. 00
5.00		0. 00	0	0	5.	. 00
6.00		0. 00	0	0		. 00
7.00		0.00	0	0		. 00
8. 00 9. 00		0. 00 0. 00	0	0		. 00
10.00		0.00	o	0	1	. 00
11. 00		0. 00	Ö	Ö	1	. 00
12.00		0.00	0	0		. 00
13.00		0. 00	0	0	1	. 00
14.00		0. 00	0	0	1	. 00
15.00		0.00	0	0		. 00
16. 00 17. 00		0. 00 0. 00	0	0		. 00
18. 00		0.00	0	0	1	. 00
19. 00		0. 00	o	0	1	. 00
20.00		0. 00	o	0		. 00
21.00		0. 00	O	0	21.	. 00
22.00		0. 00	0	0	1	. 00
23.00		0. 00	0	0		. 00
24. 00		0.00	0	0		. 00
25. 00		000		00_ 1, 545, 685	25.	. 00
	K - MOTHER BABY		<u> </u>	1, 343, 003		
1.00	NURSERY	43. 00	2, 046, 883	275, 872	1.	. 00
	0		2, 046, 883	275, 872		
	M - MALPRACTICE					
1.00	SKILLED NURSING FACILITY	44. 00		24, 137		. 00
2. 00 3. 00	CARDI AC CATHETERI ZATI ON RESPI RATORY THERAPY	59. 00 65. 00		54, 368 6, 803		. 00 . 00
4. 00	ELECTROCARDI OLOGY	69. 00		75, 806		. 00
5. 00	ELECTROENCEPHALOGRAPHY	70. 00		58, 252	1	. 00
6.00	SLEEP LAB	70. 01		37, 756	6.	. 00
7.00	CLINIC	<u>90.</u> 00		1 <u>8, 6</u> 41		. 00
	N DENETITE DIDECTLY ASSIGNE	D	0	275, 763		
1 00	N - BENEFITS DIRECTLY ASSIGNE EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	3, 546, 440	1	00
1. 00 2. 00	LIMITLOTEE DEINEFITS DEPARTMENT	4. 00 0. 00	0	3, 546, 440		. 00 . 00
3. 00		0. 00	o	0		. 00
4. 00		0. 00	Ö	Ö	1	. 00
5.00		0.00	0_	0		. 00
	0		0	3, 546, 440		
1 00	Q - TRANSPORT	20.00	74 ((6	225		00
1. 00 2. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	71, 668 50, 328	885 621	I	. 00 . 00
3. 00	SURGICAL INTENSIVE CARE UNIT	34. 00	50, 328	72	1	. 00
4. 00	NURSERY	43. 00	513	6	I	. 00
5. 00	SKILLED NURSING FACILITY	44. 00	17, 737	219		. 00
6. 00	OPERATING ROOM	50.00	215, 967	2, 666	I	. 00
7. 00	RECOVERY ROOM	51. 00	78, 754	972		. 00
8.00	DELIVERY ROOM & LABOR ROOM	52. 00	23, 497	290		. 00
9. 00 10. 00	RADI OLOGY THE PARELITI C	54. 00 55. 00	79, 849 557	986 7	1	. 00
11.00	RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	55. 00 56. 00	998	7 12		. 00 . 00
	p===10.00.0.E	50. 00	770	12	11.	

RECLASSI FI CATI ONS

| Provi der CCN: 31-0041 | Peri od: From 01/01/2024 | To 12/31/2024 | Date/Time Prepared: Provider CCN: 31-0041 | Peri od: From 01/01/2024 | Date/Time Prepared: Provider CCN: 31-0041 | Peri od: From 01/01/2024 | Date/Time Prepared: Provider CCN: 31-0041 | Peri od: From 01/01/2024 | Page Prepared: Provider CCN: 31-0041 | Peri od: From 01/01/2024 | Page Prepared: Provider CCN: 31-0041 | Peri od: From 01/01/2024 | Page Prepared: Provider CCN: 31-0041 | Peri od: From 01/01/2024 | Page Prepared: Provider CCN: 31-0041 | Peri od: From 01/01/2024 | Page Prepared: Provider CCN: 31-0041 | Peri od: From 01/01/2024 | Page Prepared: Provider CCN: 31-0041 | Peri od: From 01/01/2024 | Page Prepared: Provider CCN: 31-0041 | Page Prepared: Prov

					То	ite/Time Prepared: '28/2025 10:36 am
		Increases			<u> </u>	 20, 2020 101 00 0
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
12.00	CT SCAN	57. 00	384, 110	4, 742		12.00
13.00	MRI	58. 00	131, 890	1, 628		13.00
14.00	CARDI AC CATHETERI ZATI ON	59.00	54, 855	677		14. 00
15. 00 16. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00	57, 779	713		15. 00 16. 00
17. 00	OCCUPATIONAL THERAPY	66. 00 67. 00	26, 395 19, 602	326 242		17. 00
18.00	SPEECH PATHOLOGY	68. 00	3, 052	38		18.00
19.00	ELECTROCARDI OLOGY	69. 00	17, 082	211		19. 00
20.00	ELECTROENCEPHALOGRAPHY	70. 00	915	11		20.00
21.00	CARDI AC REHABI LI TATI ON	76. 97	2	0		21. 00
22. 00	CLINIC	90. 00	38	Ö		22. 00
23.00	EMERGENCY	91.00	52, 730	651		23. 00
			1, 294, 114	15, 975		
	R - PHARMACY RESIDENTS					
1. 00	PARAMED ED PRGM-(SPECIFY)	23. 00	3 <u>0, 5</u> 03	$\frac{0}{0}$		1. 00
	0		30, 503	0		
1 00	W - WAGE INDEX	F 00		240, 422		1 00
1.00	ADMINISTRATIVE & GENERAL	5. 00		349, 433		1.00
2. 00 3. 00	NURSING ADMINISTRATION I&R SERVICES-OTHER PRGM.	13. 00 22. 00		9, 442 1, 479, 026		2. 00 3. 00
3.00	COSTS APPRVD	22.00		1, 479, 020		3.00
4. 00	ADULTS & PEDIATRICS	30. 00		399, 437		4.00
5. 00	INTENSIVE CARE UNIT	31. 00		234, 887		5. 00
6. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		80, 290		6. 00
7. 00	SKILLED NURSING FACILITY	44. 00		36, 010		7. 00
8. 00	OPERATING ROOM	50. 00		10, 204		8. 00
9. 00	DELIVERY ROOM & LABOR ROOM	52. 00		23, 994		9. 00
10.00	OP INFUSION	52. 01		97, 186		10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00		204, 042		11. 00
12.00	RADI OLOGY-THERAPEUTI C	55. 00		120, 555		12. 00
13.00	CT SCAN	57. 00		1, 631		13. 00
14.00	CARDI AC CATHETERI ZATI ON	59. 00		41, 106		14. 00
15. 00	RESPI RATORY THERAPY	65. 00		18, 057		15. 00
16. 00	CARDIAC REHABILITATION	76. 97		42, 667		16. 00
17.00	EMERGENCY	91. 00		299, 094		17. 00
18.00	OBSERVATI ON BEDS-DI STI NCT	92. 01	0/7 44/	1, 590		18.00
19. 00	OTHER NON REIMBURABLE	19405	367, 116			19. 00
	X - OB SUPPORT		367, 116	3, 448, 651		
1. 00	ADULTS & PEDIATRICS	30.00	210, 918	4, 434		1.00
1.00	0		210, 918	4, 434		1.00
	Y - INTERN & RESIDENT SALARY	RECLASS	=:=,::=	.,		
1.00	I &R SERVI CES-SALARY &	21. 00	7, 754, 845	0		1. 00
	FRI NGES APPRVD					
	0		7, 754, 845			
	Z - COVID-19- CONTRACT LABOR					
1. 00	ADULTS & PEDIATRICS	<u>30.</u> 00		0		1.00
	O AA CONTRACT LABOR		0	0		
1. 00	AA - CONTRACT LABOR ADULTS & PEDIATRICS	30. 00	O	0		1.00
2. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	0		2. 00
3. 00	LABORATORY	60. 00	0			3. 00
3.00	0		— — — j	$\frac{0}{0}$		3.00
	AB - HBP TEACH PART A		9	٥		
1. 00	I &R SERVI CES-OTHER PRGM.	22. 00	906, 999	10, 495		1.00
	COSTS APPRVD					
2.00		0.00	o	0		2.00
3.00		0.00		0		3.00
	0		906, 999	10, 495		
	AC - RESIDENT MALPRACTICE			-		
1. 00	I&R SERVICES-OTHER PRGM.	22. 00	0	8, 632		1.00
	COSTS APPRVD		$$ \downarrow			
E00 00	Crand Total: Increases		14 154 427	8, 632		E00.00
500.00	Grand Total: Increases		14, 154, 637	107, 882, 963		500.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2024 To 12/31/2024 Worksheet A-6 Date/Time Prepared: 5/28/2025 10:36 am Provider CCN: 31-0041

						5/28/20	025 10: 36 am
	01.01	Decreases	0.1	011	A 7 D.C.		
	Cost Center	Li ne # 7.00	Sal ary		Wkst. A-7 Ref.		
	6.00 A - MEDI CAL SURGI CAL SUPPLI ES		8. 00	9. 00	10. 00		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	58, 927	0		1.00
2. 00	OPERATION OF PLANT	7. 00	O	40, 417	o		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	127, 699	0		3. 00
4.00	DI ETARY	10. 00	0	3, 826	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	947	0		5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	914, 306	0		6. 00
7.00	PHARMACY	15. 00	0	49, 951	0		7.00
8. 00	I &R SERVICES-OTHER PRGM. COSTS APPRVD	22. 00	0	2, 741	U		8. 00
9. 00	ADULTS & PEDIATRICS	30. 00	0	1, 880, 488	0		9. 00
10.00	INTENSIVE CARE UNIT	31. 00	Ö	1, 630, 071	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34. 00	O	211, 028	0		11.00
12.00	SKILLED NURSING FACILITY	44. 00	0	118, 891	0		12. 00
13.00	OPERATING ROOM	50. 00	0	11, 422, 179	0		13. 00
14.00	RECOVERY ROOM	51. 00	0	67, 478	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52. 00	0	380, 992	0		15.00
16. 00 17. 00	OP INFUSION ANESTHESIOLOGY	52. 01 53. 00	0	127, 605 549, 273	0		16. 00 17. 00
18.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	1, 334, 256	0		18. 00
19. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	33, 220	0		19. 00
20.00	RADI OI SOTOPE	56. 00	O	1, 294	0		20. 00
21.00	CT SCAN	57. 00	0	168, 056	0		21. 00
22.00	MRI	58. 00	0	13, 993	0		22. 00
23.00	CARDI AC CATHETERI ZATI ON	59. 00	0	2, 497, 475	0		23. 00
24.00	RESPIRATORY THERAPY	65. 00	0	421, 224	0		24.00
25. 00	PHYSI CAL THERAPY	66. 00 69. 00	0	28, 431 221, 808	0		25. 00
26. 00 27. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	70. 00	0	46, 342	0		26. 00 27. 00
28. 00	CARDI AC REHABI LI TATI ON	76. 97	0	6, 805	0		28. 00
29. 00	CLI NI C	90. 00	0	267, 454	0		29. 00
30.00	EMERGENCY	91. 00	0	1, 778, 462	0		30.00
31.00	OBSERVATI ON BEDS-DISTINCT	<u> 92.</u> 01	0	16 <u>9, 7</u> 95	0		31.00
	0		0	24, 575, 434			
1. 00	B - IMPLANTABLES	E 00		4 124	٥		1.00
2. 00	ADMINISTRATIVE & GENERAL CENTRAL SERVICES & SUPPLY	5. 00 14. 00		4, 136 13, 404	0		2.00
3. 00	I &R SERVI CES-OTHER PRGM.	22. 00		11, 439	0		3. 00
	COSTS APPRVD			,			
4.00	ADULTS & PEDIATRICS	30. 00		10, 122	0		4. 00
5.00	INTENSIVE CARE UNIT	31. 00		2, 977	0		5. 00
6. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		5, 105	0		6.00
7.00	OPERATING ROOM	50. 00		16, 167, 415	0		7.00
8. 00 9. 00	RECOVERY ROOM ANESTHESI OLOGY	51. 00 53. 00		28 4, 064	0		8. 00 9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54. 00		616, 976	0		10.00
11. 00	CARDI AC CATHETERI ZATI ON	59. 00		4, 418, 195	0		11.00
12.00	ELECTROCARDI OLOGY	69. 00		12, 618			12.00
13.00	CLINIC	90. 00		240, 884	0		13. 00
14.00	EMERGENCY	<u>91.</u> 00		<u>7, 6</u> 37	0		14. 00
	C - DRUGS AND IV SOLUTIONS		0	21, 515, 000			
1. 00	PHARMACY	15. 00		47, 361, 062	0		1. 00
2. 00	ADULTS & PEDIATRICS	30. 00		313	0		2.00
3. 00	INTENSIVE CARE UNIT	31. 00		131	Ö		3.00
4.00	SKILLED NURSING FACILITY	44. 00		3, 246			4. 00
5.00	OPERATING ROOM	50. 00		370	0		5. 00
6.00	RECOVERY ROOM	51. 00		46	0		6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54. 00		1, 998	0		7. 00
8. 00	RESPIRATORY THERAPY	65. 00		1, 782	0		8.00
9. 00 10. 00	ELECTROCARDI OLOGY EMERGENCY	69. 00 91. 00		50, 577 696	0		9. 00 10. 00
11. 00	OBSERVATION BEDS-DISTINCT	92. 01		111	0		11. 00
11.00	0		$-$	47, 420, 332	— —		11.00
	D - BLOOD		-1		'		
1. 00	ADMINISTRATIVE & GENERAL	5. 00		26	0		1. 00
2.00	PHARMACY	15. 00	ļ	212	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		722	0		3.00
4. 00 5. 00	INTENSIVE CARE UNIT OPERATING ROOM	31. 00 50. 00	ł	774 154, 306	0		4. 00 5. 00
6. 00	OP INFUSION	52. 01	1	68, 061	0		6. 00
7. 00	RADI OLOGY-THERAPEUTI C	55. 00	1	1, 365	0		7. 00
8.00	CARDIAC CATHETERIZATION	59. 00	1	105			8. 00
9. 00	EMERGENCY	91. 00	1	26			9. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2024 To 12/31/2024 Date/Ti me Prepared: Provi der CCN: 31-0041

						5/28/202	5 10:36 am
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
	E - INTEREST EXPENSE		0	225, 597			
1. 00	INTEREST EXPENSE	113. 00	ol	3, 899, 053	11		1.00
2. 00	TWENEST EXILENSE	0.00	o	0, 077, 000	11		2. 00
				3, 899, 053	<u> </u>		
	F - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00		326, 742	12		1.00
2.00					12		2. 00
	0		0	326, 742			
1 00	G - RADI OLOGY RNS	E4 00	725 710	0			1 00
1. 00 2. 00	RADI OLOGY-DI AGNOSTI C	54. 00 0. 00	735, 710	0	0		1. 00 2. 00
2.00			735, 710	0	<u> </u>		2.00
	H - DIETARY		700,710	<u> </u>			
1.00	DI ETARY	10.00	807, 549	788, 858	0		1.00
	0		807, 549	788, 858			
	J - LINEN						
1.00	ADMINISTRATIVE & GENERAL	5. 00		83	0		1.00
2.00	HOUSEKEEPI NG	9.00		3, 561	0		2.00
3. 00 4. 00	DI ETARY PHARMACY	10. 00 15. 00		28, 698 1, 687	0		3. 00 4. 00
5. 00	I &R SERVI CES-OTHER PRGM.	22. 00		1, 067	0		5. 00
3.00	COSTS APPRVD	22.00		45			3.00
6.00	ADULTS & PEDIATRICS	30. 00		408, 142	o		6. 00
7.00	INTENSIVE CARE UNIT	31. 00		302, 162	o		7. 00
8.00	SURGICAL INTENSIVE CARE UNIT	34. 00		27, 246	0		8. 00
9. 00	SKILLED NURSING FACILITY	44. 00		27, 324	0		9. 00
10.00	OPERATING ROOM	50. 00		96, 212	0		10.00
11.00	RECOVERY ROOM	51.00		18, 553	0		11.00
12. 00 13. 00	DELIVERY ROOM & LABOR ROOM OP INFUSION	52. 00 52. 01		49, 076 16, 334	0		12. 00 13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54. 00		78, 331	0		14. 00
15. 00	RADI OLOGY-THERAPEUTI C	55. 00		70, 331	o o		15. 00
16. 00	RADI OI SOTOPE	56. 00		13, 146	o		16. 00
17.00	MRI	58. 00		12, 351	o		17. 00
18.00	CARDI AC CATHETERI ZATI ON	59. 00		13, 791	0		18. 00
19.00	LABORATORY	60. 00		1, 001	0		19. 00
20.00	PHYSI CAL THERAPY	66. 00		13, 668	0		20.00
21.00	ELECTROCARDI OLOGY	69.00		16, 916	0		21.00
22. 00 23. 00	ELECTROENCEPHALOGRAPHY HYPERBARI C OXYGEN THERAPY	70. 00 76. 98		9, 428 22, 198	0		22. 00 23. 00
24.00	EMERGENCY	91. 00		336, 844	0		24. 00
25.00	OBSERVATION BEDS-DISTINCT	92. 01		48, 883			25. 00
20.00	0	— <u></u> °+		1, 545, 685	<u> </u>		20.00
	K - MOTHER BABY	,	- '	,			
1.00	ADULTS & PEDIATRICS	30.00	2, 046, 883	275, 872	0		1. 00
	0		2, 046, 883	275, 872			
	M - MALPRACTICE				_1		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	275, 763	0		1.00
2. 00 3. 00		0. 00 0. 00	0	0	0		2. 00 3. 00
4. 00		0.00	0	0	0		4. 00
5. 00		0.00	0	0	0		5. 00
6. 00		0. 00	o	0	o		6. 00
7.00		0.00	O	0	o		7. 00
	0			275, 763			
	N - BENEFITS DIRECTLY ASSIGNED						
1. 00	ADMINISTRATIVE & GENERAL	5. 00		56, 929	0		1. 00
2. 00	I &R SERVI CES-OTHER PRGM.	22. 00		2, 405, 864	0		2. 00
3. 00	COSTS APPRVD ADULTS & PEDIATRICS	30. 00		64, 071	o		3. 00
4. 00	SKILLED NURSING FACILITY	44. 00		1, 012, 076	0		4. 00
5. 00	EMERGENCY	91. 00		7, 500			5. 00
0.00	0	/!. 05		3, 546, 440	$ $		0.00
	Q - TRANSPORT		<u> </u>	., ,			
1.00	ADMINISTRATIVE & GENERAL	5. 00	1, 294, 114	15, 975	0		1. 00
2.00		0. 00	o	0	o		2. 00
3. 00		0. 00	o	0	0		3. 00
4.00		0.00	O	0	0		4.00
5. 00		0.00	ol	0	l .		5.00
6. 00 7. 00		0. 00 0. 00	O	0	0		6. 00 7. 00
7. 00 8. 00		0.00	0	0			8.00
9. 00		0.00	o	0	l .		9. 00
	1	-:			, 91		

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2024 To 12/31/2024 Date/Time Prepared: Provi der CCN: 31-0041

						0 12/31/2024	5/28/2025 10:36	
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
10.00	6. 00	7. 00	8. 00	9. 00	10.00		1	0. 00
11. 00		0.00	0	0			1	1. 00
12.00		0. 00	o	0	0		1	2. 00
13.00		0. 00	0	0	0		1	3.00
14.00		0. 00	0	0	0		1	4.00
15.00		0.00	0	0				5.00
16. 00 17. 00		0. 00 0. 00	0	0	0		1	6. 00 7. 00
18.00		0.00	0	0	0		1	8. 00
19. 00		0. 00	o	0	0		1	9. 00
20.00		0.00	О	0	0		2	20.00
21.00		0. 00	0	0	0		•	21. 00
22.00		0.00	0	0	0		1	22.00
23. 00			00 1, 294, 114	<u></u> <u>0</u> 15, 975	0		2.	23. 00
	R - PHARMACY RESIDENTS		1, 294, 114	15, 975				
1.00	PHARMACY	15. 00	30, 503	0	0			1. 00
	0 — — — — —		30, 503					
	W - WAGE INDEX							
1. 00	ADMINISTRATIVE & GENERAL	5. 00	349, 433		0			1.00
2.00	NURSI NG ADMI NI STRATI ON	13.00	9, 442		0			2.00
3. 00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22. 00	1, 479, 026		U			3. 00
4. 00	ADULTS & PEDIATRICS	30. 00	399, 437		0			4. 00
5.00	INTENSIVE CARE UNIT	31.00	234, 887		0			5.00
6.00	SURGICAL INTENSIVE CARE UNIT	34. 00	80, 290		0			6.00
7. 00	SKILLED NURSING FACILITY	44. 00	36, 010		0			7. 00
8.00	OPERATING ROOM	50.00	10, 204		0			8. 00
9. 00 10. 00	DELIVERY ROOM & LABOR ROOM OP INFUSION	52. 00 52. 01	23, 994 97, 186		0		1	9. 00 0. 00
11.00	RADI OLOGY-DI AGNOSTI C	54. 00	204, 042		0			1. 00
12.00	RADI OLOGY-THERAPEUTI C	55. 00	120, 555		0		1	2. 00
13.00	CT SCAN	57. 00	1, 631		0		1	3.00
14.00	CARDIAC CATHETERIZATION	59. 00	41, 106		0		1	4.00
15.00	RESPI RATORY THERAPY	65. 00	18, 057		0		•	5. 00
16.00	CARDI AC REHABI LI TATI ON	76. 97	42, 667		0		•	6.00
17. 00 18. 00	EMERGENCY OBSERVATION BEDS-DISTINCT	91. 00 92. 01	299, 094 1, 590		0		•	7. 00 8. 00
19. 00	OTHER NON REIMBURABLE	194. 05	1, 370	367, 116	_			9. 00
	0		3, 448, 651	367, 116				
	X - OB SUPPORT							
1. 00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	<u>210, 918</u>	4,434	0			1. 00
	U INTERN & DECLIDENT CALARY	DECLACE	210, 918	4, 434				
1. 00	Y - INTERN & RESIDENT SALARY I&R SERVICES-OTHER PRGM.	22. 00	7, 754, 845	0	0			1. 00
1.00	COSTS APPRVD	22.00	7, 754, 645	O	0			1.00
	0 — — — —		7, 754, 845					
	Z - COVI D-19- CONTRACT LABOR							
1. 00	ADMINISTRATIVE & GENERAL			0	0			1. 00
	O CONTRACT LABOR		0	0				
1. 00	AA - CONTRACT LABOR SOCIAL SERVICE	17. 00	٥	0	0			1. 00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	0				2. 00
3. 00		0. 00	o	0	0			3. 00
	0 — — — — —							
	AB - HBP TEACH PART A							_
1.00	ADMINISTRATIVE & GENERAL	5. 00	288, 112	10, 495	0			1.00
2.00	ADULTS & PEDIATRICS	30. 00	204, 971	0	0			2.00
3. 00	EMERGENCY	91.00	41 <u>3, 916</u> 906, 999	<u> </u>	<u>0</u>			3. 00
	AC - RESIDENT MALPRACTICE		700, 777	10, 473				
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	8, 632	0			1.00
	0		0	8, 632				
500. 00	Grand Total: Decreases		17, 236, 172	104, 801, 428			50	00.00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 31-0041	Period: Worksheet A-7 From 01/01/2024 Part I

12/31/2024 Date/Time Prepared: To 5/28/2025 10:36 am Acqui si ti ons Begi nni ng Purchases Di sposal s and Donati on Total Bal ances Retirements 1.00 2.00 3.00 4.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 198, 713 1, 139, 748 1.00 Land 1, 139, 748 3, 070, 069 2.00 Land Improvements 0 0 0 0 2.00 3.00 3.00 Buildings and Fixtures 310, 465, 785 139, 706 53, 679, 562 53, 679, 562 4.00 Building Improvements 17, 860, 652 0 4.00 Fixed Equipment 79, 638, 021 0 5.00 0 5.00 0 6.00 6.00 Movable Equipment 215, 944, 398 3, 549, 353 3, 549, 353 0 HIT designated Assets 7.00 0 7.00 8.00 Subtotal (sum of lines 1-7) 627, 177, 638 58, 368, 663 58, 368, 663 139, 706 8.00 9.00 Reconciling Items 0 0 9.00 627, 177, 638 139, 706 Total (line 8 minus line 9) 58, 368, 663 58, 368, 663 10.00 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 338, 461 1.00 2.00 Land Improvements 3, 070, 069 2, 157, 470 2.00 Buildings and Fixtures 57, 892, 997 3.00 364, 005, 641 3.00 4.00 Building Improvements 17, 860, 652 5, 183, 612 4.00 5.00 Fixed Equipment 79, 638, 021 68, 619, 001 5.00 6.00 Movable Equipment 219, 493, 751 6.00 HIT designated Assets 7.00 7.00 8.00 Subtotal (sum of lines 1-7) 685, 406, 595 133, 853, 080 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 685, 406, 595 133, 853, 080 10.00

Heal th	Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der CO	CN: 31-0041	Peri od: From 01/01/2024	Worksheet A-7 Part II	
					To 12/31/2024		pared:
						5/28/2025 10:	
			SU	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	13, 100, 283	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	11, 341, 453	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	24, 441, 736	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	ŭ ,				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	13, 100, 283				1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	o	11, 341, 453	•			2.00
3. 00	Total (sum of lines 1-2)	o	24, 441, 736	•			3. 00
		-1	., ,	1			

Health Financial Systems	COMMUNITY MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2024 To 12/31/2024	Worksheet A-7 Part III Date/Time Pre 5/28/2025 10:	pared:
	COMI	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	•	'			
1.00 CAP REL COSTS-BLDG & FIXT	465, 912, 844				0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	219, 493, 750		,			2.00
3.00 Total (sum of lines 1-2)	685, 406, 594		685, 406, 59			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 III DECONOLILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT	ENTERS 0			0 13, 100, 283	0	1. 00
2. 00 CAP REL COSTS-BLDG & FIXT	0	l ~	1	0 13, 100, 283		2.00
3.00 Total (sum of lines 1-2)	0			0 24, 441, 736		3.00
3.00 Total (Suil Of Titles 1-2)	U	SI	JMMARY OF CAPI		U	3.00
		30	DIWINART OF CAPT	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
DART LLL DECONOLLIATION OF OATION	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		221 222			15 2/2 721	1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQULP	2, 040, 546 1, 766, 586			0 0		1.00 2.00
3.00 Total (sum of lines 1-2)	3, 807, 132		•	0 0		
5. 00 10tal (Suii 01 111165 1-2)	3,007,132	320, 742	·1	0	20, 373, 610	J 3.00

				To	12/31/2024	Date/Time Prep 5/28/2025 10:3	
				Expense Classification on		372872023 10.	30 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	B		CAP REL COSTS-BLDG & FLXT	1.00	5.00	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	В	-42 653	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
	COSTS-MVBLE EQUIP (chapter 2)	_					
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	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	61 010	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
7.00	stations excluded) (chapter 21)	В	-01, 010	ADMINISTRATIVE & GENERAL	5.00	J	7.00
8. 00	Tel evision and radio service (chapter 21)	В	-35, 847	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -11, 373, 133		0. 00	0 0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	11, 314, 230			0	12. 00
13.00	Laundry and linen service		0		0. 00	0	
14. 00 15. 00	Rental of quarters to employee		-1, 508, 938 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-1, 287	ADMINISTRATIVE & GENERAL	5. 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	В	-40, 023	OPERATION OF PLANT	7. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
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	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	therapy costs in excess of limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of limitation (chapter 14)	A-0-3	O	FITTS CAL THERAFT	00.00		24.00
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
33.00	MED & DENTAL STAFF OTHER REV	В	-263, 430	CENTRAL SERVICES & SUPPLY	14. 00	0	33.00

ADJU51	MENTS TO EXPENSES				erioa: From 01/01/2024	worksneet A-8	
					Γο 12/31/2024	Date/Time Prep 5/28/2025 10:	pared:
				Expense Classification on	Worksheet A	3/20/2023 10.	JO alli
			•	To/From Which the Amount is			
	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	
33. 01	GARNISHEE SERVICE CHARGE REV	В		EMPLOYEE BENEFITS DEPARTMENT		1	33. 01
33. 02 33. 03	OUTREACH LAB MEDICAL EDUCATION	B B		LABORATORY I&R SERVICES-OTHER PRGM.	60. 00 22. 00		33. 02 33. 03
33.03	MEDICAL EDUCATION	D		COSTS APPRVD	22.00	0	33.03
33.04	OTHER MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	o	33.04
33.05	OTHER MI SCELLANEOUS REVENUE	В	-152, 000	MAINTENANCE & REPAIRS	6. 00	0	33.05
	OTHER MI SCELLANEOUS REVENUE	В	· ·	OPERATION OF PLANT	7. 00		33. 06
	OTHER MISCELLANEOUS REVENUE	B B		PHARMACY	15. 00	1	33. 07
33. 08 33. 09	OTHER MISCELLANEOUS REVENUE OTHER MISCELLANEOUS REVENUE	В		ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00		33. 08 33. 09
33. 10	OTHER MI SCELLANEOUS REVENUE	В		RADI OLOGY-THERAPEUTI C	55. 00	1	33. 10
33. 11	1	В		LABORATORY	60.00	1	33. 11
33. 12	EMPLOYEE - HEALTH PAYMENTS	В		ADULTS & PEDIATRICS	30.00		33. 12
	EMPLOYEE - HEALTH PAYMENTS	В		INTENSIVE CARE UNIT	31. 00		33. 13
33. 14	EMPLOYEE - HEALTH PAYMENTS	В	ı	SURGICAL INTENSIVE CARE UNIT			33. 14
33. 15	EMPLOYEE - HEALTH PAYMENTS EMPLOYEE - HEALTH PAYMENTS	B B	ı	NURSERY SKILLED NURSING FACILITY	43. 00 44. 00		33. 15 33. 16
33. 17	1	B		OPERATING ROOM	50.00	1	33. 17
33. 18		В		RECOVERY ROOM	51. 00	1	33. 18
33. 19	EMPLOYEE - HEALTH PAYMENTS	В		DELIVERY ROOM & LABOR ROOM	52. 00	1	33. 19
	EMPLOYEE - HEALTH PAYMENTS	В		OP INFUSION	52. 01	0	33. 20
33. 21	EMPLOYEE - HEALTH PAYMENTS	В		ANESTHESI OLOGY	53.00	1	33. 21
	EMPLOYEE - HEALTH PAYMENTS EMPLOYEE - HEALTH PAYMENTS	B B		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00		33. 22 33. 23
	EMPLOYEE - HEALTH PAYMENTS	В		RADI OLOGI - THERAPEUTI C	56. 00		33. 24
33. 25	1	В		CT SCAN	57. 00		33. 25
33. 26	EMPLOYEE - HEALTH PAYMENTS	В	-3, 167		58. 00		33. 26
33. 27	1	В		CARDIAC CATHETERIZATION	59. 00		33. 27
33. 28	EMPLOYEE - HEALTH PAYMENTS	В		LABORATORY	60.00		33. 28
33. 29 33. 30	EMPLOYEE - HEALTH PAYMENTS EMPLOYEE - HEALTH PAYMENTS	B B	t e e e e e e e e e e e e e e e e e e e	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00		33. 29 33. 30
	EMPLOYEE - HEALTH PAYMENTS	В	t and the second se	OCCUPATIONAL THERAPY	66. 00 67. 00		33. 31
	EMPLOYEE - HEALTH PAYMENTS	В	· ·	SPEECH PATHOLOGY	68. 00	1	33. 32
	EMPLOYEE - HEALTH PAYMENTS	В	· ·	ELECTROCARDI OLOGY	69. 00	1	33. 33
33. 34	EMPLOYEE - HEALTH PAYMENTS	В	· ·	ELECTROENCEPHALOGRAPHY	70.00		33. 34
33. 35	EMPLOYEE - HEALTH PAYMENTS	В		MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 35
33. 36	EMPLOYEE - HEALTH PAYMENTS	В	t e e e e e e e e e e e e e e e e e e e	PATIENT IMPL. DEV. CHARGED TO	72. 00	0	33. 36
00.00	LINE LOTEE TIENETT TATMENTO			PATI ENTS	72.00	Ĭ	00.00
33. 37	EMPLOYEE - HEALTH PAYMENTS	В		DRUGS CHARGED TO PATIENTS	73. 00		33. 37
33. 38	EMPLOYEE - HEALTH PAYMENTS	В		CARDIAC REHABILITATION	76. 97		33. 38
	EMPLOYEE - HEALTH PAYMENTS EMPLOYEE - HEALTH PAYMENTS	В		CLI NI C EMERGENCY	90. 00 91. 00		33. 39
	EMPLOYEE - HEALTH PAYMENTS	B B		OBSERVATION BEDS-DISTINCT	92. 01		33. 40 33. 41
	EMPLOYEE - HEALTH PAYMENTS	В		OBSERVATION BEDS-DISTINCT	92. 01		33. 42
33. 43	RENTAL INCOME	В	-602, 661	ADMINISTRATIVE & GENERAL	5. 00	0	33. 43
	RENTAL I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00		33. 44
	FOUNDATION SUBSIDY	B B		EMPLOYEE BENEFITS DEPARTMEN [.] ADMINISTRATIVE & GENERAL			33. 45 33. 46
	FOUNDATION SUBSIDY FOUNDATION SUBSIDY	В		MAINTENANCE & REPAIRS	5. 00 6. 00		33. 46
	FOUNDATION SUBSIDY	В		OPERATION OF PLANT	7. 00		33. 48
	FOUNDATION SUBSIDY	В	-72, 129		10.00		33.49
33. 50	FOUNDATION SUBSIDY	В	-28, 093	NURSING ADMINISTRATION	13. 00	0	33. 50
	FOUNDATION SUBSIDY	В	ı	PHARMACY	15. 00		33. 51
	FOUNDATION SUBSIDY	B B		SOCIAL SERVICE I&R SERVICES-OTHER PRGM.	17. 00	1	33. 52
33. 33	FOUNDATION SUBSIDY	D	·	COSTS APPRVD	22. 00	0	33. 53
33. 54	FOUNDATION SUBSIDY	В		PARAMED ED PRGM-(SPECIFY)	23. 00	О	33. 54
	FOUNDATION SUBSIDY	В		ADULTS & PEDIATRICS	30. 00		33. 55
	FOUNDATION SUBSIDY	В		INTENSIVE CARE UNIT	31.00		33. 56
	FOUNDATION SUBSIDY	В		SURGICAL INTENSIVE CARE UNIT			33. 57
	FOUNDATION SUBSIDY FOUNDATION SUBSIDY	B B		SKILLED NURSING FACILITY OPERATING ROOM	44. 00 50. 00		33. 58 33. 59
	FOUNDATION SUBSIDY	В		RECOVERY ROOM	51. 00	1	33. 60
	FOUNDATION SUBSIDY	В		DELIVERY ROOM & LABOR ROOM	52. 00	1	33. 61
	FOUNDATION SUBSIDY	В		OP INFUSION	52. 01	1	33. 62
	FOUNDATION SUBSIDY	В		ANESTHESI OLOGY	53.00	1	33. 63
	FOUNDATION SUBSIDY FOUNDATION SUBSIDY	B B		RADIOLOGY-THERAPEUTIC CT SCAN	55. 00 57. 00		33. 64 33. 65
	ו שוכשטכ אוט וו השאוטו	ا م	-201	OT JOAN	37.00	ı V	

				To	12/31/2024	Date/Time Pre 5/28/2025 10:	
				Expense Classification on	Worksheet A	372872023 10.	30 alli
				To/From Which the Amount is t			
					,		
	Cook Cooker December 1	D:- (01- (2)	A -	C+ C+	1: //	WI+ A 7 D-£	
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
33. 66	FOUNDATION SUBSIDY	B		RESPI RATORY THERAPY	65. 00	5.00	33. 66
33. 67	FOUNDATION SUBSIDY	В		PHYSI CAL THERAPY	66. 00	Ő	33. 67
33. 68	FOUNDATION SUBSIDY	В		ELECTROENCEPHALOGRAPHY	70. 00	ő	33. 68
33. 69	FOUNDATION SUBSIDY	В	-44, 952	l I	90.00	0	33. 69
33.70	FOUNDATION SUBSIDY	В		EMERGENCY	91.00	0	33. 70
33. 71	INTERCOMPANY RENTAL INCOME	В	-1, 939, 077	ADMINISTRATIVE & GENERAL	5. 00	0	33. 71
33.72	INTERCOMPANY RENTAL INCOME	A	-231, 086	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 72
33.73	NON ALLOWABLE ENTERTAINMENT	A	-13, 851	ADMINISTRATIVE & GENERAL	5. 00	0	33. 73
33. 74	NON ALLOWABLE ENTERTAINMENT	A		MAINTENANCE & REPAIRS	6. 00	0	33. 74
33. 75	NON ALLOWABLE ENTERTAINMENT	A		OPERATION OF PLANT	7. 00	0	33. 75
33. 76	NON ALLOWABLE ENTERTAINMENT	A		DIETARY	10.00	0	33. 76
33. 77	NON ALLOWABLE ENTERTALINMENT	A		NURSI NG ADMI NI STRATI ON	13.00	0	33. 77
33. 78 33. 79	NON ALLOWABLE ENTERTALNMENT NON ALLOWABLE ENTERTALNMENT	A	·	PHARMACY SOCIAL SERVICE	15. 00	0	33. 78 33. 79
33. 80	NON ALLOWABLE ENTERTAINMENT	A A		I &R SERVICES-OTHER PRGM.	17. 00 22. 00	0	33. 79
33.00	NON ALLOWABLE ENTERTATIONENT	_ ^	-10, 204	COSTS APPRVD	22.00	U	33.00
33. 81	NON ALLOWABLE ENTERTALNMENT	A	-1 351	PARAMED ED PRGM-(SPECIFY)	23. 00	0	33. 81
33. 82	NON ALLOWABLE ENTERTAINMENT	A		ADULTS & PEDIATRICS	30.00	ő	33. 82
33. 83	NON ALLOWABLE ENTERTAINMENT	A	·	INTENSIVE CARE UNIT	31. 00	0	33. 83
33.84	NON ALLOWABLE ENTERTAINMENT	A	-220	SURGICAL INTENSIVE CARE UNIT	34.00	0	33. 84
33.85	NON ALLOWABLE ENTERTAINMENT	A	-1, 230	SKILLED NURSING FACILITY	44.00	0	33.85
33.86	NON ALLOWABLE ENTERTAINMENT	A	-1, 050	OPERATING ROOM	50.00	0	33. 86
33. 87	NON ALLOWABLE ENTERTAINMENT	A		RADI OLOGY-THERAPEUTI C	55. 00	0	33.87
33.88	NON ALLOWABLE ENTERTAINMENT	A		CARDI AC CATHETERI ZATI ON	59. 00	0	33. 88
33. 89	NON ALLOWABLE ENTERTAINMENT	A		PHYSI CAL THERAPY	66.00	0	33. 89
33. 90	NON ALLOWABLE ENTERTALINMENT	A		SPEECH PATHOLOGY	68.00	0	33. 90
33. 91 33. 92	NON ALLOWABLE ENTERTALNMENT	A		ELECTROENCEPHALOGRAPHY	70.00	0	33. 91
33. 92	NON ALLOWABLE ENTERTAINMENT NON ALLOWABLE ENTERTAINMENT	A A		EMERGENCY OBSERVATION BEDS-DISTINCT	91. 00 92. 01	0	33. 92 33. 93
33. 94	COMMUNITY BENEFIT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 93
33. 95	COMMUNITY BENEFIT	A		OPERATION OF PLANT	7. 00	0	33. 95
33. 96	COMMUNITY BENEFIT	A		SOCIAL SERVICE	17. 00	0	33. 96
33. 97	FQHC	A		ADMINISTRATIVE & GENERAL	5. 00	Ő	33. 97
33. 98	LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 98
33. 99	BHMG/MMG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 99
34.00	NURSE PRACTIONERS (INCLUDES	A	172, 910	ADMINISTRATIVE & GENERAL	5. 00	0	34.00
	FRI NGES)						
34. 01	NURSE PRACTIONERS (INCLUDES	A	152, 166	OPERATING ROOM	50. 00	0	34. 01
	FRI NGES)			EMBLOVEE DENEEL TO DEDARTHENT			
34. 02	PENSION ADMINISTRATION COSTS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34. 02
34.03	HBP HBP	A A		DI ETARY	10.00	0	34. 03
34. 04 34. 05	HBP	A A		SKILLED NURSING FACILITY RADIOLOGY-THERAPEUTIC	44. 00 55. 00	-	34. 04 34. 05
34. 06	HBP	A		LABORATORY	60. 00	0	34. 06
34. 07	OTHER ADJUSTMENTS (SPECIFY)	"	70, 702	E ABORT TORT	0. 00	Ő	34. 07
	(3)		· ·		2. 00]	
34.08	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 08
	(3)						
34. 09	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 09
	(3)		_			_	
34. 10	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 10
34. 11	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 11
34.11	(3)		0		0.00	U	34.11
34. 12	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 12
J 12	(3)		O		3.00		J 12
34. 13	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34. 13
	(3)						
34.14	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 14
	(3)						
34. 15	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 15
EO 00	(3)		15 054 (07				EO 00
50.00	TOTAL (sum of lines 1 thru 49)	'	-15, 351, 687				50. 00
	(Transfer to Worksheet A, column 6, line 200.)						
(1) Do	scription - all chapter referen	acoc in this co	umn nortain t	0 CMS Pub 15_1			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

Health Financial Systems		COMMUNITY MED	DICAL CENTER	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES			Period: From 01/01/2024	Worksheet A-8		
					Date/Time Pre 5/28/2025 10:	
			Expense Classification or	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2. 00	3.00	4. 00	5. 00	

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	COMMUNITY ME	In Lieu of Form CMS-2552-10			
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	3-1
OFFI CE	COSTS			From 01/01/2024 To 12/31/2024		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	83, 203, 141	71, 888, 911	1. 00
2.00	0.00			0	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL CENTER AUX	7, 256	7, 256	3.00
3. 01	5. 00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL CENTER FOU	108, 714	108, 714	3. 01
3. 02	5. 00	ADMINISTRATIVE & GENERAL	SAINT BARNABAS CORPORATION	570, 882	570, 882	3. 02
3.03	0.00			o	0	3. 03
4.00	0.00			o	0	4. 00
5.00	TOTALS (sum of lines 1-4).			83, 889, 993	72, 575, 763	5. 00
	Transfer column 6 line 5 to					

* 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.

i ci ilibai	Schicit under that Aviii.		
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:

Worksheet A-8, column 2,

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

Heal th	Financial Syste	ems		COMMUNI TY	MEDIC	AL CENTER		In Lie	u of Form C	MS-2552-10
STATEME OFFI CE		SERVICES FROM	1 RELATED	O ORGANI ZATI ONS AND	HOME	Provi der	CCN: 31-0041	Peri od: From 01/01/2024	Worksheet	A-8-1
								To 12/31/2024	Date/Ti me 5/28/2025	
	Net	Wkst. A-7 Ref								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
	A. COSTS INCUR	RED AND ADJUST	MENTS RE	EQUIRED AS A RESULT	OF TRA	ANSACTI ONS	WITH RELATE	D ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:								
1.00	11, 314, 230		0							1.00
2.00	0		כ							2. 00
3.00	0		O							3.00
3. 01	0)							3. 01
3. 02	0)							3. 02
3. 03	0)							3. 03
4.00	0)							4. 00
5.00	11, 314, 230									5. 00

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

nas no	been posted to norksheet A,	cordinas i and or 2, the amount arrowable should be margated in cordinar for 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.

