This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 31-0009 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/25/2022 1:03 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/25/2022 1:03 pm ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLARA MAASS MEDICAL CENTER ( 31-0009 ) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR			ELECTRONI C	
	1			SI GNATURE STATEMENT	
1	Rich	n Henwood	, Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Rich Henwood			2
3	Signatory Title	VP OF CORPORATE REIMBURSEMENT			3
4	Date	05/25/2022 01:03:39 PM			4

			Title XVIII				
	Cost Center Description	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	2, 040, 922	408, 527	0	-419, 421	1.00
2.00	Subprovi der - IPF	0	628	1		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-1	0		0	7. 00
200.00	Total	0	2, 041, 549	408, 528	0	-419, 421	200. 00
Tho ab	povo amounts represent "due to" or "due from"	the applicable	program for th	o alamont of t	ho abovo comple	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems CLARA MAASS MEDICAL CENTER In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0009 Period: Worksheet S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0009 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/25/2022 1:03 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1 CLARA MAASS DRIVE 1.00 PO Box: 1.00 State: NJ Zip Code: 07109-3550 County: ESSEX 2.00 City: BELLEVILLE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 CLARA MAASS MEDICAL 310009 35084 09/10/1966 Ν Р Т 3.00 1 CENTER Subprovi der - IPF PSYCH EXCLUDED UNIT Р 4.00 315009 35084 01/01/1994 Ν Ν 4.00 4 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7.00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF TRANSITIONAL CARE UNIT 315505 50084 10/07/2009 Ρ Ν 9.00 Hospi tal -Based NF 10.00 10.00 11.00 11.00 Hospi tal -Based OLTC 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ 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 uncompensated care payments for this 22.01 Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 Ν Ν Ν rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N 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.

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.

Ν

58 00

59.00

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

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

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi der C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/25/2022 1:0	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2.00	3. 00	
2.00 Are you claiming nursing and allied I any programs that meet the criteria I instructions) Enter "Y" for yes or 'is "Y", are you impacted by CR 11642 adjustement? Enter "Y" for yes or "I If line 60 is yes, complete columns:	under 42 CFR 413.85? ( 'N" for no in column 1. (or subsequent CR) NAH N" for no in column 2.	see If column 1 IE MA payment	Y	Y 23. 00	1	60. 00
instructions)						80. 01
	Y/N	IME	Direct GME	IME	Direct GME	
_	1.00	2. 00	3. 00	4.00	5. 00	
1.00 Did your hospital receive FTE slots of section 5503? Enter "Y" for yes or "I column 1. (see instructions)				0.00	0.00	61. 00
1.01 Enter the average number of unweighted FTEs from the hospital's 3 most received ending and submitted before March 23, instructions)	nt cost reports					61. 01
1.02 Enter the current year total unweigh: FTE count (excluding OB/GYN, general and primary care FTEs added under sec ACA). (see instructions)	surgery FTEs,					61. 02
1.03 Enter the base line FTE count for pri and/or general surgery residents, whi determining compliance with the 75% instructions)	ch is used for					61. 00
Enter the number of unweighted primal surgery allopathic and/or osteopathic current cost reporting period (see in	FTEs in the nstructions).					61. 0
1.05 Enter the difference between the base and/or general surgery FTEs and the oprimary care and/or general surgery I 61.04 minus line 61.03). (see instructions)	current year's FTE counts (line					61. 0
I. 06 Enter the amount of ACA \$5503 award used for cap relief and/or FTEs that care or general surgery. (see instruc	that is being are nonprimary					61. 0
	Pr	rogram Name	Program Code		Unweighted Direct GME FTE Count	
1 10 100 11 575 1 11 11 11 15		1. 00	2. 00	3.00	4.00	
1. 10 Of the FTEs in line 61.05, specify ear specialty, if any, and the number of for each new program. (see instruction column 1, the program name. Enter in program code. Enter in column 3, the unweighted count. Enter in column 4, FTE unweighted count.	FTE residents ons) Enter in column 2, the IME FTE			0.00	0.00	61. 10
1.20 Of the FTEs in line 61.05, specify exprogram specialty, if any, and the numerical dents for each expanded program instructions) Enter in column 1, the Enter in column 2, the program code.  3, the IME FTE unweighted count. Enter the direct GME FTE unweighted count.	umber of FTE (see program name. Enter in column			0. 00	0. 00	61. 20
15.10 diriode Sine i re dimorgired court.					1.00	
ACA Provisions Affecting the Health 2.00 Enter the number of FTE residents the				ind for which		62. 00
your hospital received HRSA PCRE fund 2.01 Enter the number of FTE residents tha	ding (see instructions) at rotated from a Teach	ning Health Cer	nter (THC) into			62. 0°
during in this cost reporting period Teaching Hospitals that Claim Reside						

Health Financial Systems	CLARA MA	AASS MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CC		riod: com 01/01/2021 12/31/2021	Worksheet S-2 Part I Date/Time Prep 5/25/2022 1:03	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after J			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5.00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00		65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
0 11 5501 0 11 151 5	V ETE 2	N	1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	sEffective fo	r cost reporti	ng periods	
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 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66. 00
(corumn i arviaca by (corumn i i	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67 00 Enter in column 1 the program	1. 00	2. 00	3. 00	4. 00	5. 00 0. 000000	67.00
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)			0.00	0.00	J. 000000	67.00

75. 00	Inpatient Renabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	l N		75. 00
70.00	subprovider? Enter "Y" for yes and "N" for no.	"		70.00
76. 00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in t		0	76. 00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or			
	no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y,			
	indicate which program year began during this cost reporting period. (see instructions)			
		'		
			1. 00	
00	Long Term Care Hospital PPS		M	
0.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting	neriod2 Enter	N N	80.00
1.00	"Y" for yes and "N" for no.	perrou: Litter	IN	01.00
	TEFRA Provi ders			
5. 00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o	r "N" for no.	N	85. 00
6. 00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section			86. 00
7 00	§413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N	07.00
7. 00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
	1 100 (a) (1) (b) (v) . Enter 1 100 years 1 100 no.	V	XIX	
		1. 00	2. 00	
	Title V and XIX Services			
0. 00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Υ	90.00
1 00	Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	Υ	91.00
1.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column.		'	71.00
2. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.			
3. 00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93. 0
4. 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	Υ	94. 0
+. 00	applicable column.	IN IN	'	74.0
	If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	10. 00	95. 0
6. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N	Y	96. 0
7 00	applicable column.	0.00	F 00	07.00
	If line 96 is "Y", enter the reduction percentage in the applicable column.  Does title V or XIX follow Medicare (title XVIII) for the interns and residents post	0. 00 N	5. 80 Y	97.00
6. 00	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	IN IN	'	70.00
	column 1 for title V, and in column 2 for title XIX.			
8. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.	N	Υ	98. 0°
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for			
8 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	N	Υ	98. 02
5. 02	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	IN IN	'	70.0.
	for title V, and in column 2 for title XIX.			
8. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N	N	98. 03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1			
8. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	N	98. 0
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and			70.0
	in column 2 for title XIX.			
8. 05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	N	Υ	98. 0
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			
8 06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	N	Υ	98. 0
3. 00	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in	.,	'	70.0
	column 2 for title XIX.			
	Rural Providers			
	Does this hospital qualify as a CAH?	N		105. 0
ю. UU	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106. 0
07. 00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R			107. 0
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)			
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an			
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?			
	Enter "Y" for yes or "N" for no in column 2. (see instructions)	I	l	I

ealth Financial Systems CLARA MAASS MED DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 31-0009 Pe	<u>In Lie</u> eriod:	Worksheet S-	
			rom 01/01/2021	Part I Date/Time Pr	epared
			V	5/25/2022 1: XIX	03 pm
			1. 00	2.00	
08.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108.
ork section 3472. 113(c). Effect 1 For yes of N For no.	Physi cal	Occupati onal	Speech	Respi ratory	
09.00  f this hospital qualifies as a CAH or a cost provider, are	1. 00	2.00	3.00	4.00	109.
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.
				1.00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. If	yes,	N	110.
			1. 00	2.00	
	the Frontier C	ommunity	1.00 N	2.00	111.
Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting polumn 1 is Y, or Ticipating in	period? Enter enter the column 2.			
		1. 00	2. 00	3.00	
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	period? s "Y", enter ne	N			112.
Miscellaneous Cost Reporting Information  5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	l N			0115
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	3, or E only) 93" percent (includes	, v			0113
the definition in CMS Pub. 15-1, chapter 22, §2208.1. 6.00 s this facility classified as a referral center? Enter "Y"	for yes or	N			116
"N" for no. $7.00 \mid s$ this facility legally-required to carry malpractice insur	ance? Enter	Υ			117
"Y" for yes or "N" for no.  8.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence.	,	1			118
p the portey to ordin made. Enter 2 the portey to cook .	5.1051	Premi ums	Losses	Insurance	
8.01 List amounts of malpractice premiums and paid losses:		1. 00 3, 632, 081	2.00	3.00	0118
5. Of Erst allourits of marpraetree premi and para rosses.		3,032,001			
2.02\Are malareatics promiums and paid leases reported in a cost	conton athon	than tha	1. 00 N	2.00	110
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			IN IN		118
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)			N	N	119
Enter in column 2, "Y" for yes or "N" for no.  1.00 Did this facility incur and report costs for high cost impla	antable device	s charged to	Υ		121
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1			N		122
the Worksheet A line number where these taxes are included.  Transplant Center Information					
5.00 Does this facility operate a transplant center? Enter "Y" fo	or yes and "N"	for no. If	N		125
yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, er	nter the certi	fication date			126
in column 1 and termination date, if applicable, in column 27.00   f this is a Medicare certified heart transplant center, ent		ication date			127
in column 1 and termination date, if applicable, in column 2	2.				
0 AALE this is a Madisors cortified liver transplant contor ant		ication date			128
·	)				
8.00 If this is a Medicare certified liver transplant center, entire in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified lung transplant center, enter		cation date in			129
in column 1 and termination date, if applicable, in column 2	er the certifi				130

Health Financial Systems		MEDICAL CENTER				u of Form CMS			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	TDENIIFICATION DATA	Provi der CC	N: 31-0009	From C	1: 01/01/2021 12/31/2021	Worksheet S- Part I Date/Time Pr 5/25/2022 1:	epared:		
					1 00				
131.00 If this is a Medicare certified in	testinal transplant cent	er, enter the ce	rti fi cati o	on	1. 00	2.00	131. 00		
date in column 1 and termination data 132.00 If this is a Medicare certified is	et transplant center, e	enter the certifi	cation da	te			132. 00		
in column 1 and termination date, in the second in the sec	r applicable, in column	1 2.					133. 00		
and termination date, if applicable	4.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.								
All Providers  140.00 Are there any related organization chapter 10? Enter "Y" for yes or "I are claimed, enter in column 2 the	N" for no in column 1. I	f yes, and home	office cos		Y	H53560	140. 00		
1.00		00	142 +1		3.00	-6 +1			
If this facility is part of a chain home office and enter the home off				е паше ап	id address	or the			
41. 00 Name: RWJBARNABAS HEALTH	Contractor's Name: N	NOVITAS SOLUTIONS	S Contra	actor's Nu	umber: 1200	)1	141. 0		
42.00 Street: 95 OLD SHORT HILLS ROAD  43.00 City: WEST ORANGE	PO Box: State:	NJ	Zi p Co	ode:	0705	52	142. 00 143. 00		
	1,,,,,,		, , , , , , , , , , , , , , , , , , ,						
44.00 Are provider based physicians' cos	ts included in Worksheet	A?				1. 00 Y	144. 00		
44. OOM C provider based physicians cos	ts Theradea Th Worksheet	A:				1	144.00		
AF OOL F agota for wand, samilage are al	simad on Wkat A line 7	// are the easte	For		1. 00 Y	2. 00	145 0		
45.00 If costs for renal services are clainpatient services only? Enter "Y" no, does the dialysis facility includer period? Enter "Y" for yes or "N"	for yes or "N" for no i ude Medicare utilization	n column 1. If c	olumn 1 is	S	Y		145. 0		
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/do	column 1. (See CMS Pub.			lf	N		146. 0		
						1.00			
47.00 Was there a change in the statistic 48.00 Was there a change in the order of						N N	147. 00 148. 00		
149.00 Was there a change to the simplific				for no.		N N	149. 00		
		Part A	Part		Title V	Title XIX	_		
Does this facility contain a provious charges? Enter "Y" for yes or "				ication o					
55. 00 Hospi tal	·	N	N		N	N	155. 0		
56. 00 Subprovi der – TPF 57. 00 Subprovi der – TRF		N N	N N		N N	N N	156. 0 157. 0		
58. 00 SUBPROVI DER							158. 0		
59. 00 SNF		N	N		N	N	159. 0		
60.00 HOME HEALTH AGENCY 61.00 CMHC		N	N N		N N	N N	160. 0 161. 0		
Multicampus						1.00			
65.00 Is this hospital part of a Multicar	mpus hospital that has o	one or more campu	ses in di	fferent C	BSAs?	N	165. 0		
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus			
	0	1. 00	2. 00	3. 00	4. 00	5. 00			
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in						0.0	166. 0		
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)									
CBSA in column 4, FTE/Campus in						1.00			
CBSA in column 4, FTE/Campus in column 5 (see instructions)	) incentive in the Ameri	can Recovery and	d Reinvest	ment Act		1.00			
CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT 67.00)s this provider a meaningful user	under §1886(n)? Enter	"Y" for yes or "	N" for no	·		1.00			
CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT 167.00) is this provider a meaningful user 168.00 if this provider is a CAH (line 109.10).	under §1886(n)? Enter 5 is "Y") and is a meani	"Y" for yes or " ngful user (line	N" for no	·	r the		167. 00		
CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT 67.00)s this provider a meaningful user	under §1886(n)? Enter 5 is "Y") and is a meani T assets (see instructi	"Y" for yes or " ngful user (line ons)	N" for no. e 167 is "'	Y"), ente					

Health Financial Systems	CLARA MAASS MEDIC	CAL CENTER	In Li€	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI				Worksheet S-2	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
			Begi nni ng	Endi ng	) pili
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	1.00	2.00	170. 00		
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have section 1876 Medicare cost plans reported	N	C	171. 00		
"Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instr	column 1 is yes, en		n		

	Financial Systems CLARA MAASS ME				eu of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 01/01/2021 To 12/31/2021	Date/Time Pre	epared:
				Y/N	5/25/2022 1:0 Date	03 pm
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	sponses. Ente			
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS		<u>'</u>			
	Provider Organization and Operation  Has the provider changed ownership immediately prior to the	a baginning of	the east	T N	I	1 00
1.00	reporting period? If yes, enter the date of the change in a	rolumn 2 (see	instructions)	N		1.00
	Treporting period: 11 yes, enter the date of the change in t	corumir 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home commedical supply companies) that are related to the providence of the pr	offices, drug der or its	N			3.00
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)					
	,		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
1. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A	04/30/2022	4.00
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
. 00	Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column	2. If ves is	the provider	N		6.00
. 00	is the legal operator of the program?	2. 11 yos, 15	the provider	14		0.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see instructions.  Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.					7. 00 8. 00
. 00	Are costs claimed for Interns and Residents in an approved graduate medical education N program in the current cost report? If yes, see instructions.					9. 00
0. 00	Was an approved Intern and Resident GME program initiated of	or renewed in t	he current	N		10.00
1 00	cost reporting period? If yes, see instructions.	l O D in on Ann	veo, cod	N		11 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R In an App	rovea	N		11. 0
	Treaching Frogram on worksheet A: 11 yes, see instructions.				Y/N	
					1.00	
	Bad Debts				•	
2. 00	Is the provider seeking reimbursement for bad debts? If yes	•			N	12. 00
3. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	3	· ·		N	13.00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti				N N	14. 00
	<u> </u>		rt A		t B	
		Y/N	Date	Y/N	Date	
	Deap D I	1.00	2.00	3. 00	4. 00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16. 00
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	03/01/2022	Y	03/01/2022	17. 00
8. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems CLARA MAASS ME	EDICAL CENTER		In Lie	u of Form CMS	-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S- Part II Date/Time Pr 5/25/2022 1:	epared:	
	·	Descri	pti on	Y/N	Y/N	US PIII	
		(		1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	The post of data is the other based in the other day do the other based in the other base	Y/N	Date	Y/N	Date		
21. 00	Was the cost report prepared only using the provider's	1.00 N	2. 00	3. 00 N	4. 00	21. 00	
21.00	records? If yes, see instructions.	IN		IN .		21.00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost		23. 00	
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?		24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? I	f yes, see		26. 00	
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit		27. 00	
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into dur	ing the cost	reporti ng		28. 00	
29. 00	period? If yes, see instructions.  00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)						
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions urity with new	debt? If ves	see		30.00	
31. 00	instructions. Has debt been recalled before scheduled maturity without is					31. 00	
	instructions. Purchased Services						
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ntractual		32. 00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	olied pertainin	g to competi	tive bidding? If		33. 00	
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physicians?		34. 00	
35. 00	If line 34 is yes, were there new agreements or amended exilphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. 00	
	priyarara durring the coat reporting perrous ir yes, see II	isti ucti Ulis.		Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
	Were home office costs claimed on the cost report?					36. 00	
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?	'		37. 00	
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			,		38. 00	
39. 00	If line 36 is yes, did the provider render services to other see instructions.			,		39. 00	
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00	
		1.	00	2	00		
	Cost Report Preparer Contact Information	1.		Ζ.			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RI CHARD		HENWOOD		41. 00	
42. 00		RWJBARNABAS HE	ALTH			42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	0732-923-8074		RI CH. HENWOOD@R\	NJBH. ORG	43. 00	

Heal th Fi	nancial Systems CLARA	A MAASS MED	OLCAL CENTER		In Lie	u of Form CN	S-2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	INAI RE	Provider CCN:		i: 01/01/2021 12/31/2021	Worksheet S Part II Date/Time F 5/25/2022 1	repared:
			3.00	_			
Co	ost Report Preparer Contact Information						
41. 00 En	nter the first name, last name and the title/pos	ition \	/P OR CORPORATE				41. 00
	eld by the cost report preparer in columns 1, 2, espectively.	and 3,	REIMBURSEMENT				
42. 00 En	nter the employer/company name of the cost repor	t					42. 00
1.	reparer.						
	nter the telephone number and email address of t	he cost					43. 00
re	eport preparer in columns 1 and 2, respectively.						