6.00	HEALTHCARE	6. 00
7.00		7.00
8.00		8.00
7. 00 8. 00 9. 00		9. 00
10. 00 100. 00		10.00
100.00		100.00

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

PROVI DER BASED PHYSI CI AN ADJUSTMENT

Provi der CCN: 31-0041
From 01/01/2024
To 12/31/2024
Peri od:
From 01/01/2024
To 12/31/2024
Pare/Time Prepared:

					-	Γο 12/31/2024	Date/Time Pre 5/28/2025 10:	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		AGGREGATE-ADMINISTRATIVE &	4, 571, 036			211, 500	8, 966	1. 00
2. 00	30.00	GENERAL AGGREGATE-ADULTS &	3, 803, 857	2, 887, 655	916, 202	197, 500	9, 649	2. 00
2 00	F0.00	PEDI ATRI CS	10.000	10.000			0	2 00
3. 00 4. 00		AGGREGATE-OPERATING ROOM AGGREGATE-ANESTHESIOLOGY	18, 000 2, 687, 178			-	5, 579	3. 00 4. 00
5. 00		AGGREGATE-RADI OLOGY-DI AGNOST	2, 067, 176					5. 00
6. 00		I C AGGREGATE-CARDI AC	125, 474				0, 201	6. 00
7. 00		CATHETERI ZATI ON AGGREGATE-RESPI RATORY	10, 557	10, 557	0	0	0	7. 00
		THERAPY					_	
8. 00		AGGREGATE - ELECTROCARDI OLOGY	117, 634		117, 634	211, 500	208	8. 00
9. 00	70.00	AGGREGATE-ELECTROENCEPHALOGR APHY	89, 212	89, 212	0	0	0	9. 00
10.00	70. 01	AGGREGATE-SLEEP LAB	58, 589	58, 589	0	0	0	10. 00
11. 00		AGGREGATE-CLI NI C	28, 927			o	0	11. 00
12.00	91.00	AGGREGATE-EMERGENCY	2, 536, 040	690, 907	1, 845, 133	211, 500	18, 146	12.00
200.00			16, 124, 773					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Mal practi ce	
				Limit	Continuing Education	Share of col. 12	Insurance	
	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		AGGREGATE-ADMINISTRATIVE &	911, 687	45, 584			918, 780	1. 00
2. 00		GENERAL AGGREGATE-ADULTS &	916, 191	45, 810	0	0	0	2. 00
3. 00		PEDIATRICS AGGREGATE-OPERATING ROOM	7.07.77	0			0	3. 00
4. 00		AGGREGATE-OPERATING ROOM AGGREGATE-ANESTHESIOLOGY	567, 288				0	4. 00
5. 00		AGGREGATE-RADI OLOGY-DI AGNOST	424, 975			-	0	5. 00
6. 00		I C AGGREGATE-CARDI AC	0	0	0	0	54, 368	
7. 00	65.00	CATHETERI ZATI ON AGGREGATE-RESPI RATORY	0	0	0	0	6, 803	7. 00
8. 00		THERAPY AGGREGATE-ELECTROCARDI OLOGY	21, 150	1, 058	0		75, 806	8. 00
9. 00		AGGREGATE-ELECTROENCEPHALOGR	21, 150	1, 038	ő	o o	58, 252	9. 00
10.00	70. 01	APHY AGGREGATE-SLEEP LAB	0	0	0	0	37, 756	10. 00
11.00		AGGREGATE-CLI NI C	0	0	0	0	18, 641	11.00
12.00	91.00	AGGREGATE-EMERGENCY	1, 845, 134			0	0	12.00
200.00			4, 686, 425				1, 170, 406	200. 00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		AGGREGATE-ADMINISTRATIVE &	181, 121	1, 092, 808		3, 669, 939		1. 00
2. 00	30.00	GENERAL AGGREGATE-ADULTS &	0	916, 191	11	2, 887, 666		2. 00
2 00	FO 00	PEDI ATRI CS		_		10.000		2 00
3. 00 4. 00		AGGREGATE-OPERATING ROOM AGGREGATE-ANESTHESIOLOGY		0 567, 288				3. 00 4. 00
5. 00		AGGREGATE-RADI OLOGY-DI AGNOST	0	424, 975				5. 00
5.00	34.00	I C		724, 7/3	25	1, 000, 274		3.00
6. 00	59. 00	AGGREGATE-CARDI AC CATHETERI ZATI ON	0	0	0	125, 474		6. 00
7. 00	65. 00	AGGREGATE-RESPI RATORY THERAPY	0	0	0	10, 557		7. 00
8. 00	69 00	AGGREGATE-ELECTROCARDI OLOGY	75, 806	96, 956	20, 678	20, 678		8. 00
9. 00		AGGREGATE-ELECTROENCEPHALOGR	0	0	0	89, 212		9. 00
10.00	70 01	AGGREGATE-SLEEP LAB	n	n	0	58, 589		10. 00
11. 00		AGGREGATE-CLI NI C	Ö	Ö	0	1		11. 00
12.00		AGGREGATE-EMERGENCY	0	1, 845, 134	0	1		12.00
200. 00			256, 927	4, 943, 352	20, 719	11, 373, 133		200.00

Period: Worksheet B From 01/01/2024 Part I To 12/31/2024 Date/Time Prepared: COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 31-0041

					To	12/31/2024	Date/Time Pre 5/28/2025 10:	
				CAPI TAL REI	ATED COSTS		07 207 2020 10.	00 4111
		Cook Cooker Donnel at long	Nat Francisco	DIDC & FLVT	MVDLE FOULD	EMDL OVEE	C	
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7)	1 00	2.00	4.00	4.0	
	GENER	AL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1.00		CAP REL COSTS-BLDG & FLXT	15, 362, 731	15, 362, 731				1. 00
2.00		CAP REL COSTS-MVBLE EQUIP	13, 212, 879		13, 212, 879	07 005 047		2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	37, 740, 890 114, 273, 312	154, 957 1, 001, 988		37, 895, 847 2, 226, 917	123, 395, 588	4. 00 5. 00
6. 00		MAINTENANCE & REPAIRS	575, 397	47, 695		54, 821	682, 413	6.00
7. 00		OPERATION OF PLANT	13, 176, 783			888, 380	15, 168, 961	7. 00
8. 00		LAUNDRY & LINEN SERVICE	1, 410, 819		-	0	1, 410, 819	•
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	6, 236, 914 5, 961, 638			659, 585 601, 459	7, 083, 216 6, 946, 870	•
11.00	1	CAFETERI A	87, 469			158, 376	509, 167	•
13.00	1	NURSING ADMINISTRATION	4, 966, 395			878, 503	6, 668, 328	•
14.00		CENTRAL SERVICES & SUPPLY	4, 155, 914			429, 698	5, 507, 465	
15.00		PHARMACY MEDI CAL RECORDS & LI BRARY	6, 828, 075		1	1, 284, 152 0	8, 432, 294	
16. 00 17. 00		SOCIAL SERVICE	5, 490, 157	0 0		622, 586	0 6, 112, 743	16. 00 17. 00
21. 00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	7, 754, 845	Ö		1, 520, 872	9, 275, 717	21. 00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	4, 413, 136	352, 992	0	302, 305	5, 068, 433	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	139, 519	0	0	23, 882	163, 401	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	43, 638, 979	3, 207, 466	93, 668	7, 034, 552	53, 974, 665	30.00
31.00		INTENSIVE CARE UNIT	29, 097, 896			5, 193, 598	36, 154, 086	
34.00	1	SURGICAL INTENSIVE CARE UNIT	3, 890, 683			685, 179	4, 720, 890	
43.00		NURSERY	3, 439, 137		1	607, 916	4, 246, 665	
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	4, 558, 196	247, 564	1, 208	790, 487	5, 597, 455	44. 00
50.00		OPERATING ROOM	15, 006, 933	976, 778	1, 679, 969	2, 130, 059	19, 793, 739	50. 00
51.00		RECOVERY ROOM	1, 836, 849			347, 121	2, 330, 397	1
52.00		DELIVERY ROOM & LABOR ROOM	3, 990, 583			739, 679	5, 235, 692	1
52. 01 53. 00		OP INFUSION ANESTHESIOLOGY	1, 872, 889 756, 081	239, 763 28, 680		326, 264 22, 879	2, 444, 900 807, 640	1
54.00		RADI OLOGY-DI AGNOSTI C	10, 204, 939			1, 376, 718	12, 913, 233	
55.00		RADI OLOGY-THERAPEUTI C	5, 909, 113	415, 972		931, 486	7, 944, 036	1
56.00	1	RADI OI SOTOPE	1, 437, 902			122, 536	1, 619, 471	56.00
57. 00 58. 00	05/00	CT SCAN	3, 496, 349 1, 249, 614			547, 112 206, 177	4, 064, 971 1, 729, 614	57. 00 58. 00
59.00	1	CARDI AC CATHETERI ZATI ON	4, 600, 264			769, 592	6, 317, 294	
60.00		LABORATORY	18, 938, 449	· ·		0	19, 698, 185	
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	-	0	0	
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	4, 786, 001 2, 265, 839	53, 975 153, 581		776, 974 440, 378	5, 921, 925 2, 879, 849	
67.00		OCCUPATIONAL THERAPY	1, 354, 771	7, 686		265, 474	1, 627, 931	
68.00		SPEECH PATHOLOGY	390, 825			76, 573	491, 432	
69.00		ELECTROCARDI OLOGY	3, 404, 844			541, 989	4, 186, 624	
70. 00 70. 01		ELECTROENCEPHALOGRAPHY SLEEP LAB	1, 693, 222	266, 149 0		285, 776 4, 086	2, 399, 136 4, 086	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	24, 573, 975	0	0	4, 080	24, 573, 975	
72.00		IMPL. DEV. CHARGED TO PATIENTS	21, 513, 589	0	0	0	21, 513, 589	
73.00	1	DRUGS CHARGED TO PATIENTS	47, 415, 628	0	0	0	47, 415, 628	1
76. 97 76. 98		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	736, 581 265, 437	70, 151 74, 568	1	132, 982	941, 986 340, 005	
77.00		ALLOGENEIC STEM CELL ACQUISITION	203, 437	74, 300		0	340, 003	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0		Ō	0	78. 00
		TIENT SERVICE COST CENTERS	700 074			/= a=a	7// 000	
90. 00 91. 00		CLINIC EMERGENCY	700, 971 20, 015, 800	0 1, 639, 684		65, 051 3, 072, 255	766, 022 24, 941, 977	90. 00 91. 00
92.00		OBSERVATION BEDS (NON-DISTINCT PART	20, 013, 000	1, 037, 004	214, 230	3,072,233	24, 741, 777	
92.01		OBSERVATION BEDS-DISTINCT	3, 339, 663	0	0	630, 429	3, 970, 092	
05.00		REIMBURSABLE COST CENTERS		_		٥		05.00
		AMBULANCE SERVICES OPIOID TREATMENT PROGRAM	0	0		0		95. 00 102. 00
102.00		AL PURPOSE COST CENTERS			<u> </u>	<u>0</u>		102.00
	11300	INTEREST EXPENSE						113.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	528, 168, 875	15, 362, 731	13, 157, 598	37, 774, 858	527, 992, 605	118. 00
194 00		I MBURSABLE COST CENTERS MI SCELLANEOUS	n	0		οl	n	194. 00
		PUBLIC RELATIONS	546	Ö	o o	o	546	194. 01
194. 03	07952	LI GHTHOUSE	56, 646			10, 989	67, 635	
194. 04	107953	KIDS & FAMILY	0	0	0	이	0	194. 04

Health Financial Systems	ICAL CENTER		In Lie	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 31-0041		Peri od: From 01/01/2024	Worksheet B Part I	
				To 12/31/2024		pared: 36 am
		CAPITAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4. 00	4A	
194.05 07954 OTHER NON REIMBURABLE	562, 305	0	55, 28	110, 000	727, 586	194. 05
194. 06 07955 GRANTS/TRI ALS	7, 061	0		0	7, 061	194. 06
194. 07 07956 RETAIL PHARMACY	0	0		0	0	194. 07
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0		0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	528, 795, 433	15, 362, 731	13, 212, 87	37, 895, 847	528, 795, 433	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

Peri od: Worksheet B From 01/01/2024 Part I To 12/31/2024 Date/Time Prepared: 5/28/2025 10:36 am

Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/28/2025 10: HOUSEKEEPING	
cost center bescription	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
CENEDAL CEDALOF COCT CENTEDS	5. 00	6. 00	7.00	8. 00	9. 00	
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						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	123, 395, 588					5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	207, 713	890, 126				6.00
7. 00 00700 0PERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE	4, 617, 128 429, 425	14, 997 0		1, 840, 244		7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	2, 155, 989	11, 004	_	1, 640, 244	9, 499, 200	9.00
10. 00 01000 DI ETARY	2, 114, 488	19, 539		18, 398		10.00
11. 00 01100 CAFETERI A	154, 980	16, 261			0	11. 00
13.00 O1300 NURSING ADMINISTRATION	2, 029, 706	7, 954		0	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	1, 676, 362	37, 379			1	1
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 566, 622	9, 758	220, 799 0	0	0	15. 00 16. 00
17. 00 01700 SOCI AL SERVI CE	1, 860, 597	0		0		17.00
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD	2, 823, 343	0	ő	0	ĺ	21.00
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	1, 542, 730	22, 193	502, 143	0	161, 689	
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	49, 736	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1 44 400 700	004 (54	1 - 10 - 700	400.070		
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	16, 428, 788 11, 004, 581	201, 654			4, 446, 432 1, 320, 456	
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	1, 436, 944	111, 047 8, 563			1, 320, 456	1
43. 00 04300 NURSERY	1, 292, 600	12, 043		0.017	Ö	1
44.00 04400 SKILLED NURSING FACILITY	1, 703, 753	15, 564		33, 081	Ō	1
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	6, 024, 818	61, 411				
51. 00 05100 RECOVERY ROOM	709, 326	8, 763		22, 482	0	51.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 52.01 03190 OP INFUSION	1, 593, 640 744, 179	28, 219 15, 074		58, 662 19, 793	350, 325 0	52. 00 52. 01
53. 00 05300 ANESTHESI OLOGY	245, 829	1, 803			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 930, 530	39, 120			1	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 418, 006	26, 152			161, 689	
56. 00 05600 RADI 0I SOTOPE	492, 935	902			0	56. 00
57. 00 05700 CT SCAN	1, 237, 296	1, 352			0	57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	526, 460 1, 922, 858	5, 348 38, 057		14, 867 16, 711	161, 689 336, 851	
60. 00 06000 LABORATORY	5, 995, 734	23, 992		3, 059		1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0,770,701	20, 772	0 12,000	0,007	Ö	63.00
65. 00 06500 RESPIRATORY THERAPY	1, 802, 516	3, 393	76, 782	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	876, 568	9, 656				
67. 00 06700 OCCUPATI ONAL THERAPY	495, 510	483			0	67.00
68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY	149, 582	1, 511			0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 274, 325 730, 249	8, 015 16, 733		16, 871 11, 424		69. 00 70. 00
70. 01 07001 SLEEP LAB	1, 244	10, 733	0	11, 424	l ő	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 479, 827	0	0	0	Ō	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 548, 306	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	14, 432, 369	0	0	0	0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	286, 722	4, 410			0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION	103, 491	4, 688 0		26, 012	0	76. 98 77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>					70.00
90. 00 09000 CLI NI C	233, 162	0	0	0	0	90.00
91. 00 09100 EMERGENCY	7, 591, 839	103, 088	2, 332, 511	467, 402	1, 751, 626	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4 000 447					92.00
92. 01 09201 OBSERVATI ON BEDS-DI STI NCT OTHER REIMBURSABLE COST CENTERS	1, 208, 417	0	0	0	0	92. 01
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
102. 00 10200 OPI OI D TREATMENT PROGRAM		0				102.00
SPECIAL PURPOSE COST CENTERS	-1					
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	123, 151, 223	890, 126	19, 801, 086	1, 840, 244	9, 499, 200	118. 00
NONREI MBURSABLE COST CENTERS	1 0				· ·	101.00
194. 00 07950 MI SCELLANEOUS 194. 01 07951 PUBLI C RELATI ONS	0	0		0		194. 00 194. 01
194. 01 07951 PUBLIC RELATIONS 194. 03 07952 LI GHTHOUSE	166 20, 587	0	0	0		194. 01
194. 04 07953 KIDS & FAMILY	20, 387	0	0	0		194. 03
194. 05 07954 OTHER NON REIMBURABLE	221, 463	0	Ö	0		194. 05
194. 06 07955 GRANTS/TRI ALS	2, 149	0	0	0	0	194. 06
194. 07 07956 RETAI L_PHARMACY	0	0	0	0	0	194. 07
200. 00 Cross Foot Adjustments		_		_	_	200.00
201.00 Negative Cost Centers	0	0	0	0	1 0	201. 00

Health Financial Systems	COMMUNITY MEDI	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der 0	F	Period: From 01/01/2024 To 12/31/2024	Worksheet B Part I Date/Time Pre 5/28/2025 10:	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6. 00	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118 through 201)	123, 395, 588	890, 126	19, 801, 086	1, 840, 244	9, 499, 200	202. 00

Provi der CCN: 31-0041

Period: Worksheet B From 01/01/2024 Part I To 12/31/2024 Date/Time Prepared:

			10	12/31/2024	Date/lime Pre 5/28/2025 10:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVI CES & SUPPLY		
	10. 00	11. 00	13. 00	14.00	15. 00	
GENERAL SERVICE COST CENTERS	1		1			4 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP			•			1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
6. 00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	9, 541, 384	4 040 007				10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	1, 048, 326	l l			11.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	0	21, 267 23, 143	1 ' '	8, 461, 991		13. 00 14. 00
15. 00 01500 PHARMACY	0	38, 781	l l	36, 711	11, 304, 965	ı
16. 00 01600 MEDI CAL RECORDS & LI BRARY	o o	00, 701		00, 711	0	16.00
17. 00 01700 SOCI AL SERVI CE	O	18, 139	200, 128	o	0	17. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	68, 804	1	0	0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	1, 251	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	E 17/ /77	248, 322	2 015 274	25 422	0	30.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	5, 176, 677 3, 560, 062	248, 322 157, 624		35, 432 34, 481	0	30.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	275, 863	18, 765		5, 045	0	34.00
43. 00 04300 NURSERY	0	4, 378		0, 0.10	0	43.00
44.00 04400 SKILLED NURSING FACILITY	528, 782	23, 143		2, 810	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	64, 426		38, 107	0	50.00
51. 00 05100 RECOVERY ROOM	0	7, 506		236	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 52.01 03190 OP INFUSION	0	21, 892		8, 412	0	52.00
52. 01 03190 OP I NFUSI ON 53. 00 05300 ANESTHESI OLOGY	0	11, 259 1, 251	111, 471	1, 551 72	0	52. 01 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		47, 537		8, 577	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	20, 641		121	0	55.00
56. 00 05600 RADI OI SOTOPE	O	2, 502		86	0	56.00
57.00 05700 CT SCAN	0	12, 510	0	o	0	57.00
58. 00 05800 MRI	0	5, 004	1	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	18, 139	1	7, 266	0	59.00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY	0	23, 143	0	483	0	63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	12, 510	1	121	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		7, 506	1	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	o	2, 502	1	ō	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	16, 888	86, 304	1, 200	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	8, 757		13, 812	0	70.00
70. 01 07001 SLEEP LAB	0	0		0	0	70. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	4, 580, 505	0	,
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0	0	3, 642, 231	0 11, 304, 965	
76. 97 07697 CARDI AC REHABI LI TATI ON		3, 753	50, 949	46	11, 304, 703	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0, 739	30, 747	0	0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	0	Ō	ō	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	o	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	1, 876		831	0	90.00
91. 00 09100 EMERGENCY	0	110, 087	1, 057, 451	38, 818	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 01 09201 OBSERVATION BEDS-DISTINCT	o	21 247	255 201	E 027	0	92. 00 92. 01
OTHER REIMBURSABLE COST CENTERS	U	21, 267	255, 381	5, 037	0	92.01
95. 00 09500 AMBULANCE SERVICES	0	0	0	O	0	95. 00
102.00 10200 OPIOID TREATMENT PROGRAM	o	0	1	ō		102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 541, 384	1, 044, 573	8, 905, 249	8, 461, 991	11, 304, 965	118. 00
NONREI MBURSABLE COST CENTERS				ما		
194. 00 07950 MI SCELLANEOUS		0		0		194. 00
194. 01 07951 PUBLI C RELATI ONS 194. 03 07952 LI GHTHOUSE		0		0		194. 01 194. 03
194. 04 07953 KIDS & FAMILY		0		0		194. 03
194. 05 07954 OTHER NON REIMBURABLE		3, 753		0		194. 05
194. 06 07955 GRANTS/TRI ALS		0, 730	1, 967	o		194. 06
194. 07 07956 RETAIL PHARMACY	0	0	o	o		194. 07
200.00 Cross Foot Adjustments	<u> </u>					200. 00

Health Fina	ancial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - GENERAL SERVICE COSTS		Provi der C		Period: From 01/01/2024	Worksheet B Part I	
					Γο 12/31/2024	Date/Time Pre 5/28/2025 10:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI OI	SERVICES &		
					SUPPLY		
		10.00	11. 00	13.00	14.00	15. 00	
201. 00	Negative Cost Centers	0	0	(0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	9, 541, 384	1, 048, 326	8, 907, 210	8, 461, 991	11, 304, 965	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0041

				1	0 12/31/2024	Date/lime Pre 5/28/2025 10:	
				INTERNS &	RESI DENTS	07 207 2020 10.	OO GIII
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR		PARAMED ED	
		RECORDS &		Y & FRINGES	PRGM. COSTS	PRGM	
		16. 00	17. 00	21. 00	22. 00	23. 00	
	GENERAL SERVICE COST CENTERS	10.00	17.00	21.00	22.00	23.00	
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 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERI A						10.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0					16. 00
17. 00	01700 SOCI AL SERVI CE	0	8, 191, 607				17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	, ,			21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	235, 109		7, 601, 101	044 000	22.00
23. 00			0			214, 388	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	2, 136, 320	5, 563, 242	3, 495, 046	0	30.00
31.00	03100 NTENSIVE CARE UNIT		1, 176, 421		652, 754	0	31.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		90, 716		002,701	0	34.00
43. 00	04300 NURSERY	0	127, 583		Ö	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	0			0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	,		656, 103	0	50.00
51.00	05100 RECOVERY ROOM	0	92, 836		-	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	298, 948		0	0	52.00
52. 01	03190 OP INFUSION	0	159, 693		17, 413	0	52. 01
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	19, 102 414, 439		124, 791 98, 226	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		277, 057		90, 220	0	55.00
56. 00	05600 RADI OI SOTOPE	0	9, 551	•	o	0	56.00
57.00	05700 CT SCAN	0	14, 327	1	0	0	57.00
58.00	05800 MRI	0	56, 657	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	403, 169		0	0	59. 00
60.00	06000 LABORATORY	0	254, 172	1	23, 440	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	35, 950		72, 330	0	65. 00 66. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		102, 292 5, 119		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY		16, 008		0	0	68. 00
69. 00		0	84, 909		80, 366	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	177, 267			0	1
	07001 SLEEP LAB	0	0		0	0	
71.00		0	0	0	0	0	
72.00		0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	214, 388	
76. 97		0	46, 724		0	0	
76. 98 77. 00	07698 HYPERBARI C OXYGEN THERAPY 07700 ALLOGENEI C STEM CELL ACQUISITION	0	49, 665 0	1	0	0	1
	07800 CAR T-CELL IMMUNOTHERAPY				0	0	1
70.00	OUTPATIENT SERVICE COST CENTERS				٥		70.00
90.00	09000 CLI NI C	0	0	1, 090, 902	685, 347	0	90.00
91.00		0	1, 092, 105			0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	0	0	0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS		T	T			
	09500 AMBULANCE SERVICES	0		•			95.00
102.00	10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
118. 00		0	8, 191, 607	12, 099, 060	7, 601, 101	214, 388	
1 10.00	NONREI MBURSABLE COST CENTERS		5, 171, 007	12, 077, 000	7, 301, 101	214, 300	1.10.00
194. 00	07950 MI SCELLANEOUS	0	0	0	O	0	194. 00
	07951 PUBLIC RELATIONS	0	Ō	0	o	0	194. 01
	07952 LI GHTHOUSE	0	0	0	О	0	194. 03
	07953 KIDS & FAMILY	0	0	0	0		194. 04
	07954 OTHER NON REIMBURABLE	0	0	0	0		194. 05
194. 06	5 07955 GRANTS/TRI ALS	0	0	0	0	0	194. 06

Health Financial Systems	COMMUNITY MED	DICAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Period: From 01/01/2024	Worksheet B	
					Date/Time Pre 5/28/2025 10:	pared: 36 am
			INTERNS	& RESI DENTS		
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	SERVICES-SALA Y & FRINGES	RSERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM	
	16. 00	17. 00	21.00	22. 00	23. 00	

0

0

8, 191, 607

0 194. 07 0 200. 00 0 201. 00 214, 388 202. 00

0 0 0

12, 099, 060

0

7, 601, 101

194.07|07956| RETAIL PHARMACY 200.00| Cross Foot Adjus 201.00| Negative Cost Ce 202.00| TOTAL (sum lines

Cross Foot Adjustments
Negative Cost Centers
TOTAL (sum lines 118 through 201)

Period: Worksheet B From 01/01/2024 Part I To 12/31/2024 Date/Time Prepared: COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 31-0041

					To	Date/Time Pr 5/28/2025 10	
		Cost Center Description	Subtotal	Intern &	Total	, 37 24 2 2 2	
			F	Residents Cost & Post			
				Stepdown			
			24.00	Adjustments	27, 00		
	GENER	AL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00		CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL					4. 00 5. 00
6. 00	1	MAINTENANCE & REPAIRS					6.00
7. 00	1	OPERATION OF PLANT					7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING					8. 00 9. 00
10.00	1	DI ETARY					10.00
11.00		CAFETERI A					11. 00
13.00	1	NURSI NG ADMI NI STRATI ON					13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY					14. 00 15. 00
16.00	1	MEDICAL RECORDS & LIBRARY					16. 00
17. 00	1	SOCI AL SERVI CE					17. 00
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM. COSTS APPRVD					21. 00 22. 00
23.00	1	PARAMED ED PRGM-(SPECIFY)					23.00
		IENT ROUTINE SERVICE COST CENTERS	,				
30.00		ADULTS & PEDIATRICS	99, 777, 966	-9, 058, 288	90, 719, 678		30.00
31. 00 34. 00		INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	60, 091, 771 7, 068, 908	-1, 691, 776 0	58, 399, 995 7, 068, 908		31.00 34.00
43.00	1	NURSERY	6, 031, 369	Ö	6, 031, 369		43.00
44.00	04400	SKILLED NURSING FACILITY	8, 587, 342	o	8, 587, 342		44. 00
E0 00		LARY SERVICE COST CENTERS	20 477 224	1 700 455	20 07/ 070		
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	30, 677, 334 3, 512, 939	-1, 700, 455 0	28, 976, 879 3, 512, 939		50. 00 51. 00
52.00		DELIVERY ROOM & LABOR ROOM	8, 528, 436	Ö	8, 528, 436		52. 00
52. 01	1	OP INFUSION	3, 894, 122	-45, 130	3, 848, 992		52. 01
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	1, 439, 923 18, 819, 205	-323, 428 -254, 577	1, 116, 495 18, 564, 628		53. 00 54. 00
55.00	1	RADI OLOGY-THERAPEUTI C	11, 510, 771	-234, 377	11, 510, 771		55.00
56.00		RADI OI SOTOPE	2, 161, 777	o	2, 161, 777		56.00
57.00	1	CT SCAN	5, 361, 055	0	5, 361, 055		57. 00
58. 00 59. 00	05800	CARDI AC CATHETERI ZATI ON	2, 620, 646 10, 166, 950	0 0	2, 620, 646 10, 166, 950		58. 00 59. 00
60.00	06000	LABORATORY	26, 578, 753	-60, 751	26, 518, 002		60.00
63.00	1	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	8, 051, 653	-187, 461	7, 864, 192		65. 00 66. 00
67.00	1	OCCUPATIONAL THERAPY	4, 277, 721 2, 147, 483	0	4, 277, 721 2, 147, 483		67.00
68.00	1	SPEECH PATHOLOGY	695, 224	o	695, 224		68. 00
69.00		ELECTROCARDI OLOGY	6, 064, 773	-208, 289	5, 856, 484		69.00
70. 00 70. 01		ELECTROENCEPHALOGRAPHY SLEEP LAB	3, 735, 985 33, 884	0	3, 735, 985 33, 884		70. 00 70. 01
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	36, 634, 307	o	36, 634, 307		71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	31, 704, 126	o	31, 704, 126		72. 00
73.00		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	73, 367, 350	0	73, 367, 350 1, 434, 382		73. 00 76. 97
76. 97 76. 98		HYPERBARIC OXYGEN THERAPY	1, 434, 382 629, 936	ol	629, 936		76. 98
	07700	ALLOGENEIC STEM CELL ACQUISITION	0	ō	0		77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0	0		78. 00
90. 00		TIENT SERVICE COST CENTERS	2, 795, 574	-1, 776, 249	1, 019, 325		90.00
91.00		EMERGENCY	43, 880, 661	-4, 393, 757	39, 486, 904		91.00
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
92. 01		OBSERVATION BEDS-DISTINCT REIMBURSABLE COST CENTERS	5, 460, 194	0	5, 460, 194		92. 01
95. 00		AMBULANCE SERVICES	0	0	0		95. 00
	10200	OPIOID TREATMENT PROGRAM	0	O	0		102. 00
110 00		AL PURPOSE COST CENTERS	T				112 00
113.00	1	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	527, 742, 520	-19, 700, 161	508, 042, 359		113. 00 118. 00
		IMBURSABLE COST CENTERS	52., 7.12, 520	. 7, 700, 101			
	07950	MI SCELLANEOUS	0	0	0		194. 00
		PUBLIC RELATIONS	712	0	712		194. 01 194. 03
	1	LI GHTHOUSE KIDS & FAMILY	88, 222 0	0	88, 222 0		194. 03
194. 05	07954	OTHER NON REIMBURABLE	952, 802	ő	952, 802		194. 05
194. 06	07955	GRANTS/TRI ALS	11, 177	o	11, 177		194. 06

Health Financial Systems	COMMUNITY MEDI	CAL CENTER		In Li€	u of Form CMS-2552-	<u>-10</u>
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 31-0041	Peri od: From 01/01/2024 To 12/31/2024		d: m
Cost Center Description	Subtotal F	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24. 00	25. 00	26.00			
194. 07 07956 RETAIL PHARMACY	0	0		0	194.	07
200.00 Cross Foot Adjustments	0	0		0	200.	00
201.00 Negative Cost Centers	0	0		0	201.	00
202.00 TOTAL (sum lines 118 through 201)	528, 795, 433	-19, 700, 161	509, 095, 2	72	202.	00

Period: Worksheet B From 01/01/2024 Part II To 12/31/2024 Date/Time Prepared: Provi der CCN: 31-0041

Cast Center Poseription						10	12/31/2024	Date/lime Pre 5/28/2025 10:	
DEBERAL SERVICE OOST CENTERS 1.00 2.00 2A 4.00 1.00 2.00 2A 4.00 1.00 2A 4.00 2.00 2A 4.00 2A					CAPITAL REI	LATED COSTS		0, 20, 2020 101	00 a
DEBERAL SERVICE COST CENTERS									
DERNAM SERVICE DOST CENTERS Del NECL COSTS 1.00 2.00 2.00 2.00 1.			Cost Center Description		BLDG & FIXT	MVBLE EQUIP	Subtotal		
PRIFICAL SERVICE COST CENTERS									
1.00		1		0	1.00	2.00	2A	4. 00	
2.00 00000 CAP REL COSTS-AVELE EDUIP 154,957 154,957 2.00 154,957	1 00								1 00
4.00 DOCOCO BURL STATE IT S. DEPARTIENT 0 154, 97 4.00 164, 97 16, 97 4.00 16.00 1									
DOCED ADMINI INSTRATIVE A SCHWENT 28, 913 1,001,988 5,891,371 6,924,772 9,107 5,00 0,000 0				o	154. 957	0	154, 957	154, 957	
7.00 000000 000000 000000 000000 000000				28, 913					
8.00 0.0000 LAURINEY & LINEN SERVICE 0 0 0 0 0 0 0 0 0									
9.00 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.00000000					·				
10.00 01000 DETARY		1	•	0	-		-	-	
11.00 01100 CAFFTERIA 0 258,858 4,687 263,307 3,593 13,00 1300 01300 MURSING ABUNISTRATION 0 1040 CENTRAL SERVICES & SUPPLY 236,122 594,533 327,320 1,157,978 1,777 14,00 10400 CENTRAL SERVICES & SUPPLY 236,122 594,533 327,320 1,157,978 5,781 15,00 10400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 0 0 0				19, 003					
14.00 01400 CENTRAL SERVICES & SUPPLY 226, 125 594, 533 327, 323 21, 136, 726 14.00 16.00 10.00 1		1	l e e e e e e e e e e e e e e e e e e e	0					
15.00 01500 PHARMACY 8,658 155,215 164,852 328,725 5,251 15,00 10.00									
16.00 10-tool 10-tool									
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 2.546 17.00 21.00 21.00 21.00 21.00 22.00 0 353,822 1.736 22.00 23.00 2		1	l .	8, 658	155, 215				
21.00 02100 IAS SERVICES-SALARY & FRINCES APPRIVD 0 0 0 0 0 2.19 21.00 20.00 20.00 1.87 SERVICE-STHER PROVIDE SCRIPTS 0 0 0 0 0 0 0 98 23.00				0	0		ĭ	-	
0 0 0 0 0 0 0 0 0 0		1	l .	Ö	0		Ö		
INPATI ENT ROUTINE SERVICE COST CENTERS 39, 989 3, 207, 466 93, 668 3, 341, 123 28, 757 30, 00 310. 00 30100 AURITS & PEDIATRICS 39, 989 3, 207, 466 93, 668 3, 341, 123 28, 757 310. 00 310. 00 30100 INTERSI VE CARE UNIT 1, 655 136, 2071 80, 271 146, 668 2, 202, 234 00 430. 00 43000 SURGI CAL INTERSIVE CARE UNIT 1, 655 136, 2071 80, 271 146, 668 2, 202, 234 00 430. 00 43000 SURGI CAL INTERSIVE CARE UNIT 1, 655 136, 2071 80, 257 146, 668 2, 200, 234 00 430. 00 43000 SURGI CAL INTERSIVE CARE UNIT 1, 655 136, 2071 80, 255 176, 277 30, 30, 30 30, 300 30, 300 SURICE CARE UNITS 1, 679, 969 3, 812, 572 877, 779 139, 384 7, 70, 700 7, 700	22.00			830	352, 992		353, 822	1, 236	
03.000 ADULTS & PEDIATRICS 39, 989 3, 207, 466 93, 668 3, 341, 123 28, 752 30, 00 30.00 03.000 INTERSIVE CARE UNIT 28, 229 1, 766, 277 96, 318 1, 890, 821 21, 238 31 00 34.00 03400 MURSERY 0 191, 553 8, 590, 821 146, 683 2, 802 34 00 44.00 03400 MUSERY 0 191, 553 8, 590 199, 617 2, 486, 43 00 44.00 04400 MUSERY 0 191, 553 8, 590 199, 617 2, 486, 43 00 44.00 04400 MUSERY 0 191, 553 8, 590 199, 617 2, 486, 43 00 04400 MUSERY 0 04400	23.00			0	0	0	0	98	23. 00
31.00 03100 INTERIS IVE CARE UNIT 28, 229 1, 766, 277 96, 315 1,890, 821 21,238 31 0.0	20.00			20,000	2 207 444	02.440	2 241 122	20. 752	20.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT		1	•						
43.00 04300 NURSERY 0 191,553 8,059 199,612 2,48e 43.00 44.00 4400 541,000 551,000 5504 42.00 541,000 551,000 5504 541,000 541,0									
MOCILLARY SERVICE COST CENTERS 1,679,969 3,812,572 8,711 50,00	43.00	04300	NURSERY	o			199, 612		43.00
50.00	44.00			5, 404	247, 564	1, 208	254, 176	3, 233	44. 00
51.00 05100 RECOVERY ROOM 6.7772 139, 384 7, 043 153, 199 1, 420 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 9, 779 448, 840 56, 590 515, 209 3, 025 52.00 52.00 03190 DELIVERY ROOM & LABOR ROOM 9, 779 448, 840 56, 590 515, 209 3, 025 52.00 53.00 05300 ARSTHESI OLOGY 10, 239 28, 860 0 38, 919 49, 53.00 53.00 05300 ARSTHESI OLOGY 10, 239 28, 860 0 38, 919 49, 53.00 53.00 05300 ARSTHESI OLOGY 10, 239 28, 860 0 0 0 0 0 0 0 0 0	FO 00			1 155 005	07/ 770	1 (70 0(0	2 012 572	0.711	F0 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 9,779 448,840 56,590 515,209 3,025 52.00 53.00 05300 OFFICIAL ROOM 10,239 28,660 0 38,919 94 53.00 054.00 OFFICIAL ROOM NO OFFICIAL ROOM									
1.00 1.00									
54 00 05400 RADI OLOGY-DI AGNOSTIC 72, 917 622, 238 709, 338 1, 404, 493 5, 630 54, 00 550 00 5500 RADI OLOGY-DI AGNOSTIC 591 415, 972 687, 466 1, 104, 028 3, 809 55. 00 56, 00 05600 RADI OLOGY-THERAPEUTIC 3, 508 14, 340 44, 693 62, 541 501 56, 00 57, 00 0570 0T SCAN 8, 608 21, 510 0 30, 1138 2, 237 57, 00 57, 00 0570 0T SCAN 8, 608 21, 510 0 30, 1138 2, 237 57, 00 58, 00 05800 MB 7, 646 85, 064 188, 759 281, 469 843 88, 00 69, 00 05900 CARDI AC CATHETERI ZATI ON 41, 985 605, 311 342, 121 989, 423 3, 147 59, 00 63, 00 63, 00 65,									
55.00		1	•						
56 00 0.5600 RADI DI SOTOPE 3.508 14, 340 44, 693 62, 541 501 56, 00 57. 00 57.00 CT SCAN 8, 608 21, 510 0 30, 118 2, 237 57. 00 58. 00 0.5800 MRI 7, 646 85, 064 188, 759 281, 469 843 58. 00 59. 00 0.5900 CARDI AC CATHETERI ZATI ON 41, 985 605, 317 342, 121 999, 423 3, 147 59. 00 63. 00 60.00 LABORATORY 0 3811, 614 378, 122 759, 736 0 60. 00		1	i e						
57 00 05700 CT SCAN 8,608 21,510 0 30,118 2,237 57.00									
58.00 05800 MR 7, 646 85, 064 188, 759 281, 469 843 58.00				1					
60.00 06000 LABORATORY 0 381,614 378,122 759,736 0 60.00 63.00 6300 6300 6300 6300 6300 6300 6300 6300 6300 6300 6300 6300 6300 6300 6500 RESPIRATORY THERAPY 4,523 153,581 20,051 178,155 1,801 66.00		1	l e e e e e e e e e e e e e e e e e e e						
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 42.630 53.975 304.975 421,580 3.177 65.00 06600 PHYSICAL THERAPY 4.523 153,581 20.051 178,155 1.801 66.00 67.00 06600 PHYSICAL THERAPY 0 7.686 0 7.686 1.086 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0 7.686 0 7.686 1.086 67.00 68.00 06800 SPECET PATHOLOGY 0 24.034 0 24.034 313 68.00 69.00 06900 ELECTROCARDIOLOGY 42.049 127,482 112,309 281,840 2.216 69.00 70.00 07000 ELECTROCARDIOLOGY 42.049 127,482 112,309 281,840 2.216 69.00 70.00 07000 SLEEP LAB 0 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 74,568 0 74,568 0 76,98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 78.00 07000 CELL LIMINIONIFERAPY 0 0 0 0 0 0 78.00 07000 07000 0700 0700 0 0				41, 985				3, 147	
65.00 06500 06500 RESPI RATORY THERAPY 62,630 53,975 304,975 421,580 3,177 65.00		1	l .	0	381, 614		759, 736	-	
66.00 66600 PHYSI CAL THERAPY 4,523 153,581 20,051 178,155 1,801 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 7,686 0 7,686 1,086 67.00 68.00 06800 SPEECH PATHOLOGY 0 24,034 0 24,034 313 68.00 69.00 06900 ELECTROCARDI OLOGY 42,049 127,482 112,309 281,840 2,216 69.00 69.00 06900 ELECTROCARDI OLOGY 42,049 127,482 112,309 281,840 2,216 69.00 70.00 70.00 TOOO ELECTROCROEPHALOGRAPHY 14,664 266,149 153,989 434,802 1,169 70.00 70.01 07001 SLEEP LAB 0 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 76.97 07697 CARDI AC REHABIL LITATION 538 70,151 2,272 72,961 544 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 74,568 0 74,568 0 74,568 0 76.98 77.00 07700 ALLOGENBI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 77.00 09000 CLINIC 0 0 0 0 0 0 0 77.00 09000 CLINIC 0 0 0 0 0 0 77.00 09000 CLINIC 0 0 0 0 0 0 77.00 09000 CLINIC 0 0 0 0 0 77.00 09000 CLINIC 0 0 0 0 0 77.00 09000 DEBERGENCY 55,611 1,639,684 214,238 1,909,533 12,564 91.00 78.00 09000 DEBERGENCY 55,611 1,639,684 214,238 1,909,533 12,564 91.00 79.01 09000 DEBERGENCY 55,611 1,639,684 214,238 1,909,533 12,564 91.00 79.01 09000 DEBERGENCY 55,611 1,639,684 214,238 1,909,533 12,564 91.00 79.01 09000 DEBERGENCY 55,611 1,639,684 214,238 1,909,533 12,564 91.00 79.01 09000 DEBERGENCY 59,433 0 0 0 0 0 0 79.01 09000 DEBERGENCY 0 0 0 0 0 0 79.01 09000 DEBERGENCY 0 0 0 0 0 0 79.01 09000 0900 0900 0900 0900 0900 0900 79.01 09000 0900 0900 0900 0900 0900 0900				62 620	52 075	"	421 500	-	
67.00 06700 05CUIPATI ONAL THERAPY 0 7,686 0 7,686 1,086 67.00 68.00 06800 SPEECH PATHOLOGY 42,049 127,482 112,309 281,840 2,216 69.00 70.00 06900 ELECTROCARDI OLOGY 42,049 127,482 112,309 281,840 2,216 69.00 70.01 07000 ELECTROENCEPHALOGRAPHY 14,664 266,149 153,989 434,802 1,169 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 75.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 76.97 07697 CARDI AC REHABILITATION 538 70,151 2,272 72,961 544 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 74,568 0 74,568 0 77,00 77.00 07500 CAR T -CELL IMMUNOTHERAPY 0 0 0 0 0 0 77.00 07000 CLINI C 0 0 0 0 0 78.00 07000 OVIDINI C 0 0 0 0 79.00 09000 CLINI C 0 0 0 0 0 78.00 09000 CLINI C 0 0 0 0 0 78.00 09000 OSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 78.00 07000 OSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 79.00 09201 OSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 79.00 09200 OSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 79.00 09200 OSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 79.00 09200 OSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 79.00 09200 OSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 79.00 07950 MISCELLARCEUS 0 0 0 0 0 0 0 79.00 07950 MISCELLARCEUS 0 0 0 0 0 0 0 79.00 07950 MISCELLARCEUS 0 0 0 0 0 0 0 79.00 07950 MISCELLARCEUS 0 0 0 0 0 0 0 0 79.00 07950 MISCELLARCEUS 0 0 0 0 0 0 0 0 79.00 07950 MISCELLARCEUS 0 0 0 0 0 0 0 0 0									
69.00 06900 ELECTROCARDI OLOGY 42,049 127,482 112,309 281,840 2,216 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 14,664 266,149 153,989 434,802 1,169 70.00 70.01 SLEED LAB 0 0 0 0 0 0 0 17 70.01 70.									
70.00 07000 ELECTROENCEPHALOGRAPHY 14,664 266,149 153,989 434,802 1,169 70.00 70.01 07001 SLEEP LAB 0									
70. 01 07001 SLEEP LAB 0 0 0 0 0 17 70. 01									
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 71. 00 0 0 0 0 0 0 0 0 0				14, 664	266, 149	153, 989	434, 802		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 00 73. 00 73. 00 74.977 76.97 76				0	0		0		
76. 97				Ö	0	O	ō	-	
76. 98		1	•	0	0	0	0	0	
77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 266 90. 00 91. 00 09100 EMERGENCY 55, 611 1, 639, 684 214, 238 1, 909, 533 12, 564 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 92. 01 09201 OBSERVATION BEDS-DISTINCT 5, 943 0 0 5, 943 2, 578 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 102. 00 10200 OPIOLD TREATMENT PROGRAM 0 0 0 0 0 113.00 11300 INTEREST EXPENSE 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 914, 581 15, 362, 731 13, 157, 598 30, 434, 910 154, 462 118. 00 194. 01 07950 MI SCELLANEOUS 0 0 0 0 0 0 194. 01 07951 PUBLIC RELATIONS 0 0 0 0 0 194. 04 07953 KIDS & FAMILY 0 0 0 0 0 194. 04 07953 KIDS & FAMILY 0 0 0 0 0 194. 04 07953 KIDS & FAMILY 0 0 0 0 194. 04 07953 KIDS & FAMILY 0 0 0 0 0 100. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.				538					
78. 00				0				-	
OUTPATI ENT SERVI CE COST CENTERS O				0			0		
91. 00	70.00			<u> </u>		<u> </u>	<u> </u>		70.00
92. 00				0	0	0	0	266	
92. 01				55, 611	1, 639, 684	214, 238	1, 909, 533	12, 564	
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O				F 042	0		0 E 043	2 570	
95. 00	92.01			5, 943	0	0	5, 943	2,578	92.01
102. 00	95.00			O	0	0	ol	0	95. 00
113. 00		1	l e e e e e e e e e e e e e e e e e e e						
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 914, 581 15, 362, 731 13, 157, 598 30, 434, 910 154, 462 118. 00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 0 0 0 0 0 194. 00 194. 01 194. 01 194. 03 07952 LI GHTHOUSE 0 0 0 0 0 0 194. 01 194. 03 194. 04 07953 KI DS & FAMILY 0 0 0 0 0 0 194. 04									
NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 194. 01 07951 PUBLI C RELATIONS 0 0 0 0 0 194. 01 194. 03 07952 LI GHTHOUSE 0 0 0 0 0 45 194. 03 194. 04 07953 KI DS & FAMI LY 0 0 0 0 0 194. 04			1	4 044 504	45 0/0 704	10 157 500			
194. 00 07950 MI SCELLANEOUS 0 0 0 0 194. 00 194. 01 07951 PUBLI C RELATIONS 0 0 0 0 0 194. 01 194. 03 07952 LI GHTHOUSE 0 0 0 0 45 194. 03 194. 04 07953 KI DS & FAMI LY 0 0 0 0 0 194. 04	118.00			1, 914, 581	15, 362, 731	13, 157, 598	30, 434, 910	154, 462	118.00
194. 01 07951 PUBLI C RELATIONS 0 0 0 0 194. 01 194. 03 07952 LI GHTHOUSE 0 0 0 0 45 194. 03 194. 04 07953 KI DS & FAMI LY 0 0 0 0 0 194. 04	194. 00			n	n	n	n	0	194. 00
194. 04 07953 KIDS & FAMILY 0 0 0 0 0 194. 04				O	0		ő		
				o	0	0	o		
194. USID 195 UI DI DI DI DI DI DI DI		1	•	0	0	0	0		
	194. 05	lu/954	UINEK NOW KEIMBUKABLE	<u> </u> 0	0	55, 281	55, 281	450	194. 05

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Period: From 01/01/2024	Worksheet B Part II	
				To 12/31/2024	Date/Time Pre	pared:
					5/28/2025 10:	36 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
194. 06 07955 GRANTS/TRI ALS	1, 388	0		0 1, 388	0	194. 06
194. 07 07956 RETAIL PHARMACY	0	0		0 0	0	194. 07
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)	1, 915, 969	15, 362, 731	13, 212, 87	9 30, 491, 579	154, 957	202. 00

Provi der CCN: 31-0041

Peri od: Worksheet B From 01/01/2024 Part II To 12/31/2024 Date/Time Prepared: 5/28/2025 10:36 am

Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/28/2025 10: HOUSEKEEPING	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	6, 933, 379	(0.470				5.00
6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT	11, 671 259, 435	69, 479 1, 171				6. 00 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	24, 129	1, 171		24, 129		8.00
9. 00 00900 HOUSEKEEPI NG	121, 144	859	_		329, 032	1
10. 00 01000 DI ETARY	118, 812	1, 525			0	10.00
11. 00 01100 CAFETERI A	8, 708	1, 269		0	0	1
13. 00 01300 NURSI NG ADMI NI STRATI ON	114, 048	621	12, 731	0	0	
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	94, 194	2, 918			12, 135	1
16.00 01600 MEDICAL RECORDS & LIBRARY	144, 218	762 0		0	0 0	
17. 00 01700 SOCIAL SERVICE	104, 546	Ö	0	Ö	Ö	
21.00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	158, 643	0	0	0	Ō	
22.00 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	86, 685	1, 732	35, 524	0	5, 601	22. 00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY)	2, 795	0	0	0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	922, 955	15 727	222 700	(4(0	154 011	30.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE UNIT	618, 343	15, 737 8, 668			154, 011 45, 738	
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	80, 741	668			45, 730	1
43. 00 04300 NURSERY	72, 631	940			Ö	1
44.00 04400 SKILLED NURSING FACILITY	95, 733	1, 215		434	0	44.00
ANCILLARY SERVICE COST CENTERS			,			
50. 00 05000 OPERATI NG ROOM	338, 532	4, 793				
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	39, 857	684	14, 027	295 769	12 125	
52.00 05200 DELIVERY ROOM & LABOR ROOM 52.01 03190 OP INFUSION	89, 546 41, 815	2, 203 1, 177			12, 135 0	
53. 00 05300 ANESTHESI OLOGY	13, 813	141			Ö	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	220, 855	3, 054			5, 601	
55. 00 05500 RADI OLOGY-THERAPEUTI C	135, 867	2, 041	41, 862		5, 601	55.00
56. 00 05600 RADI 0I SOTOPE	27, 698	70			0	1
57. 00 05700 CT SCAN	69, 523	106			0	
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	29, 582 108, 045	417 2, 971		195 219		
60. 00 06000 LABORATORY	336, 898	1, 873			0	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	Ö	1
65. 00 06500 RESPIRATORY THERAPY	101, 283	265	5, 432	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	49, 254	754		217	5, 601	1
67. 00 06700 OCCUPATI ONAL THERAPY	27, 843	38		0	0	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	8, 405	118			0 0	1
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	71, 604 41, 032	626 1, 306		221 150		
70. 01 07001 SLEEP LAB	70	0	0	0	Ö	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	420, 289	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	367, 947	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	810, 949	0	_	0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	16, 111	344			0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION	5, 815 0	366 0			0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	_	_	0	•
OUTPATIENT SERVICE COST CENTERS	-					1
90. 00 09000 CLINIC	13, 101	0	0		0	
91. 00 09100 EMERGENCY	426, 583	8, 047	165, 013	6, 128	60, 673	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92. 01 09201 OBSERVATI ON BEDS-DI STI NCT OTHER REI MBURSABLE COST CENTERS	67, 900	0	0	0	0	92. 01
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
102.00 10200 OPIOID TREATMENT PROGRAM	o	Ö				102.00
SPECIAL PURPOSE COST CENTERS	-1					
113.00 11300 INTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 919, 648	69, 479	1, 400, 820	24, 129	329, 032	118. 00
NONREI MBURSABLE COST CENTERS		0	1 0	0	0	104 00
194. 00 07950 MI SCELLANEOUS 194. 01 07951 PUBLI C RELATI ONS	0	0	0	0		194. 00 194. 01
194. 03 07952 LI GHTHOUSE	1, 157	0	0	-		194. 01
194. 04 07953 KIDS & FAMILY	0	ő	0	Ö		194. 04
194. 05 07954 OTHER NON REIMBURABLE	12, 444	0	0	Ö		194. 05
194. 06 07955 GRANTS/TRI ALS	121	0	0	0		194. 06
194. 07 07956 RETAI L PHARMACY	0	0	0	0	0	194. 07
200.00 Cross Foot Adjustments		_		_	_	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	COMMUNITY MEDI	ICAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2024 To 12/31/2024	Date/Time Pre	
					5/28/2025 10:	<u>36 am</u>
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE 8		LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118 through 201)	6, 933, 379	69, 47	9 1, 400, 82	20 24, 129	329, 032	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Period: Worksheet B From 01/01/2024 Part II To 12/31/2024 Date/Time Prepared: Provi der CCN: 31-0041

S/28/2025 3 Cost Center Description	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
SUPPLY 10.00 11.00 13.00 14.00 15.00	2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10.00	2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00	2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00	2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
4. 00	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS 7. 00 00700 OPERATION OF PLANT	5. 00 6. 00 7. 00 8. 00 9. 00
7. 00 00700 OPERATI ON OF PLANT	7. 00 8. 00 9. 00
	8. 00 9. 00
8 OO JOOROOJI AJINDRY & LI NEN SERVI CE	9. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 557, 089	1 10.00
11. 00 01100 DIETARY 557, 089 11. 00 01100 CAFETERI A 0 299, 975	11.00
13.00 01300 NURSI NG ADMI NI STRATI ON 0 6, 085 961, 427	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 6,622 0 1,335,719	14.00
15. 00 01500 PHARMACY 0 11, 097 0 5, 795 511, 4	
16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0 17. 00 04.700 05.000 05.	0 16.00
17. 00 01700 SOCI AL SERVI CE	0 17.00 0 21.00
22. 00 02200 1&R SERVI CES-OTHER PRGM. COSTS APPRVD 0 19, 688 0 0	0 22.00
23. 00 02300 PARAMED ED PRGM-(SPECI FY)	0 23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS 302, 248 71, 057 325, 465 5, 593	0 30.00
31. 00 03100 NTENSI VE CARE UNI T 207, 860 45, 104 216, 145 5, 443	0 31.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T 16, 107 5, 369 30, 801 796 43. 00 04300 NURSERY 0 1, 253 8, 161 0	0 34.00 0 43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY 30, 874 6, 622 17, 885 444	0 44.00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0 18, 435 76, 237 6, 015	0 50.00
51. 00 05100 RECOVERY ROOM 0 2, 148 15, 447 37	0 51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 6, 264 31, 750 1, 328 52. 01 03190 OP I NFUSI ON 0 3, 222 12, 032 245	0 52.00
52. 01 03190 OP NFUSI ON	0 52.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 13, 603 10, 008 1, 354	0 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 5, 906 7, 700 19	0 55.00
56. 00 05600 RADI 01 SOTOPE 0 716 0 14	0 56.00
57. 00 05700 CT SCAN 0 3, 580 0 0	0 57.00
58. 00 05800 MRI	0 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 5, 190 26, 501 1, 147 60. 00 06000 LABORATORY 0 0 0 0	0 60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0 63.00
65. 00 06500 RESPI RATORY THERAPY 0 6, 622 0 76	0 65.00
66. 00 06600 PHYSI CAL THERAPY 0 3, 580 0 19	0 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 2, 148 0 0	0 67.00
68. 00 06800 SPEECH PATHOLOGY 0 716 0 0 0 0 0 0 0 0 0	0 68.00
69. 00 06900 ELECTROCARDI OLOGY	0 69.00
70. 01 07001 SLEEP LAB	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 723,025	0 71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 574,929	0 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 511, 4	
76. 97 07697 CARDI AC REHABI LI TATI ON 0 1, 074 5, 499 7 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0	0 76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0	0 76. 98 0 77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0 78.00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINI C 0 537 1, 882 131	0 90.00
91. 00 09100 EMERGENCY 0 31, 501 114, 139 6, 127	0 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	92.00
92. 01 09201 0BSERVATI ON BEDS-DI STI NCT 0 6, 085 27, 565 795 0THER REI MBURSABLE COST CENTERS	0 92.01
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0	0 95.00
102.00 10200 OPLOI D TREATMENT PROGRAM 0 0 0 0	0 102.00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE	113. 00
	118.00
NONREI MBURSABLE COST CENTERS	0 194. 00
194. 01 07951 PUBLI C RELATIONS 0 0 0	0 194. 00
194. 03 07952 LI GHTHOUSE 0 0 0	0 194. 03
194. 04 07953 KIDS & FAMILY 0 0 0 0	0 194. 04
194. 05 07954 OTHER NON REI MBURABLE 0 1, 074 0	0 194. 05
194. 06 07955 GRANTS/TRI ALS 0 0 212 0	0 194. 06
194.07 07956 RETAIL PHARMACY 0 0 0 0 0 200.00 Cross Foot Adjustments	0 194. 07 200. 00
200. 00 01 033 1 001 Auj ustilients	1200.00

Health Fin	ancial Systems	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS			Provi der C		Period: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Pre	narodi	
					10 12/31/2024	5/28/2025 10:		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY		
				ADMI NI STRATI O	N SERVICES &			
					SUPPLY			
		10. 00	11. 00	13. 00	14. 00	15. 00		
201. 00	Negative Cost Centers	0	C		0 0	0	201.00	
202 00	TOTAL (sum lines 118 through 201)	557 089	200 075	961.42	7 1 335 710	511 468	202 00	

Peri od: Worksheet B From 01/01/2024 Part II To 12/31/2024 Date/Time Prepared: 5/38/2025 10:36 am Provi der CCN: 31-0041

					0 12/31/2024	5/28/2025 10:	
				INTERNS &	RESI DENTS		
	Cost Contor Doscription	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SEDVI CES OTHED	PARAMED ED	
	Cost Center Description	RECORDS &	SUCTAL SERVICE	Y & FRINGES	PRGM. COSTS	PRGM	
		LI BRARY			1110		
		16. 00	17. 00	21. 00	22. 00	23. 00	
4 00	GENERAL SERVICE COST CENTERS		ı	I			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11.00	01100 CAFETERI A						11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0					16. 00
17. 00	01700 SOCI AL SERVI CE	0	133, 883				17. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	164, 862			21. 00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	3, 843		508, 131		22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0			3, 251	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_		T			
	03000 ADULTS & PEDIATRICS	0	0.7,7.0				30.00
31. 00 34. 00	03100 NTENSI VE CARE UNIT 03400 SURGI CAL INTENSI VE CARE UNIT	0	19, 227				31. 00 34. 00
43.00	04300 NURSERY	0	1, 483 2, 085				43. 00
44. 00	04400 SKILLED NURSING FACILITY	0					44. 00
	ANCILLARY SERVICE COST CENTERS		2,070				1 00
50.00	05000 OPERATING ROOM	0	10, 633				50.00
51.00	05100 RECOVERY ROOM	0	1, 517				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 886				52. 00
52. 01	03190 OP INFUSION	0	2, 610				52. 01
53.00	05300 ANESTHESI OLOGY	0	312	•			53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	6, 774 4, 528				54. 00 55. 00
56.00	05600 RADI OLOGI - ITIERAF LUTT C	0	156				56.00
57. 00	05700 CT SCAN	0	234				57. 00
58. 00	05800 MRI	0	926				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	6, 589				59. 00
60.00	06000 LABORATORY	0	4, 154				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
65.00	06500 RESPI RATORY THERAPY	0	588	•			65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY	0	1, 672 84	•			66. 00 67. 00
68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	262				68.00
	06900 ELECTROCARDI OLOGY	0	1, 388				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0					70.00
70. 01		0	0				70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	1	0	0				73. 00
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON	0	764				76. 97
76. 98 77. 00	1	0	812 0				76. 98 77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78.00
70.00	OUTPATIENT SERVICE COST CENTERS						70.00
90.00	09000 CLI NI C	0	0				90.00
91.00	09100 EMERGENCY	0	17, 849				91.00
92.00							92. 00
92. 01	09201 OBSERVATION BEDS-DISTINCT	0	0				92. 01
05.00	OTHER REIMBURSABLE COST CENTERS		1	ı			05.00
	09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM	0		•			95. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS	U	0				102.00
113 00	11300 INTEREST EXPENSE			I			113. 00
118. 00	1 1	0	133, 883	0	0	o	118.00
2. 3.	NONREI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,		9]
	07950 MI SCELLANEOUS	0	0				194. 00
	07951 PUBLIC RELATIONS	0	0				194. 01
	3 07952 LI GHTHOUSE	0	0				194. 03
	4 07953 KIDS & FAMILY	0	0				194. 04
	5 07954 OTHER NON REIMBURABLE 5 07955 GRANTS/TRIALS	0	0				194. 05 194. 06
174.00	DOLLON ON THE WEST	<u> </u>	1 0	I	l	<u> </u>	1174.00

Health Financial Systems	COMMUNITY MEDI	CAL CENTER	L CENTER In Lie			2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der (CCN: 31-0041	Peri od: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Pre 5/28/2025 10:	
			INTERNS	& RESI DENTS		

						5/28/2025 10:	30 alli
				INTERNS &	RESI DENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
		RECORDS &		Y & FRINGES	PRGM. COSTS	PRGM	
		LI BRARY					
		16. 00	17. 00	21. 00	22.00	23. 00	
194. 07	07956 RETAIL PHARMACY	0	0				194. 07
200. 00	Cross Foot Adjustments			164, 862	508, 131	3, 251	200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	0	133, 883	164, 862	508, 131	3, 251	202.00

Period: Worksheet B From 01/01/2024 Part II To 12/31/2024 Date/Time Prepared: Provi der CCN: 31-0041

					1	o 12/31/2024 Date/lime Pr 5/28/2025 10	
		Cost Center Description	Subtotal	Intern &	Total		
				Residents Cost			
				& Post Stepdown			
				Adjustments			
			24. 00	25. 00	26. 00		
4 00		AL SERVICE COST CENTERS					1 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP					1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00	1	ADMINISTRATIVE & GENERAL					5. 00
6.00		MAINTENANCE & REPAIRS					6. 00
7. 00 8. 00	1	OPERATION OF PLANT					7. 00 8. 00
9. 00	1	LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG					9.00
10.00	1	DI ETARY					10.00
11.00	1	CAFETERI A					11. 00
13.00	1	NURSI NG ADMI NI STRATI ON					13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY					14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY					16.00
17.00	1	SOCIAL SERVICE					17. 00
21.00		I &R SERVI CES-SALARY & FRI NGES APPRVD					21.00
22. 00 23. 00		I &R SERVICES-OTHER PRGM. COSTS APPRVD					22. 00
23.00		PARAMED ED PRGM-(SPECIFY) ENT ROUTINE SERVICE COST CENTERS					23. 00
30.00		ADULTS & PEDIATRICS	5, 531, 115	0	5, 531, 115		30.00
31.00		INTENSIVE CARE UNIT	3, 261, 140	0	3, 261, 140		31.00
34.00	1	SURGICAL INTENSIVE CARE UNIT	299, 590	0	299, 590		34.00
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	306, 445 438, 225	0	306, 445 438, 225		43. 00 44. 00
44.00		LARY SERVICE COST CENTERS	430, 223	U O	430, 223		1 44.00
50.00		OPERATING ROOM	4, 380, 380	0	4, 380, 380		50.00
51.00	1	RECOVERY ROOM	228, 631	0	228, 631		51.00
52.00		DELIVERY ROOM & LABOR ROOM	712, 285	0	712, 285		52.00
52. 01 53. 00	1	OP INFUSION ANESTHESIOLOGY	335, 427 56, 534	0	335, 427 56, 534		52. 01 53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	1, 734, 931	Ö	1, 734, 931		54.00
55.00	1	RADI OLOGY-THERAPEUTI C	1, 311, 361	0	1, 311, 361		55.00
56.00	1	RADI OI SOTOPE	93, 348	0	93, 348		56.00
57. 00 58. 00	05800	CT SCAN	107, 963 329, 026	0 0	107, 963 329, 026		57. 00 58. 00
59. 00		CARDI AC CATHETERI ZATI ON	1, 215, 817	o	1, 215, 817		59.00
60.00		LABORATORY	1, 141, 105	o	1, 141, 105		60.00
63.00	1	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	539, 023 256, 509	0	539, 023 256, 509		65. 00 66. 00
67.00		OCCUPATI ONAL THERAPY	39, 659	o	39, 659		67.00
68.00	06800	SPEECH PATHOLOGY	36, 267	О	36, 267		68. 00
69. 00		ELECTROCARDI OLOGY	385, 061	0	385, 061		69. 00
		ELECTROENCEPHALOGRAPHY SLEEP LAB	512, 826	0	512, 826		70.00
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	3, 169 1, 143, 314	0	3, 169 1, 143, 314		70. 01 71. 00
		IMPL. DEV. CHARGED TO PATIENTS	942, 876	Ö	942, 876		72.00
73.00		DRUGS CHARGED TO PATIENTS	1, 322, 417	0	1, 322, 417		73. 00
76. 97	1	CARDI AC REHABI LI TATI ON	104, 364 89, 406	0	104, 364		76. 97
76. 98 77. 00	1	HYPERBARIC OXYGEN THERAPY ALLOGENEIC STEM CELL ACQUISITION	89, 406	0	89, 406 0		76. 98 77. 00
		CAR T-CELL IMMUNOTHERAPY	Ö	Ö	0		78. 00
		TIENT SERVICE COST CENTERS					
90.00		CLINIC EMERGENCY	15, 917	0	15, 917		90.00
91. 00 92. 00		OBSERVATION BEDS (NON-DISTINCT PART	2, 758, 157	0	2, 758, 157		91. 00 92. 00
92. 01		OBSERVATION BEDS-DISTINCT	110, 866	o	110, 866		92. 01
	OTHER	REIMBURSABLE COST CENTERS					
		AMBULANCE SERVICES	0		0		95.00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0		102. 00
113. 00		INTEREST EXPENSE					113.00
118. 00)	SUBTOTALS (SUM OF LINES 1 through 117)	29, 743, 154	o	29, 743, 154		118. 00
		IMBURSABLE COST CENTERS					4.5
	1	MI SCELLANEOUS PUBLIC RELATIONS	0	0	0		194. 00 194. 01
		LI GHTHOUSE	1, 202	0	1, 202		194. 01
	1	KIDS & FAMILY	0	o	0		194. 04
	1	OTHER NON REIMBURABLE	69, 249		69, 249		194. 05
194. 06	07955	GRANTS/TRI ALS	1, 721	0	1, 721		194. 06

Heal th Finar	ncial Systems	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS			Provi der CO	CN: 31-0041	Peri od:	Worksheet B	
					From 01/01/2024 To 12/31/2024	Part II Date/Time Pre	narod:
					10 12/31/2024	5/28/2025 10:	36 am
	Cost Center Description	Subtotal	Intern &	Total			
			Residents Cost				
			& Post				
			Stepdown				
			Adjustments				
		24. 00	25. 00	26. 00			
194. 07 07956	RETAIL PHARMACY	0	0		0		194. 07
200. 00	Cross Foot Adjustments	676, 244	0	676, 24	14		200. 00
201. 00	Negative Cost Centers	0	0		0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	30, 491, 579	0	30, 491, 57	79		202. 00