 
 Heal th Financial
 Systems
 CLARA MA

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 31-0009

				To	12/31/2021	Date/Time Prep 5/25/2022 1:03	
						I/P Days / 0/P	<del>D</del> iii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number		Avai I abl e			
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	290	105, 850	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		290	105, 850	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	32	11, 680	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						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43. 00				0	13.00
14. 00	Total (see instructions)		322	117, 530	0. 00	0	14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00	0	0		0	16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	44. 00	20	7, 300		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	26. 25
27. 00	Total (sum of lines 14-26)		342				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						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

Health Financial Systems CLARA MAHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 31-0009

				T	o 12/31/2021	Date/Time Pre 5/25/2022 1:0	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		D piii
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	19, 894	1, 947	73, 833			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)	21, 333	19, 563				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	19, 894	1, 947	73, 833			7. 00
	beds) (see instructions)	4 474		0.550			
8. 00	INTENSIVE CARE UNIT	1, 471	1, 716	8, 553			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)		2 20/	4 110			12.00
13. 00 14. 00	NURSERY	21 2/5	3, 306	4, 113 86, 499		1 200 00	13. 00 14. 00
15. 00	Total (see instructions)	21, 365	6, 969 0	86, 499 0	0. 00	1, 380. 88	15. 00
16. 00	CAH visits SUBPROVIDER - IPF	0	0	0	0.00	0.00	1
17. 00	SUBPROVIDER - IPF	U	U	U	0.00	0.00	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	2, 255	0	4, 677	0.00	28. 34	
20. 00	NURSING FACILITY	2, 255		4,077	0.00	20. 34	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)			0			24. 10
25. 00	CWHC - CWHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	1, 409. 22	27. 00
28. 00	,		0	123			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			427			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	22	1, 267			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	,	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

				To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
	Full Time Equivalents		Di so	charges		·
Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11. 00	12. 00	13.00	14.00	15. 00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		C	2, 12			1.00
2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation			2, 53	5 4, 778 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14.00   Total (see instructions) 15.00   CAH visits	0. 00	(	2, 42	673	13, 505	14. 00 15. 00
16. 00   SUBPROVIDER - IPF   17. 00   SUBPROVIDER - IRF   18. 00   SKILLED NURSING FACILITY   20. 00   NURSING FACILITY   21. 00   OTHER LONG TERM CARE   22. 00   HOME HEALTH AGENCY   23. 00   AMBULATORY SURGICAL CENTER (D. P.)   24. 00   HOSPICE   24. 10   HOSPICE (non-distinct part)   25. 00   CMHC - CMHC   26. 00   RURAL HEALTH CLINIC   26. 25   FEDERALLY QUALIFIED HEALTH CENTER   27. 00   Observation Bed Days   29. 00   Ambulance Trips   30. 00   Employee discount days (see instruction)	0. 00 0. 00 0. 00 0. 00		)	0 0	0	16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 10 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges				0		31. 00 32. 00 32. 01 33. 00 33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 31-0009

					To	12/31/2021	Date/Time Prep 5/25/2022 1:03	
		Wkst. A Line Number	Amount Reported	Reclassification of Salaries	Sal ari es	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷	<b>5</b>
				(from Wkst. A-6)	(col.2 ± col. 3)	col. 4	col . 5)	
	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	118, 915, 873	C	118, 915, 873	2, 931, 188. 72	40. 57	1. 00
2.00	Non-physician anesthetist Part		C	C	0	0.00	0. 00	2. 00
3.00	Non-physician anesthetist Part		C	C	0	0.00	0.00	3. 00
4.00	Physician-Part A - Administrative		56, 878	C	56, 878	1, 055. 00	53. 91	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		6, 632, 897	) C	1	0. 00 44, 460. 00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		C	C	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	C	0	0.00	0.00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		C	C	О	0.00	0.00	7. 01
8.00	Home office and/or related organization personnel		C	C	0	0.00	0. 00	8. 00
9.00	SNF	44. 00	2, 255, 379	1	-11	58, 953. 95		9.00
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		645, 160	268, 629	913, 789	183, 565. 66	4. 98	10. 00
11. 00	Contract Labor: Direct Patient		19, 440, 705	j C	19, 440, 705	124, 073. 00	156. 69	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		C	C	0	0.00	0.00	12. 00
13. 00	services Contract Labor: Physician-Part		C	C	0	0.00	0. 00	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		C	C	0	0.00	0.00	14. 00
	wage-related costs		45 004 704		45 004 704	040 744 /		
14. 01 14. 02	Home office salaries Related organization salaries		15, 234, 731 C	C	15, 234, 731 0	219, 711. 64 0. 00	1	14. 01 14. 02
15. 00	Home office: Physician Part A		C	C	0	0.00	0.00	15. 00
16. 00	- Administrative Home office and Contract		C	C	0	0.00	0.00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		C		0	0. 00	0.00	16. 01
	- Teachi ng				0			
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS			) C	U	0.00	0.00	16. 02
17. 00	Wage-related costs (core) (see		29, 228, 250	C	29, 228, 250			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 619, 002 0		2, 619, 002 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	C	0			21. 00
22. 00	Physician Part A - Administrative		8, 530	C	8, 530			22. 00
22. 01 23. 00 24. 00 25. 00	Physician Part A - Teaching		435, 142 0 0		0 435, 142 0 0			22. 01 23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		3, 755, 687	,	3, 755, 687			25. 50
25. 51	(core) Related organization		C	C	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		C	C	О			25. 52

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 31-0009 Period: Worksheet S-3

13.00

14.00

15.00

16.00

17.00

18.00

						rom 01/01/2021	Part II	
					T	o 12/31/2021	Date/Time Prep 5/25/2022 1:03	pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
		14dilliber	Reported	(from Wkst.	(col . 2 ± col .	Salaries in	col . 5)	
				A-6)	3)	col . 4	601. 0)	
		1.00	2. 00	3.00	4.00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII	ES						
26.00	Employee Benefits Department	4. 00	758, 791	0	758, 791	12, 865. 84	58. 98	26. 00
27.00	Administrative & General	5. 00	9, 544, 974	0	9, 544, 974	245, 943. 19	38. 81	27. 00
28.00	Administrative & General under		2, 662, 248	0	2, 662, 248	9, 215. 00	288. 90	28. 00
	contract (see inst.)					·		
29.00	Maintenance & Repairs	6. 00	115, 963	0	115, 963	1, 950. 00	59. 47	29. 00
30.00	Operation of Plant	7. 00	2, 618, 232	0	2, 618, 232	104, 400. 46	25. 08	30. 00
31.00	Laundry & Linen Service	8. 00	242, 754	0	242, 754	12, 349, 92	19. 66	31.00
32.00	Housekeepi ng	9. 00	2, 891, 421	0	2, 891, 421	153, 682. 00	18. 81	32. 00
33.00	Housekeeping under contract		0	0	0	0.00		33. 00
	(see instructions)							
34.00	Dietary	10. 00	2, 220, 656	-826, 546	1, 394, 110	71, 302. 59	19. 55	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	826, 546	826, 546	50, 012. 00	16. 53	36. 00
	Maintenance of Personnel	12. 00	0	0	0	0.00		37. 00
20 00	Nursing Administration	12 00	F 70/ /20	1	F 704 420	124 522 70		20.00

5, 796, 638

4, 577, 368

1, 041, 796

1, 653, 422

669, 119

-268, 629

25, 308. 55

88, 427. 57

33, 706. 97

32, 120. 96

0.00

0.00 126, 522. 70

45. 82

26. 44

30. 91 41. 00

51. 47 42. 00

0.00 43.00

38.00

39. 00 48. 73 40. 00

5, 796, 638

669, 119 4, 308, 739

1, 041, 796

1, 653, 422

Pharmacy

39. 00

40.00

41.00

42.00

Central Services and Supply

Medical Records & Medical

38.00 Nursing Administration

Records Library

Social Service

43.00 Other General Service

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

					''	0 12/31/2021	5/25/2022 1:03	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		114, 945, 224	0	114, 945, 224	2, 895, 943. 72	39. 69	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 900, 539	268, 629	3, 169, 168	242, 519. 61	13. 07	2.00
	instructions)							
3.00	Subtotal salaries (line 1		112, 044, 685	-268, 629	111, 776, 056	2, 653, 424. 11	42. 13	3.00
	minus line 2)							
4.00	Subtotal other wages & related		34, 675, 436	0	34, 675, 436	343, 784. 64	100. 86	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		32, 992, 467	0	32, 992, 467	0.00	29. 52	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		179, 712, 588	-268, 629	179, 443, 959	2, 997, 208. 75	59. 87	6.00
7.00	Total overhead cost (see		34, 793, 382	-268, 629	34, 524, 753	967, 807. 75	35. 67	7. 00
	instructions)							

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 31-0009	Peri od:	Worksheet S-3
		From 01/01/2021	

	To 12/31/2021	Date/Time Prep 5/25/2022 1:03	pared: 3 pm
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	4, 371, 080	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	311, 856	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1, 351, 774	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	173, 925	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)	14, 031, 239	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	308, 633	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	90, 747	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)	389, 492	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	112, 014	14.00
15. 00	'Workers' Compensation Insurance	1, 013, 311	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16, 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	8, 652, 569	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	531, 746	19.00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	315, 916	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	31, 654, 302	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
		'	

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lieu of Form CMS-2552-10			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Prepared: 5/25/2022 1:03 pm		

		1	o 12/31/2021	Date/lime Prep   5/25/2022 1:03	
	Cost Center Description		Contract Labor		J PIII
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	31, 654, 302	1.00
2.00	Hospi tal		0	31, 654, 302	2.00
3.00	Subprovi der - IPF		0	0	3. 00
4.00	Subprovi der - IRF				4.00
5.00	Subprovi der - (0ther)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF		0	0	8. 00
9.00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA				11. 00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15. 00
16.00	Hospi tal -Based-CMHC				16. 00
17. 00	Renal Dialysis		0	0	17.00
18.00	Other		0	0	18. 00

0,	IL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 31-000		eri od:	Worksheet S-10	0	
			To	rom 01/01/2021 ) 12/31/2021	Date/Time Prep 5/25/2022 1:03		
	· · · · · · · · · · · · · · · · · · ·				1. 00		
Į	Uncompensated and indigent care cost computation						
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line 202 co	lumn 8	3)	0. 188265	1.	
	Medicaid (see instructions for each line)						
	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				62, 415, 528 Y	2. 3.	
	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?						
	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid						
	Medi cai d charges						
- 1	Medicaid cost (line 1 times line 6)						
	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if						
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	each line)		l			
	Net revenue from stand-alone CHIP	· · · · · · · · · · · · · · · · · · ·			0	9	
	Stand-alone CHIP charges				0		
	Stand-alone CHIP cost (line 1 times line 10)				0	11	
	Difference between net revenue and costs for stand-alone CHIP (li enter zero)	ine 11 minus line	9; 11	< zero then	0	12	
	Other state or local government indigent care program (see instru	uctions for each I	i ne)				
	Net revenue from state or local indigent care program (Not includ				517, 178	13	
	Charges for patients covered under state or local indigent care p	program (Not inclu	ided in	lines 6 or	6, 791, 108	14	
	10)				1 270 520	   15	
	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indic	ment care program	(Line	15 minus line	1, 278, 528 761, 350		
	13; if < zero then enter zero)	gent care program	(11110	10 minus inne	701,000	, , ,	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local i	ndi gen	it care program	ns (see		
į			ndi gen	it care program			
. 00 . 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos	ding charity care spital operations			0	18	
. 00 . 00 . 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	ding charity care spital operations			0	18	
. 00 . 00 . 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos	ding charity care spital operations	jrams (		0		
. 00 . 00 . 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	ding charity care spital operations indigent care prog  Uninsu patier	grams (	sum of lines Insured patients	0 0 17, 422, 950 Total (col. 1 + col. 2)	18	
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00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to function for each line, appropriations or transfers for support of host total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16)  Uncompensated Care (see instructions for each line)	ding charity care spital operations Indigent care prog Uninsu patier 1.00	red hts	sum of lines Insured patients 2.00	0 0 17, 422, 950 Total (col. 1 + col. 2) 3.00	18 19	
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00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of	Uni nsu pati er 1.00  Iity 119,08  ts (see 22,41	red nts	Insured patients 2.00	0 0 17, 422, 950 Total (col. 1 + col. 2) 3.00 148, 224, 752 51, 557, 651	18 19 20 21	
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00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to function for each line, appropriations or transfers for support of host total unreimbursed cost for Medicaid, CHIP and state and local is and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care	ding charity care spital operations indigent care progration undigent care progration 1.00  lity 119,08  ts (see 22,41	red hts ) 37,019 9,918 0	Insured patients 2.00 29,137,733 29,137,733	0 0 17, 422, 950 Total (col. 1 + col. 2) 3. 00 148, 224, 752 51, 557, 651 0	20 21 22	
00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)	ding charity care spital operations indigent care progration Uninsupatier 1.00  Lity 119,08  ts (see 22,41  ff as 22,41	red nts ) 37,019 9,918 0	Insured patients 2.00 29,137,733 0 29,137,733	0 0 17, 422, 950 Total (col. 1 + col. 2) 3.00 148, 224, 752 51, 557, 651 0 51, 557, 651	20 21 22 23	
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00   i   i   i   i   i   i   i   i   i	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is a series of the series of t	ding charity care spital operations indigent care proguent in the spital operations in the spital operations in the spital operation of the spital operation operation operation operation operation operation operation operation operations operation operation operations operation operation operations operation	red hts ) 37,019 9,918 0 19,918	Insured patients 2.00 29,137,733 29,137,733 0 29,137,733	0 0 17, 422, 950 Total (col. 1 + col. 2) 3.00 148, 224, 752 51, 557, 651 0 51, 557, 651	20 21 22 23	
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is a series of the series of t	ding charity care spital operations indigent care progration and patier 1.00  lity 119,08  ts (see 22,41  days beyond a len rogram? indigent care program	red hts ) 37,019 9,918 0 19,918	Insured patients 2.00 29,137,733 29,137,733 0 29,137,733	0 0 17, 422, 950 Total (col. 1 + col. 2) 3.00 148, 224, 752 51, 557, 651 0 51, 557, 651 1.00 N	20 21 22 23 24 25	
00   00   00   00   00   00   00   00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local is 1, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care print line 24 is yes, enter the charges for patient days beyond the stay limit	ding charity care spital operations indigent care progration and patier 1.00  lity 119,08  ts (see 22,41  days beyond a lengram? indigent care program?ructions)	red (ts.)  87,019  19,918  0  19,918  output  output	Insured patients 2.00 29,137,733 29,137,733 0 29,137,733	0 0 0 17, 422, 950  Total (col. 1 + col. 2) 3.00  148, 224, 752  51, 557, 651  0 51, 557, 651  1.00  N	200 211 222 232 244 255 26	
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the second content of the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructions)	ding charity care spital operations indigent care progration 1.00  Iity 119,08  Is (see 22,41  days beyond a len rogram? indigent care progrations) (see instructions)	red (ts.)  87,019  19,918  0  19,918  output  output	Insured patients 2.00 29,137,733 29,137,733 0 29,137,733	0 0 0 17, 422, 950  Total (col. 1 + col. 2) 3.00  148, 224, 752  51, 557, 651  0 51, 557, 651  1.00  N  0 14, 484, 264 1, 108, 962 1, 706, 095	20 21 22 23 24 25 26 27 27	
. 00   .	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is a series of the series of the entire facility (see instructions)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit total bad debt expense for the entire hospital complex (see instructions)  Medicare allowable bad debts for the entire hospital complex (see Mon-Medicare bad debt expense (see instructions)	ding charity care spital operations indigent care progration 1.00  Iity 119,08  Its (see 22,41  days beyond a len rogram? indigent care program? indigent care progrations) (see instructions)	red hts )	Insured patients 2.00 29,137,733 29,137,733 0 29,137,733	0 0 0 17, 422, 950  Total (col. 1 + col. 2) 3.00  148, 224, 752  51, 557, 651  0 51, 557, 651  1.00  N 0  14, 484, 264 1, 108, 962 1, 706, 095 12, 778, 169	20 21 22 23 24 25 26 27 27 28	
. 00   .	Grants, donations and total unreimbursed cost for Medicaid, CHIP nstructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care proposed in the patients and the stay limit total bad debt expense for the entire hospital complex (see instructions)  Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see	ding charity care spital operations indigent care progration 1.00  Iity 119,08  Its (see 22,41  days beyond a len rogram? indigent care program? indigent care progrations) (see instructions)	red hts )	Insured patients 2.00 29,137,733 29,137,733 0 29,137,733	0 0 0 17, 422, 950  Total (col. 1 + col. 2) 3.00  148, 224, 752  51, 557, 651  0 51, 557, 651  1.00  N  0 14, 484, 264 1, 108, 962 1, 706, 095	20 21 22 23 24 25 26 27 27 28 29	

Heal th	Financial Systems	CLARA MAASS MED			In Lie	eu of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO	CN: 31-0009	Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021		
					<b>1</b>	5/25/2022 1:0	3 pm
	Cost Center Description	Sal ari es	0ther		Reclassificati		
				+ col . 2)	ons (See A-6)	(col. 3 +-	
						col . 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		7, 664, 198				
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		6, 159, 062	6, 159, 062			
3. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	758, 791	0 26, 076, 177	26, 834, 968	0	0 26, 834, 968	
5. 00	00500 ADMINISTRATIVE & GENERAL	9, 544, 974	79, 261, 165	88, 806, 139			1
6. 00	00600 MAI NTENANCE & REPAI RS	115, 963	28, 213	144, 176		144, 176	
7.00	00700 OPERATION OF PLANT	2, 618, 232	6, 642, 622	9, 260, 85	-6, 959	9, 253, 895	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	242, 754	361, 082	603, 83			1
9.00	00900 HOUSEKEEPI NG	2, 891, 421	1, 379, 567	4, 270, 988			9.00
10.00	01000 DI ETARY	2, 220, 656	4, 777, 979 0				
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	5, 796, 638	376, 656		2, 604, 339 4 3, 034		1
14. 00	01400 CENTRAL SERVICES & SUPPLY	669, 119	519, 391	1, 188, 510			
15. 00	01500 PHARMACY	4, 577, 368	16, 765, 294				
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 041, 796	987, 455	2, 029, 25	1 -176	2, 029, 075	16. 00
17. 00	01700 SOCIAL SERVICE	1, 653, 422	1, 174, 973				1
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(	0 274, 522	274, 522	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	20 5/7 102	0 217 720	27 004 025	10 051 /51	50, 236, 474	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	29, 567, 103 7, 682, 185	8, 317, 720 2, 894, 983	37, 884, 823 10, 577, 168			1
40. 00	04000 SUBPROVI DER - I PF	7,002,103	2,074,703		0 - 740, 000		1
43. 00	04300 NURSERY	1, 524, 026	129, 048		-	_	
44. 00	04400 SKILLED NURSING FACILITY	2, 255, 379	768, 056	3, 023, 43!			
	ANCILLARY SERVICE COST CENTERS						1
50. 00	05000 OPERATING ROOM	8, 698, 973	26, 723, 434				
51.00	05100 RECOVERY ROOM	1, 792, 761	302, 595				
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	2, 686, 181 3, 367, 220	688, 037 1, 965, 762	3, 374, 218 5, 332, 982			
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 696, 780	917, 367	2, 614, 14			
56. 00	05600 RADI OI SOTOPE	633, 470	555, 759				
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	359, 792	18, 314				
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 683, 378	2, 516, 653	4, 200, 03	-2, 042, 646	2, 157, 385	59.00
60.00	06000 LABORATORY	3, 134, 673	7, 431, 070	10, 565, 743			1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	7(0,14)		1, 038, 801		
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 472, 355 979, 069	769, 446 787, 068				
67. 00	06700 OCCUPATI ONAL THERAPY	162, 755	1, 435				1
68. 00	06800 SPEECH PATHOLOGY	219, 503	5, 820				1
69. 00	06900 ELECTROCARDI OLOGY	576, 650	22, 827	599, 47			
70.00	07000 ELECTROENCEPHALOGRAPHY	167, 417	24, 252	191, 669	9 -4, 675	186, 994	70.00
	07001 SLEEP LAB	16, 848	144, 786				
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	`	.0,020, ,, .		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		11, 262, 302 18, 979, 945		
74.00		12, 000	2, 058, 097				
76. 97	07697 CARDI AC REHABI LI TATI ON	204, 405	12, 489	216, 89			•
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	961, 071	579, 696			1, 545, 567	90. 00
90. 01	09001 WOUND CARE CENTER	742, 371	966, 246	1, 708, 61			1
90. 02	09002 CLINIC - BARIATRIC	316, 453	318, 430	634, 883			1
90. 03 90. 22	09004 VACCI NATI ON CENTER 09003 SAFE HOUSE	33, 627 888, 552	6, 493 364, 452				
90. 22	09100 EMERGENCY	11, 794, 694	5, 190, 770	1, 253, 004 16, 985, 464		.,,	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 7, 74, 0, 74	3, 170, 770	10, 700, 40	2,271,707	14, 073, 737	92.00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	1, 509, 888	560, 458	2, 070, 346	6 -155, 968	1, 914, 378	1
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	0	950, 812	950, 812	2 -475, 953	474, 859	95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300   NTEREST EXPENSE	110 270 712	6, 095, 262				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	118, 270, 713	224, 261, 471	342, 532, 184	4 -479, 215	342, 052, 969	1118.00
194 00	07950 MI SCELLANEOUS	0	0	(	0 (	0	194. 00
	07951 PUBLIC RELATIONS		0				194. 01
	07952 OTHER NON REIMBURSABLE	491, 067	28, 529	519, 596	6 0	519, 596	
194. 06	07953 GRANTS/TRI ALS	154, 093	409, 959	564, 052	2 0	564, 052	194. 06
	07954 RETAIL PHARMACY	O	357, 990	357, 990		357, 990	1
	07955 NON ALLOWABLE TRANSPORTATION	110 015 073	0		479, 215		
200.00	TOTAL (SUM OF LINES 118 through 199)	118, 915, 873	225, 057, 949	343, 973, 822	2 0	343, 973, 822	<sub>1</sub> 200.00