CEMERAL SERVICE COST CENTERS
1.00
2.00
4. 00 00400 CMPLOYEE BENEFITS DEPARTMENT 5, 403 0 193, 229, 249 -123, 395, 588 053, 399, 545 5. 00 00500 AMIN INTERNATIVE & GENERIAL 34, 497 4, 170, 737 11, 163 279, 580 0 6,82, 413 6. 00 0. 00000 OPERATION OF PLAINT 8, 317 61, 235 4, 529, 802 0 15, 168, 961 7. 00 0. 00 0 0 0 0 0 1, 1410, 819 8. 00 0. 00000 AUDITOR PLAINT 8, 317 61, 235 4, 529, 802 0 15, 168, 961 7. 00000 0. 000000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 00000000
6.00 00600 MAINTENANCE & REPAIRS 1, 663 3, 185 279, 530 0 682, 413 6.00 8.00 00800 LAUMDRY & LINEN SERVICE 0 0 0 0 0 1, 110, 819 8.00 9.00 00900 HOUSEKEEPING 6, 103 8, 269 3, 363, 188 0 7, 083, 216 9, 00 9.01 00900 HOUSEKEEPING 10, 836 51, 661 3, 066, 807 0 6, 946, 870 10, 00 9.01 00000 HOUSEKEEPING 9, 018 3, 317 807, 549 90 9.01 00000 HOUSEKEEPING 9, 018 3, 317 807, 549 0 5509, 167 11, 00 9.01 00000 HOUSEKEEPING 9, 018 3, 317 807, 549 0 5509, 167 11, 00 9.01 0000 HOUSEKEEPING 9, 018 3, 317 807, 549 0 5509, 167 11, 00 9.01 0000 HOUSEKEEPING 9, 018 3, 317 807, 549 0 5509, 167 11, 00 9.01 0000 HOUSEKEEPING 9, 018 3, 317 807, 549 0 5509, 465 14, 00 9.01 0000 HOUSEKEEPING 9, 018 3, 317 807, 549 30 6, 666, 328 13, 00 9.01 0000 HOUSEKEEPING 9, 018 3, 317 436 0 6, 666, 328 13, 00 9.01 0000 HOUSEKEEPING 9, 018 3, 317 436 0 6, 666, 328 13, 00 9.01 0000 HOUSEKEEPING 9, 018 3, 317 436 0 6, 666, 328 13, 00 9.01 0000 HOUSEKEEPING 9, 018 4, 411 493, 212 4, 479, 436 0 6, 666, 328 13, 00 9.01 0000 HOUSEKEEPING 9, 018 116, 666 6, 547, 823 0 8, 432, 294 15, 00 9.01 0000 HOUSEKEEPING 9, 114, 114, 114, 114, 114, 114, 114, 1
7.00 00700
8. 00 00800 LAUNDRY & LINEN SERVICE 0 0 0 1, 410, 819 8. 00 00 0000 0015 0000 0015 001
10.0 01000 DIETARY 10, 836 51, 661 3, 066, 807 0 6, 946, 870 10. 00 10. 00 10100 CAFETERI A 9, 018 3, 317 807, 549 0 509, 167 11. 00 13. 00 01300 NURSI NG ADMINI STRATI ON 4, 411 493, 212 4, 479, 436 0 6, 668, 328 13. 00 14. 00 01400 CENTRAL SERVI CES & SUPPLY 20, 730 231, 644 2, 191, 007 0 5, 507, 465 14. 00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 0 0
11.00 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000 0110000 0110000 0110000 0110000 01100000 01100000 01100000000
13.00 01300 NURSING ADMINISTRATION 4, 411 493, 212 4, 479, 436 0 6, 668, 328 33. 00 10.00
15. 00 01500 PIARMANCY 0 0 0 0 0 0 0 0 0
16. 00 16.00 16. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 1
17.00 01700 SOCI AL SERVI CE 0 0 0 3, 174, 530 0 6, 112, 743 17. 00 17. 00 17. 754 845 0 9, 275, 717 21. 00 22.00 2200 18R SERVI CES-SALARY & FRI NGES APPRVD 12, 308 0 1, 541, 438 0 5, 068, 433 22. 00 23.00 2
22. 00 02200 12R SERVICES-OTHER PRCM. COSTS APPRVD 12, 308 0 1, 541, 438 0 5, 068, 433 22. 00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 121, 775 0 163, 401 23. 00 110, 175 10 163, 401 23. 00 110, 175 10 163, 401 24. 00 163, 401 25. 00 1
23.00 02300 PARAMED ED PROM-(SPECI FY) 0 0 121,775 0 163,401 23.00
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 111, 837 66, 289 35, 869, 189 0 53, 974, 665 31.00 03100 INTENSI VE CARE UNI T 61, 586 68, 162 26, 481, 871 0 36, 154, 086 31.00 34.00 03400 SURGI CAL INTENSI VE CARE UNI T 4, 749 6, 247 3, 493, 691 0 4, 720, 890 34.00 43.00 04300 NURSERY 6, 679 5, 703 3, 099, 731 0 4, 246, 665 43.00 04400 SKI LLED NURSI NG FACI LI TY 8, 632 855 4, 030, 649 0 5, 597, 455 44.00 04400 SKI LLED NURSI NG FACI LI TY 8, 632 855 4, 030, 649 0 5, 597, 455 44.00 05100 RECOVERY ROOM 34, 486 4, 984 1, 769, 951 0 2, 330, 397 51.00 05100 RECOVERY ROOM 4, 860 4, 984 1, 769, 951 0 2, 330, 397 55.00 05200 DELI VERY ROOM 4, 860 4, 984 1, 769, 951 0 2, 330, 397 55.00 05200 DELI VERY ROOM 8 LABOR ROOM 15, 650 40, 049 3, 771, 585 0 5, 235, 692 52.00 1309 OP INFUSI ON 8, 360 4, 235 1, 663, 601 0 2, 444, 900 52.01 53.00 ANESTHESI OLOGY 1, 000 0 116, 657 0 807, 640 53.00 55.00 05500 RADI OLOGY-THERAPEUTI C 21, 696 501, 998 7, 019, 810 0 12, 913, 233 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 21, 696 501, 998 7, 019, 810 0 12, 913, 233 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55.00 55.00 05500 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55.00 05600 RADI OLOGY-THERAPEUTI C 13, 504 486, 519 4, 749, 597 0 7, 944, 036 55.00 05600 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55.00 05600 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55.00 05600 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55.00 05600 RADI ALTORY 14, 14, 14, 14, 14, 14, 14, 14, 14, 14,
30. 00 03000 ADULTS & PEDIATRICS 111, 837 66, 289 35, 869, 189 0 53, 974, 665 30. 00 31. 00 03100 INTENSI VE CARE UNIT 61, 586 68, 162 26, 481, 871 0 36, 154, 086 31. 00 4300 SURGI CAL INTENSI VE CARE UNIT 4, 749 6, 247 3, 493, 691 0 4, 226, 863 40. 00 03400 SURGI CAL INTENSI VE CARE UNIT 4, 749 6, 247 3, 493, 691 0 4, 246, 665 43. 00 43. 00 04400 SKI LLED NURSI NG FACI LITY 8, 66, 679 5, 703 3, 099, 731 0 4, 246, 665 43. 00 04400 SKI LLED NURSI NG FACI LITY 8, 8632 855 4, 030, 649 0 5, 597, 455 44. 00 04400 SKI LLED NURSI NG FACI LITY 8, 8632 855 4, 030, 649 0 5, 597, 455 44. 00 04400 SKI LLED NURSI NG FACI LITY 8, 8632 855 4, 030, 649 0 5, 597, 455 44. 00 04400 SKI LLED NURSI NG FACI LITY 8, 8632 855 4, 030, 649 0 5, 597, 455 44. 00 04400 SKI LLED NURSI NG ROOM 34, 860 4, 984 1, 769, 951 0 2, 330, 397 51. 00 05100 RECOVERY ROOM 4, 860 4, 984 1, 769, 951 0 2, 330, 397 51. 00 05200 DELI VERY ROOM & LABOR ROOM 15, 650 40, 049 3, 771, 585 0 5, 235, 692 52. 00 05200 DELI VERY ROOM & LABOR ROOM 8, 360 4, 235 1, 663, 601 0 2, 444, 900 52. 01 03190 0P I NFUSI ON 8, 360 4, 235 1, 663, 601 0 2, 444, 900 52. 01 05300 AMESTHESI OLOGY 1, 000 0 116, 657 0 807, 640 53. 00 05400 RADI OLOGY-JI AGNOSTI C 21, 696 501, 988 7, 019, 810 0 12, 913, 233 54. 00 05500 RADI OLOGY-JI AGNOSTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 05500 RADI OLOGY-JI AGNOSTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 05500 RADI OLOGY-JI AGNOSTI C 21, 696 501, 988 7, 019, 810 0 0 12, 913, 233 54. 00 05700 CT SCAN 750 0 2, 789, 694 0 4, 604, 971 75. 00 05700 CT SCAN 750 0 0, 7, 944, 036 55. 00 0500 RADI OLOGY-JI AGNOSTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 0500 RADI OLOGY-JI AGNOSTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 0500 RADI OLOGY-JI AGNOSTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 0500 RADI OLOGY-JI AGNOSTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 0500 RADI OLOGY-JI AGNOSTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 0500 RADI OLOGY-JI AGNOSTI C 14, 504 486, 519 4, 749,
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT
43. 00 04300 NURSERY 6, 679 5, 703 3, 099, 731 0 4, 246, 665 43. 00 44. 00 04400 SKI LLED NURSI NG FACI LITY 8, 632 855 4, 030, 649 0 5, 597, 455 44. 00 05000 OPERATI NG ROOM 34, 058 1, 188, 913 10, 861, 056 0 19, 793, 739 50. 00 51. 00 05100 RECOVERY ROOM 4, 860 4, 984 1, 769, 951 0 2, 330, 397 51. 00 52. 01 03190 OP I NFUSI ON 8, 360 4, 235 1, 663, 601 0 2, 444, 900 52. 01 53. 00 05300 ANESTHESI OLOGY 1, 000 0 116, 657 0 807, 640 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 21, 696 501, 998 7, 019, 810 0 12, 913, 233 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 55. 00 05500 CT SCAN 750 0 2, 789, 694 0 4, 064, 971 57. 00 55. 00 05500 CT SCAN 750 0 2, 789, 694 0 4, 064, 971 57. 00 58. 00 05800 MRI 2, 966 133, 585 1, 051, 287 0 17, 294, 59. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 21, 106 242, 119 3, 924, 108 0 6, 317, 294 59. 00 60. 00 06000 LABORATORY 13, 306 267, 597 0 0 19, 698, 185 60. 00 60. 00 06500 RESPIRATORY HERAPY 1, 882 215, 831 3, 961, 749 0 5, 921, 925 65. 00 60. 00 06600 RESPIRATORY HERAPY 268 0 1, 353, 638 0 1, 627, 931 67. 00 60. 00 06700 OCCUPATI ONAL THERAPY 268 0 1, 353, 638 0 1, 627, 931 67. 00 60. 00 06900 ELECTROCARDI OLOGY 4, 445 79, 481 2, 763, 574 0 4, 166, 624 69. 00 60. 00 07000 ELECTROENCEPHALOGRAPHY 9, 280 108, 978 1, 457, 154 0 2, 399, 136 70. 00 60. 00 07000 ELECTROENCEPHALOGRAPHY 9, 280 108, 978 1, 457, 154 0 2, 399, 136 70. 00 60. 00 07000 ELECTROENCEPHALOGRAPHY 9, 280 108, 978 1, 457, 154 0 2, 399, 136 70. 00 60. 00 07000 ELECTROENCEPHALOGRAPHY 9, 280 108, 978 1, 457, 154 0 2, 399, 136 70. 00 60. 00 07000 ELECTROENCEPHALOGRAPHY 9, 280 108, 978 1, 457,
44. 00 04400 SKILLED NURSING FACILITY 8, 632 855 4, 030, 649 0 5, 597, 455 44. 00
50. 00 OSOOO OPERATI NG ROOM 34, 058 1, 188, 913 10, 861, 056 0 0 19, 793, 739 50. 00 51. 00 OS100 RECOVERY ROOM 4, 860 4, 984 1, 769, 951 0 2, 330, 397 51. 00 52. 01 O3190 DELI VERY ROOM & LABOR ROOM 15, 650 40, 049 3, 771, 585 0 0 52. 35, 692 52. 00 52. 01 O3190 DP INFUSI ON 8, 360 4, 235 1, 663, 601 0 0 2, 444, 900 52. 01 53. 00 O5300 ANESTHESI OLOGY 1,000 0 0 116, 657 0 807, 640 53. 00 54. 00 O5400 RADI OLOGY-DI AGNOSTI C 21, 696 501, 998 7, 019, 810 0 0 12, 913, 233 54. 00 55. 00 O5500 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 56. 00 O5500 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 57. 00 O5700 CT SCAN 750 0 0 2, 789, 694 0 4, 644, 971 57. 00 58. 00 O5800 MRI 0500 MRI 0500 050
51.00 05100 RECOVERY ROOM 4,860 4,984 1,769,951 0 2,330,397 51.00 52.01 05200 DELIVERY ROOM & LABOR ROOM 15,650 40,049 3,771,585 0 5,235,692 52.00 52.01 03190 OP INFUSION 8,360 4,235 1,663,601 0 2,444,900 52.00 53.00 05300 ANESTHESI OLOGY 1,000 0 116,657 0 807,640 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 21,696 501,998 7,019,810 0 12,913,233 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 14,504 486,519 4,749,597 0 7,944,036 55.00 56.00 05600 RADI OLOGY-THERAPEUTI C 14,504 486,519 4,749,597 0 7,944,036 55.00 57.00 05500 RADI OLOGY-THERAPEUTI C 14,504 486,519 4,749,597 0 7,944,036 55.00 58.00 05800 MRI
52. 00 05200 DELI VERY ROOM & LABOR ROOM 15, 650 40, 049 3, 771, 585 0 5, 235, 692 52. 00 52. 01 03190 OP I NEUSI ON 8, 360 4, 235 1, 663, 601 0 2, 444, 900 52. 01 53. 00 05300 ANESTHESI OLOGY 1, 000 0 116, 657 0 807, 640 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 21, 696 501, 998 7, 019, 810 0 12, 913, 233 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 56. 00 05600 RADI OLSOTOPE 500 31, 629 624, 804 0 1, 619, 471 56. 00 57. 00 05700 CT SCAN 750 0 2, 789, 694 0 4, 064, 971 57. 00 58. 00 O5800 MRI 2, 966 133, 585 1, 051, 287 0 1, 729, 614 58. 00 60. 00 0 60600 <td< td=""></td<>
52. 01 03190 OP INFUSION 8, 360 4, 235 1, 663, 601 0 2, 444, 900 52. 01 53. 00 05300 ANESTHESI OLOGY 1,000 0 116, 657 0 807, 640 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 21, 696 501, 998 7, 019, 810 0 12, 913, 233 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 57. 00 05700 CT SCAN 750 0 2, 789, 694 0 4, 064, 971 57. 00 58. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 21, 696 501, 998 7, 019, 810 0 12, 913, 233 54. 00 55. 00 05500 RADI OLOGY - THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 7, 944, 036 55. 00 56. 00 05600 RADI OL SOTOPE 500 31, 629 624, 804 0 1, 619, 471 56. 00 57. 00 05800 MRI 2, 966 133, 585 1, 051, 287 0 4, 064, 971 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 21, 106 242, 119 3, 924, 108 0 6, 317, 294 59. 00 60. 00 06000 LABORATORY 13, 306 267, 597 0 0 19, 698, 185 60. 00 65. 00 06500 RESPI RATORY THERAPY 1, 882 215, 831 3, 961, 749 0 5, 921, 925 65. 00 66. 00 06600 PHSI CAL THERAPY 5, 355 14, 190 2, 245, 463 0 2, 879, 849 66. 00 67. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 14, 504 486, 519 4, 749, 597 0 4, 749, 597 0 0 7, 944, 036 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 500 31, 629 624, 804 0 0 1, 619, 471 56. 00 57. 00 05700 CT SCAN 750 0 2, 789, 694 0 0 4, 064, 971 57. 00 58. 00 05800 MRI 2, 966 133, 585 1, 051, 287 0 0 1, 729, 514 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 21, 106 242, 119 3, 924, 108 0 0 6, 317, 294 59. 00 60. 00 06000 LABORATORY 13, 306 267, 597 0 0 19, 698, 185 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 0 5, 921, 925 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 882 215, 831 3, 961, 749 0 2, 245, 463 0 2, 879, 849 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 268 0 1, 353, 638 0 0 1, 627, 931 67. 00 68. 00 06800 SPEECH PATHOLOGY 838 0 390, 439 0 0 4, 186, 624 69. 00 69. 00 06900 ELECTROCARDI OLOGY 4, 445 79, 481 2, 763, 574 0 0 4, 186, 624 69. 00 70. 00 07000 ELECTROCARDI OLOGY 4, 445 79, 481 2, 763, 574 0 0 2, 399,
56. 00 05600 RADI OI SOTOPE 500 31, 629 624, 804 0 1, 619, 471 56. 00 57. 00 05700 CT SCAN 750 0 2, 789, 694 0 4, 064, 971 57. 00 58. 00 05800 MRI 2, 966 133, 585 1, 051, 287 0 1, 729, 614 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 21, 106 242, 119 3, 924, 108 0 6, 317, 294 59. 00 60. 00 06000 LABORATORY 13, 306 267, 597 0 0 19, 698, 185 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0
57. 00 05700 CT SCAN 750 0 2, 789, 694 0 4, 064, 971 57. 00 58. 00 05800 MRI 2, 966 133, 585 1, 051, 287 0 1, 729, 614 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 21, 106 242, 119 3, 924, 108 0 6, 317, 294 59. 00 60. 00 06000 LABORATORY 13, 306 267, 597 0 0 19, 698, 185 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 </td
59. 00 05900 CARDI AC CATHETERI ZATI ON 21, 106 242, 119 3, 924, 108 0 6, 317, 294 59. 00 60. 00 06000 LABORATORY 13, 306 267, 597 0 0 19, 698, 185 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 63. 00 65. 00 06500 RESPI RATORY THERAPY 1, 882 215, 831 3, 961, 749 0 5, 921, 925 65. 00 66. 00 06600 PHYSI CAL THERAPY 5, 355 14, 190 2, 245, 463 0 2, 879, 849 66. 00 68. 00 06800 SPEECH PATHOLOGY 838 0 390, 439 0 491, 432 68. 00 69. 00 06900 ELECTROCARDI OLOGY 4, 445 79, 481 2, 763, 574 0 4, 186, 624 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 9, 280 108, 978 1, 457, 154 0 2, 399, 136 70. 00
60. 00 06000 LABORATORY 13, 306 267, 597 0 0 19, 698, 185 60. 00 63. 00 65. 00 06500 RESPIRATORY THERAPY 1, 882 215, 831 3, 961, 749 0 5, 921, 925 65. 00 66. 00 06600 PHYSI CAL THERAPY 5, 355 14, 190 2, 245, 463 0 2, 879, 849 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 268 0 1, 353, 638 0 1, 627, 931 67. 00 6800 SPEECH PATHOLOGY 838 0 390, 439 0 491, 432 68. 00 69. 00 06900 ELECTROCARDI OLOGY 4, 445 79, 481 2, 763, 574 0 4, 186, 624 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 9, 280 108, 978 1, 457, 154 0 2, 399, 136 70. 00 070000 07
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 63. 00 65. 00 06500 RESPIRATORY THERAPY 1,882 215,831 3,961,749 0 5,921,925 65. 00 66. 00 06600 PHYSI CAL THERAPY 5,355 14,190 2,245,463 0 2,879,849 66. 00 67.00 06700 0CCUPATI ONAL THERAPY 268 0 1,353,638 0 1,627,931 67. 00 6800 SPEECH PATHOLOGY 838 0 390,439 0 491,432 68. 00 69. 00 06900 ELECTROCARDI OLOGY 4,445 79,481 2,763,574 0 4,186,624 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 9,280 108,978 1,457,154 0 2,399,136 70. 00 0.000 0
66. 00 06600 PHYSI CAL THERAPY 5,355 14,190 2,245,463 0 2,879,849 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 268 0 1,353,638 0 1,627,931 67. 00 68. 00 06800 SPEECH PATHOLOGY 838 0 390,439 0 491,432 68. 00 69. 00 06900 ELECTROCARDI OLOGY 4,445 79,481 2,763,574 0 4,186,624 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 9,280 108,978 1,457,154 0 2,399,136 70. 00
67. 00 06700 0CCUPATI ONAL THERAPY 268 0 1, 353, 638 0 1, 627, 931 67. 00 68. 00 06800 SPEECH PATHOLOGY 838 0 390, 439 0 491, 432 68. 00 69. 00 06900 ELECTROCARDI OLOGY 4, 445 79, 481 2, 763, 574 0 4, 186, 624 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 9, 280 108, 978 1, 457, 154 0 2, 399, 136 70. 00
68. 00 06800 SPEECH PATHOLOGY 838 0 390, 439 0 491, 432 68. 00 69. 00 06900 ELECTROCARDI OLOGY 4, 445 79, 481 2, 763, 574 0 4, 186, 624 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 9, 280 108, 978 1, 457, 154 0 2, 399, 136 70. 00
69. 00 06900 ELECTROCARDI OLOGY
70. 01 07001 SLEEP LAB
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 21,513,589 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 47,415,628 73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 2, 446 1, 608 678, 068 0 941, 986 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 2, 600 0 0 340, 005 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78. 00
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 0 0 331, 693 0 766, 022 90. 00 91. 00 09100 EMERGENCY 57, 172 151, 616 15, 665, 261 0 24, 941, 977 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00
92. 01 09201 0BSERVATI ON BEDS-DISTINCT 0 0 3, 214, 521 0 3, 970, 092 92. 01
OTHER REIMBURSABLE COST CENTERS O O O O O O 95.00 95.00 AMBULANCE SERVI CES O O O O O O 95.00
102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 10102. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 INTEREST EXPENSE 113. 00 1130
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 535, 663 9, 311, 629 192, 612, 333 -123, 395, 588 404, 597, 017 118. 00 NONREI MBURSABLE COST CENTERS
194. 00 07950 MI SCELLANEOUS 0 0 0 0 194. 00
194. 01 07951 PUBLI C RELATIONS 0 0 546 194. 01
194. 03 07952 LI GHTHOUSE 0 0 56, 030 0 67, 635 194. 03 194. 04 07953 KI DS & FAMI LY 0 0 0 0 0 0 194. 04
<u> </u>

Heal th Financial	Systems	In Lieu of Form CMS-2552-10				
COST ALLOCATION -	- STATISTICAL BASIS		Provi der	CCN: 31-0041	Period: From 01/01/202 To 12/31/202	Worksheet B-1 24 Date/Time Prepared: 5/28/2025 10:36 am

				1	0 12/31/2024	5/28/2025 10:	
		CAPITAL REL	ATED COSTS			10, 20, 2020 10.	00 4
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
				DEPARTMENT (GROSS		(ACCUM COST)	
				SALARI ES)			
		1. 00	2. 00	4. 00	5A	5. 00	
194. 05	07954 OTHER NON REIMBURABLE	0	39, 122	560, 886	0	727, 586	194. 05
194. 06	07955 GRANTS/TRI ALS	0	0	0	0	7, 061	194. 06
194. 07	07956 RETAIL PHARMACY	0	0	0	0	0	194. 07
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers					l .	201. 00
202. 00	Cost to be allocated (per Wkst. B,	15, 362, 731	13, 212, 879	37, 895, 847		123, 395, 588	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	28. 679843	1. 413029			0. 304380	
204. 00	Cost to be allocated (per Wkst. B,			154, 957		6, 933, 379	204.00
205 00	Part II)			0 00000		0 017102	205 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000802		0. 017103	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
200.00	(per Wkst. B-2)						200.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Heal th Financial Systems

COMMUNITY MEDICAL CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Date/Time Prepared:
5/28/2025 10: 36 am

Cost Center Description

MAINTENANCE & OPERATION OF PLANT
(SQUARE FEET)

							5/28/2025 10:	36 am
		Cost Center Description	MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
			(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVI CE)		
					LAUNDRY)			
	loenen	AL OFFICE OF COOT OFFITTED	6. 00	7. 00	8. 00	9. 00	10.00	
1 00		AL SERVICE COST CENTERS		Γ	I I		Γ	1 00
1.00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1.00
2.00	1							2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00		ADMINISTRATIVE & GENERAL	402 440		•			5.00
6.00		MAINTENANCE & REPAIRS	493, 660	l				6.00
7.00	1	OPERATION OF PLANT	8, 317	485, 343				7.00
8.00		LAUNDRY & LINEN SERVICE	4 102	0	_, -,, - : -	2 020		8.00
9.00	1	HOUSEKEEPI NG	6, 103			2, 820	471 544	9.00
10.00		DI ETARY	10, 836 9, 018	1		0	471, 564	10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	4, 411	9, 018 4, 411		0	0	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	20, 730	l	1	104		14.00
15. 00		PHARMACY	5, 412	l		0	0	15.00
16. 00		MEDICAL RECORDS & LIBRARY	5,412	5, 412	1	0	0	16.00
17. 00	1	SOCIAL SERVICE	0	0	1	0	0	17. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	0	0	1	0	0	21.00
22. 00		I &R SERVICES-OTHER PRGM. COSTS APPRVD	12, 308	ı	1	48	0	22. 00
		PARAMED ED PRGM-(SPECIFY)	12, 300	12, 300	1	0	0	23. 00
23.00		IENT ROUTINE SERVICE COST CENTERS	0		١			23.00
30. 00		ADULTS & PEDIATRICS	111, 837	111, 837	558, 423	1, 320	255, 847	30.00
31. 00	1	INTENSIVE CARE UNIT	61, 586	l		392	175, 949	31.00
34. 00		SURGICAL INTENSIVE CARE UNIT	4, 749			0	13, 634	
43. 00	1	NURSERY	6, 679	l		0	13,034	43.00
44. 00		SKILLED NURSING FACILITY	8, 632	l	1	0		
44.00		LARY SERVICE COST CENTERS	0,032	0,032	37, 443		20, 134	1 44.00
50. 00		OPERATING ROOM	34, 058	34, 058	128, 184	40	0	50.00
51.00		RECOVERY ROOM	4, 860	•		0	Ö	51.00
52. 00	1	DELIVERY ROOM & LABOR ROOM	15, 650	l		104	Ö	52.00
52. 01		OP INFUSION	8, 360			0	Ö	52. 01
53. 00	1	ANESTHESI OLOGY	1, 000	1		0	Ö	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	21, 696	1	1	48		54.00
55. 00	1	RADI OLOGY-THERAPEUTI C	14, 504	14, 504		48	l	55.00
56. 00		RADI OI SOTOPE	500		1	0		56.00
57. 00		CT SCAN	750			0		57.00
58. 00	05800		2, 966	l .		48	l	58.00
59. 00	1	CARDI AC CATHETERI ZATI ON	21, 106	1		100	ő	59.00
60.00		LABORATORY	13, 306	l		0	Ö	60.00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0		0	Ö	63.00
65. 00		RESPI RATORY THERAPY	1, 882		- 1	0	o o	65. 00
66. 00	1	PHYSI CAL THERAPY	5, 355	l	1	48		66. 00
67. 00		OCCUPATIONAL THERAPY	268	l		0	o o	67. 00
68. 00		SPEECH PATHOLOGY	838			0	o o	68. 00
69. 00		ELECTROCARDI OLOGY	4, 445	ł	1	0	Ö	69. 00
70.00		ELECTROENCEPHALOGRAPHY	9, 280	l		0	o o	70. 00
70. 01		SLEEP LAB	0	ľ		0		70. 01
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	Ö	0	Ō	
		IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	0	Ō	
73. 00		DRUGS CHARGED TO PATIENTS	0	Ö	o	0	0	
76. 97		CARDI AC REHABI LI TATI ON	2, 446	2, 446	o	0	Ō	76. 97
		HYPERBARI C OXYGEN THERAPY	2, 600	l	1	0	o o	76. 98
77.00		ALLOGENEIC STEM CELL ACQUISITION	0	0	1	0	0	77. 00
	1	CAR T-CELL IMMUNOTHERAPY	0	0	o	0	0	78. 00
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	0	0	0	0	0	90.00
91.00	1	EMERGENCY	57, 172	57, 172	529, 028	520	0	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART	.,]			92.00
	1	OBSERVATION BEDS-DISTINCT	0	0	o	0	0	
		REIMBURSABLE COST CENTERS	_	_	-			
95.00		AMBULANCE SERVICES	0	0	0	0	0	95. 00
		OPIOID TREATMENT PROGRAM	0	l .		0		102.00
		AL PURPOSE COST CENTERS						
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	493, 660	485, 343	2, 082, 875	2, 820	471, 564	118. 00
		IMBURSABLE COST CENTERS				,	,	
194.00		MI SCELLANEOUS	0	0	0	0	0	194. 00
	1	PUBLIC RELATIONS	0	Ō	1	0	l e	194. 01
		LI GHTHOUSE	0	0	ol	0	l e	194. 03
		KIDS & FAMILY	0	0	ol	0		194. 04
		OTHER NON REIMBURABLE	0	0	o	0		194. 05
		GRANTS/TRI ALS	0	0	O	0		194. 06
		RETAIL PHARMACY	0	o	0	0		194. 07

	llool +b	inancial Cyatama	COMMUNITY MED	U.CAL CENTED		ا بر ا	u of Form CNC 1	DEED 10
		inancial Systems	COMMUNITY MED				u of Form CMS-2	
	COST ALL	OCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
						From 01/01/2024		
						Γο 12/31/2024	Date/Time Pre 5/28/2025 10:	pared:
1		C+ C+	MAINTENANCE O	ODEDATION OF	L ALINDDY 0	HOUGEKEEDING	1'	SO alli
		Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
			(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVICE)		
				,	LAUNDRY)			
			6. 00	7. 00	8. 00	9. 00	10.00	
	200.00	Cross Foot Adjustments						200.00
	201.00	Negative Cost Centers						201.00
	202. 00	Cost to be allocated (per Wkst. B,	890, 126	19, 801, 086	1, 840, 24	9, 499, 200	9, 541, 384	202.00
		Part I)						
	203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 803116	40. 798128	0. 88351	1 3, 368. 510638	20. 233487	203.00
	204. 00	Cost to be allocated (per Wkst. B,	69, 479	1, 400, 820	24, 129	329, 032	557, 089	204. 00

0. 140743

2. 886247

0. 011584

1. 181365 205. 00

206. 00

207. 00

116. 678014

205. 00

206.00

207. 00

Unit cost multiplier (Wkst. B, Part

(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)

NAHE adjustment amount to be allocated

Part II)

11)

0031 7	ALLOCATION - STATISTICAL BASIS		From 01/01/2024 To 12/31/2024			Date/Time Prepared: 5/28/2025 10:36 am	
	Cost Center Description	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG	,	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	•	11. 00	HRS) 13. 00	REQUI S.) 14. 00	15. 00	16. 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 15. 00 16. 00 17. 00 21. 00 22. 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 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I & SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM. COSTS APPRVD	1, 676 34 37 62 0 29 0	1, 612, 419 0 0 0 0 36, 228	45, 400, 541 196, 965 0 0 0	50, 581, 492 0 0 0	0 0 0 0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 21. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	2	1	0	0	0	23. 00
30. 00 31. 00 34. 00 43. 00 44. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04300 NURSERY 04400 SKILLED NURSING FACILITY	397 252 30 7 37	545, 837 362, 499 51, 656 13, 687	190, 101 184, 999 27, 068 0 15, 077	0 0 0	0 0 0 0 0	30. 00 31. 00 34. 00 43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	102	127 050	204 455	0	0	F0 00
50. 00 51. 00 52. 00 52. 01 53. 00 54. 00 55. 00 66. 00 67. 00 68. 00 67. 00 68. 00 70. 00 70. 00 72. 00 73. 00 76. 97 76. 98	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 03190 OP INFUSION 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROENCEPHALOGRAPHY 07001 SLEEP LAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS	103 12 35 18 2 76 33 4 20 8 29 0 0 37 20 12 4 27 14 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25, 907 53, 249 20, 179 0 16, 785 12, 913 0 0 44, 445 0 0 0 15, 623 0 5, 169 0 0 9, 223 0 0 0	24, 575, 433 19, 541, 437 0 246 0 0	0 0 0 0 50, 581, 492 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	70. 00 70. 01 71. 00 72. 00 73. 00 76. 97 76. 98 77. 00 78. 00
90.00	09000 CLINIC	3		4, 459	0	0	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	176	191, 424	208, 267	O	0	91. 00 92. 00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	34	46, 230	27, 026	0	0	
95. 00 102. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	C		0		0	95. 00 102. 00
113. 00 118. 00	11300 INTEREST EXPENSE	1, 670	1, 612, 063	45, 400, 541	50, 581, 492	0	113. 00 118. 00
194. 03 194. 03 194. 04 194. 04	07950 MI SCELLANEOUS 107951 PUBLI C RELATIONS 307952 LI GHTHOUSE 407953 KI DS & FAMI LY 07954 OTHER NON REIMBURABLE 07955 GRANTS/TRIALS	0 0 0 6	0 0	0 0 0 0 0	0 0 0 0 0	0 0 0 0	194. 00 194. 01 194. 03 194. 04 194. 05 194. 06

Health Fina	ncial Systems	COMMUNITY MED	OICAL CENTER		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2024	Worksheet B-1	
					To 12/31/2024	Date/Time Pre 5/28/2025 10:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTES)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
				SUPPLY	REQUIS.)	LI BRARY	
			(DIRECT NRSING	(COSTED		(TIME SPENT)	
			HRS)	REQUIS.)			
		11. 00	13.00	14. 00	15. 00	16. 00	
	RETAIL PHARMACY	0	0		0		194. 07
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 048, 326	8, 907, 216	8, 461, 99	1 11, 304, 965	0	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	625. 492840	5. 524132	0. 18638	5 0. 223500	0. 000000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	299, 975	961, 427	1, 335, 71	9 511, 468	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	178. 982697	0. 596264	0. 02942	0. 010112	0. 000000	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

Provi der CCN: 31-0041

					To	12/31/2024	Date/Time Prepared: 5/28/2025 10:36 am
				INTERNS &	RESI DENTS		
		Cost Center Description	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
			(SQUARE FEET)	Y & FRINGES (ASSIGNED	PRGM. COSTS (ASSI GNED	PRGM (ASSI GNED	
			(SQUARE TEET)	TIME)	TI ME)	TIME)	
	GENER	AL SERVICE COST CENTERS	17. 00	21. 00	22. 00	23. 00	
1.00	00100	CAP REL COSTS-BLDG & FLXT					1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00	1	ADMINISTRATIVE & GENERAL					5. 00
6.00	1	MAINTENANCE & REPAIRS					6.00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE					7. 00 8. 00
9.00	1	HOUSEKEEPI NG					9.00
10. 00 11. 00	1	DI ETARY CAFETERI A					10. 00 11. 00
13.00	01300	NURSING ADMINISTRATION					13. 00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY					14. 00 15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY					16. 00
17. 00 21. 00		SOCIAL SERVICE I&R SERVICES-SALARY & FRINGES APPRVD	428, 833	272, 392			17. 00 21. 00
22. 00	1	I&R SERVICES-OTHER PRGM. COSTS APPRVD	12, 308	272, 372	272, 392		22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0			499	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	111, 837	125, 248	125, 248	O	30.00
31.00		INTENSIVE CARE UNIT	61, 586	23, 392	23, 392	0	31.00
34. 00 43. 00	1	SURGICAL INTENSIVE CARE UNIT NURSERY	4, 749 6, 679	0		0 0	34. 00 43. 00
44. 00	04400	SKILLED NURSING FACILITY	8, 632	0		Ö	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	34, 058	23, 512	23, 512	O	50.00
51.00	1	RECOVERY ROOM	4, 860	23, 312		ō	51.00
52. 00 52. 01	1	DELIVERY ROOM & LABOR ROOM OP INFUSION	15, 650 8, 360	0 624	1	0	52. 00 52. 01
53. 00		ANESTHESI OLOGY	1, 000	4, 472		0	53. 00
54.00	1	RADI OLOGY THE PARELLE C	21, 696	3, 520		0	54.00
55. 00 56. 00	1	RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	14, 504 500	0		0	55. 00 56. 00
57.00	05700	CT SCAN	750	0	-	o	57. 00
58. 00 59. 00	05800	MRI CARDI AC CATHETERI ZATI ON	2, 966 21, 106	0		0	58. 00 59. 00
60.00	06000	LABORATORY	13, 306	840	840	0	60.00
63. 00 65. 00	1	BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	0 1, 882	0 2, 592	0 2, 592	0	63. 00 65. 00
66.00	06600	PHYSI CAL THERAPY	5, 355	0	l	Ö	66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	268 838	0		0	67. 00 68. 00
69.00		ELECTROCARDI OLOGY	4, 445	2, 880		o	69.00
70. 00 70. 01	1	ELECTROENCEPHALOGRAPHY SLEEP LAB	9, 280	0	0	O	70. 00 70. 01
70.01		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	70.01
	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	2, 446	0	0	499 0	73. 00 76. 97
	1	HYPERBARI C OXYGEN THERAPY	2, 600	0	0	o	76. 98
77. 00 78. 00		ALLOGENEIC STEM CELL ACQUISITION CAR T-CELL IMMUNOTHERAPY	0	0	0	0	77. 00 78. 00
	OUTPA	TIENT SERVICE COST CENTERS		0.1.5.0	0.4.5.0	٠١	
90. 00 91. 00		CLINIC EMERGENCY	0 57, 172	24, 560 60, 752		0	90. 00 91. 00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92. 00
92. 01		OBSERVATION BEDS-DISTINCT REIMBURSABLE COST CENTERS	0	0	0	0	92. 01
	09500	AMBULANCE SERVICES	0	0		0	95. 00
102. 00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	0	102. 00
	11300	INTEREST EXPENSE					113. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	428, 833	272, 392	272, 392	499	118. 00
	07950	MI SCELLANEOUS	0	0	0	0	194. 00
		PUBLI C RELATIONS LIGHTHOUSE	0	0	0	0	194. 01 194. 03
194. 04	07953	KIDS & FAMILY		0		0	194. 04
194. 05	07954	OTHER NON REIMBURABLE	0	0	0	O	194. 05

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-0041 Period: From 01/01/	
To 12/31/	5/28/2025 10:36 am
I NTERNS & RESI DENTS	
Cost Center Description SOCIAL SERVICE SERVICES-SALAR SERVICES-OTHER Y & FRINGES PRGM. COSTS PRGM	TD
(SQUARE FEET) (ASSIGNED (ASSIGNED (ASSIGN	0
TIME) TIME) TIME)	
17. 00 21. 00 22. 00 23. 00	
194. 06 07955 GRANTS/TRI ALS 0 0 0 0	0 194.06
194. 07 07956 RETAI L PHARMACY 0 0 0	0 194. 07
200.00 Cross Foot Adjustments	200.00
201.00 Negative Cost Centers	201.00
202.00 Cost to be allocated (per Wkst. B, 8, 191, 607 12, 099, 060 7, 601, 101 214	388 202.00
Part I)	
203.00 Unit cost multiplier (Wkst. B, Part I) 19.102091 44.417824 27.905008 429.63	271 203.00
204.00 Cost to be allocated (per Wkst. B, 133,883 164,862 508,131 3	251 204.00
Part II)	
205.00 Unit cost multiplier (Wkst. B, Part 0.312203 0.605238 1.865440 6.51	030 205. 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)	207. 00

Health Financial Systems	COMMUNITY MED	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 31-0041	Period: Worksheet C From 01/01/2024 Part I To 12/31/2024 Date/Time Prep 5/28/2025 10:3		
		Title	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	

						5/28/2025 10:	36 am
			Title	: XVIII	Hospi tal	PPS	
	·				Costs		
	Coot Conton Docomintion	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	Cost Center Description			Total Costs		TOTAL COSTS	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
20.00		00 710 (70		00 710 /7	11	00 710 (00	20.00
30.00	03000 ADULTS & PEDIATRICS	90, 719, 678		90, 719, 67		90, 719, 689	30.00
31.00	03100 INTENSIVE CARE UNIT	58, 399, 995		58, 399, 99			
34.00	03400 SURGICAL INTENSIVE CARE UNIT	7, 068, 908		7, 068, 90	8 0	7, 068, 908	34.00
43.00	04300 NURSERY	6, 031, 369		6, 031, 36	9 0	6, 031, 369	43.00
44.00	04400 SKILLED NURSING FACILITY	8, 587, 342		8, 587, 34		8, 587, 342	
11.00	ANCILLARY SERVICE COST CENTERS	0,007,012		0,007,01		0,007,012	11.00
FO 00		20 07/ 070		20 07/ 07		20 07/ 070	FO 00
50.00	05000 OPERATING ROOM	28, 976, 879		28, 976, 87			
51.00	05100 RECOVERY ROOM	3, 512, 939		3, 512, 93		3, 512, 939	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 528, 436		8, 528, 43	6 0	8, 528, 436	52.00
52. 01	03190 OP INFUSION	3, 848, 992		3, 848, 99	2 0	3, 848, 992	52. 01
53.00	05300 ANESTHESI OLOGY	1, 116, 495		1, 116, 49		1, 116, 500	
54. 00	05400 RADI OLOGY-DI AGNOSTI C						
		18, 564, 628		18, 564, 62		18, 564, 653	
55.00	05500 RADI OLOGY-THERAPEUTI C	11, 510, 771		11, 510, 77		11, 510, 771	55.00
56.00	05600 RADI 0I SOTOPE	2, 161, 777		2, 161, 77		2, 161, 777	56.00
57.00	05700 CT SCAN	5, 361, 055		5, 361, 05	5 0	5, 361, 055	57.00
58.00	05800 MRI	2, 620, 646		2, 620, 64		2, 620, 646	
59.00	05900 CARDI AC CATHETERI ZATI ON	10, 166, 950		10, 166, 95		10, 166, 950	
		1					
60.00	06000 LABORATORY	26, 518, 002		26, 518, 00		26, 518, 002	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63.00
65.00	06500 RESPI RATORY THERAPY	7, 864, 192	0	7, 864, 19	2 0	7, 864, 192	65.00
66.00	06600 PHYSI CAL THERAPY	4, 277, 721	0	4, 277, 72	1 0	4, 277, 721	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	2, 147, 483	l o	2, 147, 48		2, 147, 483	67. 00
68. 00	06800 SPEECH PATHOLOGY	695, 224		695, 22		695, 224	
69.00	06900 ELECTROCARDI OLOGY	5, 856, 484		5, 856, 48		5, 877, 162	
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 735, 985		3, 735, 98	5 0	3, 735, 985	
70. 01	07001 SLEEP LAB	33, 884		33, 88	4 0	33, 884	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	36, 634, 307		36, 634, 30	7 0	36, 634, 307	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	31, 704, 126		31, 704, 12		31, 704, 126	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	73, 367, 350		73, 367, 35		73, 367, 350	
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 434, 382		1, 434, 38		1, 434, 382	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	629, 936		629, 93	6 0	629, 936	76. 98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0			0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS				-		1
90.00	09000 CLINIC	1, 019, 325		1, 019, 32	5 0	1, 019, 325	90.00
91.00	09100 EMERGENCY	39, 486, 904		39, 486, 90		39, 486, 904	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	113, 495		113, 49	5	113, 495	92.00
92.01	09201 OBSERVATI ON BEDS-DI STI NCT	5, 460, 194		5, 460, 19	4 0	5, 460, 194	92. 01
	OTHER REIMBURSABLE COST CENTERS						1
95.00		0			0 0	0	95. 00
	10200 OPIOID TREATMENT PROGRAM						102.00
102.00		1 0			J	U	1102.00
	SPECIAL PURPOSE COST CENTERS		1	ı			
	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	508, 155, 854	0	508, 155, 85	4 20, 719	508, 176, 573	200.00
201.00		113, 495		113, 49		113, 495	
202. 00		508, 042, 359					
202.00	Total (300 mistractions)	1 300, 042, 337	1	1 300, 042, 33	/ 20, / 17	300,003,070	1202.00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-0041	Peri od: Worksheet C From 01/01/2024 Part I To 12/31/2024 Date/Time Prepared:

					10 12/31/2024	5/28/2025 10:	
			Ti tl e	e XVIII	Hospi tal	PPS	<u> </u>
			Charges	, ,,,,,,	1100pr tur	1.0	
	Cost Center Description	Inpati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
	•		'	+ col. 7)	Ratio	I npati ent	
				,		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	563, 635, 386		563, 635, 38			30.00
31.00	03100 INTENSIVE CARE UNIT	474, 363, 055		474, 363, 05			31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	47, 891, 546		47, 891, 54	6		34.00
43.00	04300 NURSERY	23, 052, 464		23, 052, 46			43.00
44.00	04400 SKILLED NURSING FACILITY	21, 136, 957		21, 136, 95	7		44. 00
	ANCILLARY SERVICE COST CENTERS				T		
50.00	05000 OPERATING ROOM	57, 312, 544	56, 985, 997				
51.00	05100 RECOVERY ROOM	9, 499, 974	11, 250, 874			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	20, 703, 222	6, 685, 698			0. 000000	
52. 01	03190 OP INFUSION	55, 318	20, 943, 398			0. 000000	
53.00	05300 ANESTHESI OLOGY	13, 601, 696	10, 917, 599			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	34, 578, 759	50, 867, 224			0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	3, 877, 124	87, 807, 282			0. 000000	
56.00	05600 RADI OI SOTOPE	2, 599, 303	3, 496, 032			0. 000000	
57.00	05700 CT SCAN	75, 949, 941	68, 756, 757			0. 000000	
58. 00	05800 MRI	22, 353, 241	16, 074, 364			0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	41, 095, 951	41, 054, 332			0. 000000	
60.00	06000 LABORATORY	137, 097, 902	82, 501, 071	219, 598, 97		0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C)	0. 000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	58, 205, 053	1, 313, 131			0. 000000	
66.00	06600 PHYSI CAL THERAPY	15, 786, 695	1, 547, 858			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	12, 140, 735	587, 865			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	3, 723, 735	854, 330			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	36, 563, 114	62, 902, 983			0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 531, 554	8, 025, 462	11, 557, 01		0. 000000	
70. 01	07001 SLEEP LAB	0	10.015.050		0. 000000	0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 435, 333	12, 265, 950			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	24, 556, 710	18, 987, 409			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	23, 768, 978	78, 686, 379			0.000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 015	4, 040, 966			0.000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	95, 000	4, 644, 862			0.000000	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	1	0.000000	0.000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	C)	0. 000000	0. 000000	78. 00
90. 00	09000 CLINIC	121 422	15, 451, 276	15, 582, 90	9 0. 065413	0. 000000	90.00
91.00	09100 EMERGENCY	131, 633				0.00000	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	140, 905, 583 365, 100	267, 504, 572 315, 600			0. 000000	
92.00	1 1						
92.01	O9201 OBSERVATION BEDS-DISTINCT OTHER REIMBURSABLE COST CENTERS	21, 805, 490	42, 968, 315	64, 773, 80	5 0. 084296	0. 000000	92. 01
95. 00	09500 AMBULANCE SERVICES	0	C		0. 000000	0. 000000	95.00
	10200 OPIOID TREATMENT PROGRAM		C		0.000000	0.00000	102.00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		1	<u> </u>		102.00
113 00	11300 I NTEREST EXPENSE						113. 00
200. 00	1 1	1, 907, 821, 111	977 437 596	2, 885, 258, 69	7		200.00
200.00		1, 707, 021, 111	711, 431, 300		'		201.00
202. 00	1 1	1, 907, 821, 111	977, 437, 586	2, 885, 258, 69	7		202.00
	1.11. (888 1.181 481 6.18)	1 ., , , , , , , , , , , , , , , , , , ,	, ,	1 =, 555, 255, 67	*1	ı	

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-0041	Peri od: From 01/01/2024 Worksheet C Part I To 12/31/2024 Date/Ti me Prepared: 5/28/2025 10: 36 am		

				5/28/2025 10:36 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
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				44.00
50. 00 05000 OPERATING ROOM	0. 253519			50.00
51. 00 05100 RECOVERY ROOM	0. 169291			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 311383			52.00
52.00 03200 DELI VERT ROOM & LABOR ROOM 52.01 03190 OP I NFUSI ON	0. 183297			52.00
1	1			
53. 00 05300 ANESTHESI OLOGY	0. 045536			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 217268			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 125548			55. 00
56. 00 05600 RADI 0I SOTOPE	0. 354661			56.00
57.00 05700 CT SCAN	0. 037048			57.00
58. 00 05800 MRI	0. 068197			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 123760			59.00
60. 00 06000 LABORATORY	0. 120756			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 132131			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 246774			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 168713			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 151860			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 059087			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 323266			70.00
70. 01 07000 ELECTROENCEPHALOGRAPHT	0. 000000			70.00
				71. 00
· · · · · · · · · · · · · · · · · · ·	1. 233425			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 728092			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 716091			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 354783			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 132902			76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 065413			90.00
91. 00 09100 EMERGENCY	0. 096684			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 166733			92.00
92. 01 09201 OBSERVATI ON BEDS-DI STI NCT	0. 084296			92. 01
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
102.00 10200 OPIOLD TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS	· '			
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201. 00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
252. 55	1			1202.00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-0041	Peri od: From 01/01/2024 To 12/31/2024	Worksheet C Part I Date/Time Prepared: 5/28/2025 10:36 am

					0 12/31/2024	Date/IIme Pre 5/28/2025 10:	
			Ti tl	e XIX	Hospi tal	TEFRA	
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PATIENT ROUTINE SERVICE COST CENTERS	T	Г				
	000 ADULTS & PEDIATRICS	90, 719, 678		90, 719, 678		90, 719, 689	
	100 INTENSIVE CARE UNIT	58, 399, 995		58, 399, 995		58, 399, 995	
	400 SURGICAL INTENSIVE CARE UNIT	7, 068, 908		7, 068, 908		7, 068, 908	
	300 NURSERY	6, 031, 369		6, 031, 369		6, 031, 369	
	400 SKILLED NURSING FACILITY	8, 587, 342		8, 587, 342	2 0	8, 587, 342	44. 00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATI NG ROOM	28, 976, 879		28, 976, 879		28, 976, 879	
	100 RECOVERY ROOM	3, 512, 939	l .	3, 512, 939		3, 512, 939	51.00
	DELIVERY ROOM & LABOR ROOM	8, 528, 436		8, 528, 436		8, 528, 436	
	190 OP I NFUSI ON	3, 848, 992		3, 848, 992		3, 848, 992	52. 01
	300 ANESTHESI OLOGY	1, 116, 495		1, 116, 495		1, 116, 500	
	400 RADI OLOGY-DI AGNOSTI C	18, 564, 628		18, 564, 628		18, 564, 653	
	500 RADI OLOGY-THERAPEUTI C	11, 510, 771		11, 510, 771		11, 510, 771	55. 00
	600 RADI OI SOTOPE	2, 161, 777		2, 161, 777		2, 161, 777	56. 00
	700 CT SCAN	5, 361, 055		5, 361, 055		5, 361, 055	1
	800 MRI	2, 620, 646		2, 620, 646		2, 620, 646	
	900 CARDI AC CATHETERI ZATI ON	10, 166, 950		10, 166, 950		10, 166, 950	
	000 LABORATORY	26, 518, 002		26, 518, 002	0	26, 518, 002	
	300 BLOOD STORING, PROCESSING & TRANS.	0	_	(0	0	63.00
	500 RESPI RATORY THERAPY	7, 864, 192	0			7, 864, 192	
	600 PHYSI CAL THERAPY	4, 277, 721	0	.,		4, 277, 721	66. 00
	0700 OCCUPATI ONAL THERAPY	2, 147, 483	0	_, ,		2, 147, 483	1
	800 SPEECH PATHOLOGY	695, 224	0	0,0,22		695, 224	
	900 ELECTROCARDI OLOGY	5, 856, 484		5, 856, 484		5, 877, 162	
	000 ELECTROENCEPHALOGRAPHY	3, 735, 985		3, 735, 985		3, 735, 985	
	001 SLEEP LAB	33, 884		33, 884		33, 884	
	100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	36, 634, 307		36, 634, 307		36, 634, 307	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	31, 704, 126		31, 704, 126		31, 704, 126	
	300 DRUGS CHARGED TO PATIENTS	73, 367, 350		73, 367, 350		73, 367, 350	1
	697 CARDI AC REHABI LI TATI ON	1, 434, 382		1, 434, 382		1, 434, 382	
	698 HYPERBARIC OXYGEN THERAPY	629, 936		629, 936		629, 936	
	700 ALLOGENEIC STEM CELL ACQUISITION	0		(0	
	800 CAR T-CELL IMMUNOTHERAPY	0		(0	0	78. 00
	TPATIENT SERVICE COST CENTERS	1 010 225		1 010 225	- 0	1 010 225	00.00
	0000 CLINIC	1, 019, 325		1, 019, 325		1, 019, 325	
	2100 EMERGENCY	39, 486, 904		39, 486, 904		39, 486, 904	91.00
	2200 OBSERVATION BEDS (NON-DISTINCT PART	113, 495	l e	113, 495		113, 495	
	201 OBSERVATION BEDS-DISTINCT HER REIMBURSABLE COST CENTERS	5, 460, 194		5, 460, 194	l 0	5, 460, 194	92. 01
	PER REIMBURSABLE COST CENTERS PSOO AMBULANCE SERVICES	0		() O	0	95. 00
	200 OPIOID TREATMENT PROGRAM	0	l e				102.00
	ECIAL PURPOSE COST CENTERS				/		102.00
	300 INTEREST EXPENSE						113. 00
200. 00	Subtotal (see instructions)	508, 155, 854	0	508, 155, 854	20, 719	508, 176, 573	
201. 00	Less Observation Beds	113, 495		113, 495		113, 495	
202. 00	Total (see instructions)	508, 042, 359					
202.00	1.014. (500 111511 4011 6115)	1 000, 012, 007	١	1 300, 012, 00	20,717	300, 000, 010	1-32.00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-0041	From 01/01/2024	Worksheet C Part I Date/Time Prepared:

				10 12/31/2024	5/28/2025 10:	
		Ti tl	e XIX	Hospi tal	TEFRA	00 4
		Charges			•	
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
· ·	·	·	+ col. 7)	Rati o	I npati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	563, 635, 386		563, 635, 38	6		30.00
31.00 03100 INTENSIVE CARE UNIT	474, 363, 055		474, 363, 05	5		31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	47, 891, 546		47, 891, 54	6		34.00
43. 00 04300 NURSERY	23, 052, 464		23, 052, 46	4		43.00
44.00 04400 SKILLED NURSING FACILITY	21, 136, 957		21, 136, 95	7		44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	57, 312, 544	56, 985, 997	114, 298, 54	0. 253519	0. 253519	50.00
51.00 05100 RECOVERY ROOM	9, 499, 974	11, 250, 874	20, 750, 84	0. 169291	0. 169291	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	20, 703, 222	6, 685, 698	27, 388, 92	0. 311383	0. 311383	52.00
52.01 03190 OP INFUSION	55, 318	20, 943, 398	20, 998, 71	6 0. 183297	0. 183297	52. 01
53. 00 05300 ANESTHESI OLOGY	13, 601, 696	10, 917, 599	24, 519, 29	0. 045535	0. 045535	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	34, 578, 759	50, 867, 224	85, 445, 98	0. 217267	0. 217267	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 877, 124	87, 807, 282	91, 684, 40	0. 125548	0. 125548	55.00
56. 00 05600 RADI 0I SOTOPE	2, 599, 303	3, 496, 032	6, 095, 33	0. 354661	0. 354661	56.00
57. 00 05700 CT SCAN	75, 949, 941	68, 756, 757	144, 706, 69	0. 037048	0. 037048	57.00
58. 00 05800 MRI	22, 353, 241	16, 074, 364	38, 427, 60	0. 068197	0. 068197	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	41, 095, 951	41, 054, 332			0. 123760	
60. 00 06000 LABORATORY	137, 097, 902	82, 501, 071			0. 120756	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000	0. 000000	63.00
65. 00 06500 RESPIRATORY THERAPY	58, 205, 053	1, 313, 131	59, 518, 18	4 0. 132131	0. 132131	65.00
66. 00 06600 PHYSI CAL THERAPY	15, 786, 695	1, 547, 858			0. 246774	
67. 00 06700 OCCUPATI ONAL THERAPY	12, 140, 735	587, 865			0. 168713	67.00
68.00 06800 SPEECH PATHOLOGY	3, 723, 735	854, 330	4, 578, 06	0. 151860	0. 151860	68.00
69. 00 06900 ELECTROCARDI OLOGY	36, 563, 114	62, 902, 983	99, 466, 09	7 0. 058879	0. 058879	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 531, 554	8, 025, 462			0. 323266	70.00
70. 01 07001 SLEEP LAB	0	0		0. 000000	0. 000000	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 435, 333	12, 265, 950	29, 701, 28	1. 233425	1. 233425	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	24, 556, 710	18, 987, 409			0. 728092	
73.00 07300 DRUGS CHARGED TO PATIENTS	23, 768, 978	78, 686, 379	102, 455, 35	7 0. 716091	0. 716091	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 015	4, 040, 966	4, 042, 98	0. 354783	0. 354783	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	95, 000	4, 644, 862	4, 739, 86	0. 132902	0. 132902	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0. 000000	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>					1
90. 00 09000 CLINIC	131, 633	15, 451, 276	15, 582, 90	9 0. 065413	0. 065413	90.00
91. 00 09100 EMERGENCY	140, 905, 583	267, 504, 572			0. 096684	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	365, 100	315, 600			0. 166733	•
92. 01 09201 OBSERVATION BEDS-DISTINCT	21, 805, 490	42, 968, 315			0. 084296	
OTHER REIMBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	. , ,				
95. 00 09500 AMBULANCE SERVI CES	0	0		0. 000000	0. 000000	95.00
102. 00 10200 OPIOLD TREATMENT PROGRAM	o	0)		102.00
SPECIAL PURPOSE COST CENTERS	-	-	•			1
113. 00 11300 NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	1, 907, 821, 111	977, 437, 586	2, 885, 258, 69	7		200.00
201.00 Less Observation Beds		, ,				201.00
202.00 Total (see instructions)	1, 907, 821, 111	977, 437, 586	2, 885, 258, 69	7		202.00
				'		

Health Financial Systems	systems COMMUNITY MEDICAL CENTER In Lieu o				
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-0041	Peri od: From 01/01/2024 Part I To 12/31/2024 Date/Ti me Prepared: 5/28/2025 10:36 am			

				5/28/2025 10:36 am
		Title XIX	Hospi tal	TEFRA
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				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. 0
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51. 0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 0
52.01 03190 OP INFUSION	0. 000000			52. 0
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 0
56. 00 05600 RADI 0I SOTOPE	0. 000000			56. 0
57. 00 05700 CT SCAN	0. 000000			57. 0
58. 00 05800 MRI	0. 000000			58. 0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 0
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 0
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 0
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 0
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70. 0
70. 01 07001 SLEEP LAB	0. 000000			70. 0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 0
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 9
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 9
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 0
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 0
OUTPATIENT SERVICE COST CENTERS	0.00000			70.0
90. 00 09000 CLI NI C	0. 000000			90.0
91. 00 09100 EMERGENCY	0. 000000			91. 0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 0
92. 01 09201 OBSERVATION BEDS-DISTINCT	0. 000000			92. 0
OTHER REIMBURSABLE COST CENTERS	0.00000			72. 0
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 0
102. 00 10200 OPI OI D TREATMENT PROGRAM	0.00000			102. 0
SPECIAL PURPOSE COST CENTERS				102.0
113. 00 11300 NTEREST EXPENSE				113. 0
200.00 Subtotal (see instructions)				200. 0
201.00 Less Observation Beds				201. 0
202.00 Total (see instructions)				202. 0
	ı			1202.00

Health Financial Systems	COMMUNITY MEDICAL CENTER			u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICAID ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 31-0041	From 01/01/2024	Worksheet C Part II Date/Time Prepared:

				10) 12/31/2024	5/28/2025 10:	
			Ti tl	e XIX	Hospi tal	TEFRA	oo aiii
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	0031 0011101 203011 pt1 011		(Wkst. B, Part		Reducti on	Reduction	
		I, col. 26)		Cost (col. 1 -	Noddo ti on	Amount	
		1, 601. 20)	11 (01. 20)	col. 2)		Amount	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1					
	05000 OPERATING ROOM	28, 976, 879	4, 380, 380	24, 596, 499	438, 038	1, 426, 597	50.00
	05100 RECOVERY ROOM	3, 512, 939			22, 863	190, 490	1
	05200 DELIVERY ROOM & LABOR ROOM	8, 528, 436			71, 229	453, 337	52.00
	03190 OP INFUSION	3, 848, 992	1		33, 543	203, 787	52. 01
	05300 ANESTHESI OLOGY	1, 116, 495	1		5, 653	61, 478	1
	05400 RADI OLOGY-DI AGNOSTI C	18, 564, 628	1		173, 493	976, 122	54.00
	05500 RADI OLOGY-THERAPEUTI C	11, 510, 771	1, 311, 361		131, 136	591, 566	1
	05600 RADI OI SOTOPE	2, 161, 777	93, 348		9, 335	119, 969	
	05700 CT SCAN	5, 361, 055			10, 796	304, 679	1
	05800 MRI	2, 620, 646			32, 903	132, 914	58.00
	05900 CARDI AC CATHETERI ZATI ON	10, 166, 950			121, 582	519, 166	
	06000 LABORATORY	26, 518, 002	1, 141, 105		114, 111	1, 471, 860	
	06300 BLOOD STORING, PROCESSING & TRANS.	20, 310, 002	1, 141, 103		0	1, 471, 000	1
	06500 RESPIRATORY THERAPY	7, 864, 192		-	53, 902	424, 860	1
	06600 PHYSI CAL THERAPY	4, 277, 721	256, 509		25, 651	233, 230	
	06700 OCCUPATI ONAL THERAPY	2, 147, 483			3, 966	122, 254	
	06800 SPEECH PATHOLOGY	695, 224	36, 267		3, 627	38, 220	
	06900 ELECTROCARDI OLOGY	5, 856, 484	l		38, 506	317, 343	1
	07000 ELECTROENCEPHALOGRAPHY	3, 735, 985	1		51, 283	186, 943	1
	07001 SLEEP LAB	33, 884			317	1, 781	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	36, 634, 307	1, 143, 314		114, 331	2, 058, 478	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	31, 704, 126			94, 288	1, 784, 153	
	07300 DRUGS CHARGED TO PATIENTS	73, 367, 350			132, 242	4, 178, 606	
	07697 CARDI AC REHABI LI TATI ON	1, 434, 382	104, 364		10, 436	77, 141	1
	07698 HYPERBARI C OXYGEN THERAPY	629, 936	l		8, 941	31, 351	76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION	027, 730	l		0, 741	01, 331	1
	07800 CAR T-CELL IMMUNOTHERAPY	0		-	0	0	
	OUTPATIENT SERVICE COST CENTERS			<u> </u>	0	0	70.00
	09000 CLINIC	1, 019, 325	15, 917	1, 003, 408	1, 592	58, 198	90.00
	09100 EMERGENCY	39, 486, 904	2, 758, 157		275, 816	2, 130, 267	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	113, 495			692	6, 181	1
	09201 OBSERVATION BEDS-DISTINCT	5, 460, 194	1		11, 087	310, 261	
	OTHER REIMBURSABLE COST CENTERS	3, 400, 174	110,000	3, 347, 320	11,007	310, 201	/2.01
	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	10200 OPI OI D TREATMENT PROGRAM	0			0	_	102.00
	SPECIAL PURPOSE COST CENTERS			١	<u> </u>	0	102.00
	11300 INTEREST EXPENSE						113.00
200. 00	· · · · · · · · · · · · · · · · · · ·	337, 348, 562	19, 913, 559	317, 435, 003	1, 991, 359	18, 411, 232	
201. 00		113, 495			692		201. 00
202. 00		337, 235, 067			1, 990, 667		
_52.00	1.324. (1.110 201)	1 55., 255, 567	, , , , , , , , , , , , , , ,	1 0, 320, 120	., ,,,,,,		1-02.00

Health Financial Systems	COMMUNITY MEDICA	In Lieu	u of Form CMS-2552-10	
CALCULATION OF OUTPATIENT SERVICE COST T REDUCTIONS FOR MEDICAID ONLY	O CHARGE RATIOS NET OF	Provider CCN: 31-0041	From 01/01/2024	Worksheet C Part II Date/Time Prepared:

Cost Center Description							5/28/2025 10:36 am
Capit tal and Covortion Cost Cost to Charge Operating Cost C						Hospi tal	TEFRA
Capit tal and Operating Cost Part II, col lumin Ratio (Gol. 6 Reduction 8)		Cost Center Description	Cost Net of	Total Charges	Outpati ent		
ANCILLARY SERVICE COST CENTERS		г.	Capital and	(Worksheet C.	Cost to Charge		
Reduction B)							
ANCILLARY SERVICE COST CENTERS							
ANCIL LARY SERVICE COST CENTERS 50.00							
50. 00 05000 0FERTING ROOM 27, 112, 244 114, 298, 541 0. 237206 50. 00 50. 00 50. 00 05200 0FELVERY ROOM 3. 299, 586 20. 750, 848 920 0. 159010 51. 00 52. 00 05200 0FELVERY ROOM 8. 003, 870 27, 388, 920 0. 292230 52. 00 52. 00 52. 00 05200 0FELVERY ROOM 8. 003, 870 27, 388, 920 0. 292230 52. 00 53. 00 05300 ANESTHESI OLOGY 1. 049, 364 24, 519, 295 0. 042797 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 17, 415, 013 85, 445, 983 0. 203813 54. 00 55. 00 05500 RADI OLOGY-DI HERAPEUTI C 10, 788, 069 91, 684, 406 55. 00 05500 RADI OLOGY-DI HERAPEUTI C 10, 788, 069 91, 684, 406 55. 00 05600 RADI OLOGY-DI HERAPEUTI C 10, 788, 069 91, 684, 406 55. 00 05600 RADI OLOGY-DI HERAPEUTI C 10, 788, 069 91, 684, 406 0. 117665 55. 00 05600 RADI OLOGY-DI HERAPEUTI C 10, 788, 069 91, 684, 406 0. 034866 57. 00 05700 CT SCAN 5. 045, 5800 144, 706, 698 0. 034866 57. 00 05700 CT SCAN 5. 045, 5800 144, 706, 698 0. 034866 57. 00 05700 CT SCAN 5. 045, 5800 144, 706, 698 0. 034866 57. 00 05900 CARDI AC CATHETERI ZATI ON 9. 526, 202 82, 150, 283 0. 115961 59. 00 05900 CARDI AC CATHETERI ZATI ON 9. 526, 202 82, 150, 283 0. 115961 59. 00 05900 CARDI AC CATHETERI ZATI ON 9. 526, 202 82, 150, 283 0. 113534 60. 00 06000 06000 LEDAR TORY THERAPY 7. 385, 430 59, 518, 184 0. 124087 65. 00 06500 RESPIRATORY THERAPY 7. 385, 430 59, 518, 184 0. 124087 65. 00 06500 PRYSI CAL THERAPY 7. 348, 543 19, 759 11, 557, 016 0. 05500 PRYSI CAL THERAPY 7. 348, 543 19, 759 11, 557, 016 0. 05500 PRYSI CAL THERAPY 7. 349, 536 0. 043600 9. 05000 0500		ANOLILIADY CERVILOR COCT OFNITERS	6.00	7.00	8.00		
51 00 05100 RECOVERY ROOM Second Secon				444 000 544	0.00700/		
52. 00 05200 DELIVERY ROOM & LABOR ROOM 8, 003,870 27, 388, 920 0. 292230 52. 00 53. 00 05300 ANESTHESI OLOGY 1, 049,364 24, 519, 295 0. 042797 53. 00 54. 00 05400 RODI OLOGY_DIACMOSTIC 17, 415, 013 85, 445, 981 0. 203813 54. 00 05400 RODI OLOGY_DIACMOSTIC 17, 415, 013 85, 445, 981 0. 203813 54. 00 0550 RODI OLOGY_THERAPEUTIC 10, 788, 069 91, 684, 406 0. 117665 55. 00 05500 RODI OLOGY_THERAPEUTIC 10, 788, 069 91, 684, 406 0. 117665 55. 00 05600 RODI OLOGY_THERAPEUTIC 10, 788, 069 91, 684, 406 0. 017665 55. 00 05600 RODI OLOGY_THERAPEUTIC 10, 788, 069 91, 684, 406 0. 017665 55. 00 05800 RODI OLOGY_THERAPEUTIC 10, 788, 069 91, 684, 406 0. 017665 0. 034866 57. 00 05700 CT SCAN 5. 045, 580 144, 706, 698 0. 034866 57. 00 05900 CRSI OLOGY_THERAPEUTIC 92, 454, 829 38, 427, 605 0. 063882 58. 00 05800 CRSI OLOGY_THERAPEUTIC 92, 622 282, 150, 283 0. 115961 59. 00 06000 CABOL AC CATHETERIZATION 9, 526, 2021 82, 150, 283 0. 013534 60. 00 06000 LABORATORY 94, 932, 031 219, 598, 973 0. 113534 60. 00 06000 RESPIRATORY THERAPY 4, 018, 840 17, 334, 535 0. 231840 66. 00 0600 PHYSI CAL THERAPY 4, 018, 840 17, 334, 535 0. 231840 66. 00 0600 PHYSI CAL THERAPY 4, 018, 840 17, 334, 535 0. 231840 66. 00 0600 PHYSI CAL THERAPY 4, 018, 840 17, 334, 535 0. 142719 68. 00 0600 DELECTROCARDI OLOGY 5, 500, 635 99, 466, 097 0. 055302 69, 00 00000 06000 ELECTROCARDI OLOGY 5, 500, 635 99, 466, 097 0. 055302 69, 00 000000 000000 000000 0000000		1 1			1		
52.01 03190 DP INFUSION 3.611,662 20.988,716 0.171994 52.01							
53.00 0R300 ANESTHESI OLOGY 1.049, 364 24, 519, 295 0.042797 53.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 003, 870	27, 388, 920	0. 292230		52.00
54.00 05400 RADIO LOGY-DI AGNOSTI C 17, 415, 013 85, 445, 983 0.203813 55.00 55.00 05500 RADIO LOGY-THERAPEUTI C 10, 788, 069 91, 684, 406 0.117665 55.00 56.00 05600 RADIO I SOTOPE 2, 032, 473 6, 095, 335 0.33447 56.00 57.00 05700 CT SCAN 5, 045, 580 144, 706, 698 0.034868 57.00 0.05800 MRI 2, 454, 829 38, 427, 605 0.063882 58.00 0.000 0.00000 LABORATORY 24, 932, 031 219, 598, 973 0.113534 60.00 0.000 0.000 LABORATORY 424, 932, 031 219, 598, 973 0.113544 60.00 0.000 0.000 0.00000 0.00000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.00000000	52.01	03190 OP INFUSION	3, 611, 662	20, 998, 716	0. 171994		52. 01
54.00 05400 RADIO LOGY-DI AGNOSTI C 17, 415, 013 85, 445, 983 0.203813 55.00 55.00 05500 RADIO LOGY-THERAPEUTI C 10, 788, 069 91, 684, 406 0.117665 55.00 56.00 05600 RADIO I SOTOPE 2, 032, 473 6, 095, 335 0.33447 56.00 57.00 05700 CT SCAN 5, 045, 580 144, 706, 698 0.034868 57.00 0.05800 MRI 2, 454, 829 38, 427, 605 0.063882 58.00 0.000 0.00000 LABORATORY 24, 932, 031 219, 598, 973 0.113534 60.00 0.000 0.000 LABORATORY 424, 932, 031 219, 598, 973 0.113544 60.00 0.000 0.000 0.00000 0.00000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.00000000	53.00	05300 ANESTHESI OLOGY	1, 049, 364	24, 519, 295	0. 042797		53.00
55.00 05500 RADIO LOGY-THERAPEUTI C					1		
56. 00 05600 RADI OI SOTOPE 2, 032, 473 6, 095, 335 0, 333447 56. 00 57. 00 5		1 1					
57.00 05700 CT SCAN 5,045,580 144,706,698 0,034868 57.00 58.00 05800 MRI 2,454,829 38,427,605 0.063882 58.00 05900 CARDI AC CATHETERI ZATI ON 9,526,202 82,150,283 0.115961 59.00 06000 LABORATORY 24,932,031 219,598,973 0.113534 60.00 06300 06000 STORI NG, PROCESSI NG & TRANS. 0 0 0.000000 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0.000000 63.00 06000 CARDI ACT THERAPY 7,385,430 59,518,184 0.124087 65.00 066.00 PHYSI CAL THERAPY 4,018,840 17,334,553 0.231840 0.60.00 0.000000 0.60.00 0.000000							
58. 00 05900 CARDI AC CATHETERI ZATI ON 9, 526, 202 82, 150, 283 0. 115961 59. 00 06000 LABORATORY 24, 932, 031 219, 598, 973 0. 113534 60. 00 63. 00 06300 BLOOD STORN INC, PROCESSI NG & TRANS. 0 0. 0000000 63. 00 06500 RESPI RATORY THERAPY 7, 385, 430 59, 518, 184 0. 124087 65. 00 06500 06500 RESPI RATORY THERAPY 4, 018, 840 17, 334, 553 0. 231840 66. 00 06600 06700 070000 070000 070000 070000 07000 070000 070000 070000 070000 070000 070000 070000 070000 070000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 07000000 07000000 070000000 07000000 070000000 070000000 0700000000							
59.00 05000 05000 CARDI AC CATHETERI ZATI ON 9, 526, 202 82, 150, 283 0.115961 0.00 0.000000 0.60000 0.0000000 0.63.00 0.00000000							
60.00 06000 LABORATORY 24, 932, 031 219, 598, 973 0.113534 60.00 63.00 63.00 63.00 63.00 63.00 63.00 65.00 06500 RESPIRATORY THERAPY 7, 385, 430 59, 518, 184 0.124087 65.00 66.00 06500 RESPIRATORY THERAPY 7, 385, 430 59, 518, 184 0.124087 65.00 66.00 06600 PHYSI CAL THERAPY 2, 021, 263 12, 728, 600 0.158797 67.00 06700 0CCUPATI ONAL THERAPY 2, 021, 263 12, 728, 600 0.158797 68.00 68.00 06800 SPEECH PATHOLOGY 653, 377 4, 578, 065 0.142719 68.00 69.00							
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0		1 1					
65.00 06500 RESPIRATORY THERAPY 7, 385, 430 59, 518, 184 0, 124087 65.00 66.00 06600 PHYSI CAL THERAPY 4, 018, 840 17, 334, 553 0. 231840 66.00 66.00 66.00 6700 0CCUPATI ONAL THERAPY 2, 021, 263 12, 728, 600 0. 158797 67.00 68.00 06800 SPECH PATHOLOGY 5, 500, 635 99, 466, 097 0. 055302 69.00	60.00	06000 LABORATORY	24, 932, 031	219, 598, 973	0. 113534		60.00
66. 00	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000		63.00
66. 00 06600 PHYSICAL THERAPY 4, 018, 840 17, 334, 553 0. 231840 66. 00 670. 00 06700 0CCUPATI ONAL THERAPY 2, 221, 263 12, 728, 600 0. 158797 67. 00 68. 00 06800 SPEEC PATHOLOGY 653, 377 4, 578, 065 0. 142719 68. 00 69. 00 06900 ELECTROCARDI OLOGY 5, 500, 635 99, 466, 097 0. 055302 69. 00 070. 00 07000 ELECTROENCEPHALOGRAPHY 3, 497, 759 11, 557, 016 0. 302652 70. 00 07001 SLEEP LAB 3, 497, 759 11, 557, 016 0. 302652 70. 00 07001 SLEEP LAB 3, 497, 759 11, 557, 016 0. 302652 70. 00 07001 MEDI CAL SUPPLIES CHARGED TO PATI ENT 34, 461, 498 29, 701, 283 1. 160270 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 29, 825, 685 43, 544, 119 0. 684953 72. 00 07300 DRUGS CHARGED TO PATI ENTS 69, 056, 502 102, 455, \$57 0. 674016 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 1, 346, 805 4, 042, 981 0. 333122 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 589, 644 4, 739, 862 0. 124401 76. 98 07800 CAR T-CELL I MUNOTHERAPY 0 0. 000000 0. 000000 77. 00 0. 0000000 0. 0	65.00	06500 RESPIRATORY THERAPY	7, 385, 430	59, 518, 184	0. 124087		65.00
67. 00 06700 OCCUPATI ONAL THERAPY 2, 021, 263 12, 728, 600 0. 158797 68. 00 68. 00 68. 00 68. 00 68. 00 69. 00 69. 00 60					1		
68. 00 06800 SPEECH PATHOLOGY 653, 377 4, 578, 065 0. 142719 69. 00 06900 ELECTROCARDI OLOGY 5, 500, 635 99, 466, 097 0. 055302 69. 00 70. 00 70.00 TOO OLOGY 70. 00 70.00 70. 00 70.							
69. 00 06900 ELECTROCARDI OLOGY 5, 500, 635 99, 466, 097 0. 055302 69. 00 70. 00 7000 ELECTROENCEPHALOGRAPHY 3, 497, 759 11, 557, 016 0. 302652 70. 00 70. 01 70. 01 SLEEP LAB 31, 786 0 0. 000000 70. 01 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 29, 825, 685 43, 544, 119 0. 684953 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 69, 056, 502 102, 455, 357 0. 674016 73. 00 76. 97 76. 97 76. 97 76. 97 76. 97 76. 98 76. 97 76. 98 76. 97 76. 98 76. 98 76. 98 77. 00 7700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0. 000000 77. 00 7700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0. 000000 77. 00 00000 000000 000000 000000 000000							
70. 00 07000 ELECTROENCEPHALOGRAPHY 3, 497, 759 11, 557, 016 0. 302652 70. 00 70. 01 7001 SLEEP LAB 31, 786 0 0. 000000 70. 01 70.							
70. 01 07001 SLEEP LAB 31, 786 0 0.000000 70. 01							
71. 00		1 1					
72. 00		1 1					
73. 00			34, 461, 498	29, 701, 283	1. 160270		
76. 97	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	29, 825, 685	43, 544, 119	0. 684953		72.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY 589, 644 4, 739, 862 0. 124401 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0. 000000 0. 000000 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0. 000000 0. 000000 78. 00 000000 000000 000000 000000 000000	73.00	07300 DRUGS CHARGED TO PATIENTS	69, 056, 502	102, 455, 357	0. 674016		73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY 589, 644 4, 739, 862 0. 124401 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0. 000000 0. 000000 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0. 000000 0. 000000 78. 00 000000 000000 000000 000000 000000	76. 97	07697 CARDI AC REHABI LI TATI ON	1, 346, 805	4, 042, 981	0. 333122		76. 97
77. 00 78. 00 78. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0.000000 78. 00 000000 CLI NI C 09000 CLI NI C 90. 00 91. 00 99200 OBSERVATI ON BEDS (NON-DISTINCT PART 106, 622 680, 700 0.156636 92. 00 992. 01 07800 OP300 OBSERVATI ON BEDS (NON-DISTINCT PART 5, 138, 846 64, 773, 805 0.079335 92. 01 0710 OTHER REIMBURSABLE COST CENTERS 95. 00 102. 00 102. 00 102. 00 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 201. 00 Subtotal (sum of lines 50 thru 199) 201. 00 Subtotal (sum of lines 50 thru 199) 201. 00 201. 00 Less Observation Beds 200. 00 201. 00 Less Observation Beds 200. 00 201. 00 202. 00 0.0000000 0.0000000 0.0000000 0.000000					1		
78. 00			1				
OUTPATI ENT SERVI CE COST CENTERS 90.00 O9000 CLI NI C 959, 535 15, 582, 909 0.061576 90.00 O9100 EMERGENCY 37, 080, 821 408, 410, 155 0.090793 91.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART 106, 622 680, 700 0.156636 92.00 O9201 OBSERVATI ON BEDS-DI STI NCT 5, 138, 846 64, 773, 805 0.079335 92.01 OTHER REI MBURSABLE COST CENTERS 0 0.000000 0.000000 95.00 O000000 O000000 O000000 O000000 O000000 O000000 O000000 O0000000 O0000000 O0000000 O0000000 O0000000 O0000000 O0000000 O0000000 O00000000			-				
90. 00 09000 CLINI C 959, 535 15, 582, 909 0. 061576 90. 00 91. 00 09100 EMERGENCY 37, 080, 821 408, 410, 155 0. 090793 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 106, 622 680, 700 0. 156636 92. 00 09201 0BSERVATI ON BEDS-DI STI NCT 5, 138, 846 64, 773, 805 0. 079335 92. 01 07100	76.00		J U	0	0.000000		78.00
91. 00			050 505	45 500 000	0.04574		
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 106, 622 680, 700 0.156636 92. 00 09201 0BSERVATI ON BEDS-DI STINCT 5, 138, 846 64, 773, 805 0.079335 92. 01 07HER REI MBURSABLE COST CENTERS 0 0 0.0000000 0.00000000		1 1	1				
92. 01							
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	106, 622	680, 700	0. 156636		92.00
95. 00	92.01	09201 OBSERVATION BEDS-DISTINCT	5, 138, 846	64, 773, 805	0. 079335		92. 01
95. 00		OTHER REIMBURSABLE COST CENTERS					
102. 00	95 00		0	0	0.000000		95.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 316,945,971 1,755,179,289 200.00 201.00 Less Observation Beds 106,622 0 201.00			1				
113.00	102.00				0.000000		102.00
200.00 Subtotal (sum of lines 50 thru 199) 316,945,971 1,755,179,289 200.00 201.00 Less Observation Beds 106,622 0 0	112 00						112 00
201.00 Less Observation Beds 106,622 0 201.00			21/ 045 274	1 755 170 000			
					1		
202.00 Iotal (line 200 minus line 201) 316,839,349 1,755,179,289							
	202. 00) Iotal (line 200 minus line 201)	316, 839, 349	1, 755, 179, 289			202. 00

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part I Date/Time Pre 5/28/2025 10:	pared: 36 am
		Title	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	5, 531, 115	0	5, 531, 11	5 66, 344	83. 37	30.00
31.00 INTENSIVE CARE UNIT	3, 261, 140		3, 261, 14	0 45, 965	70. 95	31.00
34.00 SURGICAL INTENSIVE CARE UNIT	299, 590		299, 59	0 3, 574	83. 82	34.00
43. 00 NURSERY	306, 445		306, 44	5 4, 236	72. 34	43.00
44.00 SKILLED NURSING FACILITY	438, 225		438, 22	5 6, 859	63. 89	44.00
200.00 Total (lines 30 through 199)	9, 836, 515		9, 836, 51	5 126, 978		200. 00
Cost Center Description	Inpati 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	45, 608	3, 802, 339				30.00
31.00 INTENSIVE CARE UNIT	2, 907	206, 252				31.00
34.00 SURGICAL INTENSIVE CARE UNIT	1, 556	130, 424				34.00
43. 00 NURSERY	0	0)			43.00
44.00 SKILLED NURSING FACILITY	4, 056	259, 138				44.00
200.00 Total (lines 30 through 199)	54, 127	4, 398, 153				200. 00