Peri od: From 01/01/2021 To 12/31/2021

Worksheet A Date/Time Prepared: 5/25/2022 1:03 pm

				5/25/2022 1:0	3 pm
	Cost Center Description		Net Expenses		
		(See A-8) F	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-31, 841	11, 092, 057		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	-25, 588	8, 908, 105		2. 00
3.00	00300 OTHER CAP REL COSTS	25, 300	0, 700, 103		3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	157, 358	26, 992, 326		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-20, 864, 522	51, 944, 459	l .	5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	144, 176		6.00
7. 00	00700 OPERATION OF PLANT	-339, 902	8, 913, 993		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	601, 561		8. 00
9. 00	00900 HOUSEKEEPI NG	l ol	4, 255, 731		9. 00
10.00	01000 DI ETARY	-849	4, 391, 809		10.00
11. 00	I I	-465, 554	2, 138, 785		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-407	6, 175, 921		13. 00
14. 00	1 1	0	870, 711		14. 00
15. 00		-14, 100	5, 024, 009		15. 00
16. 00	I I	-887	2, 028, 188		16.00
17. 00	I I	0	2, 827, 720		17. 00
23.00	1 1	o	274, 522		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			1
30.00	03000 ADULTS & PEDIATRICS	-4, 976, 966	45, 259, 508		30.00
31.00	03100 INTENSIVE CARE UNIT	-2, 135, 864	7, 501, 244		31.00
40.00	04000 SUBPROVI DER - I PF	O	0		40.00
43.00	04300 NURSERY	-169, 743	2, 729, 833		43.00
44.00	04400 SKILLED NURSING FACILITY	-38, 473	2, 394, 565		44. 00
	ANCI LLARY SERVI CE COST CENTERS				
50.00	· · · · · · · · · · · · · · · · · · ·	-3, 214, 642	11, 727, 973		50.00
51.00	I I	-390	1, 999, 291		51.00
52.00	+ I	-188	2, 838, 621		52. 00
54.00		-414, 625	4, 645, 843		54. 00
55. 00		-722, 135	1, 863, 458		55. 00
56. 00		-328	1, 184, 078		56. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	-195	374, 876		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-398, 867	1, 758, 518		59. 00
60. 00	06000 LABORATORY	-48, 881	9, 430, 779		60.00
63. 00	·	0	1, 038, 801		63. 00
65. 00	06500 RESPI RATORY THERAPY	-14, 733	2, 807, 551		65. 00
66. 00	I I	-760	1, 629, 343		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-78	228, 733		67. 00
68. 00		-11	281, 984		68. 00
69. 00		-1, 507	590, 243		69. 00
70. 00	I I	-10	186, 984		70.00
70. 01	07001 SLEEP LAB	-18, 498	136, 865		70. 01
71.00		-424	16, 826, 550		71.00
72. 00		-448	11, 261, 854		72. 00
73.00		-708	18, 979, 237		73.00
74.00		-14, 545	2, 015, 081		74.00
76. 97		-58	215, 647		76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	-646, 263	899, 304		00 00
	09000 CLINIC				90.00
90. 01 90. 02		-42, 067	1, 199, 454		90. 01
90. 02		-382, 115 0	257, 055 39, 811		90. 02 90. 03
90. 03	I I	-84	1, 252, 920		90. 03
91. 00	I I	-2, 083, 081	12, 610, 676		90. 22
92. 00	+ I	-2,003,001	12,010,070		92.00
92. 00	09201 OBSERVATION BEDS-DISTINCT PART	-161	1, 914, 217		92.00
72.01	OTHER REIMBURSABLE COST CENTERS	-101	1, 714, 217		72.01
95 00	09500 AMBULANCE SERVICES	14, 500	489, 359		95. 00
73.00	SPECIAL PURPOSE COST CENTERS	14, 300	407, 337		73.00
113 00	11300 INTEREST EXPENSE	O	0		113. 00
118. 00		-36, 898, 640	305, 154, 329		118. 00
110.00	NONREI MBURSABLE COST CENTERS	30, 070, 040	303, 134, 327		1110.00
194 00	0 07950 MI SCELLANEOUS	O	0		194. 00
	1 07951 PUBLIC RELATIONS	0	0	l .	194. 00
	5 07952 OTHER NON REIMBURSABLE	-150, 216	369, 380	l .	194. 05
	6 07953 GRANTS/TRI ALS	130, 210	564, 052		194. 05
	7 07954 RETAIL PHARMACY		357, 990		194. 07
	2 07955 NON ALLOWABLE TRANSPORTATION	ا م	479, 215		194. 12
200.00		-37, 048, 856	306, 924, 966		200.00

Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/25/2022 1:03 pm

		Increases			5/25/2022 1:0	03 pm
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - MEDICAL SURGICAL SUPPLIES					
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	16, 826, 974		1. 00
2.00	PATTENT	0.00	0	0		2. 00
3.00		0.00	Ö	0		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	0		9. 00
10.00		0.00	o	0		10. 00
11.00		0. 00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	Ö	0		16. 00
17. 00		0. 00	0	0		17.00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	o	0		22. 00
23. 00		0.00	0	0		23. 00
24.00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00 27. 00		0. 00 0. 00	0	0		26. 00 27. 00
28. 00		0.00	o	0		28. 00
29. 00		0.00	0	0		29.00
30. 00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32. 00 33. 00		0. 00 0. 00	0	0		32. 00 33. 00
34. 00		0.00	0	0		34. 00
35. 00		0.00	o	0		35. 00
36.00		0. 00	0	0		36.00
37. 00		0.00	0	0		37. 00
38. 00 39. 00		0. 00 0. 00	0	0		38. 00 39. 00
39.00			— — — <del>0</del>	16, 826, 974		39.00
	B - IMPLANTABLES		<u> </u>	10,020,771		
1.00	IMPL. DEV. CHARGED TO	72. 00	0	11, 262, 302		1. 00
2.00	PATI ENTS	0.00		0		2 00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0.00	Ö	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0. 00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10. 00
11. 00		0. 00	0	O		11. 00
	0		0	11, 262, 302		
1 00	C - DRUGS AND IV SOLUTIONS DRUGS CHARGED TO PATIENTS	73.00	O	18, 979, 945		1 00
1. 00 2. 00	DIGGS CHARGED TO PATTENTS	0.00	0	18, 979, 945		1. 00 2. 00
3.00		0.00	0	0		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	0	0		9. 00
10.00		0.00	Ö	0		10. 00
11. 00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
14. 00 15. 00		0.00	0	0		14.00
16. 00		0.00	Ö	0		16. 00
17. 00		0.00	0	0		17. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 31-0009 

					10	12/31/2021	5/25/2022 1:03 pm
		Increases			<u>'</u>		
	Cost Center	Li ne #	Sal ary	0ther			
10.00	2. 00	3.00	4. 00	5. 00			10.00
18.00		0. 00 0. 00	0	0			18. 00
19. 00 20. 00		0.00	0	0			19. 00 20. 00
21. 00		0.00	0	0			21. 00
22. 00		0.00	0	0			22. 00
23. 00		0.00	0	0			23. 00
24. 00		0.00	0	0			24. 00
25. 00		0.00	ol	ō			25. 00
26.00		0.00	O	O			26. 00
	0			18, 979, 945			
	D - BLOOD						
1. 00	BLOOD STORING, PROCESSING &	63. 00		1, 038, 801			1.00
2 00	TRANS.	12.00		7 000			2.00
2.00	NURSING ADMINISTRATION	13.00		<u>7, 989</u> 1, 046, 790			2. 00
	E - INTEREST		<u> </u>	1,040,790			
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	ol	3, 379, 469			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2.00	o	2, 715, 793			2. 00
	0			6, 095, 262			
	F - PROPERTY INSURANCE		1				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00		80, 231			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP			5 <u>8, 8</u> 38			2. 00
	0		0	139, 069			
1 00	G - DI ETARY	44.00	007 547	4 777 700			1.00
1. 00	CAFETERI A	<u>11.</u> 00	<u>826, 5</u> 46 826, 546	1,777,793			1.00
	H - UNALLOWABLE TRANSPORTATIO	INI	820, 540	1, 777, 793			
1. 00	NON ALLOWABLE TRANSPORTATION	194. 12	0	479, 215			1. 00
2. 00	NON ALLOWABLE TRANSPORTATION	0.00	0	0			2. 00
3. 00		0.00	o	ő			3.00
4.00		0.00	O	O			4. 00
5.00		0.00	0	О			5. 00
6.00		0.00	0	0			6. 00
	0		0	479, 215			
	K - DIRECTOR EXPENSE						
1.00	OCCUPATI ONAL THERAPY	67. 00	65, 817	0			1.00
2. 00	SPEECH PATHOLOGY		5 <u>7, 4</u> 88	<u>o</u>			2. 00
	M - MALPRACTICE		123, 305	U			
1. 00	ADMINISTRATIVE & GENERAL	5.00	ol	31, 320			1.00
2. 00	ADULTS & PEDIATRICS	30.00	o o	101, 206			2.00
3.00	INTENSIVE CARE UNIT	31.00	o	176, 068			3.00
4. 00	SKILLED NURSING FACILITY	44.00	o	3, 458			4.00
5.00	CARDIAC CATHETERIZATION	59.00	O	22, 675			5. 00
6.00	RESPIRATORY THERAPY	65.00	o	1, 186			6. 00
7.00	RENAL DIALYSIS	74. 00	0	1, 183			7. 00
8.00	CLINIC	90.00	0	11, 616			8. 00
9. 00	WOUND CARE CENTER	90. 01	0	3, 458			9. 00
10.00	CLINIC - BARLATRIC	90. 02	0	6, 770			10.00
11. 00	EMERGENCY	<u>91.</u> 00		119, 951			11. 00
	R - PHARMACY RESIDENTS		υ	478, 891			
1. 00	PARAMED ED PRGM-(SPECIFY)	23.00	268, 629	5, 893			1.00
1.00	0		268, 629				1.00
	S - MOTHERBABY		200, 027	5, 575			
1.00	NURSERY	43.00	1, 119, 163	196, 927			1.00
	TOTALS		1, 119, 163	196, 927			
	V - RADI OLOGY SUPPORT						
1.00	RADI OLOGY-THERAPEUTI C	55. 00	13, 105	0			1. 00
2.00	RADI OI SOTOPE	<u>56.</u> 00		0			2. 00
	0		20, 954	0			
1 00	X - COVID-19- CONTRACT LABOR	20.00	21	15 447 457			4 00
1. 00	ADULTS & PEDIATRICS	30.00	0	<u>15, 117, 1</u> 5 <u>7</u> 15, 117, 157			1. 00
500 00	Grand Total: Increases		2, 358, 597	72, 406, 218			500. 00
550.00	prana rotar. Frici eases	ļ	2, 330, 371	12,400,210			1 300. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | To 12/31/2021 | Date/Time Prepared: | 5/25/2022 1:03 pm Provider CCN: 31-0009

						5/	25/2022 1:03 pm
		Decreases		0.11			
-	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00 A - MEDI CAL SURGI CAL SUPPLI ES	7. 00	8. 00	9. 00	10. 00		
1.00	ADMINI STRATI VE & GENERAL	5. 00	0	272, 510	0		1.00
2.00	OPERATION OF PLANT	7. 00	0	6, 959	0		2. 00
3.00	LAUNDRY & LINEN SERVICE	8. 00	0	2, 275	o		3. 00
4.00	HOUSEKEEPI NG	9. 00	0	15, 257	0		4. 00
5.00	DI ETARY	10. 00	0	1, 638	0		5. 00
6. 00	NURSING ADMINISTRATION	13. 00	0	4, 278	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00	0	313, 270	0		7.00
8. 00 9. 00	MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	80, 065 176	0		8. 00 9. 00
10. 00	SOCIAL SERVICE	17. 00	0	675	0		10.00
11. 00	ADULTS & PEDIATRICS	30.00	o	1, 292, 791	o		11. 00
12.00	INTENSIVE CARE UNIT	31.00	0	992, 402	o		12. 00
13.00	ADULTS & PEDIATRICS	30. 00	0	38, 958	0		13. 00
14. 00	NURSERY	43. 00	0	64, 693	0		14.00
15. 00	SKILLED NURSING FACILITY	44.00	0	45, 714	0		15. 00
16. 00 17. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	10, 977, 680 84, 982	0		16. 00 17. 00
18.00	DELIVERY ROOM & LABOR ROOM	52.00	0	474, 665	0		18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54. 00	Ö	171, 300	o		19. 00
20. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	30, 384	o		20. 00
21.00	RADI OI SOTOPE	56.00	0	9, 197	О		21. 00
22.00	MAGNETIC RESONANCE IMAGING	58.00	0	2, 548	0		22. 00
	(MRI)				_		
23. 00	CARDI AC CATHETERI ZATI ON	59.00	0	484, 244	0		23. 00
24. 00 25. 00	LABORATORY RESPIRATORY THERAPY	60. 00 65. 00	0	7, 655	0		24. 00 25. 00
26. 00	PHYSICAL THERAPY	66. 00	0	221, 469 12, 671	0		26. 00
27. 00	OCCUPATI ONAL THERAPY	67.00	0	1, 196	o		27. 00
28. 00	SPEECH PATHOLOGY	68. 00	o	816	o		28. 00
29. 00	ELECTROCARDI OLOGY	69. 00	О	5, 524	О		29. 00
30.00	ELECTROENCEPHALOGRAPHY	70. 00	0	4, 675	0		30. 00
31. 00	SLEEP LAB	70. 01	0	5, 431	0		31.00
32.00	RENAL DIALYSIS	74.00	0	25, 175	0		32.00
33. 00	CARDIAC REHABILITATION CLINIC	76. 97 90. 00	0	1, 189	0		33.00
34. 00 35. 00	WOUND CARE CENTER	90.00	0	6, 759 148, 801	0		34. 00 35. 00
36. 00	CLINIC - BARIATRIC	90.01	0	2, 483	0		36.00
37. 00	VACCINATION CENTER	90. 03	ő	309	o		37. 00
38. 00	EMERGENCY	91.00	0	894, 644	0		38. 00
39. 00	OBSERVATION BEDS-DISTINCT	<u>92.</u> 01	0	12 <u>1, 5</u> 16	0		39. 00
	0		0	16, 826, 974			
1 00	B - IMPLANTABLES	F 00		F 00F	0		1.00
1. 00 2. 00	ADMINISTRATIVE & GENERAL CENTRAL SERVICES & SUPPLY	5. 00 14. 00		5, 885 4, 197	0		1. 00 2. 00
3. 00	INTENSIVE CARE UNIT	31.00		9, 093	0		3. 00
4.00	OPERATING ROOM	50.00	•	9, 263, 753	Ö		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00		73, 642	o		5. 00
6.00	MAGNETIC RESONANCE IMAGING	58. 00		72	0		6. 00
	(MRI)				_		
7.00	CARDI AC CATHETERI ZATI ON	59.00		1, 570, 728	0		7. 00
8. 00 9. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00		1, 485 58	0		8. 00 9. 00
10. 00	WOUND CARE CENTER	90. 01		319, 873	0		10.00
11. 00	EMERGENCY	91.00		13, 516	o		11. 00
	0 = = = = =			11, 262, 302			
	C - DRUGS AND IV SOLUTIONS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	14, 966	0		1. 00
2.00	NURSI NG ADMI NI STRATI ON	13.00	0	514	0		2.00
3. 00 4. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	332 15, 949, 966	0		3. 00 4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	217, 917	0		5. 00
6. 00	INTENSIVE CARE UNIT	31.00	Ö	114, 623	o		6. 00
7. 00	ADULTS & PEDIATRICS	30.00	Ö	353	Ö		7. 00
8.00	NURSERY	43.00	O	4, 895	O		8. 00
9.00	SKILLED NURSING FACILITY	44. 00	O	548, 141	o		9. 00
10.00	OPERATING ROOM	50.00	0	218, 637	0		10.00
11. 00	RECOVERY ROOM	51.00	0	10, 693	0		11.00
12. 00 13. 00	DELIVERY ROOM & LABOR ROOM	52. 00 54. 00	0	60, 744	0		12. 00 13. 00
14. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00	0	6, 618 11, 275	0		14. 00
15. 00	RADI OI SOTOPE	56.00	ol	3, 475	0		15. 00
16. 00	MAGNETIC RESONANCE I MAGING	58. 00	o	415	Ö		16. 00
	(MRI)						
	·						

| Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | To 12/31/2021 | Date/Time Prepared: | 5/25/2022 1:03 pm Provider CCN: 31-0009

						5/25/2022 1:03	pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
17. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	10, 349	l .	•	17. 00
18.00	LABORATORY	60.00	0	51, 360		•	18.00
19.00	RESPIRATORY THERAPY	65. 00	0	197, 749	l .	•	19.00
20.00	ELECTROCARDI OLOGY	69.00	0	2, 203	l 1	•	20.00
21. 00	SLEEP LAB	70. 01	0	840	l .		21. 00
22. 00	RENAL DIALYSIS	74.00	0	16, 479	l 1	•	22. 00
23. 00	CLINIC	90.00	0	57	l .	•	23. 00
24. 00	WOUND CARE CENTER	90. 01	0	1, 880		•	24. 00
25. 00	EMERGENCY	91.00	0	1, 501, 012	l .		25. 00
26. 00	OBSERVATI ON BEDS-DISTINCT	<u>92.</u> 01		3 <u>4, 4</u> 5 <u>2</u> 18, 979, 945		4	26. 00
	D - BLOOD		U <sub>I</sub>	10, 979, 943			
1.00	OPERATING ROOM	50.00		19, 722	O		1. 00
2. 00	LABORATORY	60.00		1, 027, 068	l I		2. 00
2.00	0			1, 046, 790			2.00
	E - INTEREST		<u> </u>	1,010,770			
1.00	I NTEREST EXPENSE	113. 00	0	6, 095, 262	11		1. 00
2.00		0.00	0	0	11		2. 00
				6, 095, 262			
	F - PROPERTY INSURANCE				<u> </u>		
1.00	ADMINISTRATIVE & GENERAL	5. 00		139, 069	12		1.00
2.00		0.00	O	0	12		2.00
				139, 069			
	G - DIETARY	<u> </u>					
1.00	DI ETARY	10.00	826, 546	<u>1, 777, 7</u> 93	0		1.00
	0		826, 546	1, 777, 793			
	H - UNALLOWABLE TRANSPORTATIO	N					
1.00	NURSING ADMINISTRATION	13. 00	0	163	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	45	0		2.00
3.00	INTENSIVE CARE UNIT	31. 00	0	10	l .		3.00
4.00	ADULTS & PEDIATRICS	30. 00	0	558	l .		4. 00
5.00	EMERGENCY	91. 00	0	2, 486			5.00
6.00	AMBULANCE SERVICES	95.00	0	47 <u>5, 9</u> 53			6. 00
	0		0	479, 215			
	K - DIRECTOR EXPENSE		400 005				
1.00	PHYSI CAL THERAPY	66.00	123, 305	0	l .		1.00
2. 00		0.00	0	$ \frac{0}{0}$	0		2. 00
	U NAL DRACTI CE		123, 305	0			
1 00	M - MALPRACTICE	F 00	ما	470, 001			1 00
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	478, 891	0		1.00
2.00		0.00	0	0			2.00
3.00		0.00	0	0	-		3.00
4. 00 5. 00		0. 00 0. 00	0	0			4. 00 5. 00
6. 00		0.00	0	0			6. 00
7. 00		0.00	0	0	_		7. 00
8. 00		0.00	0	0	0		8. 00
9. 00		0.00	0	0	o		9. 00
10. 00		0.00	0	0	_		10. 00
11. 00		0.00	o	0	o		11. 00
11.00						'	11.00
	R - PHARMACY RESIDENTS		<u> </u>	470,071			
1.00	PHARMACY	15. 00	268, 629	5, 893	0		1. 00
1.00	0		268, 629	5, 893	$$ $ ^{4}$		1. 00
	S - MOTHERBABY		200, 027	5, 575			
1.00	ADULTS & PEDIATRICS	30.00	1, 119, 163	196, 927	0		1. 00
50	TOTALS		1, 119, 163	19 <u>6, 927</u>			00
	V - RADI OLOGY SUPPORT		., , ,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
1.00	RADI OLOGY-DI AGNOSTI C	54.00	20, 954	0	0		1. 00
2. 00		0.00	23, 731				2. 00
			20, 954	0	$$ $ ^{4}$		. 50
	X - COVI D-19- CONTRACT LABOR		20, 701				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	15, 117, 157	0		1.00
	TOTALS						
500.00	Grand Total: Decreases		2, 358, 597	72, 406, 218		50	00.00
		'			'	1	