Hool +h	Financial Systems	COMMUNITY MED	NICAL CENTED		ln lio	u of Form CMS-2	2552 10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der Co		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part II Date/Time Pre 5/28/2025 10:	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 380, 380				824, 179	
51.00	05100 RECOVERY ROOM	228, 631			3, 564, 718	39, 276	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	712, 285				1, 350	
52.01	03190 OP INFUSION	335, 427	20, 998, 716	0. 01597	40, 327	644	52. 01
53.00	05300 ANESTHESI OLOGY	56, 534	24, 519, 295	0. 00230	06 4, 151, 116	9, 572	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 734, 931	85, 445, 983	0. 02030	15, 280, 323	310, 252	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 311, 361	91, 684, 406	0. 01430	1, 447, 256	20, 700	55.00
56.00	05600 RADI OI SOTOPE	93, 348	6, 095, 335	0. 01531	1, 088, 570	16, 671	56.00
57.00	05700 CT SCAN	107, 963	144, 706, 698	0. 00074	32, 605, 101	24, 323	57.00
58.00	05800 MRI	329, 026	38, 427, 605	0. 00856	8, 847, 870	75, 755	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 215, 817	82, 150, 283	0. 01480	00 15, 110, 134	223, 630	59.00
60.00	06000 LABORATORY	1, 141, 105	219, 598, 973	0. 00519		294, 898	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	00	0	63.00
65.00	06500 RESPIRATORY THERAPY	539, 023	59, 518, 184	0. 00905	26, 746, 273	242, 214	65.00
66.00	06600 PHYSI CAL THERAPY	256, 509	17, 334, 553	0. 01479	7, 398, 938	109, 489	66.00
67.00	06700 OCCUPATI ONAL THERAPY	39, 659				16, 606	67.00
68. 00	06800 SPEECH PATHOLOGY	36, 267				14, 517	1
69.00	06900 ELECTROCARDI OLOGY	385, 061				61, 882	
70.00	07000 ELECTROENCEPHALOGRAPHY	512, 826				59, 146	1
70. 01	07001 SLEEP LAB	3, 169			,	0,,0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 143, 314				258, 315	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	942, 876				218, 422	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 322, 417				146, 581	
76. 97	07697 CARDI AC REHABI LI TATI ON	104, 364				29	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	89, 406				100	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	07, 400			1	0	1
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		l .		0	
70.00	OUTPATIENT SERVICE COST CENTERS		1	0.00000	0	0	70.00
90.00	09000 CLINIC	15, 917	15, 582, 909	0. 00102	126, 399	129	90.00
91.00	09100 EMERGENCY	2, 758, 157		l .		396, 630	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 920				1, 136	
92.00	09201 OBSERVATION BEDS-DISTINCT PART	110, 866			1	14, 486	1
7∠. U I	OTHER REIMBURSABLE COST CENTERS	110, 800	04,773,805	0.0017	۵, 401, 381	14, 480	72.01
95. 00	09500 AMBULANCE SERVICES			1			95. 00
200.00		10 013 550	1, 755, 179, 289		314, 668, 181	3, 380, 932	
200.00	Trotal (Tries 30 till bugil 177)	17, 713, 337	1, 133, 117, 207	I	314,000,101	3, 300, 732	1200.00

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		rs Provider C		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part III Date/Time Pre 5/28/2025 10:	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments	4.00	0.4	0.00	0.00	
INDATIONE DOUTING CERVILOE COST CENTERS	1A	1. 00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			1			20.00
	0	0	•	0	0	
31. 00 03100 INTENSIVE CARE UNIT	0	0		0	0	
34.00 03400 SURGI CAL INTENSIVE CARE UNIT 43.00 04300 NURSERY	0	0		0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
200.00 Total (lines 30 through 199)	0	0		0	_	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dation	t Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	3 - (01. 0)	Frogram Days	
		minus col. 4)				
	4. 00	5.00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	66, 34	4 0.00	45, 608	30.00
31.00 03100 INTENSIVE CARE UNIT		0	45, 96	5 0.00	2, 907	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	3, 57	4 0.00	1, 556	34.00
43. 00 04300 NURSERY		0	4, 23	6 0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	6, 85	9 0.00	4, 056	44.00
200.00 Total (lines 30 through 199)		0	126, 97	8	54, 127	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	. 1					l
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	COMMUNITY N	MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	T ANCILLARY SERVICE OTHER F	PASS Provi der CCN: 31-0041	Period: Worksheet D Part IV To 12/31/2024 Date/Time Prepared:

					To 12/31/2024	Date/Time Pre 5/28/2025 10:	
			Title	e XVIII	Hospi tal	PPS	30 aiii
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		
		Anesthetist	Program	Program	Post-Stepdown		
			Post-Stepdown		Adjustments		
			Adjustments		.,		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
52.01	03190 OP INFUSION	0	0		0 0	0	52. 01
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MRI	0	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
70. 01	07001 SLEEP LAB	0	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	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0)	0	214, 388	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0)	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0)	0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	0	0)	0 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200. 00	Total (lines 50 through 199)	0	0)	0 0	214, 388	200.00

Health Financial Systems	Ith Financial Systems COMMUNITY MEDICAL CENTER In Lie						
APPORTIONMENT OF INPATIENT/OUTPATIENT / THROUGH COSTS	ANCILLARY SERVICE OTHER PASS		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part IV Date/Time Prepared: 5/28/2025 10:36 am			
		Title XVIII	Hospi tal	PPS			
Cost Center Description		Total Cost Total		Ratio of Cost			

					0 12/31/2024	Date/lime Pre 5/28/2025 10:	pared: 36 am
			Title	XVIII	Hospi tal	PPS	00 am
	Cost Center Description	All Other	Total Cost	Total	Total Charges	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						
	05000 OPERATI NG ROOM	0	0			0. 000000	
51. 00	05100 RECOVERY ROOM	0	0			0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	· ·	,,	0. 000000	
	03190 OP INFUSION	0	0	`	20, ,,0, , .0	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0	· ·		0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	·	,	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		, ,	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	0			0. 000000	1
57.00	05700 CT SCAN	0	0			0. 000000	
58. 00	05800 MRI	0	0			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0			0. 000000	
60.00	06000 LABORATORY	0	0		, ,	0. 000000	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		_	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		,,	0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		/ /	0. 000000	
	06800 SPEECH PATHOLOGY	0	0	(.,	0. 000000	
	06900 ELECTROCARDI OLOGY	0	0	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0	(, ,	0. 000000	
	07001 SLEEP LAB	0	0	(, I	0. 000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	١ .		0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	0	214, 388			0. 002093	
	07697 CARDI AC REHABI LI TATI ON	0	0	·	.,	0. 000000	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	`	., ,	0. 000000	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		, I	0. 000000	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0			0. 000000	
	09100 EMERGENCY	0	0			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			0. 000000	
92. 01	09201 OBSERVATION BEDS-DISTINCT	0	0	(64, 773, 805	0. 000000	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	_					95.00
200. 00	Total (lines 50 through 199)	0	214, 388	214, 388	1, 755, 179, 289		200. 00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	Provi der CC		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part IV Date/Time Pre 5/28/2025 10:	pared: 36 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	21, 505, 566		15, 943, 618		
51.00	05100 RECOVERY ROOM	0. 000000	3, 564, 718		2, 978, 600	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	51, 923		7, 272	0	52.00
52.01	03190 OP NFUSI ON	0. 000000	40, 327		7, 524, 455	0	
53.00	05300 ANESTHESI OLOGY	0. 000000	4, 151, 116		3, 084, 204	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	15, 280, 323		9, 984, 463	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 447, 256		34, 760, 876	0	55.00
56.00	05600 RADI 0I SOTOPE	0. 000000	1, 088, 570		1, 050, 871	0	
57.00	05700 CT SCAN	0. 000000	32, 605, 101		20, 389, 223	0	57.00
58.00	05800 MRI	0. 000000	8, 847, 870		4, 362, 672	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	15, 110, 134		16, 598, 802	0	59.00
60.00	06000 LABORATORY	0. 000000	56, 754, 741		14, 148, 660	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	26, 746, 273		3 446, 381	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	7, 398, 938		150, 700	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	5, 329, 227		39, 617	0	
68.00	06800 SPEECH PATHOLOGY	0. 000000	1, 832, 439		6, 671	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	15, 986, 046		22, 779, 257	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 332, 892		2, 104, 379	0	70.00
70. 01	07001 SLEEP LAB	0. 000000	0		0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	6, 710, 528		3, 833, 760	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	10, 087, 369		7, 209, 480	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 002093	11, 356, 741		· · ·	71, 995	
	07697 CARDI AC REHABI LI TATI ON	0. 000000	1, 137		1, 742, 775	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	5, 288		2, 369, 430	0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78.00
	OUTPATIENT SERVICE COST CENTERS						I

0.000000

0. 000000 0. 000000

0.000000

126, 399 58, 733, 924 111, 754

8, 461, 581

314, 668, 181

8, 954, 636 54, 402, 016 158, 670

15, 102, 638

284, 532, 175

0 0 0

23, 770

90.00

0 91.00 0 92.00

92.01

95.00

0

71, 995 200. 00

09000 CLI NI C

200. 00

91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | 0BSERVATI ON | BEDS | (NON-DISTINCT | PART | 92. 01 | 09201 | 0BSERVATI ON | BEDS-DISTINCT |

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

Health Financial Systems	COMMUNI T	Y MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE (From 01/01/2024	Worksheet D Part V Date/Time Prepared:

					To 12/31/2024	Date/Time Pre 5/28/2025 10:	pared: 36 am
			Title	XVIII	Hospi tal	PPS	<u> </u>
				Charges		Costs	
	Cost Center Description	Cost to Charge	PS Reimbursed		Cost	PPS Services	
			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						
50.00	05000 OPERATING ROOM	0. 253519	15, 943, 618		0	4, 042, 010	50.00
51.00	05100 RECOVERY ROOM	0. 169291	2, 978, 600		0 0	504, 250	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 311383	7, 272		0	2, 264	52.00
52.01	03190 OP INFUSION	0. 183297	7, 524, 455		0	1, 379, 210	52. 01
53.00	05300 ANESTHESI OLOGY	0. 045535	3, 084, 204		0	140, 439	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 217267	9, 984, 463		o	2, 169, 294	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 125548	34, 760, 876		o	4, 364, 158	55. 00
56.00	05600 RADI OI SOTOPE	0. 354661	1, 050, 871		o o	372, 703	
57.00	05700 CT SCAN	0. 037048	20, 389, 223		o o	755, 380	57. 00
58.00	05800 MRI	0. 068197	4, 362, 672		ol o	297, 521	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 123760	16, 598, 802		ol ol		1
60.00	06000 LABORATORY	0. 120756	14, 148, 660		ol ol	1, 708, 536	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		ol ol	0	1
65.00	06500 RESPI RATORY THERAPY	0. 132131	446, 381		o o	58, 981	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 246774	150, 700		o o	37, 189	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 168713	39, 617			6, 684	1
68.00	06800 SPEECH PATHOLOGY	0. 151860	6, 671			1, 013	1
69. 00	06900 ELECTROCARDI OLOGY	0. 058879	22, 779, 257			1, 341, 220	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 323266	2, 104, 379		o o	680, 274	1
70. 01	07001 SLEEP LAB	0. 000000	2, .0., 0.,			0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 233425	3, 833, 760		o o	4, 728, 655	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 728092	7, 209, 480			5, 249, 165	
	07300 DRUGS CHARGED TO PATIENTS	0. 716091	34, 398, 049		25, 937	24, 632, 133	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 354783	1, 742, 775		0 20, 707	618, 307	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 132902	2, 369, 430			314, 902	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	2, 307, 430			0	1
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0			0	
70.00	OUTPATIENT SERVICE COST CENTERS	0.000000			<u> </u>		70.00
90 00	09000 CLINIC	0. 065413	8, 954, 636		228	585, 750	90.00
91.00	09100 EMERGENCY	0. 096684	54, 402, 016		0		1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 166733	158, 670				1
92. 01	09201 OBSERVATION BEDS-DISTINCT	0. 084296	15, 102, 638				1
7Z. U I	OTHER REIMBURSABLE COST CENTERS	0.004290	13, 102, 030	'	J ₁ U	1,213,072	1 /2.01
95 00	09500 AMBULANCE SERVICES	0.000000			o		95. 00
200.00		0.000000	284, 532, 175		26, 165	62, 603, 659	
201. 00			204, 332, 173		0 20, 103		201.00
201.00	Only Charges						231.00
202. 00			284, 532, 175		26, 165	62, 603, 659	202 00
202.00	1 5 955 (1 200 11110 201)	1	20., 302, 170	1	20, 100	52,000,007	,_02.00

Health Financial Syste	ems	CO	DMMUNITY MEDICAL	L CENTER	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF MEDI	CAL, OTHER HEALTH	SERVICES AND VA	CCINE COST		From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared:

				10 12/31/2024	5/28/2025 10:	
		Title	XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost	1			
, , , , , , , , , , , , , , , , , , ,	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 OPERATI NG 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	o	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1			55. 00
56. 00 05600 RADI OI SOTOPE	ol	Ö	1			56.00
57. 00 05700 CT SCAN	Ö	0	•			57. 00
58. 00 05800 MRI	ő	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	Ö	0	•			59. 00
60. 00 06000 LABORATORY	o o	0	1			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	•			63. 00
65. 00 06500 RESPIRATORY THERAPY	o o	0	•			65. 00
66. 00 06600 PHYSI CAL THERAPY		0	•			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	•			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	•			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0	1			70.00
70. 01 07001 SLEEP LAB	0	0	1			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		18, 573	1			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	18, 373	1			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
78. 00 07700 ALLOGENETC STEW CELL ACCOUNTY TON 78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	1			78.00
OUTPATIENT SERVICE COST CENTERS	l U	U				78.00
90. 00 09000 CLINIC	0	15	I			90.00
91. 00 09100 EMERGENCY	0	0	1			
	1		•			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	•			92.00
92. 01 09201 0BSERVATI ON BEDS-DI STI NCT	0	0	1			92. 01
OTHER REIMBURSABLE COST CENTERS			I			05.00
95. 00 09500 AMBULANCE SERVICES	0	10 500				95. 00
200.00 Subtotal (see instructions)	0	18, 588				200.00
201.00 Less PBP Clinic Lab. Services-Program	미					201. 00
Only Charges (Line 200 Line 201)		10 500				202.00
202.00 Net Charges (line 200 - line 201)	0	18, 588	I			202. 00

Heal th	Financial Systems	COMMUNITY MED	OLCAL CENTER			In Lie	u of Form CMS-:	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PAS		CN: 31-0041 CCN: 31-5490		riod: om 01/01/2024 12/31/2024	Worksheet D Part IV Date/Time Pre 5/28/2025 10:	pared: 36 am
			Titl∈	xVIII	Sk	illed Nursing Facility	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Program Post-Stepdown Adjustments			Allied Health Post-Stepdown Adjustments	Allied Health	
	ANCILLARY SERVICE COST CENTERS	1. 00	2A	2. 00		3A	3. 00	
50.00	05000 OPERATING ROOM			I	0	0	0	50.00
50.00	05100 RECOVERY ROOM	0			0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	0	
52. 00	03190 OP INFUSION	0			0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0			0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0			0	0	0	56.00
57.00	05700 CT SCAN	0			0	0	0	57.00
58.00	05800 MRI	0			O	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	0	59.00
60.00	06000 LABORATORY	0	0		O	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	l 0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
70. 01	07001 SLEEP LAB	0	0		0	0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	214, 388	73. 00
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	76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	0		1	0	0	0	
01 NN	09100 EMERGENCY	0	1	I	Ω	0	0	91 00

0 0 0

0

0

91. 00 92. 00

92.01 95.00 214, 388 200. 00

0 0

90. 00 09000 CETNIC
91. 00 09100 EMERGENCY
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART
92. 01 09201 OBSERVATION BEDS-DISTINCT
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

200.00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PAS			Period: From 01/01/2024 To 12/31/2024	Worksheet D Part IV Date/Time Pre 5/28/2025 10:	pared: 36 am
			Title	XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	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						4
	05000 OPERATING ROOM	0			0 114, 298, 541	0. 000000	
	05100 RECOVERY ROOM	0			0 20, 750, 848		
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 27, 388, 920		
	03190 OP INFUSION	0	0		0 20, 998, 716		
3.00	05300 ANESTHESI OLOGY	0	0		0 24, 519, 295		
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 85, 445, 983		
5. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 91, 684, 406		
	05600 RADI 0I S0T0PE	0	0		0 6, 095, 335		
	05700 CT SCAN	0	0		0 144, 706, 698		
8. 00	05800 MRI	0	0		0 38, 427, 605		
9. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 82, 150, 283		
	06000 LABORATORY	0	0		0 219, 598, 973	•	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0. 000000	
5.00	06500 RESPIRATORY THERAPY	0	0		0 59, 518, 184	0. 000000	
	06600 PHYSI CAL THERAPY	0	0		0 17, 334, 553		
	06700 OCCUPATI ONAL THERAPY	0	0		0 12, 728, 600		
	06800 SPEECH PATHOLOGY	0	0		0 4, 578, 065		
	06900 ELECTROCARDI OLOGY	0	0		0 99, 466, 097	0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 11, 557, 016		
	07001 SLEEP LAB	0	0		0		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 29, 701, 283		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 43, 544, 119		
	07300 DRUGS CHARGED TO PATIENTS	0	214, 388			0. 002093	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 042, 981	l	
	07698 HYPERBARIC OXYGEN THERAPY	0	ı		0 4, 739, 862		
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0		
8. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0. 000000	78.0
	OUTPATIENT SERVICE COST CENTERS		1	1			4
	09000 CLINIC	0			0 15, 582, 909	l	
	09100 EMERGENCY	0	1		0 408, 410, 155		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 680, 700	l	
	09201 OBSERVATI ON BEDS-DI STI NCT	0	0		0 64, 773, 805	0. 000000	92. (
	OTHER REIMBURSABLE COST CENTERS		T				4
	09500 AMBULANCE SERVICES						95. (
00.00	Total (lines 50 through 199)	0	214, 388	214, 38	8 1, 755, 179, 289		200.

Heal th	Financial Systems	COMMUNITY MEDI	CAL CENTER		Inlie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der Co	CN: 31-0041	Peri od:	Worksheet D	2002 10
THROUG	H COSTS		Component		From 01/01/2024 To 12/31/2024	Part IV Date/Time Pre 5/28/2025 10:	
			Title	XVIII	Skilled Nursing		<u> </u>
					Facility		
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col. 7)		Costs (col. 8		Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
	05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
	05100 RECOVERY ROOM	0. 000000	0		o o	0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		o o	0	
	03190 OP INFUSION	0. 000000	6, 002		0 0	0	52. 01
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	65, 204		0 0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56.00	05600 RADI 0I SOTOPE	0. 000000	2, 390		0	0	56.00
57.00	05700 CT SCAN	0. 000000	0		0	0	57.00
58.00	05800 MRI	0. 000000	0		0 0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	
60.00	06000 LABORATORY	0. 000000	905, 545		0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	
65.00	06500 RESPI RATORY THERAPY	0. 000000	89, 188		0	0	
	06600 PHYSI CAL THERAPY	0. 000000	10, 142		0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	134, 250		0	0	
	06800 SPEECH PATHOLOGY	0. 000000	22, 617		0	0	
	06900 ELECTROCARDI OLOGY	0.000000	15, 101		0	0	
	07000 ELECTROENCEPHALOGRAPHY	0.000000	2, 283 0		0 0	0	
	07001 SLEEP LAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000 0. 000000	1, 331		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 331		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	229, 805	48		0	
	07697 CARDIAC REHABILITATION	0.002093	229, 603		0 0	0	
-	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	
-	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		o o	0	
	OUTPATIENT SERVICE COST CENTERS	0.000000			<u> </u>		70.00
	09000 CLINIC	0. 000000	0		0 0	0	90.00
	09100 EMERGENCY	0. 000000	0		o o	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92.00
	09201 OBSERVATION BEDS-DISTINCT	0. 000000	0		0	0	
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)				1 0		200.00

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C		Period: From 01/01/2024 To 12/31/2024		pared: 36 am
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Swi ng 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	5, 531, 115	0	5, 531, 11	5 66, 344	83. 37	30.00
31.00 INTENSIVE CARE UNIT	3, 261, 140		3, 261, 14	0 45, 965	70. 95	31.00
34.00 SURGICAL INTENSIVE CARE UNIT	299, 590		299, 59	0 3, 574	83. 82	34.00
43. 00 NURSERY	306, 445		306, 44	5 4, 236	72. 34	43.00
44.00 SKILLED NURSING FACILITY	438, 225		438, 22	5 6, 859	63. 89	44.00
200.00 Total (lines 30 through 199)	9, 836, 515		9, 836, 51	5 126, 978		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	1, 198					30.00
31.00 INTENSIVE CARE UNIT	975	69, 176				31.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	1			34.00
43. 00 NURSERY	2, 116	153, 071				43.00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (lines 30 through 199)	4, 289	322, 124				200. 00

Heal th	Financial Systems	COMMUNITY MED	OLCAL CENTER		In lie	u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der Co		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part II Date/Time Pre 5/28/2025 10:	pared:
				e XIX	Hospi tal	TEFRA	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	0.00	4.00	F 00	
	ANOLLI ADV. CEDVI OF COCT OFNITEDS	1. 00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCILLARY SERVICE COST CENTERS	4 200 200	114 200 541	0.0202	701 (00	20.241	FO 00
50.00	05000 OPERATING ROOM	4, 380, 380		0. 03832			1
51.00	05100 RECOVERY ROOM	228, 631				1, 578	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	712, 285			· ·		
52. 01	03190 OP INFUSION	335, 427				0	
53.00	05300 ANESTHESI OLOGY	56, 534			· ·	557	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 734, 931			· ·	11, 812	
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 311, 361				949	
56.00	05600 RADI OI SOTOPE	93, 348				1, 023	
57.00	05700 CT SCAN	107, 963				1, 096	
58. 00	05800 MRI	329, 026			· ·	4, 805	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 215, 817				11, 853	1
60.00	06000 LABORATORY	1, 141, 105	219, 598, 973			14, 366	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0				0	
65.00	06500 RESPI RATORY THERAPY	539, 023				10, 531	65.00
66.00	06600 PHYSI CAL THERAPY	256, 509			98 177, 953	2, 633	66.00
67.00	06700 OCCUPATI ONAL THERAPY	39, 659	12, 728, 600	0. 00311	132, 098	412	67.00
68.00	06800 SPEECH PATHOLOGY	36, 267	4, 578, 065	0. 00792	76, 656	607	68. 00
69.00	06900 ELECTROCARDI OLOGY	385, 061	99, 466, 097	0. 00387	71 659, 156	2, 552	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	512, 826	11, 557, 016	0. 04437	74 100, 913	4, 478	70.00
70.01	07001 SLEEP LAB	3, 169	0	0. 00000	00	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 143, 314	29, 701, 283	0. 03849	179, 088	6, 894	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	942, 876	43, 544, 119	0. 02165	141, 436	3, 063	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 322, 417	102, 455, 357	0. 01290	776, 223	10, 019	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	104, 364	4, 042, 981	0. 02581	14 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	89, 406	4, 739, 862	0. 01886	53 0	0	76. 98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0. 00000	00	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	00	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	15, 917	15, 582, 909	0. 00102	1, 710	2	90.00
91.00	09100 EMERGENCY	2, 758, 157	408, 410, 155	0. 00675	1, 995, 590	13, 476	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 920	680, 700	0. 01016	0	0	1
92.01	09201 OBSERVATION BEDS-DISTINCT	110, 866				351	92. 01
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES						95.00
200. 00	Total (lines 50 through 199)	19, 913, 559	1, 755, 179, 289		13, 558, 999	145, 410	200. 00

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.		TS Provider C		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part III Date/Time Pre 5/28/2025 10:	pared:
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00 03000 ADULTS & PEDIATRICS	0	0	1	0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	0	34.00
43. 00 04300 NURSERY	0	0)	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	o	0	1	0 0		44.00
200.00 Total (lines 30 through 199)	o	0	1	0 0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	00,0			
31.00 03100 INTENSIVE CARE UNIT		0	45, 96	5 0.00	975	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	3, 57	4 0.00	0	34.00
43. 00 04300 NURSERY		0	4, 23	6 0.00	2, 116	43.00
44.00 04400 SKILLED NURSING FACILITY		0	6, 85	9 0.00	0	44.00
200.00 Total (lines 30 through 199)		0	126, 97	8	4, 289	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	o					200. 00

Health Financial Systems	COMMUNI TY	MEDI CAL	_ CENTER	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER	PASS	Provi der CCN: 31-0041	From 01/01/2024 To 12/31/2024	Worksheet D Part IV Date/Time Prepared:

					10 12/31/2024	5/28/2025 10:	
			Ti tl	e XIX	Hospi tal	TEFRA	00 4
	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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
52. 01	03190 OP I NFUSI ON	0	0		0	0	52. 01
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57.00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MRI	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	
60.00	06000 LABORATORY	0	0		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	l .	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
	07001 SLEEP LAB	0	0		0	0	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	214, 388	
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			1			
90.00	09000 CLINIC	0	0		0 0	0	1
	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	1 /2.00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	0	0		0 0	0	92. 01
05.05	OTHER REIMBURSABLE COST CENTERS		·				
95.00	09500 AMBULANCE SERVICES	_	_			044.000	95.00
200. 00	Total (lines 50 through 199)	0	0	1	0 0	214, 388	1200. OO

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 31-0041	Peri od: From 01/01/2024 Part IV To 12/31/2024 Date/Ti me Prepared: 5/28/2025 10: 36 am

THROUG	n costs				o 12/31/2024	Date/Time Pre 5/28/2025 10:	pared: 36 am
			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	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				111 000 511	0.00000	
	05000 OPERATI NG ROOM	0	0			0. 000000	
	05100 RECOVERY ROOM	0	0	1			
	05200 DELIVERY ROOM & LABOR ROOM	0	0	·	,,		
	03190 OP INFUSION	0	0	·	.,		1
53.00	05300 ANESTHESI OLOGY	0	0	`			
	05400 RADI OLOGY-DI AGNOSTI C	0	0		,		•
	05500 RADI OLOGY-THERAPEUTI C	0	0		,		
	05600 RADI OI SOTOPE	0	0		-, ,		1
	05700 CT SCAN	0	0	· ·			
	05800 MRI	0	0	· ·	, - ,		
	05900 CARDI AC CATHETERI ZATI ON	0	0		,		•
	06000 LABORATORY	0	0		,		•
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	· ·	_	0. 000000	
	06500 RESPI RATORY THERAPY	0	0	`			
	06600 PHYSI CAL THERAPY	0	0		,		
	06700 OCCUPATI ONAL THERAPY	0	0	`	.2, ,20,000		•
	06800 SPEECH PATHOLOGY	0	0	`	.,		
	06900 ELECTROCARDI OLOGY	0	0	(
	07000 ELECTROENCEPHALOGRAPHY	0	0	(, ,		
	07001 SLEEP LAB	0	0	(-	0.00000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(43, 544, 119		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	214, 388	214, 388			
	07697 CARDIAC REHABILITATION	0	0	(1,012,701	0. 000000	1
	07698 HYPERBARIC OXYGEN THERAPY	0	0		., ,		76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0		1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	· ·			1
	09100 EMERGENCY	0	0	·	,,		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				1
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	0	0	(64, 773, 805	0. 000000	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95.00
200. 00	Total (lines 50 through 199)	0	214, 388	214, 388	1, 755, 179, 289		200. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-		
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provi der CO	CN: 31-0041	Peri od: From 01/01/2024	Worksheet D Part IV	
TIROUGH COSTS				To 12/31/2024	Date/Time Prep 5/28/2025 10:3	
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.	-	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	

			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.	•	Costs (col. 8	, and the second	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	791, 699	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	143, 194	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	461, 875	0	0	0	52.00
52.01	03190 OP INFUSION	0. 000000	0	0	0	0	52. 01
53.00	05300 ANESTHESI OLOGY	0. 000000	241, 694	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	581, 768		0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	66, 342	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0. 000000	66, 777	0	0	0	56.00
57.00	05700 CT SCAN	0. 000000	1, 469, 803	0	0	0	57.00
58.00	05800 MRI	0. 000000	561, 229		0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	800, 905		0	o o	59.00
60.00	06000 LABORATORY	0. 000000	2, 764, 780		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	2,701,700	Ö	0	Ö	63.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	1, 162, 848		0		65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	177, 953		0	l ő	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	132, 098	-	0	1	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	76, 656	·	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	659, 156		0	l ő	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	100, 913	0	0	0	70.00
70.00	07001 SLEEP LAB	0. 000000	100, 719		0	0	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	179, 088	· -	0	o o	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	141, 436		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 002093	776, 223		0	1	73.00
	07697 CARDIAC REHABILITATION	0.000000	770, 223 N	1, 023	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	0	76. 98
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0.000000	0	0	0	ľ	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	·	0		1
76.00	OUTPATIENT SERVICE COST CENTERS	0.000000		U		0	76.00
90.00	09000 CLINIC	0.000000	1, 710	0	0	0	90.00
	09100 EMERGENCY	0. 000000	1, 710		0	1	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1, 995, 590		-	1	
		0. 000000	•	0	0		92.00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	0. 000000	205, 262	0	0	0	92. 01
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES			T			95.00
95. 00 200. 00			12 EEO 000	1 / 25	0	_	
200.00	Trotal (Tries 50 through 199)	1	13, 558, 999	1, 625	0	ı	200. 00

Health Financial Systems	COMMUNITY MEDICA	In Lieu of Form CMS-2552-10		
APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 31-0041	Peri od: From 01/01/2024	Worksheet D Part V

				To 12/31/2024		pared:
		Ti +I	e XIX	Hospi tal	772872025 TO.	30 alli
		11 (1	Charges	1103pi tai	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
oost center bescription		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(300 11131.)	
	Part I, col. 9	11131.)	Subject To	Subject To		
	art 1, cor. /		Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		2.00	0.00		0.00	
50. 00 05000 OPERATING ROOM	0. 237206	0		111, 562	0	50.00
51. 00 05100 RECOVERY ROOM	0. 159010	0		34, 096	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 292230	0		717, 084	0	
52. 01 03190 OP NFUSION	0. 171994	0		51, 363	0	1
53. 00 05300 ANESTHESI OLOGY	0. 042797	0		26, 453	0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 203813	0		585, 346	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 117665	0		245, 047	o o	1
56. 00 05600 RADI OI SOTOPE	0. 333447	0		10, 066	o o	56.00
57. 00 05700 CT SCAN	0. 034868	0		1, 015, 553	o o	ı
58. 00 05800 MRI	0. 063882	0		128, 267	o o	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 115961	0	1	0 120, 20,	ő	1
60. 00 06000 LABORATORY	0. 113534	0		2, 179	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		2, 1, 7	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 124087	0		3, 291	o o	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 231840	0		0, 2,1	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 158797	0		456	o o	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 142719	0		3, 999	o o	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 055302	0		156, 532	o o	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 302652	0		10, 444	o o	1
70. 01 07001 SLEEP LAB	0. 000000	0		0 0	Ö	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 160270	0		7, 374	o o	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 684953	0		9, 774	o o	1 , 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 674016	0	•	138, 638	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 333122	0		39	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 124401	0		0	0	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	Ö	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	Ö	1
OUTPATIENT SERVICE COST CENTERS	0.000000			<u> </u>		70.00
90. 00 09000 CLINIC	0. 061576	0		59, 115	0	90.00
91. 00 09100 EMERGENCY	0. 090793	0		7, 829, 926	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 156636	0		0 7,027,720	0	92.00
92. 01 09201 0BSERVATI ON BEDS-DI STI NCT	0. 079335	0		856, 332	Ö	
OTHER REIMBURSABLE COST CENTERS	0.077333			5 050, 552		/2.01
95. 00 09500 AMBULANCE SERVICES	0.000000	0		O		95. 00
200.00 Subtotal (see instructions)	0.00000	0		12, 002, 936	0	200.00
201.00 Less PBP Clinic Lab. Services-Progr	am	O		0 12,002,730		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		12, 002, 936	0	202. 00
			•			

Health Financial Systems		COMMUNITY MEDICA	L CENTER	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST		Period: From 01/01/2024	Worksheet D
					Date/Time Prepared:

				10 12/31/2024	Date/IIMe Pre 5/28/2025 10:	
		Ti tl	e XIX	Hospi tal	TEFRA	oo uiii
	Cos	sts				
Cost Center Description	Cost	Cost				
P	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	26, 463				50.00
51.00 05100 RECOVERY ROOM	0	5, 422				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1				52.00
52.01 03190 OP INFUSION	0		1			52. 01
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					55.00
56. 00 05600 RADI OI SOTOPE	0		1			56.00
57. 00 05700 CT SCAN	0	-,	1			57.00
58. 00 05800 MRI	0	,	1			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	-,	1			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	l .				66.00
67. 00 06700 OCCUPATI ONAL THERAPY			1			67.00
68. 00 06800 SPEECH PATHOLOGY	0					68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
70. 00 07000 ELECTROCARDI OLOGT		3, 161				70.00
70. 00 07000 ELECTROENCEPHALOGRAPHT 70. 01 07001 SLEEP LAB	0					70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	_	1			71.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		•			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	-,	1			73.00
73.00 07300 DROGS CHARGED TO PATTENTS 76. 97 07697 CARDI AC REHABI LI TATI ON	0	93, 444				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	13				76. 97
	0					
	0					77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS		2 (40	I			1 00 00
90. 00 09000 CLI NI C	0					90.00
91. 00 09100 EMERGENCY	0		1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	l .	•			92.00
92. 01 09201 0BSERVATI ON BEDS-DI STI NCT	0	67, 937				92. 01
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVI CES	0					95.00
200.00 Subtotal (see instructions)	0	,				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	_	1 050 551				
202.00 Net Charges (line 200 - line 201)	0	1, 350, 801	l			202. 00

COMMUNITY MID CALL CIVITY Provider CON 31-0011 Per land (Michisher LOT) Per land (Michisher LO						
Cost Center Description Cost Center Description						
Section Part ALL PROVIDER COMPONENTS 1.00	COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 31-0041	From 01/01/2024		
PRET L - ALL PROVIDER COMPONENTS 1.00				10 12/31/2024		pared: 36 am
PART I - ALL PROVIDER COMPONENTS IMPAILINI DAYS IMPAILINI DA			Title XVIII	Hospi tal		
PART I - ALL PROVIDER COMPONENTS		Cost Center Description			1 00	
IMPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Impatt ent days (including private room days, excluding swing-bed and newborn days) 6,344 2.00		I NPATI ENT DAYS				
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00						1
do not complete this line. 1.00 Semi-private room days (excluding swing-bed and observation bod days) 1.01 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost 1.02 Proporting period 1.03 Proporting period (if calendar year, enter 0 on this line) 1.04 Proporting period (if calendar year, enter 0 on this line) 1.05 Proporting period (if calendar year, enter 0 on this line) 1.06 Proporting period (if calendar year, enter 0 on this line) 1.07 Proporting period (if calendar year, enter 0 on this line) 1.08 Proporting period (if calendar year, enter 0 on this line) 1.09 Proporting period (if calendar year, enter 0 on this line) 1.00 Proporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 1.00 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) 1.00 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) 1.00 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) 1.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Proporting December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Proporting period (if calendar year, enter 0 on this line) 1.00 Proporting period (if the period period (if calendar year, enter 0 on this line) 1.00 Proporting period (if the period period (if the				rivate room days		
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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) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 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) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Simi-private room cost differential (line 3 x line 35)	21.00		ns)		90, 719, 689	21.00
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) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 3x x line 31) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22.00] 31	ber 31 of the cost repor	ting period (line	0	22. 00
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 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Private room cost differential adjustment (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35)	23 00		r 31 of the cost reportio	na period (line 6	0	23 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) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average pri vate room per diem charge (line 29 ÷ line 3) 33.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 34.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 30.00 Swing-bed cost reporting period (line 3 x line 35) 26.00 Zeno 26.00 27.00 Polytate room cost differential adjustment (line 37 x line 31) 28.00 Average period (line 8	20.00		or or the cost reportin	ig perrod (Trile o	9	20.00
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 Fivate 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) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35)	24.00] 9 11 91	er 31 of the cost reporti	ng period (line	0	24. 00
x line 20) 26.00 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 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average pri vate room per diem charge (line 29 ÷ line 3) 32.00 Average semi-pri vate room per diem charge (line 29 ÷ line 3) 33.00 Average semi-pri vate room charge diem charge (line 30 ÷ line 4) 34.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 0 26.00 26.00 27.00 28.00 28.00 29.00 30.	25 00	· · · · · · · · · · · · · · · · · · ·	31 of the cost reporting	neriod (line 8	0	25 00
27.00 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) 90,719,689 27.00 Private room charges (excluding swing-bed and observation bed charges) 028.00 Semi-private room charges (excluding swing-bed charges) 030.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 04.00 Average private room per diem charge (line 29 ÷ line 3) 05.00 Average semi-private room per diem charge (line 30 ÷ line 4) 05.00 Average per diem private room cost differential (line 34 x line 31) 05.00 Average per diem private room cost differential (line 34 x line 31) 07.00 08.00 09.719,689 27.00 28.00 29.00 30.00	20.00		or or the dost reporting	g perrou (rriie o	9	20.00
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) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 29 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0 28.00 28.00 29.00 30.00 30.00 30.00 30.00 30.00 31.00 32.00 34.00 35.00 36.00						1
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 34.00 Average semi-private room per diem charge (line 29 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0 28.00 29.00 30.00 0.000000 31.00 0.000 32.00 32.00 34.00 35.00 36.00 Private room cost differential (line 34 x line 31)	27.00		(line 21 minus line 26)		90, 719, 689	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 30.00 30.00 0.000000 31.00 0.000 32.00 0.000 33.00 0.000 35.00 0.000 35.00 0.000 35.00 0.000 35.00 0.000 35.00 0.000 35.00 0.000 35.00 0.000 35.00 0.000 35.00 0.000000 31.000 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.0000000 31.00 0.000000 32.00 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 31.0000000 31.0000000 31.0000000 31.00000000 31.0000000 31.0000000 31.0000000 31.0000000 31.0000000 31.000000000 31.00000000 31.000000000 31.000000000 31.0000000000	28. 00		ed and observation bed ch	narges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.000000 31.00 0.000000 31.00 0.000 32.00 0.000 33.00 0.000 33.00 0.000 34.00 0.000 36.00						1
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00			÷ line 28)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 33.00 0.00 34.00 0.00 35.00 0.00 36.00			. 11116 20)			1
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 0 36.00						
36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00				ctions)		
		, , ,	ine 31)			1
			and private room cost di	fferential (line		

	PART I - ALL PROVIDER COMPONENTS INDATIENT DAYS		
1 00	INPATIENT DAYS	66 244	1. 00
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	66, 344	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	66, 344	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4 00	do not complete this line.	44 241	4 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	66, 261	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period	0	, 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period	_	
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	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	45, 608	9. 00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	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	0	11.00
	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)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically 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)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	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)	90, 719, 689	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
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	0	25. 00
	x line 20)		
26.00	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)	90, 719, 689	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	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	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 + line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)		32. 00
	Average semi-private room per diem charge (line 30 ÷ line 4)		
			33.00
	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0 710 (00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	90, 719, 689	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 367. 41	
39.00	Program general inpatient routine service cost (line 9 x line 38)	62, 364, 835	39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	62, 364, 835	41.00