				To	12/31/2021	Date/Time Prep 5/25/2022 1:03	
				Acqui si ti ons		372372022 1.0	) piii
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	458, 886	0	0	0	0	1. 00
2.00	Land Improvements	2, 188, 133	0	0	0	0	2. 00
3.00	Buildings and Fixtures	180, 074, 819	7, 639, 843	0	7, 639, 843	545	3. 00
4.00	Building Improvements	336, 692	0	0	0	0	4. 00
5.00	Fi xed Equipment	24, 036, 290	0	0	0	0	5. 00
6.00	Movable Equipment	114, 685, 612	1, 981, 038	0	1, 981, 038	1, 189, 214	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	321, 780, 432	9, 620, 881	0	9, 620, 881	1, 189, 759	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	321, 780, 432	9, 620, 881	0	9, 620, 881	1, 189, 759	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	458, 886	1, 393, 446				1. 00
2.00	Land Improvements	2, 188, 133	39, 827, 059				2. 00
3.00	Buildings and Fixtures	187, 714, 117	252, 960				3. 00
4.00	Building Improvements	336, 692	12, 258, 707				4. 00
5.00	Fixed Equipment	24, 036, 290	0				5. 00
6.00	Movable Equipment	115, 477, 436	43, 344, 963				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	330, 211, 554	97, 077, 135				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	330, 211, 554	97, 077, 135				10.00

Heal th	Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der CC	CN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part II	
						5/25/2022 1:0	
			SU	JMMARY OF CAP	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	,	
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	7, 664, 198	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6, 159, 062	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	13, 823, 260	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	7, 664, 198			ļ	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6, 159, 062	•		ļ	2. 00
0 00			40 000 0/0				

0 0 0

7, 664, 198 6, 159, 062 13, 823, 260

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Pre 5/25/2022 1:0	pared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	214, 734, 117				0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	115, 477, 435				0	2. 00
3.00 Total (sum of lines 1-2)	330, 211, 552		330, 211, 55			3. 00
	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
DADT III DECONOLILATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS 0			0 7, 664, 198	0	1. 00
2.00 CAP REL COSTS-BLDG & FIXT	0			0 6, 159, 062		2.00
3.00 Total (sum of lines 1-2)				0 13, 823, 260		3.00
3.00   10tai (3aii 01 111103 1 2)		SI	JMMARY OF CAPI		· · · · · ·	3.00
		50	5 WIND IN C. 1	1712		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Relate		
				d Costs (see	through 14)	
	11.00	12.00	12.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12. 00	13. 00	14. 00	15. 00	
1.00 CAP REL COSTS-BLDG & FLXT	3, 347, 628	80, 231	1	ol o	11, 092, 057	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	2, 690, 205			0 0		2.00
3.00 Total (sum of lines 1-2)	6, 037, 833			o o		
			'	1		

In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 31-0009 

					To 12/31/2021	Date/Time Prep 5/25/2022 1:03	
				Expense Classification or	n Worksheet A	372372022 1.00	э рііі
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00	I	1.00	2.00	3.00	4. 00	5. 00	4 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-31, 841	CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2.00	Investment income - CAP REL	В	-25, 588	CAP REL COSTS-MVBLE EQUIP	2.00	11	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
1. 00	di scounts (chapter 8)		0		0.00	Ĭ	1. 00
5.00	Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)		0		0.00	0	<i>(</i> 00
6. 00	Rental of provider space by suppliers (chapter 8)		U		0.00	١	6. 00
7.00	Tel ephone servi ces (pay	A	-39, 139	ADMINISTRATIVE & GENERAL	5. 00	О	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service	A	72 047	ODEDATION OF DIANT	7. 00	0	8. 00
6.00	(chapter 21)	A	-73,047	OPERATION OF PLANT	7.00	١	0.00
9.00	Parking lot (chapter 21)	В	-106, 056	OPERATION OF PLANT	7. 00	o	9. 00
10.00	Provi der-based physician	A-8-2	-13, 961, 703			o	10.00
11 00	adjustment		0		0.00		11 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		U		0.00	0	11. 00
12. 00	Related organization	A-8-1	-10, 995, 651			o	12.00
	transactions (chapter 10)						
13.00	Laundry and linen service	D.	0	CAFETERIA	0.00		13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-465, 554 0	CAFETERI A	11. 00 0. 00	l .	14. 00 15. 00
13.00	and others		O		0.00	Ĭ	13.00
16. 00	Sale of medical and surgical		0		0.00	o	16.00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0.00	o	17. 00
17.00	pati ents		0		0.00	Ĭ	17.00
18. 00	Sale of medical records and	В	-887	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
10.00	abstracts		0		0.00	0	19. 00
19. 00	Nursing and allied health education (tuition, fees,		U		0.00	١	19.00
	books, etc.)						
20. 00	Vending machines	В	-24, 538	OPERATION OF PLANT	7. 00	l .	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	o	22. 00
	overpayments and borrowings to						
22.00	repay Medicare overpayments	4 0 2	0	DECDI DATODY THEDADY	<b>45.00</b>		22.00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	U	RESPIRATORY THERAPY	65.00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization (chapter 14)		Ω	  *** Cost Center Deleted ***	114.00		25. 00
00	physicians' compensation		0				50
0/ 00	(chapter 21)		=	CAR DEL COSTO PLEO A SINT		_	2/ 62
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00		26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	o	27. 00
	COSTS-MVBLE EQUIP						
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00		29. 00 30. 00
50.00	therapy costs in excess of	N-0-3	U		67.00		50.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	^	SDEECH DATHOLOGY	40.00		31. 00
31.00	pathology costs in excess of	H-0-3	Ü	SPEECH PATHOLOGY	68. 00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32.00
33 00	Depreciation and Interest X-RAY COPY FEES	В	_7 250	RADI OLOGY-DI AGNOSTI C	54.00		33. 00
	IN INTEREST	l D	-7,250	PARE OF DE PLYONOSTIC	1 54.00	<u> </u>	

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 CLARA MAASS MEDICAL CENTER Provider CCN: 31-0009 | Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

				To	12/31/2021	Date/Time Pre 5/25/2022 1:0	
				Expense Classification on		, 0, 20, 2022 11 0	<u>Б.</u>
				To/From Which the Amount is t	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
22.01	LABORATORY OTHER DEVENUE	1.00	2. 00	3.00	4. 00	5. 00	22.01
33. 01 33. 02	LABORATORY OTHER REVENUE DRUGS SOLD TO NON-PATIENTS	B B		LABORATORY EMPLOYEE BENEFITS DEPARTMENT	60. 00 4. 00	0	
33. 03	OTHER MI SCELLANEOUS REVENUE	B		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 04	OTHER MI SCELLANEOUS REVENUE	В	-5, 335	OPERATION OF PLANT	7. 00	0	33. 04
33. 05	OTHER MI SCELLANEOUS REVENUE	В		DIETARY	10.00	0	33. 05
33. 06 33. 07	OTHER MI SCELLANEOUS REVENUE OTHER MI SCELLANEOUS REVENUE	B B		PHARMACY RADI OLOGY-DI AGNOSTI C	15. 00 54. 00	0	33. 06 33. 07
33. 07	OTHER MI SCELLANEOUS REVENUE	В		RADI OLOGY-DI AGNOSTI C	54. 00 55. 00	0	33. 07
33. 09	OTHER MI SCELLANEOUS REVENUE	В		LABORATORY	60.00	Ö	33. 09
33. 10	OTHER MI SCELLANEOUS REVENUE	В	-1, 100	ELECTROCARDI OLOGY	69. 00	0	33. 10
33. 11	OTHER MI SCELLANEOUS REVENUE	В		CLINIC	90.00	0	
33. 12 33. 13	OTHER MISCELLANEOUS REVENUE EMPLOYEE - HEALTH PAYMENTS	B B		EMERGENCY ADULTS & PEDIATRICS	91. 00 30. 00	0	33. 12 33. 13
33. 14	EMPLOYEE - HEALTH PAYMENTS	В		INTENSIVE CARE UNIT	31. 00	0	33. 14
33. 15	EMPLOYEE - HEALTH PAYMENTS	В		ADULTS & PEDIATRICS	30.00	Ö	33. 15
33. 16	EMPLOYEE - HEALTH PAYMENTS	В		NURSERY	43.00	0	33. 16
33. 17	EMPLOYEE - HEALTH PAYMENTS	В		OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	33. 17 33. 18
33. 18 33. 19	EMPLOYEE - HEALTH PAYMENTS EMPLOYEE - HEALTH PAYMENTS	B B		DELIVERY ROOM & LABOR ROOM	51. 00 52. 00	0 0	33. 18
33. 20	EMPLOYEE - HEALTH PAYMENTS	B		RADI OLOGY-DI AGNOSTI C	54.00	0	1
33. 21	EMPLOYEE - HEALTH PAYMENTS	В		RADI OLOGY-THERAPEUTI C	55.00	0	33. 21
33. 22	EMPLOYEE - HEALTH PAYMENTS	В		RADI OI SOTOPE	56. 00	0	33. 22
33. 23	EMPLOYEE - HEALTH PAYMENTS	В	-195	MAGNETIC RESONANCE IMAGING	58. 00	0	33. 23
33. 24	EMPLOYEE - HEALTH PAYMENTS	В	-336	(MRI) CARDIAC CATHETERIZATION	59. 00	0	33. 24
33. 25	EMPLOYEE - HEALTH PAYMENTS	В		LABORATORY	60.00	Ö	33. 25
33. 26	EMPLOYEE - HEALTH PAYMENTS	В		RESPIRATORY THERAPY	65. 00	0	
33. 27	EMPLOYEE - HEALTH PAYMENTS	В		PHYSI CAL THERAPY	66.00	0	33. 27
33. 28 33. 29	EMPLOYEE - HEALTH PAYMENTS EMPLOYEE - HEALTH PAYMENTS	B B		OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67. 00 68. 00	0	33. 28 33. 29
33. 30	EMPLOYEE - HEALTH PAYMENTS	В		ELECTROCARDI OLOGY	69. 00	0	33. 30
33. 31	EMPLOYEE - HEALTH PAYMENTS	В		ELECTROENCEPHALOGRAPHY	70.00	0	1
33. 32	EMPLOYEE - HEALTH PAYMENTS	В		SLEEP LAB	70. 01	0	33. 32
33. 33	EMPLOYEE - HEALTH PAYMENTS	В	-424	MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 33
33. 34	EMPLOYEE - HEALTH PAYMENTS	В	-448	PATIENT IMPL. DEV. CHARGED TO	72. 00	0	33. 34
00.0.				PATI ENTS	, 2, 00		00.0.
33. 35	EMPLOYEE - HEALTH PAYMENTS	В		DRUGS CHARGED TO PATIENTS	73. 00	0	
33. 36 33. 37	EMPLOYEE - HEALTH PAYMENTS EMPLOYEE - HEALTH PAYMENTS	B B		RENAL DIALYSIS CARDIAC REHABILITATION	74. 00 76. 97	0	
33. 38	EMPLOYEE - HEALTH PAYMENTS	В		CLINIC	90.00	0	33. 38
33. 39	EMPLOYEE - HEALTH PAYMENTS	В		WOUND CARE CENTER	90. 01	Ö	1
33. 40	EMPLOYEE - HEALTH PAYMENTS	В		CLINIC - BARIATRIC	90. 02	0	
33. 41	EMPLOYEE - HEALTH PAYMENTS	В		EMERGENCY	91.00	0	
33. 42 33. 43	EMPLOYEE - HEALTH PAYMENTS EMPLOYEE - HEALTH PAYMENTS	B B		ADULTS & PEDIATRICS OBSERVATION BEDS-DISTINCT	30. 00 92. 01	0	
33. 44	RENTAL INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 45	FOUNDATION SUBSIDY	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 46	FOUNDATION SUBSIDY	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 47	OTHER REV-RENDINA	В		OPERATION OF PLANT	7.00	0	33. 47
33. 48 33. 49	NON ALLOW FOOD AND BEVERAGE NON ALLOW FOOD AND BEVERAGE	A A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	
33. 50	NON ALLOW FOOD AND BEVERAGE	A		DI ETARY	10. 00	0	1
33. 51	NON ALLOW FOOD AND BEVERAGE	A	-110	NURSING ADMINISTRATION	13. 00	0	33. 51
33. 52	NON ALLOW FOOD AND BEVERAGE	A		OPERATING ROOM	50.00	0	•
33. 53 33. 54	NON ALLOW FOOD AND BEVERAGE NON ALLOW FOOD AND BEVERAGE	A A		RESPIRATORY THERAPY SAFE HOUSE	65. 00 90. 22	0	
33. 55	NON ALLOW FOOD AND BEVERAGE	A		EMERGENCY	91. 00	0	1
33. 56	NON ALLOW GIFTS AND DONATIONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 57	LOBBYI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 58	BHMG/MMG	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 59	ADDITIONAL CAPTIVE PHYS PRACTICE	A	-1, 380, 733	ADULTS & PEDIATRICS	30. 00	0	33. 59
33. 60	NURSE PRACTIONERS (INCLUDES	A	-2, 007, 476	ADMINISTRATIVE & GENERAL	5. 00	0	33. 60
0.5	FRI NGES)						
33. 61	NURSE PRACTIONERS (INCLUDES FRINGES)	A	-297	NURSING ADMINISTRATION	13. 00	0	33. 61
33. 62	NURSE PRACTIONERS (INCLUDES	A	-282.748	ADULTS & PEDIATRICS	30. 00	0	33. 62
	FRI NGES)	'	,	22	22.00		
	FKI NGES)						l

Heal th	Financial Systems		CLARA MAASS ME	DICAL CENTER	In Lie	eu of Form CMS-	2552-10
ADJUST	MENTS TO EXPENSES				Peri od: From 01/01/2021	Worksheet A-8	
					To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
				Expense Classification or	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	
33. 63	NURSE PRACTIONERS (INCLUDES	A	-150, 216	OTHER NON REIMBURSABLE	194.05	0	33. 63
	FRI NGES)						
33. 64	PENSION ADMINISTRATION COSTS	A	173, 925	EMPLOYEE BENEFITS DEPARTMEN	Γ 4.00	0	33. 64
33. 65	HPB OFFSET	A	-38, 473	SKILLED NURSING FACILITY	44.00	0	33. 65
33. 66	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 66
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-37, 048, 856				50.00
	(Transfer to Worksheet A,						
	1 ( 11 000 )	1				I	I

- column 6, line 200.)

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

  (2) Basis for adjustment (see instructions).

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

  B. Amount Received if cost cannot be determined.

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

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

Heal th	Financial Systems	IEDI CAL CENTER	In Li€	eu of Form CMS-	2552-10	
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 31-0009	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
	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 O	RGANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	31, 924, 730	42, 934, 881	1.00
2.00	0.00			0	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	CLARA MAASS FOUNDATION	39, 864	39, 864	3.00
3. 01	5. 00	ADMINISTRATIVE & GENERAL	ST BARNABAS CORP	304, 952	304, 952	3. 01
3. 02	95. 00	AMBULANCE SERVICES	AMBULANCE ADD ON	14, 500	0	3. 02
3.03	0.00			o	o	3. 03
4.00	0. 00			o	0	4.00
5.00	TOTALS (sum of lines 1-4).			32, 284, 046	43, 279, 697	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.

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

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

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

6.00	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
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Transfer column 6, line 5 to Worksheet A-8, column 2,

line 12.

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

Health Financial Systems			CLARA MAASS MEDICAL CENTER				In Lieu of Form CMS-2552-10			
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS	AND HOME	Provider CCN: 3	31-0009	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS							From 01/01/2021 To 12/31/2021	Date/Time Pro 5/25/2022 1:0	
	Net	Wkst. A-7 Ref.				'				
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REC	QUIRED AS A RE	SULT OF TRA	NSACTIONS WITH	RELATED (	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:								
1.00	-11, 010, 151	C	)							1. 00
2.00	0	C								2. 00
3.00	0	C								3. 00
3.01	0	C								3. 01
3.02	14, 500	C								3. 02
3.03	0	C								3. 03
4.00	0									4.00

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

5.00

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

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

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

	Comonic under the Arrive		
6.00	HEALTHCARE		6. 00
7.00			7.00
8.00			8.00
9.00			9.00
10. 00 100. 00			10.00
100.00		1	100.00

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

-10, 995, 651

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 31-0009 

						lo 12/31/2021	Date/lime Pre 5/25/2022 1:0	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Prov ider Component	уд рііі
	1 00	2.00	2.00	4.00	F 00	/ 00	Hours	
1.00	1.00	2. 00 AGGREGATE-ADMI NI STRATI VE &	3. 00 451, 105	4. 00 440, 763	5. 00 10, 342	6. 00 211, 500	7. 00 15	1. 00
2. 00		GENERAL AGGREGATE-ADULTS &	3, 366, 970		57, 630		1, 040	2. 00
3. 00		PEDIATRICS AGGREGATE-INTENSIVE CARE	2, 135, 056		0		0	3. 00
		UNI T						
4.00		AGGREGATE OPERATING POOM	169, 588		0	0	0	4. 00
5. 00 6. 00		AGGREGATE-OPERATI NG ROOM AGGREGATE-RADI OLOGY-DI AGNOST	3, 208, 758 406, 191	3, 208, 758 406, 191	0	1	0	5. 00 6. 00
7. 00	55. 00	I C AGGREGATE-RADI OLOGY-THERAPEU	721, 563	721, 563	0	0	0	7. 00
8. 00	59. 00	TI C AGGREGATE - CARDI AC CATHETERI ZATI ON	398, 531	398, 531	0	211, 500	0	8. 00
9. 00	60.00	AGGREGATE-LABORATORY	36, 670	0	36, 670	211, 500	386	9. 00
10. 00		AGGREGATE-RESPI RATORY THERAPY	14, 379		0	211, 500	0	10. 00
11. 00	70. 01	AGGREGATE-SLEEP LAB	18, 474	18, 474	0	211, 500	O	11. 00
12. 00		AGGREGATE-RENAL DIALYSIS	14, 341	14, 341	0	0	0	12.00
13.00		AGGREGATE - CLI NI C	639, 798		0	0	0	13.00
14. 00 15. 00		AGGREGATE-WOUND CARE CENTER AGGREGATE-CLINIC - BARIATRIC	41, 928 382, 103		0	211, 500	0	14. 00 15. 00
16. 00		AGGREGATE-EMERGENCY	2, 052, 791	2, 052, 791	0	0	0	16. 00
200. 00	71100		14, 058, 246		104, 642		1, 441	
	Wkst. A Line #	Cost Center/Physician	Unadj usted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE Limit	Membershi ps & Continuing Education	Component Share of col. 12	of Malpractice Insurance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		AGGREGATE-ADMINISTRATIVE &	1, 525	76	0	0	31, 320	1. 00
2. 00		GENERAL AGGREGATE-ADULTS &	105, 750	5, 288	0	0	101, 206	2. 00
3. 00	31. 00	PEDIATRICS AGGREGATE-INTENSIVE CARE	0	0	0	0	176, 068	3. 00
4. 00	43. 00	UNIT AGGREGATE-NURSERY	0	0	0	0	0	4. 00
5.00		AGGREGATE-OPERATING ROOM	0	0	0	0	3, 458	5. 00
6. 00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST I C	0	0	0	0	0	6. 00
7. 00	55. 00	AGGREGATE-RADI OLOGY-THERAPEU TI C	0	0	0	0	O	7. 00
8. 00	59. 00	AGGREGATE-CARDI AC CATHETERI ZATI ON	0	0	0	0	22, 675	8. 00
9. 00 10. 00		AGGREGATE-LABORATORY AGGREGATE-RESPIRATORY	39, 250 0	1, 963 0	0	0	0 1, 186	9. 00 10. 00
11. 00	70.01	THERAPY AGGREGATE-SLEEP LAB	,	0	0	0	0	11. 00
12. 00		AGGREGATE-RENAL DIALYSIS	Ö	0	0	Ö		12. 00
13.00		AGGREGATE-CLI NI C	0	0	0	0	11, 616	
14.00		AGGREGATE-WOUND CARE CENTER	0	0	0	0	3, 458	
15. 00 16. 00		AGGREGATE CHINIC - BARIATRIC	0	0	0	0	6, 770	
200.00	91.00	AGGREGATE-EMERGENCY	146, 525	7, 327	0	0	119, 951 478, 891	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	170,071	200.00
		I denti fi er	Component Share of col.	Limit	Di sal I owance	-		
	1.00	2.00	14 15. 00	14.00	17.00	10.00		
1. 00	1. 00 5. 00	2.00 AGGREGATE-ADMI NI STRATI VE &	718	16. 00 2, 243	17. 00 8, 099	18. 00 448, 862		1. 00
2. 00	30.00	GENERAL AGGREGATE-ADULTS &	1, 732	107, 482	0	3, 309, 340		2. 00
3. 00	31. 00	PEDIATRICS AGGREGATE-INTENSIVE CARE	0	0	0	2, 135, 056		3. 00
4. 00		UNI T AGGREGATE-NURSERY	_	0	0	169, 588		4. 00
5.00		AGGREGATE-NORSERT	0	0	0	3, 208, 758		5. 00
6. 00		AGGREGATE-RADI OLOGY-DI AGNOST	ő	ő	ő	406, 191		6. 00
7. 00	55. 00	AGGREGATE-RADI OLOGY-THERAPEU TI C	0	0	0	721, 563		7. 00
8. 00	59. 00	AGGREGATE-CARDI AC CATHETERI ZATI ON	0	0	0	398, 531		8. 00
9. 00	60. 00	AGGREGATE-LABORATORY	0	39, 250	0	0		9. 00

Health Financial Syste	ms	CLARA MAASS M	EDICAL CENTER		In Li€	eu of Form CMS-	-2552-10
PROVI DER BASED PHYSI CI	AN ADJUSTMENT		Provi der (		Peri od: From 01/01/2021	Worksheet A-8	8-2
						Date/Time Pro 5/25/2022 1:0	
Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	RCE Di sal I owance	Adj ustment		·

							1 37 237 2022 1. 03 pili	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
10.00	65. 00	AGGREGATE-RESPI RATORY	0	0	0	14, 379	10.	00
		THERAPY						
11.00	70. 01	AGGREGATE-SLEEP LAB	0	0	0	18, 474	11.	00
12.00	74. 00	AGGREGATE-RENAL DIALYSIS	0	0	0	14, 341	12.	00
13.00	90.00	AGGREGATE-CLINIC	0	0	0	639, 798	13.	00
14.00	90. 01	AGGREGATE-WOUND CARE CENTER	0	0	0	41, 928	14.	00
15. 00	90. 02	AGGREGATE-CLINIC - BARIATRIC	0	0	0	382, 103	15.	00
16. 00	91. 00	AGGREGATE-EMERGENCY	0	0	0	2, 052, 791	16.	00
200.00			2, 450	148, 975	8, 099	13, 961, 703	200.	00

COST	n Financial Systems ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 31-0009 P	eri od:	u of Form CMS-: Worksheet B	2002 1
					rom 01/01/2021	Part I Date/Time Pre	pared:
			CAPLTAL REI	LATED COSTS		5/25/2022 1:0	3 pm
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost Allocation			BENEFITS DEPARTMENT		
		(from Wkst A			DELAKTMENT		
		col. 7)					
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	4. 00	4A	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	11, 092, 057	11, 092, 057				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	8, 908, 105	,,	8, 908, 105			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	26, 992, 326	195, 441		27, 188, 333		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	51, 944, 459	861, 455		2, 196, 327	59, 097, 528	
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	144, 176 8, 913, 993	442, 185 316, 956		26, 683 602, 463	679, 718 10, 045, 149	1
8.00	00800 LAUNDRY & LINEN SERVICE	601, 561	101, 141		55, 858	758, 560	•
9.00	00900 HOUSEKEEPI NG	4, 255, 731	37, 476		665, 325	4, 970, 601	
10.00	01000 DI ETARY	4, 391, 809	302, 372		320, 789	5, 084, 087	•
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	2, 138, 785	86, 629 25, 139		190, 191 1, 333, 824	2, 415, 605	•
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 175, 921 870, 711	25, 139 145, 604	·	1, 333, 824	7, 683, 137 1, 243, 366	1
15. 00	01500 PHARMACY	5, 024, 009	101, 092		991, 454	6, 126, 738	•
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 028, 188	28, 388	15, 162	239, 720	2, 311, 458	
17. 00	01700 SOCIAL SERVICE	2, 827, 720	0		380, 457	3, 208, 177	
23. 00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTINE SERVICE COST CENTERS	274, 522	0	0	61, 812	336, 334	23.00
30. 00		45, 259, 508	2, 940, 140	92, 897	6, 545, 993	54, 838, 538	30.00
31.00	03100 I NTENSI VE CARE UNI T	7, 501, 244	659, 613		1, 767, 694	10, 088, 890	
40. 00	04000 SUBPROVI DER - I PF	o	0		0	0	40.00
43.00	04300 NURSERY	2, 729, 833	72, 533		608, 206	3, 419, 853	
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	2, 394, 565	297, 950	1, 183	518, 969	3, 212, 667	44.00
50. 00		11, 727, 973	996, 431	1, 541, 536	2, 001, 660	16, 267, 600	50.00
51.00	05100 RECOVERY ROOM	1, 999, 291	149, 317		412, 520	2, 562, 169	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 838, 621	167, 395		618, 098	3, 649, 144	
54.00	l l	4, 645, 843	404, 978		769, 986	6, 353, 715	1
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 863, 458	318, 935		393, 450	3, 359, 632	
56. 00 58. 00	05600 RADIOISOTOPE 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 184, 078 374, 876	121, 784 0	230, 921 0	147, 569 82, 789	1, 684, 352 457, 665	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 758, 518	90, 929		387, 350	2, 322, 637	
60.00	06000 LABORATORY	9, 430, 779	131, 190		721, 298	10, 296, 227	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 038, 801	0	0	0	1, 038, 801	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 807, 551	29, 585 96, 670		568, 896	3, 561, 039 1, 927, 795	
67.00	06700 OCCUPATI ONAL THERAPY	1, 629, 343 228, 733	3, 518		196, 914 52, 595	284, 846	•
68. 00	06800 SPEECH PATHOLOGY	281, 984	12, 093		63, 736	361, 651	1
69. 00	06900 ELECTROCARDI OLOGY	590, 243	56, 092		132, 689	898, 205	1
	07000 ELECTROENCEPHALOGRAPHY	186, 984	4, 642		38, 523	249, 314	
70. 01	07001 SLEEP LAB	136, 865	39, 919		3, 877	185, 730	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 826, 550 11, 261, 854	0	0	0	16, 826, 550 11, 261, 854	
73.00		18, 979, 237	0	0	0	18, 979, 237	
74. 00	07400 RENAL DIALYSIS	2, 015, 081	151, 613	0	2, 761	2, 169, 455	
76. 97	07697 CARDIAC REHABILITATION	215, 647	28, 290	1, 657	47, 034	292, 628	76. 9
00.00	OUTPATIENT SERVICE COST CENTERS	000 204	1// 220	2 727	221 145	1 200 FO/	90.00
90. 00 90. 01	09000 CLI NI C 09001 WOUND CARE CENTER	899, 304 1, 199, 454	166, 320 159, 284		221, 145 170, 822	1, 289, 506 1, 544, 940	
90. 01	09002 CLINIC - BARIATRIC	257, 055	54, 968		72, 817	385, 585	
90. 03		39, 811	0	0	7, 738	47, 549	
90. 22	09003 SAFE HOUSE	1, 252, 920	0	7, 634	204, 458	1, 465, 012	90. 22
91. 00	l l	12, 610, 676	469, 352	392, 102	2, 713, 994	16, 186, 124	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1 014 017	444 017		247 420	0 705 ((4	
92. 01	09201 OBSERVATION BEDS-DISTINCT OTHER REIMBURSABLE COST CENTERS	1, 914, 217	444, 017	0	347, 430	2, 705, 664	92.01
95. 00	09500 AMBULANCE SERVICES	489, 359	0	0	0	489, 359	95. 00
	SPECIAL PURPOSE COST CENTERS		· ·		-1		1
	11300 INTEREST EXPENSE						113. 00
118. 00	3 /	305, 154, 329	10, 711, 436	8, 907, 241	27, 039, 880	304, 624, 391	J118. 00
194 0	NONREI MBURSABLE COST CENTERS D 07950 MI SCELLANEOUS	٥	0	0	٥١	0	194. 00
	1 07951 PUBLIC RELATIONS		3, 518	•	0		194. 00
194. 0	5 07952 OTHER NON REIMBURSABLE	369, 380	356, 313		112, 996	839, 553	1
194.0	6 07953 GRANTS/TRI ALS	564, 052	0	0	35, 457	599, 509	
	7 07954 RETAIL PHARMACY	357, 990	20, 790		O	378, 780	
194. 12 200. 00	2 07955 NON ALLOWABLE TRANSPORTATION	479, 215	0	0	0	479, 215	
	O Cross Foot Adjustments	i l		I		Ü	200. 00
201.00	Negative Cost Centers		0	0	0	Ω	201.00

Health Financial Systems					u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 01/01/2021	Worksheet B Part I	
				To 12/31/2021	Date/Time Pre 5/25/2022 1:0	pared: 3 pm
		CAPI TAL REI	LATED 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	
202.00 TOTAL (sum lines 118 through 201)	306, 924, 966	11, 092, 057	8, 908, 10	27, 188, 333	306, 924, 966	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0009

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

5/25/2022 1:03 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 59, 097, 528 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 162,087 841, 805 6.00 00700 OPERATION OF PLANT 12, 468, 349 7.00 2, 395, 386 27, 814 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 180, 888 8.875 135, 948 1, 084, 271 8.00 00900 HOUSEKEEPI NG 6, 209, 562 9.00 1, 185, 299 3. 289 50.373 9 00 1, 212, 362 26, 534 10.00 01000 DI ETARY 406, 432 10.00 11.00 01100 CAFETERI A 576,030 7, 602 116, 443 0 0 11.00 01300 NURSING ADMINISTRATION 6, 998 33, 790 0 13 00 13 00 1, 832, 136 2. 206 14.00 01400 CENTRAL SERVICES & SUPPLY 296, 496 12, 777 195, 713 0 83, 981 14.00 01500 PHARMACY 15.00 1, 460, 994 8, 871 135, 882 0 62, 986 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16, 00 551, 195 2, 491 38, 157 41, 991 16, 00 01700 SOCIAL SERVICE 0 17.00 765.028 C 0 17.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 80, 203 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 077, 005 2, 743, 746 258, 002 3, 951, 987 435.390 30.00 03100 INTENSIVE CARE UNIT 31.00 2, 405, 817 57, 883 886, 618 93, 570 393, 313 31 00 04000 SUBPROVIDER - IPF 40.00 40.00 0 04300 NURSERY 43.00 815, 505 6, 365 97, 495 23, 467 41, 991 43.00 04400 SKILLED NURSING FACILITY 766, 099 400, 489 44.00 26, 146 16, 189 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 879, 204 87, 439 1, 339, 352 90. 588 766, 331 50.00 51.00 05100 RECOVERY ROOM 610, 980 13, 103 200, 704 30, 953 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 53, 765 52.00 870, 182 14, 689 225, 004 152, 216 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 515, 120 35, 538 544, 351 25, 596 99, 378 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 801, 145 27, 987 428, 696 4, 426 108, 476 55.00 05600 RADI OI SOTOPE 10, 687 6.032 56.00 401, 654 163, 696 52, 488 56.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 109.136 58.00 Ω 58.00 59.00 05900 CARDIAC CATHETERIZATION 553, 861 7,979 122, 222 6, 428 26, 244 59.00 60.00 06000 LABORATORY 2, 455, 259 11, 512 176, 339 74, 366 60.00 0 63 00 06300 BLOOD STORING, PROCESSING & TRANS. 247 715 63 00 0 0 06500 RESPIRATORY THERAPY 39, 766 65.00 849, 172 2, 596 0 65.00 06600 PHYSI CAL THERAPY 459, 706 8, 483 129, 939 66.00 6.451 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.925 309 4.729 67.00 0 06800 SPEECH PATHOLOGY 68.00 86, 240 1.061 16, 255 Λ 68.00 4, 922 75, 395 19, 596 69.00 06900 ELECTROCARDI OLOGY 214, 188 3, 290 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 59, 452 407 6, 239 0 70.00 70 01 07001 SLEEP LAB 44, 290 159 20, 995 70 01 3.503 53, 657 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 4, 012, 493 0 71.00 C C 0 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 685, 524 72.00 72.00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 525, 827 73.00 C 0 07400 RENAL DIALYSIS 13, 304 203 791 517 333 74 00 4.472 0 74 00 76. 97 07697 CARDIAC REHABILITATION 69, 781 2, 483 38, 026 20, 995 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 307, 498 14, 595 223, 559 1, 708 27, 994 90.00 90.01 09001 WOUND CARE CENTER 214, 102 62, 986 13, 978 90 01 368, 409 4,649 90.02 09002 CLINIC - BARIATRIC 91, 947 4,824 73,885 0 27, 994 90.02 09004 VACCINATION CENTER 11, 339 90.03 0 90.03 09003 SAFE HOUSE 90.22 349.350 90.22  $\cap$ 0 91 00 09100 EMERGENCY 3, 859, 776 41, 187 630, 878 238, 127 1, 322, 708 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 92. 01 09201 OBSERVATION BEDS-DISTINCT 645, 198 38, 964 596, 825 39, 011 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 116, 694 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 58, 548, 928 808, 405 11, 956, 737 1,084,271 6, 157, 773 118. 00 194. 00 07950 MI SCELLANEOUS 0 194. 00 194. 01 07951 PUBLIC RELATIONS 0 194. 01 839 309 4.729 0 194.05 07952 OTHER NON REIMBURSABLE 200, 201 31, 267 478, 938 0 51, 789 194. 05 194. 06 07953 GRANTS/TRI ALS 142, 960 0 194.06 194. 07 07954 RETAIL PHARMACY 90, 325 1,824 27, 945 0 0 194. 07 194. 12 07955 NON ALLOWABLE TRANSPORTATION 0 194, 12 114, 275 C 0 200.00 Cross Foot Adjustments 200. 00 0 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 59, 097, 528 841, 805 12, 468, 349 1, 084, 271 6, 209, 562 202. 00

Provider CCN: 31-0009

				10	12/31/2021	Date/lime Pre   5/25/2022 1:0	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	5 piii
		10.00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	. 700 445					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	6, 729, 415	3, 115, 680				10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION		173, 002				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	o	34, 612	0	1, 866, 945		14. 00
15. 00	01500 PHARMACY	O	120, 899	0	1, 556	7, 917, 926	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	46, 102		0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	43, 912	106, 037	0	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	8, 560	0	U	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	5, 537, 737	938, 524	4, 222, 527	23, 896	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	624, 211	173, 457	1, 078, 263	11, 784	0	31. 00
40.00	04000 SUBPROVI DER - I PF	o	0	0	o	0	40. 00
43.00	04300 NURSERY	0	61, 232	242, 118	1, 025	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	361, 078	80, 600	195, 923	1, 752	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	206, 389	255, 251	1, 178, 313	12, 154	0	50.00
51. 00	05100 RECOVERY ROOM	0	46, 102		631	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	74, 997	447, 727	2, 934	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	104, 233		1, 961	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	35, 266		1, 993	0	55. 00
56. 00 58. 00	05600 RADIOISOTOPE 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	17, 917 10, 750	0	269	0	56. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		37, 399		1, 548	0	59.00
60.00	06000 LABORATORY	o	116, 121	0	1, 470	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0	0	O	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	72, 494	0	689	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	25, 426	0	230	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	6, 314 9, 300	0	14	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	20, 164	7, 202	217	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	5, 432	0	2	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	1, 066, 142	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	713, 571	0 7, 917, 926	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS		0		983	7, 917, 920	74.00
76. 97	07697 CARDIAC REHABILITATION	o	4, 977	39, 482	210	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC	0	28, 810 25, 596	·	493 581	0	90.00
90. 01	09001 WOUND CARE CENTER 09002 CLINIC - BARIATRIC		25, 596 9, 926	86, 187 0	281	0	90. 01 90. 02
90. 03	09004 VACCINATION CENTER	o	1, 251	4, 718	9	0	90. 03
90. 22	09003 SAFE HOUSE	o	43, 798		О	0	90. 22
91. 00	09100 EMERGENCY	0	401, 263	1, 135, 772	17, 820	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		F4 070	000 540			92.00
92. 01	09201 OBSERVATION BEDS-DISTINCT OTHER REIMBURSABLE COST CENTERS	0	51, 278	223, 549	2, 984	0	92. 01
95. 00	09500 AMBULANCE SERVICES	0	0	0	O	0	95. 00
	SPECIAL PURPOSE COST CENTERS	-1		-	-,		
	11300 INTEREST EXPENSE						113. 00
118. 00	3 /	6, 729, 415	3, 084, 965	9, 709, 771	1, 866, 918	7, 917, 926	118. 00
104 00	NONREI MBURSABLE COST CENTERS 0 07950 MI SCELLANEOUS		0		٥	0	194. 00
	1 07951 PUBLIC RELATIONS		0	0	0		194. 00
	07952 OTHER NON REIMBURSABLE	o	23, 349	21, 498	27		194. 05
194.00	07953 GRANTS/TRI ALS	o	7, 366		o		194. 06
	7 07954 RETAIL PHARMACY	0	0	0	O		194. 07
194. 12 200. 00	2 07955 NON ALLOWABLE TRANSPORTATION	0	0	0	0	0	194. 12 200. 00
200.00			Λ	n	n	Λ	200.00
202.00		6, 729, 415	3, 115, 680	9, 731, 269	1, 866, 945	7, 917, 926	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0009