44.00 COROMARY CARE UNIT		Financial Systems	COMMUNITY MEDIC				u of Form CMS-	
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provider Co	F	rom 01/01/2024	Date/Time Pre	pared:
Cost Center Description				Title	XVIII	Hospi tal		30 aiii
1.00 2.00 3.00 4.00 5.00 2.00 3.00 4.00 5.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00		Cost Center Description		Total	Average Per Diem (col. 1 ÷	Program Days	Program Cost (col. 3 x col.	
14.00			1 00	2 00		4 00		
1.200 MTRENIVE CARE UNIT	42.00	NURSERY (title V & XIX only)						42. 00
		INTENSIVE CARE UNIT	58, 399, 995	45, 965	1, 270. 53	2, 907	3, 693, 431	1
1.00	45.00	BURN INTENSIVE CARE UNIT	7 068 908	3 574	1 077 87	1 556	3 077 566	45. 00
48.00 Program Inpatient anciliary service cost (West. D-3, col. 3, line 200) 1.00 1.0		OTHER SPECIAL CARE (SPECIFY)	7,000,700	3, 374	1, 777. 07	1, 330	3,077,300	47. 00
Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, Line 10, column 1)		·					1. 00	
17.7913,068 000							1	•
50.00 Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts II and 4,139,015 50.00 for Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 3,404,702 51.00 for Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 3,404,702 51.00 for Pass II 4,404,704 51.00 for Pass II 4,404,704,704 51.00 for Pass II 4,404,704,704 51.00 for Pass II 4,404,704,704,704,704,704,704,704,704,70		Total Program inpatient costs (sum of lines				column 1)		1
51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D., sum of Parts II 3,404,702 51.00 Intal Program excludable cost (sum of Fines 50 and 51) Total Program excludable cost (sum of Fines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical coucation costs (fine 49 minus fine 52) 120,369,351 30.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical coucation costs (fine 49 minus fine 52) 100,369,351	50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, sum	of Parts I and	4, 139, 015	50.00
17.543_717 22.00 27.543_717 27.543_717	51.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	um of Parts II	3, 404, 702	51.00
medical education costs (line 49 minus line 52)		Total Program excludable cost (sum of lines						1
54.00 Program discharges 5.01 Target amount per discharge 5.01 Permanent adjustment amount per discharge 5.01 Permanent adjustment amount per discharge 5.02 Adjustment amount per discharge 5.02 Adjustment amount per discharge (contractor use only) 5.03 Adjustment amount per discharge (contractor use only) 5.04 Adjustment amount per discharge (contractor use only) 5.05 Adjustment amount per discharge (contractor use only) 5.06 Discharge amount (file 16 4 x sum of lines 55, 55, 51, and 55, 02) plus line 55, 03) 6.07 Target amount (file 16 4 x sum of lines 54, 55, 51, and 55, 02) plus line 55, 03) 6.08 Bonus payment (see instructions) 6.09 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Difference dosts (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, no. 03 8.00 6.00 Difference dosts (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, no. 03 8.00 6.00 Difference between adjusted in patient for line 54 or line 55 from the cost reporting period ending 1996, no. 03 8.00 6.00 Difference between adjusted by the market basket) 6.10 Difference between adjusted by the market basket) 6.10 Difference between adjusted lines 54 or line 54 or line 55 from the cost reporting period ending 1996, no. 03 8.00 6.10 Difference between adjusted lines 54 or line 54 is less than the lowest of lines 55 plus 55, 01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 55, 01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 55, 01, or line 59, or line 60, enter the lesser of 50% of the target amount (line 56), otherwise enter zero. (see instructions) 6.10 Relication MPATIENT MOUTH SM MED COST 10 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	53.00	medical education costs (line 49 minus line		ated, non-phy	sician anesth	etist, and	120, 369, 351	53.00
55.00 Target amount per discharge 0.00 55.01 Permanent adjustment amount per discharge 0.00 55.01 Permanent adjustment amount per discharge (contractor use only) 0.00 55.03 CART - cell amount paid as an interlin payment 0.00 55.03 CART - cell amount paid as an interlin payment 0.00 55.03 CART - cell amount paid as an interlin payment 0.00 55.03 CART - cell amount paid as an interlin payment 0.00 55.05 CART	54.00						0	54.00
55.02 Adjustment amount per discharge (contractor use only) 0.00 55.05 0.00 Cart-cell amount paid as an interin payment 0.55.05 0.00 Cart-cell amount (((ine 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03) 0.56.00 Cart-cence between adjusted inpatient operating cost and target amount ((line 56 minus line 53) 0.57.00 0.57.00 0.00 Cart-cence between adjusted inpatient operating cost and target amount ((line 56 minus line 53) 0.57.00 0.57.00 0.00								
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81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		00 0				us line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 88.00 PASS THROUGH COST		,		242.01		, ,		81.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 84.00 85.00 PASS THROUGH COST		Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 85.00 Bed instructions (see instructions) 86.00 PAGE INSTRUCTION BED PASS THROUGH COST)				83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				c)				84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		1	•					1
	55.00			-agii 00)			1	1 55.00
	87.00						83	87. 00

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 31-0041 Peri od:			Worksheet D-1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 ÷	· line 2)			1, 367. 41	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				113, 495	89. 00
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	5, 531, 115	90, 719, 689	0. 06096	9 113, 495	6, 920	90.00
91.00 Nursing Program cost	0	90, 719, 689	0. 00000	0 113, 495	l ol	91.00
92.00 Allied health cost	0	90, 719, 689	0.00000	0 113, 495	o	92.00
93.00 All other Medical Education	0	90, 719, 689	0.00000	0 113, 495	ol	93.00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Period: From 01/01/2024	Worksheet D-1
	Component CCN: 31-5490		
	Title XVIII	Skilled Nursing	PPS
		Facility	

		Facility		
	Cost Center Description			
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)	6, 859	1. 00
2.00	Inpatient days (including private room days, excluding swing-		6, 859	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only private room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)	6, 859	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		0	5. 00
	reporting period			
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n days) through December 31 of the cost	0	7. 00
7.00	reporting period	augs) through becomber of or the cost	· ·	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	and a Barraga Caraba Barraga Caraba Land	4.057	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding swing-bed and	4, 056	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instruc			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		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)		0	12. 00
.2.00	through December 31 of the cost reporting period	(in y (iner during private reem daye)	Ü	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 Program		0	14 00
14. 00 15. 00	Total nursery days (title V or XIX only)	dili (excluding swing-bed days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)		0	16. 00
	SWING BED ADJUSTMENT			
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 Medicare rate for swing-bed SNF services applicable to service	as after December 31 of the cost	0.00	18. 00
10.00	reporting period	as arter becomes or or the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the cost	0.00	20. 00
20.00	reporting period	arter becomber 31 or the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions		8, 587, 342	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting period (line 6	0	23. 00
20.00	x line 18)	or or the east rapertring parrou (rine o	· ·	20.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December;	21 of the cost reporting period (line 9	0	25. 00
25.00	x line 20)	or the cost reporting perrod (Time 8	O	25.00
26.00	Total swing-bed cost (see instructions)		0	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)	8, 587, 342	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30. 00
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 mi	nus lina 33)(saa instructions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost differential (line	8, 587, 342	37. 00
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see			38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		39. 00
40.00	Medically necessary private room cost applicable to the Progra	,		40.00
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)		41. 00

COMPUT	Financial Systems	COMMUNITY MEDI				u of Form CMS-	
	ATION OF INPATIENT OPERATING COST			CN: 31-0041 CCN: 31-5490	Peri od: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Pre 5/28/2025 10:	pared
			Ti tl e	e XVIII	Skilled Nursing	PPS	30 aiii
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Costli		col . 2)		(col. 3 x col. 4)	
12.00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42.0
43. 00	Intensive Care Type Inpatient Hospital Unit: INTENSIVE CARE UNIT	S					43.0
	CORONARY CARE UNIT						44. 0
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. C
	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description				·	1. 00	
	Program inpatient ancillary service cost (W					1.00	48.0
	Program inpatient cellular therapy acquisit Total Program inpatient costs (sum of lines), column 1)		48. (
7.00	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,			49. (
0.00	Pass through costs applicable to Program in III)	patient routine s	ervi ces (fro	m Wkst. D, su	um of Parts I and		50.0
51. 00	Pass through costs applicable to Program in and IV)	patient ancillary	services (f	rom Wkst. D,	sum of Parts II		51. (
52. 00	Total Program excludable cost (sum of lines	50 and 51)					52.0
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		ated, non-phy	ysician anest	thetist, and		53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
	Program di scharges						54.0
	Target amount per discharge Permanent adjustment amount per discharge						55. 55.
	Adjustment amount per discharge (contractor	use only)					55.
	CAR T-cell amount paid as an interim paymen			F 00)			55.
	Target amount ((line 54 x sum of lines 55, Difference between adjusted inpatient opera				s Line 53)		56. 57.
	Bonus payment (see instructions)	tring oddit and tar	got amount (58.
9. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost rep	orting period	d endi ng 1996,		59.
50.00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54		prior year	cost report,	updated by the		60.
1 00	market basket)	F2 Line F4	_				(1)
51. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le						61.0
	53) are less than expected costs (lines 54						
52. 00	enter zero. (see instructions) Relief payment (see instructions)						62.
	Allowable Inpatient cost plus incentive pay	ment (see instruc	tions)				63.
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Decem	ber 31 of the	e cost report	ing period (See		64.
	instructions)(title XVIII only)	-					
5. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts after Decembe	er 31 of the	cost reportir	ng period (See		65.
6. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	4 plus line	65)(title XVI	II only); for		66.
	CAH, see instructions Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost r	reporting period		67. (
57 00	(line 12 x line 19)	-					
	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after De	ecember 31 of	the cost rep	porting period		68.0
	Total title V or XIX swing-bed NF inpatient						69. (
8. 00		NUDCINC EACLITY	AND ICF/IID		7)	0 507 242	70
8. 00 9. 00	PART III - SKILLED NURSING FACILITY, OTHER I				')	8, 587, 342 1, 251. 98	
8. 00 9. 00 0. 00		lity/ICF/IID rout	ine service				
8. 00 9. 00 0. 00 1. 00 2. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line	lity/ICF/IID rout cost per diem (li 71)	ine service ne 70 ÷ line	2)		5, 078, 031	1
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost appli	lity/ICF/IID rout cost per diem (li 71) cable to Program	ine service ne 70 ÷ line (line 14 x l	2) ine 35)		0	73.
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line	lity/ICF/IID rout cost per diem (li 71) cable to Program vice costs (line	ine service ne 70 ÷ line (line 14 x l 72 + line 73	2) ine 35)	Part II, column		73. 74.
68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost appli Total Program general inpatient routine ser Capital-related cost allocated to inpatient 26, line 45)	lity/ICF/IID rout cost per diem (li 71) cable to Program vice costs (line routine service	ine service ne 70 ÷ line (line 14 x l 72 + line 73	2) ine 35)	Part II, column	0 5, 078, 031 0	73. (74. (75. (
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost appli Total Program general inpatient routine ser Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ l	lity/ICF/IID rout cost per diem (li 71) cable to Program vice costs (line routine service ine 2)	ine service ne 70 ÷ line (line 14 x l 72 + line 73	2) ine 35)	Part II, column	0 5, 078, 031 0 0. 00	73. 74. 75.
98. 00 99. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost appli Total Program general inpatient routine ser Capital-related cost allocated to inpatient 26, line 45)	lity/ICF/IID rout cost per diem (li 71) cable to Program vice costs (line routine service ine 2) e 76)	ine service ne 70 ÷ line (line 14 x l 72 + line 73	2) ine 35)	Part II, column	0 5, 078, 031 0	73. 74. 75. 76. 77.
88. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 7. 00 8. 00 9. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost appli Total Program general inpatient routine ser Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ I Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce	lity/ICF/IID rout cost per diem (li 71) cable to Program vice costs (line routine service ine 2) e 76) us line 77) ss costs (from pr	ine service ne 70 ÷ line (line 14 x l 72 + line 73 costs (from)	2) ine 35)) Worksheet B,		0, 078, 031 0 0. 00 0 0 0	73. 74. 75. 76. 77. 78. 79.
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost appli Total Program general inpatient routine ser Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ I Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce Total Program routine service costs for com	lity/ICF/IID rout cost per diem (li 71) cable to Program vice costs (line routine service ine 2) e 76) us line 77) ss costs (from pr parison to the co	ine service ne 70 ÷ line (line 14 x l 72 + line 73 costs (from)	2) ine 35)) Worksheet B,		0, 078, 031 0 0. 00 0 0 0	73. 74. 75. 76. 77. 78. 79. 80.
88. 00 99. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00 11. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 00 18. 00 19. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost appli Total Program general inpatient routine ser Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ I Program capital-related costs (line 74 min Aggregate charges to beneficiaries for exce Total Program routine service cost for com Inpatient routine service cost per diem lim	lity/ICF/IID rout cost per diem (li 71) cable to Program vice costs (line routine service ine 2) e 76) us line 77) ss costs (from pr parison to the co	ine service ne 70 ÷ line (line 14 x l 72 + line 73 costs (from)	2) ine 35)) Worksheet B,		0, 078, 031 0 0. 00 0 0 0	73. 74. 75. 76. 77. 78. 79. 80. 81.
68. 00 69. 00 70. 00 71. 00 72. 00 74. 00 75. 00 76. 00 78. 00 79. 00 79. 00 80. 00 81. 00 82. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost appli Total Program general inpatient routine ser Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ I Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce Total Program routine service costs for com	lity/ICF/IID rout cost per diem (li 71) cable to Program vice costs (line routine service ine 2) e 76) us line 77) ss costs (from pr parison to the coitation line 9 x line 81)	ine service ne 70 ÷ line (line 14 x l 72 + line 73 costs (from)	2) ine 35)) Worksheet B,		0, 078, 031 0 0. 00 0 0 0 0 0 0	73. 74. 75. 76. 77. 78. 79. 80. 81. 82.
71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 30. 00 31. 00 32. 00 33. 00 34. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci Adjusted general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost appli Total Program general inpatient routine ser Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ I Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce Total Program routine service cost per diem lim Inpatient routine service cost per diem lim Inpatient routine service cost limitation (lity/ICF/IID rout cost per diem (li 71) cable to Program vice costs (line routine service ine 2) e 76) us line 77) ss costs (from pr parison to the coitation line 9 x line 81) (see instructions)	ine service one 70 ÷ line (line 14 x l 72 + line 73 costs (from) rovider recordest limitation	2) ine 35)) Worksheet B,		0, 078, 031 0 0. 00 0 0 0 0 0 0 0 0. 00	73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83.

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0041 Period: Wo			Worksheet D-1	
		Component (CCN: 31-5490	To 12/31/2024	Date/Time Pre 5/28/2025 10:	pared: 36 am_
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1. 00	
PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
87.00 Total observation bed days (see instructions)				0	87. 00
88.00 Adjusted general inpatient routine cost per		: line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			0	89. 00
Cost Center Description	Cost	Routine Cost	col umn 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	0	0	0. 00000	0 0	0	90.00
91.00 Nursing Program cost	o	0	0. 00000	0 0	0	91.00
92.00 Allied health cost	O	0	0. 00000	00	0	92.00
93.00 All other Medical Education	o	0	0. 00000	00	0	93. 00

OMPUT	ITION OF INPATIENT OPERATING COST	Provi der CCN: 31-0041	Peri od: From 01/01/2024	Worksheet D-1	
			To 12/31/2024	Date/Time Pre 5/28/2025 10:	pared: 36 am
	Cost Center Description	Title XIX	Hospi tal	TEFRA	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				-
. 00	NPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs excluding newborn)		66, 344	1.00
2. 00	Inpatient days (including private room days, excluding swing	-bed and newborn days)		66, 344	
. 00	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	rivate room days,	0	3.00
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation	hed days)		66, 261	4.00
00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	00, 201	5. 00
	reporting period	3 ,			
00	Total swing-bed SNF type inpatient days (including private re reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6. 00
00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7.00
	reporting period	3 /			
00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8.00
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excludin	a swina-bed and	1, 198	9.00
	newborn days) (see instructions)			•	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.00
. 00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year,	enter O on this line)			
00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	12.00
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar)	year, enter 0 on this li	ne)	_	
. 00	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	
5. 00 5. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			4, 236 2, 116	
00	SWING BED ADJUSTMENT			2,	
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0. 00	17. 00
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servi	res after December 31 of	the cost	0.00	18. 00
. 00	reporting period		1110 0031	0.00	10.00
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0. 00	19. 00
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20.00
00	reporting period	es arter becomber 51 or	the cost	0.00	20.00
. 00	Total general inpatient routine service cost (see instruction			90, 719, 678	
. 00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	ber 31 of the cost repor	ting period (line	0	22.00
3. 00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23. 00
	x line 18)	•			
. 00	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	er 31 of the cost report	ing period (line	0	24.00
. 00	7 x fille 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25. 00
	x line 20)				
. 00	Total swing-bed cost (see instructions)	(11 21 -1 11 2/)		00 710 (70	
7. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		90, 719, 678	27.00
. 00	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	28. 00
. 00	Private room charges (excluding swing-bed charges)		-	0	29. 00
. 00	Semi-private room charges (excluding swing-bed charges)	11 20)		0	30.00
. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m	inus lino 22)/ccc inct	ctions)	0.00	
. 00	Average per diem private room cost differential (line 32 m Average per diem private room cost differential (line 34 x l	, ,	CLI 0113)	0. 00 0. 00	
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1.00 10tal 110glam general impatient routine service cost (1116 37 + 1116 40)				
	- 1.00	Total Trogram general Impatrent routine service cost (Time 37 + Time 40)	1,000,107	- 1.00

MPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN:	Fr	eriod: fom 01/01/2024	Worksheet D-1	
				To		Date/Time Prep 5/28/2025 10:3	
	Cost Center Description	Total	Title X	Verage Per	Hospital Program Days	TEFRA Program Cost	
	oost contor bescription		npatient DaysDie		rrogram bays	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	1. 00 6, 031, 369	2. 00 4, 236	1, 423. 84	2, 116	3, 012, 845	42.
	Intensive Care Type Inpatient Hospital Units						
3.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	58, 399, 995	45, 965	1, 270. 53	975	1, 238, 767	43. 44.
1. 00 5. 00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT	7, 068, 908	3, 574	1, 977. 87	O	0	
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
	·					1. 00	
. 00	Program inpatient ancillary service cost (Wk					2, 456, 895	
i. 01	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	0 8, 346, 664	
. 00	PASS THROUGH COST ADJUSTMENTS	41 through 46.0	i) (see Thistruction)IIS)		0, 340, 004	47
. 00	Pass through costs applicable to Program inp	oatient routine s	services (from Wi	kst. D, sum	of Parts I and	322, 124	50.
. 00	<pre>III) Pass through costs applicable to Program inp</pre>	nationt ancillar	, sarvicas (from	Wket D en	m of Darts II	147, 035	51
. 00	and IV)	atrent anciriar	y services (Trolli	WKSt. D, Sui	11 01 141 13 11	147,033	31
. 00	Total Program excludable cost (sum of lines					469, 159	
. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	J 1	ated, non-physic	cian anesthe	tist, and	7, 877, 505	53
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program di scharges					527	
. 00 . 01	Target amount per discharge Permanent adjustment amount per discharge					4, 731. 79 0. 00	
.02	Adjustment amount per discharge (contractor	use only)				0.00	
03	CAR T-cell amount paid as an interim payment					0	55
00	Target amount ((line 54 x sum of lines 55, 5		2, 493, 653				
00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tai	rget amount (line	3 56 minus I	ne 53)	-5, 383, 852 0	
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost reporti	ng period e	ndi ng 1996,	0. 00	
	updated and compounded by the market basket)			.			
. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	n prior year cos	report, up	dated by the	0. 00	60
. 00	Continuous improvement bonus payment (if lir	ne 53 ÷ line 54 i	s less than the	lowest of I	ines 55 plus	0	61
	55.01, or line 59, or line 60, enter the les						
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	(60), or 1 % of	the target amou	it (line 56)	otherwise		
. 00	Relief payment (see instructions)					249, 365	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			3, 212, 177	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	nher 31 of the co		n period (See	0	64
. 00	instructions)(title XVIII only)	res em ough boool		zat roporting	j per rou (oce	Ĭ	"
. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the cos	t reporting	period (See	0	65
. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line o	64 plus line 65)	title XVIII	only): for	o	66
	CAH, see instructions		7. p. do	ti ti o ziiii	3 377		
. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 of	the cost rep	orting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routir	ne costs after De	ecember 31 of the	e cost repor	tina period	o	68
	(line 13 x line 20)			·	3 1		
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69
. 00	Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service of		ne 70 ÷ line 2)	,			71
. 00	Program routine service cost (line 9 x line	,	71.1 · · · · · · · · · · · · · · · · · ·	05)			72
00	Medically necessary private room cost application of the program general inpatient routine serv			35)			73
00	Capital -related cost allocated to inpatient	•	,	ksheet B, Pa	rt II, column		75
00	26, line 45)	no 2)					١,,,
00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76 77
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces	ss costs (from p					79
00	Total Program routine service costs for comp		ost limitation (ine 78 minu	s line 79)		80
00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81
. 00	Reasonable inpatient routine service costs (83
00	Program inpatient ancillary services (see in	nstructions)	,				84
	Utilization review - physician compensation	(see instruction	ns)				85
. 00	Total Program inpatient operating costs (sun	•	•		l		86

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2024 To 12/31/2024		
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 +	: line 2)			1, 367. 41	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				113, 495	89. 00
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	5, 531, 115	90, 719, 678	0. 060969	9 113, 495	6, 920	90.00
91.00 Nursing Program cost	0	90, 719, 678	0. 000000	0 113, 495	0	91.00
92.00 Allied health cost	0	90, 719, 678	0. 000000	0 113, 495	0	92.00
93.00 All other Medical Education	О	90, 719, 678	0. 000000	113, 495	0	93. 00

Health Financial Systems CC	MMUNITY MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 31-0041	Peri od:	Worksheet D-3	
			From 01/01/2024		
			To 12/31/2024	Date/Time Pre	
	T: +1 o	XVIII	Hooni tol	5/28/2025 10: PPS	<u>36 am</u>
Cost Conton Description	IIIIE	Ratio of Cos	Hospi tal		
Cost Center Description				Inpatient Program Costs	
		To Charges	Program Charges	(col. 1 x col.	
			Charges	2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			237, 681, 268		30.00
31.00 03100 INTENSIVE CARE UNIT			214, 996, 644		31.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T			20, 453, 045		34.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		,			
50. 00 05000 OPERATI NG ROOM		0. 25351	9 21, 505, 566	5, 452, 070	50.00
51.00 05100 RECOVERY ROOM		0. 16929		603, 475	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 31138	3 51, 923	16, 168	52.00
52.01 03190 OP INFUSION		0. 18329	7 40, 327	7, 392	52. 01
53. 00 05300 ANESTHESI OLOGY		0. 04553	6 4, 151, 116	189, 025	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21726	8 15, 280, 323	3, 319, 925	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12554	8 1, 447, 256	181, 700	55.00
56. 00 05600 RADI OI SOTOPE		0. 35466	1, 088, 570	386, 073	56.00
57.00 05700 CT SCAN		0. 03704	8 32, 605, 101	1, 207, 954	57.00
58. 00 05800 MRI		0. 06819	7 8, 847, 870	603, 398	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 12376		1, 870, 030	59.00
60. 00 06000 LABORATORY		0. 12075		6, 853, 476	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 13213		3, 534, 012	
66. 00 06600 PHYSI CAL THERAPY		0. 24677		1, 825, 866	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 16871		899, 110	1
68. 00 06800 SPEECH PATHOLOGY		0. 15186		278, 274	
69. 00 06900 ELECTROCARDI OLOGY		0. 05908		944, 568	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 32326		430, 879	
70. 01 07001 SLEEP LAB		0.00000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 23342		8, 276, 933	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 72809		7, 344, 533	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 71609		8, 132, 460	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 35478		403	
76.98 07698 HYPERBARI C OXYGEN THERAPY 77.00 07700 ALLOGENEI C STEM CELL ACQUISITION		0. 13290 0. 00000		703 0	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000		0	
OUTPATIENT SERVICE COST CENTERS		0.00000	o o	0	76.00
90. 00 09000 CLINIC		0. 06541	3 126, 399	8, 268	90.00
91. 00 09100 EMERGENCY		0. 09668		5, 678, 631	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 16673		18, 633	1
92. 01 09201 OBSERVATION BEDS-DISTINCT		0. 08429		713, 277	
OTHER REIMBURSABLE COST CENTERS		3.00427	5, 401, 301	110,211	1 /2.01
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 t	hrough 98)	1	314, 668, 181	58, 777, 236	
201.00 Less PBP Clinic Laboratory Services-Progra	9 ,	İ	0	,	201.00
202.00 Net charges (line 200 minus line 201)	J = 3-2 (01)	1	314, 668, 181		202.00
		•		•	•

NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT P	rovi der C	CN: 31-0041	Peri od:	Worksheet D-3	
	c	omponent	CCN: 31-5490	From 01/01/2024 To 12/31/2024	Date/Time Pre 5/28/2025 10:	
		Titl∈	e XVIII	Skilled Nursing Facility	PPS	<u>00 a.</u>
	Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	ATLENT ROUTINE SERVICE COST CENTERS					
	DO ADULTS & PEDIATRICS					30.
	DO INTENSIVE CARE UNIT					31.
	DO SURGICAL INTENSIVE CARE UNIT DO NURSERY					34.
	LLARY SERVICE COST CENTERS					43.
	OO OPERATING ROOM		0. 2535	19 0	0	50.
	OO RECOVERY ROOM		0. 1692		l o	
	DO DELIVERY ROOM & LABOR ROOM		0. 3113		0	52.
2. 01 0319	90 OP INFUSION		0. 1832	97 6, 002	1, 100	52.
3.00 0530	DO ANESTHESI OLOGY		0. 0455	36 0	0	53.
	DO RADI OLOGY-DI AGNOSTI C		0. 2172	·	14, 167	
	DO RADI OLOGY-THERAPEUTI C		0. 1255		0	1
	DO RADI OI SOTOPE		0. 3546		848	
	DO CT SCAN DO MRI		0. 0370 0. 0681		0	
	DO CARDI AC CATHETERI ZATI ON		0. 0681			
	OO LABORATORY		0. 1207		109, 350	
- 1	DO BLOOD STORING, PROCESSING & TRANS.		0.0000	·	0	1
	00 RESPIRATORY THERAPY		0. 1321		11, 784	65
5. 00 0660	DO PHYSI CAL THERAPY		0. 2467	74 10, 142	2, 503	66
	OO OCCUPATI ONAL THERAPY		0. 1687		22, 650	
	OO SPEECH PATHOLOGY		0. 1518		3, 435	
	DO ELECTROCARDI OLOGY		0. 0590		892	
	DO ELECTROENCEPHALOGRAPHY		0. 3232		738	
	ON SLEEP LAB		0.0000		0	
	DO MEDICAL SUPPLIES CHARGED TO PATIENT DO IMPL. DEV. CHARGED TO PATIENTS		1. 2334: 0. 7280		1, 642 0	
	DO DRUGS CHARGED TO PATIENTS		0. 7160		164, 561	
	97 CARDI AC REHABI LI TATI ON		0. 3547		0	1
	98 HYPERBARI C OXYGEN THERAPY		0. 1329		Ō	
	OO ALLOGENEIC STEM CELL ACQUISITION		0.0000		0	77
3. 00 0780	DO CAR T-CELL IMMUNOTHERAPY		0.0000	00 0	0	78
	PATIENT SERVICE COST CENTERS					
	DO CLINIC		0. 0654		l	
1	DO EMERGENCY		0. 0966		0	
	OO OBSERVATION BEDS (NON-DISTINCT PART		0. 1667		0	
	D1 OBSERVATION BEDS-DISTINCT		0. 0842	96 0	0	92
	ER REIMBURSABLE COST CENTERS DO AMBULANCE SERVICES					95
00 0950 00. 00	Total (sum of lines 50 through 94 and 96 through 98)			1, 483, 858	333, 670	
01.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		1, 403, 030	333,070	201
02. 00	Net charges (line 200 minus line 201)		1	1, 483, 858		202

Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS 0.00 O3000 ADULTS & PEDIATRICS 1.00 O3100 INTENSIVE CARE UNIT	Titl		From 01/01/2024 To 12/31/2024 Hospi tal t Inpatient Program Charges		parec 36 am
INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS	Ti tl	Ratio of Cos	t Inpatient Program	TEFRA Inpatient	
INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS			Program		
0. 00 03000 ADULTS & PEDI ATRI CS		To Charges		Program Costs	
0. 00 03000 ADULTS & PEDI ATRI CS			Charges	, , , , , , , , , , , , , , , , , , , ,	
0. 00 03000 ADULTS & PEDI ATRI CS				(col. 1 x col.	
0. 00 03000 ADULTS & PEDI ATRI CS				2)	
0. 00 03000 ADULTS & PEDI ATRI CS		1.00	2. 00	3. 00	_
		I	0 (00 570		1 20 /
1.00 U3100 INTENSIVE CARE UNIT			9, 689, 570		30.0
4.00 03400 SURGICAL INTENSIVE CARE UNIT			10, 772, 547 23, 147		34. (
3. 00 04300 NURSERY			1, 140, 487		43. (
ANCI LLARY SERVI CE COST CENTERS			1, 140, 407		J 45. \
0.00 O5000 OPERATING ROOM		0. 25351	9 791, 699	200, 711	50.
1.00 05100 RECOVERY ROOM		0. 16929	· ·		
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 31138		143, 820	
2.01 03190 OP INFUSION		0. 18329		0	52.
3. 00 05300 ANESTHESI OLOGY		0. 04553	5 241, 694	11, 006	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21726	7 581, 768	126, 399	54.
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12554	8 66, 342	8, 329	55.
6. 00 05600 RADI OI SOTOPE		0. 35466	1 66, 777	23, 683	56.
7.00 05700 CT SCAN		0. 03704			
8. 00 05800 MRI		0. 06819	· ·		
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 12376		99, 120	
0.00 06000 LABORATORY		0. 12075		l .	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	
5. 00 06500 RESPIRATORY THERAPY		0. 13213			
6.00 06600 PHYSI CAL THERAPY		0. 24677	· ·	43, 914	
7. 00 06700 0CCUPATI ONAL THERAPY 8. 00 06800 SPEECH PATHOLOGY		0. 16871	· ·		
9. 00 06900 ELECTROCARDI OLOGY		0. 15186 0. 05887			
0. 00 07000 ELECTROCARDI OLOGI 0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 32326			
0. 01 07001 SLEEP LAB		0. 00000		32,022	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 23342		1	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 72809		l	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 71609	·	555, 846	
6. 97 O7697 CARDI AC REHABI LI TATI ON		0. 35478		1	1
6. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 13290		0	1
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000		0	77.
8.00 07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	0 0	0	78.
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLI NI C		0. 06541			
1.00 09100 EMERGENCY		0. 09668		192, 942	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 16673		0	1
2. 01 09201 0BSERVATI ON BEDS-DI STI NCT		0. 08429	6 205, 262	17, 303	92.
OTHER REIMBURSABLE COST CENTERS		1			4
5. 00 09500 AMBULANCE SERVICES			10 550		95.
Total (sum of lines 50 through 94 and 96 through 98)	(1.1		13, 558, 999	2, 456, 895	
01.00 Less PBP Clinic Laboratory Services-Program only charges 02.00 Net charges (line 200 minus line 201)	(IIne 61)		13, 558, 999		201. 202.

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	Peri od: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 5/28/2025 10:36 am

	Title XVIII Hospital	5/28/2025 10: PPS	36 am
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	73, 369, 057	
1. 02	Instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	24, 223, 350	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octobe 1 (see instructions)	er 0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2. 03 2. 04	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	369, 805 5, 687	1
3. 00	Managed Care Simulated Payments	72, 815, 118	3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment	429. 77	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending of perfore 12/31/1996. (see instructions)	on 0. 00	5. 00
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0. 00 0. 00	1
6. 26	new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0.00	6. 26
7. 00	the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7. 00
7. 01	ACA \S 5503 reduction amount to the IME cap as specified under 42 CFR \S 412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cospeport straddles July 1, 2011, see instructions.	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital lunder § 5506 of ACA. (see instructions)	0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see linstructions)	0.00	8. 21
8. 28	The amount of increase if the hospital was awarded FTE cap slots under §4122 of the CAA 2023 (see instructions)		8. 28
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.28 (see instructions)	0.00	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current year from your records FTE count for residents in dental and podiatric programs.	0. 00 8. 47	1
	Current year allowable FTE (see instructions)	•	12.00
13.00	Total allowable FTE count for the prior year.		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997 otherwise enter zero.	4. 43	14.00
15.00	Sum of lines 12 through 14 divided by 3.	6. 67	
16. 00 17. 00	Adjustment for residents in initial years of the program (see instructions) Adjustment for residents displaced by program or hospital closure	84. 54	16. 00 17. 00
	Adjusted rolling average FTE count		18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 212230	
	Prior year resident to bed ratio (see instructions)	0. 224094	
21.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)	0. 212230 10, 680, 318	
22. 01	IME payment adjustment - Managed Care (see instructions)	7, 968, 741	
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
24. 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre>	0.00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25. 00
26.00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	
	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)	0.000000	ı
	IME add-on adjustment amount - Managed Care (see instructions)	0	ı
	Total IME payment (sum of lines 22 and 28)	10, 680, 318	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	7, 968, 741	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1. 62	30.00
31.00	Percentage of Medicaid patient days (see instructions)	12. 27	31.00
32. 00	Sum of lines 30 and 31	13. 89	32. 00

	Financial Systems COMMUNITY MEDICATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	wof Form CMS-2 Worksheet E Part A Date/Time Pre 5/28/2025 10:	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	Allowable disproportionate share percentage (see instruction Disproportionate share adjustment (see instructions)	ns)			33. 00 34. 00
			Prior to 10/1		
	Uncompensated Care Payment Adjustment		1.00	2. 00	
35. 00 35. 01 35. 02	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital UCP, including supplemental UCP (see instructions)		0. 000000000 0. 0000000000	0. 000000000 0	35. 00 35. 01 35. 02
35. 03 36. 00	Pro rata share of the hospital UCP, including supplemental L Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	JCP (see Instructions)	0	0	35. 03 36. 00
00.00	Additional payment for high percentage of ESRD beneficiary d	lischarges (lines 40 thro			00.00
40. 00 41. 00	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0		40. 00 41. 00
41. 00	Total ESRD Medicare covered and paid discharges (see instruc	ctions)	0		41. 00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42.00
43. 00 44. 00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		43. 00 44. 00
45.00	days) Average weekly cost for dialysis treatments (see instruction		0.00		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 4 Subtotal (see instructions)	11.01)	108, 648, 217		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	0		48. 00
	, , , , , , , , , , , , , , , , , , ,			Amount	
49. 00	Total payment for inpatient operating costs (see instruction	15)		1. 00 116, 616, 958	49 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a	•)	8, 405, 393	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	The 49 See Instructions)	,	6, 395, 745 78, 594	52. 00 53. 00
54.00	Special add-on payments for new technologies			11, 372	54. 00
54. 01	Islet isolation add-on payment	(0)		0	54. 01
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions)	69)		0	55. 00 55. 01
56.00	Cost of physicians' services in a teaching hospital (see int	ructions)		0	56. 00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, col. 11 line 200)		23, 770 131, 531, 832	58. 00 59. 00
60.00	Primary payer payments			28, 618	
61.00	Total amount payable for program beneficiaries (line 59 minu	ıs line 60)		131, 503, 214	61. 00
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			9, 213, 088 536, 512	
	Allowable bad debts (see instructions)			1, 288, 996	
65.00	Adjusted reimbursable bad debts (see instructions)			837, 847	65. 00
66.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		446, 910	
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (see instructions)	122, 591, 461 0	67. 00 68. 00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	69. 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. 00
70.50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70. 50
70. 75 70. 76	N95 respirator payment adjustment amount (see instructions) Essential medicines payment adjustment amount (see instructi	ons)		U	70. 75 70. 76
70.87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)	structions)		0	70. 89 70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92
	HVBP payment adjustment amount (see instructions)			-601, 968	70. 93
70. 93 70. 94	HRR adjustment amount (see instructions)		l	-1, 963, 623	

ALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 31-0041	Period: From 01/01/2024	Worksheet E Part A	
			To 12/31/2024	Date/Time Pre 5/28/2025 10:	
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
0/ 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			0	1.00	70.0
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96
0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
the corresponding federal year for the period ending on or af 0.98 Low Volume Payment-3	ter 10/1)		0	0	70. 98
0.99 HAC adjustment amount (see instructions)			O	0	1
.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			120, 025, 870	
.01 Sequestration adjustment (see instructions)	,			2, 400, 517	1
.02 Demonstration payment adjustment amount after sequestration				337, 997	71. 02
.03 Sequestration adjustment-PARHM pass-throughs					71.03
2.00 Interim payments				121, 405, 723	1
2.01 Interim payments-PARHM				0	72.0
B.OO Tentative settlement (for contractor use only) B.O1 Tentative settlement-PARHM (for contractor use only)				0	73. 00
1.00 Balance due provider/program (line 71 minus lines 71.01, 71.0	12 72 and			-4, 118, 367	1
73)	72, 72, and			-4, 110, 307	74.00
1.01 Balance due provider/program-PARHM (see instructions)					74.0
5.00 Protested amounts (nonallowable cost report items) in accorda	ance with			8, 575, 815	75.00
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	OT 2. U3			0	90.00
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00 Operating outlier reconciliation adjustment amount (see instr	ructions)			0	
8.00 Capital outlier reconciliation adjustment amount (see instruc				0	
1.00 The rate used to calculate the time value of money (see instr	ructions)			0. 00	94.00
5.00 Time value of money for operating expenses (see instructions))			0	
o.00 Time value of money for capital related expenses (see instruc	ctions)			0	96.00
			Pri or to 10/1	<u>0n/After 10/1</u> 2.00	
HSP Bonus Payment Amount			1.00	2.00	
00.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment					
01.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	1
02.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102. 0
HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	102 0
03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions	-)		0.0000	0.0000	103.00
Rural Community Hospital Demonstration Project (§410A Demonst		ıstment	<u> </u>		1104.0
00.00 Is this the first year of the current 5-year demonstration pe					200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.					
Cost Reimbursement					1
01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	ne 49)				201. 0
22.00 Medicare discharges (see instructions)					202. 0
V3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first war	of the curre	nt E voor domone	tration	203. 0
period)	i iiist yeai	or the curre	int 5-year delilons	11 a 11 011	
04.00 Medicare target amount					204. 00
05.00 Case-mix adjusted target amount (line 203 times line 204)					205.00
06.00 Medicare inpatient routine cost cap (line 202 times line 205))				206. 00
Adjustment to Medicare Part A Inpatient Reimbursement					
07.00 Program reimbursement under the §410A Demonstration (see inst					207. 0
18.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	iine 59)				208. 0
09.00 Adjustment to Medicare IPPS payments (see instructions)					209. 0
0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions)	1				210. 0 211. 0
Comparision of PPS versus Cost Reimbursement					12 1 1 . 0
2.00 Total adjustment to Medicare Part A IPPS payments (from line	211)				212. 0
	,		1		213. 0
3.00 Low-volume adjustment (see instructions)					1213.0