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

			То	12/31/2021	Date/Time Pre 5/25/2022 1:0	
Cost Center Description		SOCIAL SERVICE	PARAMED ED	Subtotal	Intern &	<b>у</b>
	RECORDS & LI BRARY		PRGM		Residents Cost & Post	
	LIBRARI				Stepdown	
					Adj ustments	
GENERAL SERVICE COST CENTERS	16. 00	17. 00	23. 00	24. 00	25. 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   ADMI NI STRATI VE & GENERAL 6. 00   00600   MAI NTENANCE & REPAI RS						5. 00
6. 00   00600 MAI NTENANCE & REPAI RS 7. 00   00700 OPERATI ON OF PLANT						6. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON						11. 00 13. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY						14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 991, 394					16. 00
17. 00 01700 SOCIAL SERVICE	0	4, 123, 154	425 007			17. 00
23. 00   O2300   PARAMED ED PRGM-(SPECIFY)   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	425, 097			23. 00
30. 00 03000 ADULTS & PEDIATRICS	986, 553	3, 834, 533	0	90, 848, 438	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	162, 087	0	0	15, 975, 893	0	31. 00
40. 00   04000   SUBPROVI DER -   PF	0	0	0	0	0	40.00
43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	38, 793 23, 441	0 0	0	4, 747, 844 5, 084, 384	0	43. 00 44. 00
ANCI LLARY SERVICE COST CENTERS	23, 441	<u> </u>	UU	5, 064, 364	0	44.00
50. 00 05000 OPERATI NG ROOM	229, 808	0	0	24, 312, 429	0	50. 00
51. 00   05100   RECOVERY ROOM	43, 351	0	0	3, 802, 880	0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	44, 470	0	0	5, 535, 128	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	162, 144 45, 306	0	0	8, 888, 492 4, 919, 918	0	54. 00 55. 00
56. 00   05600   RADI OI SOTOPE	27, 137	o	Ö	2, 364, 232	Ö	56. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	20, 569	0	0	598, 120	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	47, 089	0	0	3, 257, 617	0	59. 00
60. 00   06000   LABORATORY 63. 00   06300   BLOOD STORING, PROCESSING & TRANS.	227, 632 29, 752	0	0	13, 358, 926	0	60. 00 63. 00
65. 00 06500 RESPIRATORY THERAPY	35, 051	0	0	1, 316, 268 4, 560, 807	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	26, 051	Ö	Ö	2, 584, 081	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 785	0	0	367, 922	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	3, 040	0	0	477, 547	0	68. 00
69. 00   06900  ELECTROCARDI OLOGY 70. 00   07000  ELECTROENCEPHALOGRAPHY	46, 215 5, 360	0	0	1, 289, 394 326, 206	0	69. 00 70. 00
70. 01   07001   SLEEP LAB	3, 317	o	Ö	311, 651	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	49, 061	0	0	21, 954, 246	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	29, 314	0	0	14, 690, 263	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	94, 221	0	425, 097	31, 942, 308	0	73.00
74. 00   07400   RENAL DI ALYSI S 76. 97   07697   CARDI AC   REHABI LI TATI ON	15, 967 2, 298	0	0	2, 925, 305 470, 880	0	74. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	2,270	91	<u> </u>	1707000		70.77
90. 00 09000 CLI NI C	9, 622	123, 695	0	2, 167, 738		90. 00
90. 01   09001   WOUND CARE CENTER 90. 02   09002   CLINIC - BARIATRIC	24, 858	0	0	2, 346, 286 595, 437	0	90. 01 90. 02
90. 03   09004 VACCINATION CENTER	1, 276 1, 300	0	0	66, 166	0	90. 02
90. 22 09003 SAFE HOUSE	0	o	Ö	1, 879, 311	0	90. 22
91. 00 09100 EMERGENCY	436, 046	164, 926	0	24, 434, 627	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	444 054			4 440 000	0	92.00
92. 01   09201   0BSERVATI ON BEDS-DISTINCT   OTHER REIMBURSABLE COST CENTERS	116, 356	O	0	4, 419, 829	0	92. 01
95. 00 09500 AMBULANCE SERVI CES	124	0	0	606, 177	0	95. 00
SPECIAL PURPOSE COST CENTERS		- 1	- 1			
113. 00 11300 I NTEREST EXPENSE					_	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 991, 394	4, 123, 154	425, 097	303, 426, 750	0	118. 00
194. 00 07950 MI SCELLANEOUS	0	0	0	0	0	194. 00
194. 01 07951 PUBLI C RELATI ONS	0	0	0	9, 395		194. 01
194. 05 07952 OTHER NON REIMBURSABLE	0	0	0	1, 646, 622		194. 05
194. 06 07953 GRANTS/TRI ALS	0	0	0	749, 835		194. 06 194. 07
194. 07 07954 RETAIL PHARMACY 194. 12 07955 NON ALLOWABLE TRANSPORTATION		0	0	498, 874 593, 490		194. 07 194. 12
200.00 Cross Foot Adjustments		Ĭ	ő	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	2, 991, 394	4, 123, 154	425, 097	306, 924, 966	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2021 Part I | To 12/31/2021 Date/Time Prepared: 5/25/2022 1:03 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0009

			5/25/2022 1:	
	Cost Center Description	Total		
	<b>'</b>	26.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			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	01300 NURSI NG ADMI NI STRATI ON			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY			16.00
17. 00	01700 SOCIAL SERVICE			17. 00
23. 00	O2300   PARAMED ED PRGM-(SPECIFY)			23. 00
30. 00	O3000 ADULTS & PEDIATRICS	90, 848, 438		30.00
31. 00	03100 INTENSIVE CARE UNIT	15, 975, 893		31.00
40. 00	04000 SUBPROVI DER - I PF	13, 773, 073		40. 00
43. 00	04300 NURSERY	4, 747, 844		43. 00
44. 00	04400 SKILLED NURSING FACILITY	5, 084, 384		44. 00
00	ANCILLARY SERVICE COST CENTERS	0,001,001		
50.00	05000 OPERATING ROOM	24, 312, 429		50.00
51. 00	05100 RECOVERY ROOM	3, 802, 880		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 535, 128		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 888, 492		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	4, 919, 918		55. 00
56.00	05600 RADI OI SOTOPE	2, 364, 232		56. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	598, 120		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 257, 617		59. 00
60.00	06000 LABORATORY	13, 358, 926		60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 316, 268		63. 00
65. 00	06500 RESPI RATORY THERAPY	4, 560, 807		65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 584, 081		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	367, 922		67. 00
68. 00	06800 SPEECH PATHOLOGY	477, 547		68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY	1, 289, 394		69.00
70. 00	07000  ELECTROENCEPHALOGRAPHY   07001  SLEEP LAB	326, 206 311, 651		70. 00 70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 954, 246		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 690, 263		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	31, 942, 308		73. 00
74. 00	07400 RENAL DI ALYSI S	2, 925, 305		74. 00
76. 97	07697 CARDI AC REHABILI TATI ON	470, 880		76. 97
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	2, 167, 738		90. 00
90. 01	09001 WOUND CARE CENTER	2, 346, 286		90. 01
90. 02	09002 CLINIC - BARIATRIC	595, 437		90. 02
90. 03	09004 VACCINATION CENTER	66, 166		90. 03
90. 22	09003 SAFE HOUSE	1, 879, 311		90. 22
91. 00	09100 EMERGENCY	24, 434, 627		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	4, 419, 829		92. 01
05.00	OTHER REIMBURSABLE COST CENTERS	(0/ 477		05.00
95.00	09500 AMBULANCE SERVICES	606, 177		95. 00
112 00	SPECIAL PURPOSE COST CENTERS			112 00
118.00	11300 INTEREST EXPENSE	202 424 750		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	303, 426, 750		118. 00
104 00				104 00
	0 07950 MISCELLANEOUS   07951 PUBLIC RELATIONS	9, 395		194. 00 194. 01
	07951 PUBLIC RELATIONS 07952 OTHER NON REIMBURSABLE	1, 646, 622		194. 01
	07953 GRANTS/TRI ALS	749, 835		194. 05
	707954 RETAIL PHARMACY	498, 874		194. 00
	207955 NON ALLOWABLE TRANSPORTATION	593, 490		194. 07
200.00		0		200. 00
201.00				201. 00
202.00		306, 924, 966		202. 00
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| Period: | Worksheet B | From 01/01/2021 | Part II | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0009

					T	o 12/31/2021	Date/Time Pre	
				CAPI TAL REI	LATED COSTS		5/25/2022 1:0	3 pm
		C+ C+ D	D:+1	DIDC & FLVT	MANUE FOLLID	Cultatatal	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	0 1	1.00	2.00	27	4.00	
1.00	1	CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	195, 441	566	196, 007	196, 007	2. 00 4. 00
5.00		ADMINISTRATIVE & GENERAL	128, 394	861, 455		5, 085, 136	15, 835	5. 00
6.00		MAINTENANCE & REPAIRS	0	442, 185		508, 859	192	6. 00
7.00		OPERATION OF PLANT	13, 830	316, 956		542, 523	4, 344	7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	10, 282 5, 049	101, 141 37, 476		111, 423 54, 594	403 4, 797	8. 00 9. 00
10. 00	1	DI ETARY	16, 945	302, 372		388, 434	2, 313	10.00
11. 00	1	CAFETERI A	0	86, 629		86, 629	1, 371	11. 00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	1, 021 112, 588	25, 139 145, 604		174, 413 331, 277	9, 617 1, 110	13. 00 14. 00
15. 00		PHARMACY	12, 863	101, 092		124, 138	7, 148	
16. 00		MEDICAL RECORDS & LIBRARY	O	28, 388		43, 550	1, 728	
17. 00 23. 00		SOCIAL SERVICE PARAMED ED PRGM-(SPECIFY)	510 0	0		510 0	2, 743	
23.00		I ENT ROUTINE SERVICE COST CENTERS	l O	0	0	U	446	23. 00
30. 00	03000	ADULTS & PEDI ATRI CS	121, 158	2, 940, 140		3, 154, 195	47, 177	30. 00
31.00	1	INTENSIVE CARE UNIT	917	659, 613			12, 745	
40. 00 43. 00		SUBPROVIDER - IPF NURSERY	0 435	0 72, 533		0 82, 249	0 4, 385	40. 00 43. 00
44. 00		SKILLED NURSING FACILITY	842	297, 950	·	299, 975	3, 742	44. 00
F0 00		LARY SERVICE COST CENTERS		201 101	1 4 5 4 5 6 7	0.075 (45		
50. 00 51. 00	1	OPERATING ROOM RECOVERY ROOM	337, 648	996, 431 149, 317		2, 875, 615 150, 358	14, 432 2, 974	50. 00 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	1, 541	167, 395			4, 456	
54.00		RADI OLOGY-DI AGNOSTI C	119	404, 978		938, 005	5, 551	54. 00
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	15, 086 3, 433	318, 935 121, 784		1, 117, 810 356, 138	2, 837 1, 064	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	3, 433	121, 784		330, 130	597	58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	39, 541	90, 929		216, 310	2, 793	
60.00	1	LABORATORY	75, 662	131, 190		219, 812	5, 200	60.00
63. 00 65. 00		BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	10, 341	0 29, 585	_	194, 933	0 4, 102	63. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	3, 242	96, 670		104, 780	1, 420	
67. 00		OCCUPATIONAL THERAPY	0	3, 518		3, 518	379	67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	715	12, 093 56, 092		16, 646 175, 273	460 957	
70. 00		ELECTROENCEPHALOGRAPHY	o o	4, 642		23, 807	278	
70. 01		SLEEP LAB	0	39, 919	1	44, 988	28	70. 01
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	_	0	0	71. 00 72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	0	o o	0	0	
74. 00	07400	RENAL DIALYSIS	O	151, 613		151, 613	20	
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	0	28, 290	1, 657	29, 947	339	76. 97
90. 00		CLINIC	O	166, 320	2, 737	169, 057	1, 594	90. 00
90. 01	09001	WOUND CARE CENTER	14, 449	159, 284	15, 380	189, 113	1, 232	90. 01
90. 02 90. 03		CLINIC - BARIATRIC	0	54, 968 0		55, 713	525	
90. 03		VACCINATION CENTER SAFE HOUSE	0	0	7, 634	7, 634	56 1, 474	
91. 00		EMERGENCY	27, 529	469, 352		888, 983	19, 567	91. 00
92.00		OBSERVATION BEDS (NON-DISTINCT PART	0.70	0.17		0		92.00
92. 01		OBSERVATION BEDS-DISTINCT REIMBURSABLE COST CENTERS	873	444, 017	0	444, 890	2, 505	92. 01
95. 00		AMBULANCE SERVICES	0	0	0	0	0	95. 00
440.00		AL PURPOSE COST CENTERS						
113. 00 118. 00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	955, 013	10, 711, 436	8, 907, 241	20, 573, 690	194, 936	113.00
110.00		IMBURSABLE COST CENTERS	733,013	10, 711, 430	0, 707, 241	20, 373, 070	174, 730	1110.00
		MI SCELLANEOUS	0	0		0		194. 00
		PUBLIC RELATIONS OTHER NON REIMBURSABLE	0	3, 518 356, 313		3, 518 357, 177		194. 01 194. 05
		GRANTS/TRIALS		350, 313		357, 177		194. 05
194. 07	07954	RETAIL PHARMACY		20, 790	0	20, 790	0	194. 07
194. 12 200. 00		NON ALLOWABLE TRANSPORTATION	0	0	0	0	0	194. 12
200.00	1	Cross Foot Adjustments Negative Cost Centers		Ω	n	0	n	200. 00 201. 00
202.00		TOTAL (sum lines 118 through 201)	955, 013	11, 092, 057	8, 908, 105	20, 955, 175	196, 007	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0009

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part II
To 12/31/2021 Date/Time Prepared: 5/25/2022 1:03 pm

				.   ''	0 12/31/2021	5/25/2022 1:0	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS MURIE FOLL D						1.00
2. 00 4. 00	OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	5, 100, 971					5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	13, 991	523, 042				6.00
7.00	00700 OPERATION OF PLANT	206, 759	17, 282				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	15, 613	5, 515		141, 360		8. 00
9.00	00900 HOUSEKEEPI NG	102, 310	2, 043			166, 859	1
10.00	01000 DI ETARY	104, 646	16, 486			0	1
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	49, 720 158, 142	4, 723 1, 371			0 188	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	25, 592	7, 939		0	2, 257	1
15. 00	01500 PHARMACY	126, 107	5, 512		0	1, 693	1
16.00	01600 MEDICAL RECORDS & LIBRARY	47, 577	1, 548	2, 359	0	1, 128	16. 00
17. 00	01700 SOCIAL SERVICE	66, 034	0	0	0	0	1
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	6, 923	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 128, 678	160, 307	244, 347	56, 764	73, 729	30.00
31. 00	03100 INTENSIVE CARE UNIT	207, 660	35, 964			10, 569	
40. 00	04000 SUBPROVI DER - I PF	0	0	0 0	0	0	
43.00	04300 NURSERY	70, 391	3, 955	6, 028	3, 059	1, 128	43. 00
44. 00	04400 SKILLED NURSING FACILITY	66, 126	16, 245	24, 762	2, 111	0	44. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS    O5000   OPERATI NG ROOM	334, 836	54, 329	82, 811	11 010	20 502	50.00
50. 00 51. 00	05100 RECOVERY ROOM	52, 737	8, 141				1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	75, 110	9, 127			4, 090	
54.00	05400 RADI OLOGY-DI AGNOSTI C	130, 779	22, 081			2, 670	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	69, 151	17, 389	26, 506		2, 915	
56. 00	05600 RADI OI SOTOPE	34, 669	6, 640		786		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	9, 420	4.050	0	0	0	
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	47, 807 211, 927	4, 958 7, 153		838	705 1, 998	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	21, 382	7, 133		0	0	1
65. 00	06500 RESPI RATORY THERAPY	73, 297	1, 613	2, 459	0	0	1
66.00	06600 PHYSI CAL THERAPY	39, 680	5, 271			0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	5, 863	192		0	0	
68. 00	06800 SPEECH PATHOLOGY	7, 444	659			0	
69. 00 70. 00	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY	18, 488 5, 132	3, 058 253		429 0	527 0	1
70. 00	07000 ELECTROENCEPHALOGRAPHI	3, 823	2, 177 2, 177	1		564	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	346, 341	0		0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	231, 803	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	390, 650	0	0	0	0	
74.00	07400 RENAL DIALYSIS	44, 654	8, 266		583	0	
76. 97	O7697   CARDI AC REHABI LI TATI ON   OUTPATI ENT SERVI CE COST CENTERS	6, 023	1, 542	2, 351	0	564	76. 97
90. 00	09000 CLINIC	26, 542	9, 068	13, 822	223	752	90.00
90. 01	09001 WOUND CARE CENTER	31, 800	8, 685			1, 693	
90. 02	09002 CLINIC - BARIATRIC	7, 936	2, 997	4, 568	0	752	
90. 03	09004 VACCINATION CENTER	979	0	0	0	0	
90. 22	09003 SAFE HOUSE	30, 154 333, 159	0 25 501	20 007	0 31, 045	0	
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS   (NON-DISTINCT   PART	333, 159	25, 591	39, 007	31, 045	35, 543	91. 00 92. 00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	55, 691	24, 209	36, 901	5, 086	0	1
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	10, 072	0	0	0	0	95. 00
112 00	SPECIAL PURPOSE COST CENTERS						1112 00
113.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	5, 053, 618	502, 289	739, 276	141, 360	165, 467	113.00
110.00	NONREI MBURSABLE COST CENTERS	3,033,010	302, 207	137, 210	141, 300	103, 407	1110.00
194.00	07950 MI SCELLANEOUS	0	0	0	0	0	194. 00
194. 01	07951 PUBLIC RELATIONS	72	192	292	0		194. 01
	07952 OTHER NON REIMBURSABLE	17, 281	19, 427	29, 612	0		194. 05
	07953 GRANTS/TRI ALS	12, 340	0	0	0		194. 06
	07954 RETAIL PHARMACY 07955 NON ALLOWABLE TRANSPORTATION	7, 796 9, 864	1, 134	1, 728	0		194. 07 194. 12
200.00		7, 004					200. 00
201.00		0	0	0	O		201. 00
202.00		5, 100, 971	523, 042	770, 908	141, 360	166, 859	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0009

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

			To	12/31/2021	Date/Time Pre 5/25/2022 1:0	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	<b>у</b>
	10.00	11. 00	13. 00	SUPPLY 14.00	15. 00	
GENERAL SERVICE COST CENTERS	101 00	777.00	101.00		10.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00   OO200 CAP REL COSTS-MVBLE EQUIP 4.00   OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL						5. 00
6. 00   00600   MAI NTENANCE & REPAI RS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY	537, 008					10.00
11. 00   01100   CAFETERI A	0	149, 643	254 422			11. 00
13. 00   01300   NURSI NG ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	0	8, 309 1, 663	354, 129 0	201 020		13. 00 14. 00
15. 00   01500   PHARMACY	0	1, 662 5, 807	0	381, 938 318	279, 125	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	ol	2, 214	o o	0	0	16. 00
17.00 01700 SOCIAL SERVICE	o	2, 109	3, 859	0	0	17. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	411	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	441, 912	45, 078		4, 889	0	30.00
31. 00   03100   INTENSI VE CARE UNI T 40. 00   04000   SUBPROVI DER - I PF	49, 812 0	8, 331	39, 239 0	2, 411	0	31. 00 40. 00
43. 00   04300   NURSERY	0	2, 941	8, 811	210	0	43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	28, 814	3, 871	7, 130	358	0	44. 00
ANCILLARY SERVICE COST CENTERS	==, = :	2, 2	.,			
50. 00 05000 OPERATING ROOM	16, 470	12, 259	42, 880	2, 486	0	50.00
51. 00   05100   RECOVERY ROOM	0	2, 214	10, 731	129	0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	3, 602	16, 293	600	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	0	5, 006 1, 404	1, 691	401	0	54. 00 55. 00
56. 00   05600 RADI 01 SOTOPE	0	1, 694 861	3, 893 0	408 55	0	56. 00
58. 00   05800   MAGNETI C RESONANCE   MAGING (MRI)	o	516	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	1, 796	4, 811	317	0	59. 00
60. 00   06000   LABORATORY	О	5, 577	0	301	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0	3, 482	0	141	0	65. 00
66. 00   06600   PHYSI CAL THERAPY	0	1, 221	0	47	0	66.00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	303 447	0	3	0	67. 00 68. 00
69. 00   06900   ELECTROCARDI OLOGY	Ö	968	262	44	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	Ö	261	0	0	0	70. 00
70. 01   07001   SLEEP LAB	o	0	0	0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	218, 109	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	145, 983	0	72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	0	0	0	201	279, 125 0	73. 00 74. 00
76. 97   07697 CARDI AC REHABI LI TATI ON	0	239	1, 437	43	0	76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>	207	1, 107	10		70.77
90. 00 09000 CLI NI C	0	1, 384	5, 104	101	0	90. 00
90. 01 09001 WOUND CARE CENTER	0	1, 229	3, 136	119	0	90. 01
90. 02   09002   CLI NI C - BARI ATRI C	0	477	0	0	0	90. 02
90. 03   09004   VACCI NATI ON CENTER 90. 22   09003   SAFE HOUSE	0	60 2, 104	172 770	2	0	90. 03 90. 22
91. 00   09100   EMERGENCY	0	2, 104 19, 272	41, 332	3, 646	0	90. 22
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	ď	17, 272	41, 332	3, 040	O	92. 00
92. 01 09201 OBSERVATI ON BEDS-DI STI NCT	o	2, 463	8, 135	610	0	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS						
113.00   11300   INTEREST EXPENSE 118.00   SUBTOTALS (SUM OF LINES 1 through 117)	537, 008	148, 168	252 247	381, 932	279, 125	113.00
NONREI MBURSABLE COST CENTERS	337,000	140, 100	353, 347	301, 932	219, 120	116.00
194. 00 07950 MI SCELLANEOUS	ol	0	0	0	0	194. 00
194. 01 07951 PUBLI C RELATI ONS	Ö	0	Ö	o		194. 01
194.05 07952 OTHER NON REIMBURSABLE	o	1, 121	782	6		194. 05
194. 06 07953 GRANTS/TRI ALS	0	354	0	0		194. 06
194. 07 07954 RETAIL PHARMACY	0	0	0	O		194. 07
194. 12 07955 NON ALLOWABLE TRANSPORTATION	O	0	0	0	0	194. 12
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	0	0	Λ	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	537, 008	149, 643	354, 129	381, 938	279, 125	
, , -	1			1		•

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0009

				To	12/31/2021	Date/Time Pre 5/25/2022 1:0	
	Cost Center Description		SOCIAL SERVICE		Subtotal	Intern &	<b>-</b>
		RECORDS & LI BRARY		PRGM		Residents Cost & Post	
		LIBRARI				Stepdown	
						Adjustments	
GENER	AL SERVICE COST CENTERS	16. 00	17. 00	23. 00	24. 00	25. 00	
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						2. 00
1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
1	ADMINISTRATIVE & GENERAL						5.00
1	MAINTENANCE & REPAIRS OPERATION OF PLANT						6. 00 7. 00
1	LAUNDRY & LINEN SERVICE						8.00
	HOUSEKEEPI NG						9. 00
	DIETARY						10.00
	CAFETERIA NURSING ADMINISTRATION						11. 00 13. 00
	CENTRAL SERVICES & SUPPLY						14. 00
1	PHARMACY						15. 00
	MEDICAL RECORDS & LIBRARY	100, 104					16. 00
1	SOCIAL SERVICE	0	75, 255				17. 00
	PARAMED ED PRGM-(SPECIFY)   I ENT ROUTI NE SERVI CE COST CENTERS	0	0	7, 780			23. 00
	ADULTS & PEDIATRICS	33, 133	69, 987		5, 613, 857	0	30.00
	INTENSIVE CARE UNIT	5, 415	0		1, 260, 033		31. 00
1	SUBPROVIDER - IPF	0	0		104 453		40.00
1	NURSERY  SKILLED NURSING FACILITY	1, 296 783	0		184, 453 453, 917	0	43. 00 44. 00
	LARY SERVICE COST CENTERS	703	<u> </u>		433, 717		1 44.00
50.00 05000	OPERATING ROOM	7, 677	0		3, 476, 197	0	50. 00
	RECOVERY ROOM	1, 448	0		245, 176		51.00
	DELIVERY ROOM & LABOR ROOM   RADIOLOGY-DIAGNOSTIC	1, 486 5, 416	0		329, 652 1, 148, 594	0	52. 00 54. 00
	RADI OLOGY-THERAPEUTI C	1, 513	0		1, 148, 594	1	55.00
1	RADI OI SOTOPE	907	0		412, 651	0	56. 00
1	MAGNETIC RESONANCE IMAGING (MRI)	687	0		11, 220		58. 00
	CARDI AC CATHETERI ZATI ON LABORATORY	1, 573	0		289, 465		59.00
	BLOOD STORING, PROCESSING & TRANS.	7, 604 994	0		470, 475 22, 376		60. 00 63. 00
1	RESPI RATORY THERAPY	1, 171	Ö		281, 198		65. 00
	PHYSI CAL THERAPY	870	0		162, 164		66. 00
1	OCCUPATIONAL THERAPY	126	0		10, 676		67. 00
1	SPEECH PATHOLOGY   ELECTROCARDI OLOGY	102 1, 544	0		26, 763 206, 212		68. 00 69. 00
	ELECTROENCEPHALOGRAPHY	179	0		30, 296		70.00
	SLEEP LAB	111	0		55, 030	0	70. 01
	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 639	0		566, 089		71.00
	IMPL. DEV. CHARGED TO PATIENTS   DRUGS CHARGED TO PATIENTS	979 3, 147	0		378, 765 672, 922		72. 00 73. 00
	RENAL DIALYSIS	533	0		218, 470		
	CARDIAC REHABILITATION	77	0		42, 562		
	TIENT SERVICE COST CENTERS		0.050		222 224		
1	CLINIC  WOUND CARE CENTER	321 830	2, 258 0		230, 226 251, 681	0	90. 00 90. 01
	CLINIC - BARIATRIC	43	o		73, 011	Ö	90. 02
90. 03 09004	VACCINATION CENTER	43	0		1, 312	0	90. 03
	SAFE HOUSE	0	0		42, 136		90. 22
	EMERGENCY   OBSERVATION BEDS (NON-DISTINCT PART	14, 566	3, 010		1, 454, 721	0	91. 00 92. 00
	OBSERVATION BEDS (NON-DISTINCT FART	3, 887	0		584, 377	0	92. 00
	REIMBURSABLE COST CENTERS	,					
	AMBULANCE SERVICES	4	0		10, 076	0	95. 00
	AL PURPOSE COST CENTERS INTEREST EXPENSE					I	113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	100, 104	75, 255	0	20, 461, 446		118. 00
NONRE	MBURSABLE COST CENTERS		. 27 200	,	.,, , , ,		
	MI SCELLANEOUS	0	0		0		194. 00
	PUBLIC RELATIONS   OTHER NON REIMBURSABLE	0	0		4, 074 427, 613		194. 01 194. 05
	GRANTS/TRIALS	0	n		427, 613 12, 950		194. 05
1	RETAIL PHARMACY	Ö	ő		31, 448		194. 07
194. 12 07955	NON ALLOWABLE TRANSPORTATION	0	o		9, 864	0	194. 12
200.00	Cross Foot Adjustments			7, 780	7, 780		200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	100, 104	75, 255	0 7, 780	0 20, 955, 175		201. 00 202. 00
00	(		, 0, 200	, ,,,,,,,,	_5,,50,175	, 0	, 50

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2021 Part II | To 12/31/2021 Date/Time Prepared: 5/25/2022 1:03 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0009

			5/25/2022 1:	
	Cost Center Description	Total		
	, , , , , , , , , , , , , , , , , , ,	26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
6. 00	1 1			1
	00600 MAI NTENANCE & REPAI RS			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	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00	03000 ADULTS & PEDI ATRI CS	5, 613, 857		30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 260, 033		31. 00
40.00	04000 SUBPROVI DER - I PF	0		40. 00
43.00	04300 NURSERY	184, 453		43.00
44.00	04400 SKILLED NURSING FACILITY	453, 917		44. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	3, 476, 197		50. 00
51.00	05100 RECOVERY ROOM	245, 176		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	329, 652		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 148, 594		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 244, 693		55. 00
56. 00	05600 RADI OI SOTOPE	412, 651		56. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	11, 220		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	289, 465		59. 00
60.00	06000 LABORATORY	470, 475		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	22, 376		63. 00
65. 00	06500 RESPI RATORY THERAPY	281, 198		65. 00
66. 00	06600 PHYSI CAL THERAPY	162, 164		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	10, 676		67. 00
68. 00	06800 SPEECH PATHOLOGY	26, 763		68. 00
69. 00	06900 ELECTROCARDI OLOGY	206, 212		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	30, 296		70.00
70. 00	07001 SLEEP LAB	55, 030		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	566, 089		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	378, 765		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	672, 922		73. 00
74. 00	07400 RENAL DIALYSIS	218, 470		74.00
	07697 CARDI AC REHABI LI TATI ON	42, 562		76. 97
10. 71	OUTPATIENT SERVICE COST CENTERS	42, 302		- 10. <i>11</i>
90 00	09000 CLINIC	230, 226		90.00
	09001 WOUND CARE CENTER	251, 681		90. 00
	09002 CLINIC - BARIATRIC	73, 011		90.01
90. 02	09004 VACCINATION CENTER	1, 312		90. 02
90. 22	09003 SAFE HOUSE	42, 136		90. 03
90. 22	09100 EMERGENCY	1, 454, 721		91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,434,721		92.00
92. 00	,	E04 277		92.00
92.01	O9201   OBSERVATION   BEDS-DISTINCT   OTHER REIMBURSABLE COST CENTERS	584, 377		92.01
05 00		10.07/		05.00
95.00	09500 AMBULANCE SERVICES	10, 076		95. 00
112 00	SPECIAL PURPOSE COST CENTERS	T T		112 00
	11300 INTEREST EXPENSE	00 4/4 44/		113.00
118. 00	. 3 /	20, 461, 446		118. 00
40. 5	NONREI MBURSABLE COST CENTERS			
	07950 MI SCELLANEOUS	0		194. 00
	07951 PUBLIC RELATIONS	4, 074		194. 01
	07952 OTHER NON REIMBURSABLE	427, 613		194. 05
	07953 GRANTS/TRI ALS	12, 950		194. 06
	07954 RETAIL PHARMACY	31, 448		194. 07
	07955 NON ALLOWABLE TRANSPORTATION	9, 864		194. 12
200.00	1 1	7, 780		200. 00
201.00		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	20, 955, 175		202. 00
	-			

From 01/01/2021 12/31/2021 Date/Time Prepared: 5/25/2022 1:03 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL DEPARTMENT (ACCUM COST) (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 454 032 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 7, 305, 807 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 8,000 118, 157, 082 4.00 464 00500 ADMINISTRATIVE & GENERAL 3, 358, 667 247, 827, 438 5 00 35 262 9, 544, 974 -59, 097, 528 5 00 6.00 00600 MAINTENANCE & REPAIRS 18, 100 54, 681 115, 963 679, 718 6.00 10, 045, 149 7.00 00700 OPERATION OF PLANT 12, 974 173, 652 2, 618, 232 7.00 00800 LAUNDRY & LINEN SERVICE 4, 140 242, 754 0 758, 560 8.00 8.00 0 4, 970, 601 00900 HOUSEKEEPI NG 9, 898 9 00 1.534 2.891.421 9 00 10.00 01000 DI ETARY 12, 377 56, 685 1, 394, 110 5, 084, 087 10.00 01100 CAFETERI A 3,546 826, 546 2, 415, 605 11.00 0 0 0 0 11.00 01300 NURSING ADMINISTRATION 121, 587 13.00 1.029 5, 796, 638 7, 683, 137 13.00 01400 CENTRAL SERVICES & SUPPLY 5, 960 59, 939 14.00 669, 119 1, 243, 366 14 00 15.00 01500 PHARMACY 4, 138 8, 351 4, 308, 739 6, 126, 738 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1, 162 12, 435 1,041,796 2, 311, 458 16.00 0 01700 SOCIAL SERVICE 3, 208, 177 17.00 17.00 0 1, 653, 422 23.00 02300 PARAMED ED PRGM-(SPECIFY) C 268, 629 0 336, 334 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 120, 349 76, 188 28, 447, 940 0 54, 838, 538 30.00 03100 INTENSIVE CARE UNIT 31.00 27,000 131, 499 0 10,088,890 31.00 7, 682, 185 0 40.00 04000 SUBPROVI DER - I PF 0 40.00 3, 419, 853 04300 NURSERY 2,969 0 43.00 7,612 2, 643, 189 43.00 04400 SKILLED NURSING FACILITY 12, 196 970 2, 255, 379 3, 212, 667 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 40, 787 1, 264, 261 8, 698, 973 0 16, 267, 600 50.00 05100 RECOVERY ROOM 1, 792, 761 0 2, 562, 169 51.00 6, 112 854 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 6,852 20, 528 2, 686, 181 3, 649, 144 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 16, 577 437, 054 3, 346, 266 6, 353, 715 54.00 05500 RADI OLOGY-THERAPEUTI C 13,055 1, 709, 885 3, 359, 632 55.00 642, 809 0 0 0 55.00 56.00 05600 RADI OI SOTOPE 4, 985 189, 385 641, 319 1, 684, 352 56.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 359. 792 457, 665 58 00 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 3.722 70, 400 1, 683, 378 2, 322, 637 59.00 06000 LABORATORY 60.00 5, 370 10, 629 3, 134, 673 0 0 0 10, 296, 227 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 1, 038, 801 63.00 63.00 06500 RESPIRATORY THERAPY 2, 472, 355 3, 561, 039 65.00 1.211 127, 126 65.00 66.00 06600 PHYSI CAL THERAPY 3,957 3, 992 855, 764 1, 927, 795 66.00 67.00 06700 OCCUPATI ONAL THERAPY 144 228, 572 0 0 0 284, 846 67.00 06800 SPEECH PATHOLOGY 3, 148 68 00 495 276 991 361, 651 68 00 69.00 06900 ELECTROCARDI OLOGY 2, 296 97, 744 576, 650 898, 205 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 190 15, 718 167, 417 249, 314 70.00 70.01 07001 SLEEP LAB 1,634 4, 157 16, 848 0 185, 730 70.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 16, 826, 550 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 11, 261, 854 72.00 07300 DRUGS CHARGED TO PATIENTS 0 18, 979, 237 73.00 0 C 0 73.00 0 74.00 07400 RENAL DIALYSIS 6, 206 12,000 2, 169, 455 74.00 07697 CARDIAC REHABILITATION 204, 405 76.97 1.158 1, 359 292, 628 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 6,808 2, 245 961, 071 1, 289, 506 90.00 09001 WOUND CARE CENTER 12, 614 742, 371 0 1, 544, 940 90. 01 90.01 6.520 09002 CLINIC - BARIATRIC 0 385, 585 90 02 2.250 611 316, 453 90 02 90.03 09004 VACCINATION CENTER 33, 627 0 47, 549 90.03 0 0 90 22 09003 SAFE HOUSE 6, 261 888, 552 1, 465, 012 90 22 91 00 09100 EMERGENCY 0 91 00 19, 212 321, 575 11, 794, 694 16, 186, 124 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09201 OBSERVATION BEDS-DISTINCT 92.01 18, 175 0 1, 509, 888 0 2, 705, 664 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 0 489, 359 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 438, <u>452</u> 7, 305, 098 117, 511, 922 -59, 097, 528 118.00 <u>245, 526, 863</u> 118. 00 194. 00 07950 MI SCELLANEOUS 0 194. 00 0 194. 01 07951 PUBLIC RELATIONS 144 0 0 3, 518 194. 01 194. 05 07952 OTHER NON REIMBURSABLE 839, 553 194. 05 491, 067 14,585 709 0 194. 06 07953 GRANTS/TRI ALS C 154, 093 0 599, 509 194. 06 194. 07 07954 RETAIL PHARMACY 851 0 0 0 378, 780 194. 07 194. 12 07955 NON ALLOWABLE TRANSPORTATION 0 479, 215 194. 12 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00

Health Financial Systems		CLARA MAASS MEDICAL CENTER In			In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der CC		Period: From 01/01/2021 To 12/31/2021		pared:
		CADLTAL DEL	ATED COCTO			5/25/2022 1:0	3 pm
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	DEPARTMENT (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2.00	SALARI ES) 4. 00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	11, 092, 057				59, 097, 528	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	24. 430122	1. 219318	0. 23010	3	0. 238462	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)			196, 00	7	5, 100, 971	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00165	9	0. 020583	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

| Period: | Worksheet B-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-0009

				Ť	0 12/31/2021	Date/Time Prep 5/25/2022 1:03	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	<u> Б</u>
		REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	
				LAUNDRY)	,		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	392, 670					6. 00
7.00	00700 OPERATION OF PLANT	12, 974	379, 696	1			7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	4, 140 1, 534	4, 140 1, 534				8. 00 9. 00
10.00	01000 DI ETARY	12, 377	12, 377				10. 00
11.00	01100 CAFETERI A	3, 546				1	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 029 5, 960	1, 029 5, 960				13. 00 14. 00
15. 00	01500 PHARMACY	4, 138			I		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 162			-,		16.00
17. 00 23. 00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM-(SPECIFY)	0	0				17. 00 23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				-	-	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	120, 349	· ·				30. 00 31. 00
40. 00	04000 SUBPROVI DER – I PF	27,000	27,000	0			40. 00
43. 00	04300 NURSERY	2, 969	2, 969		l	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	12, 196	12, 196	20, 340	0	14, 031	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	40, 787	40, 787	113, 813	54, 750	8, 020	50. 00
51. 00	05100 RECOVERY ROOM	6, 112	6, 112	38, 889	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 852	6, 852				52.00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	16, 577 13, 055	16, 577 13, 055				54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	4, 985	4, 985				56. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	3, 722 5, 370	3, 722 5, 370		I		59. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1			63. 00
65.00	06500 RESPIRATORY THERAPY	1, 211	1, 211			· -	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 957 144	3, 957 144			0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	495	495		_		68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 296	2, 296		· ·		69. 00
70. 00 70. 01	07000 ELECTROENCEPHALOGRAPHY 07001 SLEEP LAB	190 1, 634	190 1, 634			0	70. 00 70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		· -	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	6, 206	6, 206	0 5, 619		0	73. 00 74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 158				0	76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	6, 808	6, 808	2, 146	2, 000	0	90. 00
90.00	09001 WOUND CARE CENTER	6, 520					90.00
90. 02	09002 CLINIC - BARIATRIC	2, 250		0	2, 000	0	90. 02
90. 03 90. 22	09004 VACCINATION CENTER 09003 SAFE HOUSE	0	0		0	0	90. 03 90. 22
91.00	09100 EMERGENCY	19, 212	19, 212	1	94, 500		90. 22
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT OTHER REI MBURSABLE COST CENTERS	18, 175	18, 175	49, 013	0	0	92. 01
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS			I			
113. 00 118. 00	11300  INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	377, 090	364, 116	1, 362, 264	439, 938	261, 496	113.00
110.00	NONREI MBURSABLE COST CENTERS	377,090	304, 110	1, 302, 204	439, 930	201, 490	116.00
	07950 MI SCELLANEOUS	0	0				194. 00
	O7951   PUBLIC RELATIONS   O7952   OTHER NON REIMBURSABLE	144 14, 585	144 14, 585				194. 01 194. 05
	07953 GRANTS/TRI ALS	14, 383	14, 383		3, 700		194. 05
194. 07	07954 RETAIL PHARMACY	851	851	0	0	0	194. 07
194. 12 200. 00	07955 NON ALLOWABLE TRANSPORTATION Cross Foot Adjustments	0	0	0	0		194. 12 200. 00
200.00		1					200. 00
202.00	Cost to be allocated (per Wkst. B,	841, 805	12, 468, 349	1, 084, 271	6, 209, 562		
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	2. 143798	32. 837715	0. 795933	13. 996912	25. 734294	203 00
203.00		2. 143/98	32. 03//15	0. / 70733	13. 770712	25.734294	

Health Finar	ncial Systems	CLARA MAASS ME	DICAL CENTER		In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1		
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/25/2022 1:0		
	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		
204.00	Cost to be allocated (per Wkst. B,	523, 042	770, 908	141, 36	166, 859	537, 008	204. 00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	1. 332014	2. 030330	0. 10376	0. 376115	2. 053599	205. 00	
	11)							
206.00	NAHE adjustment amount to be allocated						206. 00	
	(per Wkst. B-2)							
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00	
	Parts III and IV)							