						0 12/31/2024	Date/lime Pre 5/28/2025 10:	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement	to 10/01 3.00	On/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1. 00	1.00	2. 00	3.00	4.00	5.00	1.00
1. 01	payments DRG amounts other than outlier		73, 369, 057	0	73, 369, 057		73, 369, 057	
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	24, 223, 350	0		24, 223, 350	24, 223, 350	1. 02
1. 02	payments for discharges occurring on or after October	1. 02	21, 220, 000	0		21, 220, 000	21, 220, 000	1.02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	C		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1	1. 04	0	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		0	
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	369, 805	0	369, 805		369, 805	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	5, 687	O		5, 687	5, 687	2. 03
3. 00	Operating outlier reconciliation	2. 01	0	0	C	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	72, 815, 118	0	54, 965, 948	17, 849, 170	72, 815, 118	4. 00
F 00	Indirect Medical Education Adju		0.212220	0.212220	0.212220	0.212220		F 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 212230	0. 212230	0. 212230	0. 212230		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	10, 680, 318	0	8, 029, 363	2, 650, 955	10, 680, 318	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	7, 968, 741	0	6, 015, 364	1, 953, 377	7, 968, 741	6. 01
	Indirect Medical Education Adju	ustment for th	e Add-on for Se	ction 422 of t	he MMA	1		
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000		0. 000000		7.00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	C	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	O	С	O	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	10, 680, 318	0	8, 029, 363	2, 650, 955	10, 680, 318	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	7, 968, 741	0	6, 015, 364	1, 953, 377	7, 968, 741	9. 01
	8.01) Disproportionate Share Adjustme	ont.						1
10.00	Allowable disproportionate share percentage (see	33. 00	0.0000	0. 0000	0.0000	0.0000		10.00
11. 00	instructions) Disproportionate share	34. 00	0	0	C	0	0	11.00
11. 01	adjustment (see instructions) Uncompensated care payments Additional payment for high per	36.00	0 RD beneficiary	0 di scharges	C	0	0	11. 01
12. 00	Total ESRD additional payment	46. 00	ol	ui schai ges 0	C	O	0	12.00
	(see instructions)							
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	108, 648, 217 0	0	81, 768, 225 C	26, 879, 992 0	108, 648, 217 0	
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	116, 616, 958	0	87, 783, 589	28, 833, 369	116, 616, 958	15. 00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	8, 405, 393	0	6, 325, 618	2, 079, 775	8, 405, 393	16. 00

					1	o 12/31/2024	Date/Time Pre 5/28/2025 10:	pared:
				Title	XVIII	Hospi tal	PPS	<u> </u>
	·	W/S E, Part A		Pre/Post	Period Prior	Peri od	Total (Col 2	
		l i ne	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2. 00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54. 00	11, 372	0	11, 372	0	11, 372	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)		0	0	C	0	0	18. 00
19.00	SUBTOTAL			0	94, 120, 579	30, 913, 144	125, 033, 723	19.00
		W/S L, line	(Amounts from		.,		.,,	
			L)	0.00	2.00	4.00	F 00	
20.00	Capital DRG other than outlier	1.00	1. 00 7, 549, 847	2. 00	3. 00 5, 678, 873	4. 00 1, 870, 974	5. 00 7, 549, 847	20. 00
20. 00 20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	7, 549, 847	0		0	7, 549, 847	1
21.00	Capital DRG outlier payments	2. 00	12, 983	0	12, 983	0	12, 983	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. 0831	0. 0831	0. 0831	0. 0831		22. 00
	Indirect medical education adjustment (see instructions)	6. 00	627, 392	0	,		627, 392	
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0285	0. 0285	0. 0285	0. 0285		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	215, 171	0	161, 848	53, 323	215, 171	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	8, 405, 393	0	6, 325, 618	2, 079, 775	8, 405, 393	26. 00
		W/S E, Part A						
		line	Part A)	0.00	2.00	4.00	F 00	
07.00	I control of the state of the s	0	1. 00	2. 00	3. 00	4. 00	5. 00	07.00
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 000000	0. 000000	0	27. 00 28. 00
	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100. 00	Transfer Iow volume adjustments to Wkst. E, Pt. A.		Y					100.00

Health Financial SystemsCOMMUNITY MEDICHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Peri od:
From 01/01/2024
To 12/31/2024
Worksheet E
Part A Exhi bit 5
Date/Time Prepared: Provi der CCN: 31-0041

				10) 12/31/2024	5/28/2025 10:3	
			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	73, 369, 057	73, 369, 057		73, 369, 057	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	24, 223, 350		24, 223, 350	24, 223, 350	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O		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	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	369, 805	369, 805		369, 805	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	5, 687		5, 687	5, 687	2. 03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0 72, 815, 118	0 54, 965, 947	0 17, 849, 170	0 72, 815, 117	3. 00 4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 212230	0. 212230	0. 212230		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	10, 680, 318	8, 029, 363	2, 650, 955	10, 680, 318	6.00
6. 01	IME payment adjustment for managed care (see instructions) Indirect Medical Education Adjustment for the		7, 968, 741		1, 953, 377	7, 968, 741	6. 01
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	o	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	O	0	0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	10, 680, 318	8, 029, 363	2, 650, 955	10, 680, 318	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	7, 968, 741	6, 015, 364	1, 953, 377	7, 968, 741	9. 01
10.00	Disproportionate Share Adjustment	22.00	0.0000	0.0000	0.0000		10.00
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0.0000	0. 0000	0. 0000		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	0	0	0	0	11. 00
11.01	Uncompensated care payments	36. 00	0	0	0	0	11. 01
	Additional payment for high percentage of ESF		di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	
	Subtotal (see instructions)	47. 00	108, 648, 217	81, 768, 225	26, 879, 992	108, 648, 217	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	0	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	116, 616, 958	87, 783, 589	28, 833, 369	116, 616, 958	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	8, 405, 393	6, 325, 618	2, 079, 775	8, 405, 393	
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost		11, 372	11, 372	0	11, 372	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	0	
19. 00	SUBTOTAL			94, 120, 579	30, 913, 144	125, 033, 723	19. 00

Health Financial Systems	COMMUNITY MED	II CAI CENTER		Inlie	u of Form CMS-2	2552_10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA				Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Exhibi	t 5 pared:
		Title	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, 549, 847	5, 678, 87	3 1, 870, 974	7, 549, 847	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	.,	0	0	ı
21.00 Capital DRG outlier payments	2.00	12, 983	12, 98	3 0	12, 983	
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	. 2, , 50	.2, 70	0	0	1
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0831	0. 083	0. 0831		22. 00
23.00 Indirect medical education adjustment (see	6. 00	627, 392	471, 91	155, 478	627, 392	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0285	0. 028	0. 0285		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	215, 171	161, 84	53, 323	215, 171	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	8, 405, 393	6, 325, 61	2, 079, 775	8, 405, 393	26. 00
	Wkst. E, Pt. A, line	(Amt. from 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	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	-601, 968	-475, 21	0 -126, 758	-601, 968	30.00
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, 963, 623	-1, 408, 90	9 -554, 714	-1, 963, 623	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2. 00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0	0	32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 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 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 5/28/2025 10:36 am

		Title XVIII	Hospi tal	PPS	50 am
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			18, 588	1. 00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction	ns)		62, 531, 664 53, 677, 368	2. 00 3. 00
4. 00	OPPS or REH payments Outlier payment (see instructions)			37, 251	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruction	ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00	7. 00 8. 00
9. 00	Ancillary service other pass through costs including REH direct of	graduate medical educ	ation costs from	71, 995	9. 00
	Wkst. D, Pt. IV, col. 13, line 200			·	
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			18, 588	11. 00
	Reasonable charges				
	Ancillary service charges			26, 165	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			26, 165	14. 00
15. 00	Aggregate amount actually collected from patients liable for paym	ment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for pa		~	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only i	if line 18 exceeds li	ne 11) (see	26, 165 7, 577	
. , . 00	instructions)		, (333	,, ,,,,	. , , , ,
20.00	Excess of reasonable cost over customary charges (complete only i	fline 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			18, 588	21. 00
	Interns and residents (see instructions)			10, 300	22.00
	Cost of physicians' services in a teaching hospital (see instruct	tions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			53, 786, 614	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		I	0	25. 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24	4 (for CAH, see instr	uctions)	9, 554, 471	26.00
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			44, 250, 731	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	50)		2, 943, 290	28. 00 28. 50
	REH facility payment amount (see instructions) ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			47, 194, 021	
	Pri mary payer payments			31, 226	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1		47, 162, 795	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
	Allowable bad debts (see instructions)			786, 015	
	Adjusted reimbursable bad debts (see instructions)			510, 910	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instruct	ti ons)		454, 608	•
38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			47, 673, 705 -522	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	davicas (saa instruc	tions)	0	39. 97 39. 98
	RECOVERY OF ACCELERATED DEPRECIATION	GOVICOS (SEE THISTING	0113)	0	39. 90
	Subtotal (see instructions)			47, 674, 227	40. 00
	Sequestration adjustment (see instructions)			953, 485	1
40. 02	Demonstration payment adjustment amount after sequestration			180, 074	40. 02 40. 03
	Sequestration adjustment-PARHM pass-throughs Interim payments			43, 069, 143	
	Interim payments-PARHM			, 50 , , . 10	41. 01
	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only)			2 471 606	42.01
43.00	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			3, 471, 525	43. 00 43. 01
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	
	§115. 2	·	•		
00.00	TO BE COMPLETED BY CONTRACTOR			0	00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0. 00	
93. 00	Time Value of Money (see instructions)			0	93. 00
				_	

Health Financial Systems	COMMUNITY MEDICA	L CENTER	In Lie	of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 31-0041	Peri od: From 01/01/2024 To 12/31/2024		
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

			'	10 12/31/2024	5/28/2025 10: 3	
		Title	XVIII	Hospi tal	PPS	
	<u> </u>	Inpatier	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	T+ 1.1 * 1.1	1. 00	2.00	3. 00	4. 00	4 00
1. 00 2. 00	Total interim payments paid to provider		118, 242, 349		43, 069, 143 0	1. 00 2. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for				٥	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	06/04/2024	2, 313, 220		0	3. 01
3. 02		10/23/2024	850, 154		0	3. 02
3. 03			(0	3. 03
3. 04 3. 05			(0	3. 04 3. 05
3.00	Provider to Program)	U	3.03
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	7.5556 THERTO TO TROOTE HIS				0	3. 51
3. 52			į (0	3. 52
3. 53					0	3. 53
3.54			(0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		3, 163, 374	1	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		121, 405, 723	3	43, 069, 143	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
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		•			
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02			(0	5. 02
5.03			(0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52	Subtatal (sum of lines E O1 E 40 minus sum of lines		(0	5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				۷	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		(3, 471, 525	6. 01
6. 02	SETTLEMENT TO PROGRAM		4, 118, 36	7	0	6. 02
7. 00	Total Medicare program liability (see instructions)		117, 287, 356		46, 540, 668	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financial Systems COMM ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10 Peri od:
From 01/01/2024
To 12/31/2024
To 12 Provider CCN: 31-0041

Component CCN: 31-5490

Title XVIII						5/28/2025 10:	<u>36 am</u>
Inpatient Part A			Title	XVIII		PPS	
Total interim payments paid to provider			Innation	t Dart A		+ R	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			ripatren	it iait A	l ai	l D	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				2.00		4. 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				2, 945, 290		0	
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero 2	2.00	1 1 3 1 3		(0	2.00
### Write "NONE" or enter a zero 3.00 ADJUSTMENTS TO PROVIDER 0 0 0 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 0 0 0 3.05 Provider to Program 4.00 ADJUSTMENTS TO PROGRAM 0 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.55 3.51 3.52 0 0 0 3.55 3.53 3.54 0 0 0 0 3.55 3.53 3.54 0 0 0 0 3.55 3.55 3.50 4.00 District inter in payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) FOR COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Al so show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider FENTATIVE TO PROGRAM 0 0 5.50 5.50 FENTATIVE TO PROGRAM 0 0 0 5.50 5.50 FOR COMPLETED BY CONTRACTOR 5.01 FIENTATIVE TO PROGRAM 0 0 0 5.50 5.50 FOR COMPLETED BY CONTRACTOR 5.02 STEVELED BY CONTRACTOR 0 0 0 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 FOR COMPLETED BY CONTRACTOR 0 0 0 5.50 5.50 FOR COMPLETED BY CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR Number CONTRACTOR CONTRACTOR Number CONTRACTOR A CONTRACTOR A CONTRACTOR A CONTRACTOR A CONTRA							
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the Interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
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 3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROGRAM ADJUSTME	2 00						2 00
To the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider ADJUSTMENTS TO PROVIDER							
ADJUSTMENTS TO PROVIDER							
3.02	3. 01					0	3. 01
3. 04						0	3. 02
ADJUSTMENTS TO PROGRAM	3.03					0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.50 3.59 3.50 3.50 3.59 3.50 3.	3.04			(0	3. 04
ADJUSTMENTS TO PROGRAM	3.05			(0	3. 05
3.51 3.52 3.53 0 0 3.51 3.52 3.53 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,945,290 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR							
3.52 3.53 3.54 3.99 3.50-3.98		ADJUSTMENTS TO PROGRAM					
3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.50 3.59 3.50 3.59 3.50						-	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 0 3.54						-	
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09 3.59-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,945,290 0 4.00							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 2,945,290 0 4.00		Subtatal (sum of lines 2.01.2.40 minus sum of lines					
A. 00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 99					U	3. 99
Contractor	4 00			2 945 290		0	4 00
appropriate TO BE COMPLETED BY CONTRACTOR	1. 00			2, 710, 270	1		1.00
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		TO BE COMPLETED BY CONTRACTOR					
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVI DER							
Solution Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM S	г 01				<u></u>		 1
5.03 Provider to Program S.50 TENTATIVE TO PROGRAM O		TENTATIVE TO PROVIDER					
Provider to Program							
TENTATI VE TO PROGRAM	5.05	Provider to Program			η	0	3.03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) O 1.00 2.00	5. 50			(0	5.50
5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 6.00 Determined net settlement amount (balance due) based on 6.00 1							
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) O 1. 00 2. 00						O	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day//r) 0 1. 00 2. 00		5. 50-5. 98)					
6. 01 SETTLEMENT TO PROVIDER 481 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 0 0 7. 00 Total Medicare program liability (see instructions) 2, 945, 771 0 7. 00 Contractor NPR Date (Mo/Day/Yr)	6.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 0 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
7.00 Total Medicare program liability (see instructions) 2,945,771 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				481			
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00) 045 334	ון		
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total Medicale program Trability (see Instructions)		2, 945, 77		_	7.00
0 1.00 2.00							
			()			
	8. 00	Name of Contractor					8. 00

	Financial Systems COMMUNITY MEDICA			u of Form CMS-2	<u> 2552-10</u>	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0041	Peri od:	Worksheet E-3		
		Component CCN: 31-5490	From 01/01/2024 To 12/31/2024		narod:	
		Component Con. 31-3490	10 12/31/2024	5/28/2025 10:		
		Title XVIII	Skilled Nursing	PPS	00 4	
			Facility			
				1. 00		
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTH	ER HEALTH SERVICES FOR T	TITLE XVIII PART	A PPS SNF		
	SERVI CES					
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)					
1. 00	Resource Utilization Group Payment (RUGS)			3, 046, 606		
2.00	Routine service other pass through costs			0	2.00	
3.00	Ancillary service other pass through costs			481 3, 047, 087	3. 00 4. 00	
4. 00	4.00 Subtotal (sum of lines 1 through 3)					
	COMPUTATION OF NET COST OF COVERED SERVICES					
5. 00	Medical and other services (Do not use this line as vaccine of	costs are included in lir	ne 1 of W/S E,		5. 00	
,	Part B. This line is now shaded.)				,	
6. 00	Deducti bl e			0	6. 00	
7. 00	Coinsurance			41, 208	7. 00	
8. 00	Allowable bad debts (see instructions)			0	8. 00	
9.00	Reimbursable bad debts for dual eligible beneficiaries (see i	nstructions)		0	9.00	
10.00	Adjusted reimbursable bad debts (see instructions)			0	10.00	
11.00	Utilization review	0 1437	,	0	11.00	
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 1	0 and 11)(see instruction	ons)	3, 005, 879	12.00	
13.00	Inpatient primary payer payments			0	13.00	
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14. 00 14. 50		
	4.50 Pioneer ACO demonstration payment adjustment (see instructions)					
14. 98	1 3			0	14. 98	
	Demonstration payment adjustment amount before sequestration			0	14. 99	
	Subtotal (see instructions			3, 005, 879		
	Sequestration adjustment (see instructions)			60, 108		
	Demonstration payment adjustment amount after sequestration	0	15. 02			

15.75 Sequestration for non-claims based amounts (see instructions)
16.00 Interim payments

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

17.00 Tentative settlement (for contractor use only)

15. 75 16. 00 17. 00 18. 00

0 2, 945, 290

0

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2025 10:36 am
	Title XIX	Hospi tal	TEFRA

				5/28/2025 10:	36 am
		Title XIX	Hospi tal	TEFRA	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEI	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		3, 212, 177		1.00
2.00	Medical and other services			1, 350, 801	2.00
3.00	Organ acquisition (certified transplant programs only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3, 212, 177	1, 350, 801	4.00
5.00	Inpatient primary payer payments		l ol		5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		3, 212, 177	1, 350, 801	
	COMPUTATION OF LESSER OF COST OR CHARGES			.,,	
	Reasonable Charges				
8. 00	Routine service charges		21, 625, 751		8.00
9. 00	Ancillary service charges		13, 558, 999	12, 002, 936	
10.00	Organ acquisition charges, net of revenue		0	12,002,700	10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	i i		35, 184, 750	12, 002, 936	•
12.00	CUSTOMARY CHARGES		35, 164, 750	12,002, 730	12.00
13. 00	Amount actually collected from patients liable for payment fo	r corvi coc on a charge	l	0	13.00
13.00	basis	i services on a charge	٩	Ü	13.00
14.00	Amounts that would have been realized from patients liable fo	r navment for services on	o	0	14.00
14.00	a charge basis had such payment been made in accordance with		٩	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		35, 184, 750	12, 002, 936	
17. 00		Ly if line 14 eyecods	31, 972, 573	12, 002, 936	
17.00	Excess of customary charges over reasonable cost (complete on	ry it fille to exceeds	31, 972, 573	10, 652, 135	17.00
10 00	line 4) (see instructions)	luifling 4 avagada ling	0	0	10 00
18. 00	Excess of reasonable cost over customary charges (complete on 16) (see instructions)	Ty IT TITLE 4 exceeds TITLE	٩	0	18. 00
10.00				0	10 00
19.00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see inst		0 040 477	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		3, 212, 177	1, 350, 801	21.00
00.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			00.00
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
	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	Titles V or XIX (sum of lines 21 and 27)		3, 212, 177	1, 350, 801	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	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)	3, 212, 177	1, 350, 801	
32.00	Deducti bl es		0	0	
33.00	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0		35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	3, 212, 177	1, 350, 801	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
	Subtotal (line 36 ± line 37)		3, 212, 177	1, 350, 801	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3, 212, 177	1, 350, 801	40.00
41.00	Interim payments		4, 937, 152	1, 503, 050	
42.00	Balance due provider/program (line 40 minus line 41)		-1, 724, 975	-152, 249	42.00
43.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	Peri od: From 01/01/2024	Worksheet E-3 Part VII
	Component CCN: 31-5490	To 12/31/2024	Date/Time Prepared: 5/28/2025 10:36 am
	Title XIX	Skilled Nursing	Cost
		Eacility	

		Title XIX	Facility	COST	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES END TITLES V OD VIV		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CES TOR TITLES V OR ALL	V JERVICES		
1. 00	Inpati ent hospi tal /SNF/NF servi ces		0		1. 00
2. 00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0	O	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		o o	0	4. 00
5. 00	Inpatient primary payer payments		0	o .	5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		9	J	7.00
	Reasonable Charges				
8. 00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		0	0	9. 00
10.00	Organ acquisition charges, net of revenue		o	J.	10.00
11. 00	Incentive from target amount computation		o		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		o	0	
	CUSTOMARY CHARGES		-1	-	
13.00	Amount actually collected from patients liable for payment for se	ervices on a charge	0	0	13. 00
	basis	g-		_	
14.00	Amounts that would have been realized from patients liable for pa	ayment for services on	O	0	14.00
	a charge basis had such payment been made in accordance with 42 (
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15. 00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only i	f 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 instruc-	tions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	npleted for PPS provide			
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31. 00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	0	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		

	Financial Systems COMMUNITY MEDICA GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CCN:		Peri od:	u of Form CMS-2 Worksheet E-4	
EDI CAL	EDUCATION COSTS			From 01/01/2024 To 12/31/2024	Date/Time Pre	
		Title X	VIII	Hospi tal	5/28/2025 10: PPS	36 an
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT Jnweighted resident FTE count for allopathic and osteopathic	programs for o	ast roporti	ng pori ods	0. 00	1.0
	ending on or before December 31, 1996.	programs for C	ost reporti	ng perrous	0.00	'.'
	FTE cap adjustment under §131 of the CAA 2021 (see instruction				0.00	
	Jnweighted FTE resident cap add-on for new programs per 42 CF Rural track program FTE cap limitation adjustment after the c				0. 00 0. 00	1
	the CAA 2021 (see instructions)	sap builtuing wi	ndow crosco	dilder 3127 of	0.00	
1	Amount of reduction to Direct GME cap under section 422 of MM		/ >		0.00	3.
	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	e with 42 CFR §	413.79 (m).	(see	0. 00	3.
02 A	Adjustment (increase or decrease) to the hospital's rural tra				0. 00	3.
4	orograms with a rural track Medicare GME affiliation agreemen 49075 (August 10, 2022) (see instructions)			, ,		
	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		ograms due	to a Medicare	0. 00	4.
	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)	tructions for c	ost reporti	ng peri ods	0. 00	4.
02 A	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	ts (see instru	ctions for	cost reporting	0. 00	4.
21 T	The amount of increase if the hospital was awarded FTE cap sl nstructions)	ots under §126	of the CA	A 2021 (see	0. 00	4.
28 T	The amount of increase if the hospital was awarded FTE cap sl	ots under §412	2 of the CA	AA 2023 (see		4.
00 F	nstructions) TE adjusted cap (line 1 plus and 1.01, plus line 2, plus lin			nus lines 3 and	0. 00	5
00 U	3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.28 Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your					6.
	records (see instructions) Enter the lesser of line 5 or line 6				0.00	7.
00 L	Little resser of time 5 of time 0	Pi	rimary Care	0ther	Total	/.
00 14	W. J. J. ETE		1.00	2.00	3.00	
р	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	pathi c	0. 0	0.00	0. 00	
	If line 6 is less than 5 enter the amount from line 8, otherw		0. 0	0.00	0. 00	9.
	multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1					
	f Worksheet S-2, Part I, line 68, is "Y", see instructions.	1, 2022, 01				
	Weighted dental and podiatric resident FTE count for the curr			8. 47		10
1	Unweighted dental and podiatric resident FTE count for the cu	urrent year	0.0	8. 47		10
	Total weighted FTE count Total weighted resident FTE count for the prior cost reportin	na vear (see	0. C 0. C			11
	instructions)	ig year (see	0. 0	7.11		12
	Total weighted resident FTE count for the penultimate cost re year (see instructions)	eporti ng	0. 0	0 4.43		13
	Rolling average FTE count (sum of lines 11 through 13 divided	d by 3).	0.0	0 6. 67		14
	Adjustment for residents in initial years of new programs		35. 7			15
	Unweighted adjustment for residents in initial years of new p		35. 7			15
- 1	Adjustment for residents displaced by program or hospital clo		0. 0			16
	Jnweighted adjustment for residents displaced by program or h closure	nospi tai	O. C	0.00		16
00 A	Adjusted rolling average FTE count		35. 7			17
1	Per resident amount		0. 0			18
- 1	Per resident amount under §131 of the CAA 2021		137, 735. 6		10 5/4 040	18
00 [A	Approved amount for resident costs		4, 928, 18	0 7, 636, 062	12, 564, 242	19
00 A	Additional unweighted allopathic and osteopathic direct GME F	TE resident ca	p slots red	cei ved under 42	1. 00	20
. 00 1/1	Sec. 413.79(c)(4)		•			
S	Direct GME FTE unweighted resident count over cap (see instru	JCTIONS)			0. 00 0. 00	1
. 00 S		ructions)				
. 00 D	Allowable additional direct GME FTE Resident Count (see instr	,	tructions)			1
. 00 D		,	tructions)		0.00	1

	DUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co	CN: 31-0041	Peri od:	Worksheet E-4	
DICAL ED	UCATION COSTS			From 01/01/2024 To 12/31/2024	Date/Time Pre 5/28/2025 10:	
		Title	XVIII	Hospi tal	PPS	
			Inpatient Pa	rt Managed Care	Total	
			1.00	2. 00	3. 00	
COMP	PUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
	atient Days (see instructions) (Title XIX - see S-2 Part I	X. line	50. 0	71 37, 827		26.0
	2, column 2)	.,				
. 00 Tota	al Inpatient Days (see instructions)		116, 8	59 116, 859		27. C
.00 Rati	io of inpatient days to total inpatient days		0. 4284 ⁻	74 0. 323698		28.0
. 00 Prog	gram direct GME amount		5, 383, 4	4, 067, 020	9, 450, 471	29. C
. 01 Perd	cent reduction for MA DGME			2. 74		29. 0
. 00 Redu	uction for direct GME payments for Medicare Advantage			111, 436	111, 436	30.0
.00 Net	Program direct GME amount				9, 339, 035	31.0
					1. 00	
	ECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI CATION COSTS)	E XVIII ONLY	(NURSING PR	OGRAM AND PARAME	DI CAL	
	al dialysis direct medical education costs (from Wkst. B,	Pt. I, sum o	of col. 20 an	d 23, lines 74	0	32.0
	94)					
	al dialysis and home dialysis total charges (Wkst. C, Pt.			74 and 94)	0	
	io of direct medical education costs to total charges (line	e 32 ÷ line	33)		0. 000000	
	icare outpatient ESRD charges (see instructions)				0	
	icare outpatient ESRD direct medical education costs (line		35)		0	36.
	DRTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	t A Reasonable Cost					
	sonable cost (see instructions)				136, 038, 186	
	an acquisition and HSCT acquisition costs (see instruction				0	
	t of physicians' services in a teaching hospital (see inst	ructions)			0	39. (40. (
	mary payer payments (see instructions) al Part A reasonable cost (sum of lines 37 through 39 minu	o lino 40)			28, 618	1
	al Part A reasonable cost (sum of fines 37 through 39 minu: t B Reasonable Cost	s rine 40)			136, 009, 568	41.1
	sonable cost (see instructions)				62, 622, 247	42. (
	mary payer payments (see instructions)				31, 226	1
	al Part B reasonable cost (line 42 minus line 43)				62, 591, 021	
	al reasonable cost (sum of lines 41 and 44)				198, 600, 589	
	io of Part A reasonable cost to total reasonable cost (lin	e 41 ÷ line	45)		0. 684840	1
	io of Part B reasonable cost to total reasonable cost (line				0. 315160	
	OCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAI				2. 2.2.00	1
	al program GME payment (line 31)				9, 339, 035	48.
	t A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instru	uctions)		6, 395, 745	1
	t B Medicare GME payment (line 47 x 48) (title XVIII only)				2, 943, 290	

Health Financial Systems COMMUNITY MEDICAL CENTER In Lieu			u of Form CMS-2	552-10	
				Worksheet E-5	
					oared: 36 am
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see inst	ructions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00 Time value of money for operating expenses (see instructions)					6.00
7.00	Time value of money for capital related expenses (see instru	ctions)		0	7.00

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

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

Provi der CCN: 31-0041

Peri od: From 01/01/2024 To 12/31/2024 Date/Ti me Prepared: 5/28/2025 10:36 am

		General Fund	Speci fi c	Endowment Fund	5/28/2025 10: Plant Fund	36 am
		General Tund	Purpose Fund	Lildowillett Turid	Frant Tunu	
	I	1. 00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	10.025	0		0	1.00
1. 00 2. 00	Cash on hand in banks Temporary investments	10, 025		0	0	1
3. 00	Notes receivable	0	0	0	0	
4. 00	Accounts receivable	66, 583, 534	Ö	o	0	
5.00	Other recei vable	0	0	O	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-14, 616, 903	0	0	0	
7. 00	Inventory	10, 767, 804	0	0	0	1
8. 00	Prepai d expenses	4, 436, 276	0	0	0	
9. 00 10. 00	Other current assets Due from other funds	16, 108, 057 264, 788, 835		0	0	
11. 00	Total current assets (sum of lines 1-10)	348, 077, 628		0	0	
	FIXED ASSETS	0.0,077,020		<u> </u>		1 55
12.00	Land	1, 338, 461	0	0	0	12. 00
13.00	Land improvements	3, 070, 069	0	0	0	13.00
14.00	Accumulated depreciation	-2, 445, 633		-	0	
15.00	Bui I di ngs	364, 005, 641	0	0	0	
16.00	Accumulated depreciation	-157, 735, 905	0	0	0	
17.00	Leasehold improvements	17, 860, 652 -6, 451, 316	0	0	0	1
18. 00 19. 00	Accumulated depreciation Fixed equipment	79, 638, 022	0	0	0	
20. 00	Accumulated depreciation	-74, 520, 468	0	0	0	1
21. 00	Automobiles and trucks	0	0	-	0	
22. 00	Accumulated depreciation	0	0	o	0	
23.00	Maj or movable equipment	219, 493, 750	0	o	0	23. 00
24.00	Accumulated depreciation	-134, 369, 970	0	0	0	24.00
25.00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26.00	Accumul ated depreciation	0	0	0	0	
27.00	HIT designated Assets	0	0	0	0	1
28.00	Accumulated depreciation	0	0	0	0	
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	309, 883, 303	0		0	
30.00	OTHER ASSETS	307, 863, 303		<u> </u>	0	30.00
31.00	Investments	500	0	O	0	31.00
32.00	Deposits on Leases	0	0	O	0	
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	31, 836, 789		0	0	
35.00	Total other assets (sum of lines 31-34)	31, 837, 289			0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	689, 798, 220	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	20, 309, 052	0	O	0	37.00
38. 00	Salaries, wages, and fees payable	21, 187, 007	0	_	0	
39. 00	Payrol I taxes payable	0	l ő	o o	0	
40.00	Notes and Loans payable (short term)	0	0	O	0	
41.00	Deferred income	102, 867	0	O	0	41.00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	0	0	
44.00	Other current liabilities	28, 796, 314		ا ا	0	1
45.00	Total current liabilities (sum of lines 37 thru 44)	70, 395, 240	0	0	0	45.00
46. 00	LONG TERM LIABILITIES Mortgage payable	1 0	0	O	0	46. 00
47.00	Notes payable	0			0	1
48. 00	Unsecured Loans			_	0	
49. 00	Other long term liabilities	166, 882, 142		_	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	166, 882, 142		O	0	1
51.00	Total liabilities (sum of lines 45 and 50)	237, 277, 382	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	452, 520, 838				52. 00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
57.00	Plant fund balance - invested in plant			ı -	0	
58.00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				9	
59.00	Total fund balances (sum of lines 52 thru 58)	452, 520, 838	0	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	689, 798, 220	0	0	0	60.00
	[59]	l	1			I

Health FinancialSystemsCOMMUNITY MEDICAL CENTERIn Lieu of Form CMS-2552-10STATEMENT OF CHANGES IN FUND BALANCESProvider CCN: 31-0041Period: From 01/01/2024Worksheet G-1

					From 01/01/20: To 12/31/20:		pared:
						5/28/2025 10:	36 am
		General	Fund	Special P	urpose Fund	Endowment Fund	
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period	1.00	407, 968, 902	0.00	1. 00	0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		42, 515, 265				2.00
3.00	Total (sum of line 1 and line 2)		450, 484, 167			o	3.00
4.00	OTHER CHANGES IN NET ASSETS	2, 036, 671			0	0	4. 00
5.00		0			0	0	
6.00		0			0	0	
7.00		0			0	0	
8. 00 9. 00		0			0	0	
10.00	Total additions (sum of line 4-9)	0	2, 036, 671		U .		9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		452, 520, 838				11.00
12. 00	Deductions (debit adjustments) (specify)	o	102, 020, 000		o	0	
13. 00		0			Ö	Ō	
14.00		0			О	0	14. 00
15.00		0			0	0	15.00
16.00		0			0	0	
17. 00		0	_		0	0	1
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		452, 520, 838			0	19. 00
	Sheet (Title II illinus IIIIe 10)	Endowment Fund	PI ant	Fund			
		Eriadimorre i aria					
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4. 00 5. 00	OTHER CHANGES IN NET ASSETS		0				4. 00 5. 00
6. 00			0				6. 00
7. 00			0				7. 00
8. 00			0				8.00
9. 00			o				9.00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13. 00
14.00			0				14.00
15. 00 16. 00			0				15.00
16.00			0				16. 00 17. 00
17.00	Total deductions (sum of lines 12-17)	0	٩		0		18.00
19.00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)				-		55

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 31-0041

			0 12/31/2024	5/28/2025 10:	
	Cost Center Description	Inpati ent	Outpati ent	Total	JO dili
		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	592, 990, 861		592, 990, 861	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	5.00
6.00	Swing bed - NF)	0	6.00
7.00	SKILLED NURSING FACILITY	21, 217, 350)	21, 217, 350	7.00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	614, 208, 211		614, 208, 211	10.00
	Intensive Care Type Inpatient Hospital Services	·			
11.00	INTENSIVE CARE UNIT	477, 153, 272	2	477, 153, 272	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	48, 115, 328	3	48, 115, 328	14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	525, 268, 600)	525, 268, 600	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1, 139, 476, 811		1, 139, 476, 811	17. 00
18.00	Ancillary services	620, 927, 147		1, 293, 661, 822	18. 00
19.00	Outpatient services	164, 298, 391	332, 759, 354	497, 057, 745	19. 00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22.00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES		0	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	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 1, 924, 702, 349	1, 005, 494, 029	2, 930, 196, 378	28. 00
	G-3, line 1)				ļ
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		544, 147, 120		29. 00
30.00	ADD (SPECIFY)				30. 00
31.00					31. 00
32.00			1		32. 00
33.00					33. 00
34.00					34. 00
35.00					35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39.00					39. 00
40.00					40.00
41.00					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)(tran	ster	544, 147, 120		43. 00
	to Wkst. G-3, line 4)	Ţ	I	I	l

	Health Financial Systems COMMUNITY MEDICAL CENTER In Lieu STATEMENT OF REVENUES AND EXPENSES Provider CCN: 31-0041 Period:					
STATE	Worksheet G-3					
	Date/Time Prepared:					
				5/28/2025 10:	36 am	
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	2, 930, 196, 378	1. 00			
2. 00	Less contractual allowances and discounts on patients' accounts			2, 356, 778, 024	2. 00	
3. 00	Net patient revenues (line 1 minus line 2)			573, 418, 354	3. 00	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			544, 147, 120	4. 00	
5. 00	Net income from service to patients (line 3 minus line 4)			29, 271, 234	5. 00	
	OTHER INCOME					
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 communication	n servi ces		0	8. 00	
9.00	Revenue from television and radio service			0	9. 00	
10.00				0	10.00	
11. 00	Rebates and refunds of expenses			0	11. 00	
12.00				0	12.00	
13.00	Revenue from Laundry and Linen service			0	13.00	
14.00	Revenue from meals sold to employees and guests			0	14. 00	
15.00				0	15.00	
	Revenue from sale of medical and surgical supplies to other t	than patrents		0	16. 00	
17.00	3			0	17.00	
18.00				0	18.00	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
20. 00 21. 00	Revenue from gifts, flowers, coffee shops, and canteen Rental of vending machines			0	20. 00 21. 00	
21.00	1			0	21.00	
23. 00				0	23. 00	
24. 00				11, 042, 314		
24. 00	FEMA C-19			2, 201, 717	24. 00	
24. 50	COVI D-19 PHE Fundi ng			2,201,717	24. 50	
25. 00	Total other income (sum of lines 6-24)			13, 244, 031	25. 00	
	Total (line 5 plus line 25)			42, 515, 265		
	OTHER EXPENSES (SPECIFY)			0	27. 00	
28. 00	, ,			0	28. 00	
29. 00	Net income (or loss) for the period (line 26 minus line 28)			42, 515, 265	29. 00	
			·	•		

CALCIII	Financial Systems COMMUNITY ME	DI CAL CENTER	In Lie	u of Form CMS-2	<u> 2552-10</u>	
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet L Parts I-III Date/Time Pre 5/28/2025 10:		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD			1.00		
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier			7, 549, 847	1.00	
1. 01	Model 4 BPCI Capital DRG other than outlier				1. 01	
2.00	Capital DRG outlier payments			12, 983	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 cos	322. 47	3. 00			
4. 00	Number of interns & residents (see instructions)	91. 21	4. 00			
5.00	Indirect medical education percentage (see instructions)	8. 31	5. 00 6. 00			
6. 00						
7. 00	1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 1.62 7.					
7.00	30) (see instructions)	A patrent days (worksheet	L, part A Title	1.02	7.00	
8. 00	Percentage of Medicaid patient days to total days (see in:		12. 27	8.00		
9.00	Sum of lines 7 and 8	13. 89	9.00			
10.00	Allowable disproportionate share percentage (see instruct	2. 85	10.00			
11.00	Disproportionate share adjustment (see instructions)				11.00	
12.00	Total prospective capital payments (see instructions)			8, 405, 393	12. 00	
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST					
1.00	Program inpatient routine capital cost (see instructions)			0	1.00	
2.00	Program inpatient ancillary capital cost (see instructions	s)		0	2. 00	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00	
4. 00 5. 00	Capital cost payment factor (see instructions)				4. 00 5. 00	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	3.00	
				1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
1. 00	Program inpatient capital costs (see instructions)			0	1.00	
2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	tances (see instructions)		0	2. 00	
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)	tances (see instructions)		0 0	2. 00 3. 00	
2. 00 3. 00 4. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	tances (see instructions)		0 0 0 0.00	2. 00 3. 00 4. 00	
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0 0 0 0.00	2. 00 3. 00 4. 00 5. 00	
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	e instructions)	x line 6)	0 0 0 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary	e instructions)	x line 6)	0 0 0 0.00 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums: Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordicapital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7)	e instructions) nary circumstances (line 2 :	x line 6)	0 0 0 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary	e instructions) nary circumstances (line 2 : oplicable)	,	0 0 0 0.00 0 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinated (line 5 plus line 7) Current year capital payments (from Part I, line 12, as and Current year comparison of capital minimum payment level (Carryover of accumulated capital minimum payment level over	e instructions) nary circumstances (line 2 : oplicable) to capital payments (line 8	less line 9)	0 0 0 0.00 0 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as and Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	e instructions) nary circumstances (line 2 : oplicable) to capital payments (line 8 er capital payment (from pr	less line 9) ior year	0 0 0 0.00 0 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums: Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordic Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	e instructions) nary circumstances (line 2 : oplicable) to capital payments (line 8 er capital payment (from pr	less line 9) ior year ne 11)	0 0 0.00 0 0.00 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums' Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary capital minimum payment level carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, et carryover of accumulated capital minimum payment level over carryover of accumulated cap	e instructions) nary circumstances (line 2 : oplicable) to capital payments (line 8 er capital payment (from pr l payments (line 10 plus line) nter the amount on this line	less line 9) ior year ne 11)	0 0 0 0.00 0.00 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums: Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary circumstances (see Capital minimum payment level for extraordinary current year capital payments (from Part I, line 12, as an Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level overwheeld L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, et Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	e instructions) nary circumstances (line 2 : oplicable) to capital payments (line 8 er capital payment (from pr l payments (line 10 plus line) ter the amount on this line er capital payment for the	less line 9) ior year ne 11)	0 0 0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums' Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordic Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level oven Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, et Carryover of accumulated capital minimum payment level oven (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	e instructions) nary circumstances (line 2 : oplicable) to capital payments (line 8 er capital payment (from pr l payments (line 10 plus linter the amount on this linter capital payment for the instructions)	less line 9) ior year ne 11)	0 0 0 0.00 0 0.00 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	