	Financial Systems	CLARA MAASS ME		04 0000		eu of Form CMS-	
COSTA	ALLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: from 01/01/2021 fo 12/31/2021	Worksheet B-1 Date/Time Pre 5/25/2022 1:0	pared:
	Cost Center Description	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS	S piii
		11 00	HRS)	REQUIS.)	15.00	CHARGES)	
	GENERAL SERVICE COST CENTERS	11. 00	13.00	14. 00	15. 00	16. 00	
1. 00 2. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 2. 00 4. 00
5. 00 6. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						5. 00 6. 00 7. 00
8. 00 9. 00 10. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY						8. 00 9. 00 10. 00
11. 00	01100 CAFETERI A	109, 552	1				11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	6, 083 1, 217	1	29, 466, 202	,		13. 00 14. 00
15. 00	01500 PHARMACY	4, 251	1	24, 555			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 621	o	C	0	1, 611, 696, 521	16. 00
17. 00	01700 SOCIAL SERVICE	1, 544		O	_	l	
23. 00	02300   PARAMED ED PRGM-(SPECIFY)   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	301	0	C	0	0	23. 00
30. 00		33,000	389, 294	377, 160	0	531, 502, 411	30.00
31. 00	03100   NTENSI VE CARE UNI T	6, 099		185, 980			1
40. 00	04000 SUBPROVI DER - I PF	C	1	C	_	l .	
43. 00	04300 NURSERY	2, 153		16, 182			1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	2, 834	18, 063	27, 648	0	12, 629, 862	44.00
50. 00	05000 OPERATING ROOM	8, 975	108, 634	191, 822	. 0	123, 818, 898	50.00
51. 00	05100 RECOVERY ROOM	1, 621	1	9, 958			1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 637		46, 313			1
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	3, 665 1, 240	1	30, 955 31, 453			1
56. 00	05600 RADI OI SOTOPE	630	1	4, 238		.,	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	378		C			1
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 315	1	24, 429		,,	1
60.00	06000 LABORATORY	4, 083	1	23, 209 0			
63. 00 65. 00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	2, 549	1	10, 878			1
66. 00	06600 PHYSI CAL THERAPY	894	1	3, 631		1	•
67. 00	06700 OCCUPATI ONAL THERAPY	222		219		_, -,,	•
68. 00 69. 00	O6800   SPEECH PATHOLOGY   O6900   ELECTROCARDI OLOGY	327 709	1	2 422			•
70.00	07000 ELECTROCARDI OLOGY	191	1	3, 422 30			
70. 01	07001 SLEEP LAB	C	1	C		l	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C		16, 827, 081			
	07200 I MPL. DEV. CHARGED TO PATIENTS	C		11, 262, 353		15, 794, 297	
74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	C	1	15, 509		50, 765, 728 8, 602, 674	1
	07697 CARDI AC REHABILI TATI ON	175	1 -1	3, 315		l	
	OUTPATIENT SERVICE COST CENTERS						
90.00	O9000   CLI NI C   O9001   WOUND CARE CENTER	1, 013	1	7, 775			
90. 01 90. 02	09001 WOUND CARE CENTER 09002 CLINIC - BARIATRIC	900		9, 169 0		1	1
90. 03	09004 VACCINATION CENTER	44		137	_	l	
90. 22	09003 SAFE HOUSE	1, 540	1	C	0		
	I I	14, 109	104, 712	281, 260	0	234, 938, 784	1
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS-DISTINCT	1, 803	20, 610	47, 089	0	62, 691, 850	92. 00 92. 01
72.01	OTHER REIMBURSABLE COST CENTERS	1,000	20,010	47,007		02, 071, 030	72.01
95.00	09500 AMBULANCE SERVICES	C	0	C	0	66, 905	95. 00
440.00	SPECIAL PURPOSE COST CENTERS				1		140.00
118.00	11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	108, 472	895, 188	29, 465, 770	18, 989, 987	1, 611, 696, 521	113. 00 118. 00
	07950 MI SCELLANEOUS	C	1	C		l .	194. 00
	O7951   PUBLIC RELATIONS   O7952   OTHER NON REIMBURSABLE	821	1 -1	432		l .	194. 01 194. 05
	07953 GRANTS/TRI ALS	259		432		l .	194. 05
	07954 RETAIL PHARMACY		ol ol	C	_	0	194. 07
194. 12	07955 NON ALLOWABLE TRANSPORTATION	C	o o	C	0	0	194. 12
200.00	, ,						200.00
201. 00 202. 00		3, 115, 680	9, 731, 269	1, 866, 945	7, 917, 926	2, 991, 394	201. 00
	Part I)			., 233, 710		_, , 5 , .	
			<u> </u>				

Heal th Finar	ncial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
	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		(GROSS	
			HRS)	REQUI S. )		CHARGES)	
		11. 00	13. 00	14.00	15. 00	16. 00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	28. 440193	10. 846628	0. 06335	9 0. 416953	0. 001856	203. 00
204.00	Cost to be allocated (per Wkst. B,	149, 643	354, 129	381, 93	8 279, 125	100, 104	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	1. 365954	0. 394718	0. 01296	2 0. 014699	0. 000062	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

Health Financial Systems CLARA MAASS MEDICAL CENTER In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0009 | Period: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/25/2022 1:03 pm

				5/25/2022 1:03	
	Cost Center Description	SOCIAL SERVICE	PARAMED ED		
			PRGM		
		(TIME SPENT)	(ASSI GNED		
		17.00	TIME)		
	GENERAL SERVICE COST CENTERS	17. 00	23. 00		
	00100 CAP REL COSTS-BLDG & FLXT				1.00
	00200 CAP REL COSTS-MVBLE EQUIP				2.00
	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
	00800 LAUNDRY & LINEN SERVICE				8. 00
	00900 HOUSEKEEPI NG				9. 00
	01000 DI ETARY				10.00
	01100 CAFETERI A				11.00
	01300 NURSI NG ADMI NI STRATI ON				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY				15. 00 16. 00
	01700 SOCIAL SERVICE	100			17. 00
	02300 PARAMED ED PRGM-(SPECIFY)	0	2, 860		23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	2,000		20.00
30. 00	03000 ADULTS & PEDIATRICS	93	0		30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0		31. 00
40. 00	04000 SUBPROVI DER - I PF	0	0		40. 00
	04300 NURSERY	0	0		43. 00
	04400 SKILLED NURSING FACILITY	0	0		44. 00
	ANCILLARY SERVICE COST CENTERS				F0 00
	05000 OPERATING ROOM	0	0		50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 0	0		51. 00 52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
	05500 RADI OLOGY-THERAPEUTI C		0		55.00
	05600 RADI OI SOTOPE	o	Ö		56.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	o		58. 00
	05900 CARDI AC CATHETERI ZATI ON	O	O		59. 00
60.00	06000 LABORATORY	O	0		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
	06500 RESPI RATORY THERAPY	0	0		65. 00
	06600 PHYSI CAL THERAPY	0	0		66. 00
	06700 OCCUPATI ONAL THERAPY	0	0		67. 00
	06800 SPEECH PATHOLOGY	0	0		68.00
	06900  ELECTROCARDI OLOGY 07000  ELECTROENCEPHALOGRAPHY	0	0		69. 00 70. 00
	07000 ELECTROENCEPHALOGRAPHY 07001 SLEEP LAB	o	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	o	Ö		72.00
	07300 DRUGS CHARGED TO PATIENTS	o	2, 860		73. 00
	07400 RENAL DIALYSIS	0	0		74. 00
76. 97	07697 CARDIAC REHABILITATION	0	0		76. 97
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	3	0		90.00
	09001 WOUND CARE CENTER	0	0		90. 01
	09002 CLINIC - BARIATRIC	0	0		90. 02
	09004 VACCINATION CENTER 09003 SAFE HOUSE	0 0	0		90. 03 90. 22
	09100 EMERGENCY	0	0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	-	o <sub>l</sub>		92.00
	09201 OBSERVATION BEDS-DISTINCT	0	o		92. 01
	OTHER REIMBURSABLE COST CENTERS		-1		
	09500 AMBULANCE SERVICES	0	0		95. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 I NTEREST EXPENSE				113. 00
118. 00	1 7	100	2, 860		118. 00
	NONREI MBURSABLE COST CENTERS				
	07950 MI SCELLANEOUS	0	0		194. 00
	07951 PUBLIC RELATIONS	0	0		194. 01
	07952 OTHER NON REIMBURSABLE 07953 GRANTS/TRIALS	0	0		194. 05 194. 06
	07953 GRANTS/TRIALS 07954 RETALL PHARMACY		0	-	194. 06
	07955 NON ALLOWABLE TRANSPORTATION		0		194. 07
200.00	Cross Foot Adjustments		Ĭ		200.00
201.00	Negative Cost Centers		İ		201. 00
202.00	Cost to be allocated (per Wkst. B,	4, 123, 154	425, 097		202. 00
	Part I)				1
203.00	Unit cost multiplier (Wkst. B, Part I)	41, 231. 540000	148. 635315		203. 00

Heal th Finar	ncial Systems	CLARA MAASS MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC	CN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B- Date/Time Pr 5/25/2022 1:	epared:
	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)				
		17. 00	23. 00				
204. 00	Cost to be allocated (per Wkst. B, Part II)	75, 255	7, 780				204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	752. 550000	2. 720280				205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0				206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0. 000000				207. 00

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 31-0009	Peri od: From 01/01/2021	Worksheet C Part I

					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/25/2022 1:0	pared: 3 pm
			Title	XVIII	Hospi tal	PPS	
					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	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	90, 848, 438		90, 848, 43	0 8	90, 848, 438	30. 00
31.00	03100 INTENSIVE CARE UNIT	15, 975, 893		15, 975, 89	3 0	15, 975, 893	31.00
40.00	04000 SUBPROVI DER - I PF	0			0 0	0	40. 00
43.00	04300 NURSERY	4, 747, 844		4, 747, 84	4 0	4, 747, 844	43.00
44.00	04400 SKILLED NURSING FACILITY	5, 084, 384		5, 084, 38	4 0	5, 084, 384	44.00
	ANCILLARY SERVICE COST CENTERS	<del>,</del>					
50.00	05000  OPERATI NG ROOM	24, 312, 429		24, 312, 42	9 0	24, 312, 429	50. 00
51.00	05100 RECOVERY ROOM	3, 802, 880		3, 802, 88	0 0	3, 802, 880	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 535, 128		5, 535, 12	8 0	5, 535, 128	52. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	8, 888, 492		8, 888, 49	2 0	8, 888, 492	54.00
55.00	05500  RADI OLOGY-THERAPEUTI C	4, 919, 918		4, 919, 91	8 0	4, 919, 918	55. 00
56.00	05600  RADI 0I SOTOPE	2, 364, 232		2, 364, 23	2 0	2, 364, 232	56. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	598, 120		598, 12	0 0	598, 120	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 257, 617		3, 257, 61	7 0	3, 257, 617	59. 00
60.00	06000 LABORATORY	13, 358, 926		13, 358, 92	6 0	13, 358, 926	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 316, 268		1, 316, 26	8 0	1, 316, 268	63. 00
65.00	06500 RESPI RATORY THERAPY	4, 560, 807	0	4, 560, 80	7 0	4, 560, 807	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 584, 081	0	2, 584, 08	1 0	2, 584, 081	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	367, 922	0	367, 92	2 0	367, 922	67. 00
68.00	06800 SPEECH PATHOLOGY	477, 547	0	477, 54	7 0	477, 547	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 289, 394		1, 289, 39	4 0	1, 289, 394	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	326, 206		326, 20	6 0	326, 206	70. 00
70. 01	07001 SLEEP LAB	311, 651		311, 65	1 0	311, 651	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 954, 246		21, 954, 24	6 0	21, 954, 246	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 690, 263		14, 690, 26	3 0	14, 690, 263	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	31, 942, 308		31, 942, 30	8 0	31, 942, 308	73. 00
74.00	07400 RENAL DIALYSIS	2, 925, 305		2, 925, 30	5 0	2, 925, 305	74. 00
76. 97	07697 CARDI AC REHABILITATION	470, 880		470, 88	0 0	470, 880	76. 97
	OUTPATIENT SERVICE COST CENTERS	·					
90.00	09000  CLI NI C	2, 167, 738		2, 167, 73	8 0	2, 167, 738	90. 00
90. 01	09001 WOUND CARE CENTER	2, 346, 286		2, 346, 28	6 0	2, 346, 286	90. 01
90. 02	09002 CLINIC - BARIATRIC	595, 437		595, 43	7 0	595, 437	90. 02
90. 03	09004 VACCINATION CENTER	66, 166		66, 16	6 0	66, 166	90. 03
90. 22	09003 SAFE HOUSE	1, 879, 311		1, 879, 31	1 0	1, 879, 311	90. 22
91.00	09100 EMERGENCY	24, 434, 627		24, 434, 62	7 0	24, 434, 627	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	151, 094		151, 09	4	151, 094	92.00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	4, 419, 829		4, 419, 82	9 0	4, 419, 829	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	606, 177		606, 17	7 0	606, 177	95. 00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						113. 00
200.00	,	303, 577, 844	0			,,	
201.00		151, 094		151, 09		151, 094	
202.00	Total (see instructions)	303, 426, 750	0	303, 426, 75	0 0	303, 426, 750	202. 00

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 31-0009	Peri od:	Worksheet C

From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/25/2022 1:03 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col. 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 530, 932, 161 530, 932, 161 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 87, 331, 264 87, 331, 264 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 43.00 04300 NURSERY 20, 901, 473 20, 901, 473 43.00 04400 SKILLED NURSING FACILITY 44.00 12, 629, 862 12, 629, 862 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 28, 936, 800 94, 882, 098 123, 818, 898 0.196355 0.000000 50.00 05100 RECOVERY ROOM 16, 928, 485 23, 357, 370 0.162813 0.000000 51.00 6, 428, 885 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 16, 744, 868 7, 215, 194 23, 960, 062 0.231015 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 37, 569, 392 49, 792, 853 87, 362, 245 0.101743 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 866, 212 23, 544, 320 24, 410, 532 0. 201549 0.000000 55.00 05600 RADI OI SOTOPE 4, 381, 715 10, 239, 332 56,00 14, 621, 047 0.161701 0.000000 56, 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 7, 563, 644 3, 519, 047 11, 082, 691 0.053969 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 14, 267, 652 11, 103, 414 25, 371, 066 0. 128399 0.000000 59.00 60.00 06000 LABORATORY 66, 017, 168 56, 629, 407 122, 646, 575 0.108922 0.000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 2, 184, 578 16, 030, 237 63.00 13.845.659 0.082112 0.000000 63.00 65.00 06500 RESPIRATORY THERAPY 18, 052, 097 833,000 18, 885, 097 0.241503 0.000000 65.00 8, 035, 367 14, 035, 939 66.00 06600 PHYSI CAL THERAPY 6,000,572 0.184105 0.000000 66.00 06700 OCCUPATIONAL THERAPY 2, 039, 241 0.180421 0.000000 67.00 1,085,357 953.884 67.00 68.00 06800 SPEECH PATHOLOGY 1, 541, 371 96, 421 1, 637, 792 0.291580 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 14, 345, 225 10, 555, 260 24, 900, 485 0.051782 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 593, 130 294, 752 2, 887, 882 0.112957 0.000000 70.00 70 01 07001 SLEEP LAB 1, 787, 096 1 787 096 0 174390 0 000000 70 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 8, 813, 530 17, 620, 157 26, 433, 687 0.830540 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 7, 059, 793 8, 734, 504 15, 794, 297 0. 930099 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 33, 330, 372 17, 435, 356 50, 765, 728 0.629210 0.000000 73.00 07400 RENAL DIALYSIS 74.00 8, 049, 786 552, 888 8, 602, 674 0.340046 0.000000 74.00 76.97 07697 CARDIAC REHABILITATION 1, 238, 091 1, 238, 091 0.380327 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 35 559 5, 148, 684 5, 184, 243 0 418140 0.000000 90 00 09001 WOUND CARE CENTER 90.01 1, 108, 484 12, 284, 785 13, 393, 269 0. 175184 0.000000 90.01 09002 CLINIC - BARIATRIC 687, 431 687, 431 0.866177 0.000000 90.02 90.02 09004 VACCINATION CENTER 90.03 3, 183 697, 114 700, 297 0.094483 0.000000 90.03 0.000000 90 22 09003 SAFE HOUSE r 0.000000 90 22 C 171, 240, 605 91.00 09100 EMERGENCY 63, 698, 179 234, 938, 784 0.104004 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 264961 92.00 24, 150 546, 100 570, 250 0.000000 92.00 92.01 09201 OBSERVATION BEDS-DISTINCT 9, 949, 900 52, 741, 950 62, 691, 850 0.070501 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 66, 905 66, 905 9.060265 0.000000 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 587, 589, 078 1, 611, 696, 521 Subtotal (see instructions) 1, 024, 107, 443 200. 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 1, 024, 107, 443 587, 589, 078 1, 611, 696, 521 202.00 Heal th Financial Systems

CLARA MAASS MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0009

Period:
From 01/01/2021
To 12/31/2021

Date/Time Prepared:

5/25/2022 1:03 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 40. 00 | 04000 | SUBPROVI DER - I PF 40 00 43.00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 0. 196355 05000 OPERATING ROOM 50.00 51.00 05100 RECOVERY ROOM 0. 162813 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 231015 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 101743 54 00 55. 00 | 05500 | RADI OLOGY-THERAPEUTI C 0. 201549 55.00 56.00 56.00 05600 RADI OI SOTOPE 0.161701 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.053969 58.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.128399 59.00 60.00 06000 LABORATORY 0. 108922 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.082112 63.00 06500 RESPIRATORY THERAPY 0. 241503 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 0.184105 66.00 67.00 06700 OCCUPATIONAL THERAPY 0. 180421 67.00 06800 SPEECH PATHOLOGY 68.00 0. 291580 68.00 06900 ELECTROCARDI OLOGY 0.051782 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 112957 70.00 70.01 07001 SLEEP LAB 0.174390 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.830540 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0. 930099 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.629210 73.00 07400 RENAL DIALYSIS 0. 340046 74.00 74.00 76. 97 07697 CARDIAC REHABILITATION 0. 380327 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.418140 90.00 09001 WOUND CARE CENTER 0. 175184 90.01 90.01 09002 CLINIC - BARLATRIC 90 02 0.866177 90.02 09004 VACCINATION CENTER 0.094483 90.03 90.03 90. 22 09003 SAFE HOUSE 0.000000 90. 22 91.00 09100 EMERGENCY 0. 104004 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 264961 92.00 92.00 09201 OBSERVATION BEDS-DISTINCT 92.01 0.070501 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95 00 9. 060265 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201. 00 201.00 Less Observation Beds

202.00

202.00

Total (see instructions)

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-0009	Peri od: Worksheet C

					rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/25/2022 1:0	pared: 3 pm
			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	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00	03000 ADULTS & PEDIATRICS	90, 848, 438		90, 848, 438	O	90, 848, 438	30.00
31. 00	03100 INTENSIVE CARE UNIT	15, 975, 893		15, 975, 893	1	15, 975, 893	
40. 00	04000 SUBPROVI DER - I PF	13, 773, 073		13, 773, 075		0	1
43. 00	04300 NURSERY	4, 747, 844		4, 747, 844	1	4, 747, 844	
44. 00	04400 SKILLED NURSING FACILITY	5, 084, 384		5, 084, 384		5, 084, 384	
	ANCI LLARY SERVI CE COST CENTERS				-1	2, 22 ., 22 .	
50.00	05000 OPERATI NG ROOM	24, 312, 429		24, 312, 429	0	24, 312, 429	50.00
51.00	05100 RECOVERY ROOM	3, 802, 880		3, 802, 880	o	3, 802, 880	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 535, 128		5, 535, 128	o	5, 535, 128	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 888, 492		8, 888, 492	. 0	8, 888, 492	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	4, 919, 918		4, 919, 918	o	4, 919, 918	55. 00
56.00	05600  RADI 0I SOTOPE	2, 364, 232		2, 364, 232	. 0	2, 364, 232	56. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	598, 120		598, 120	0	598, 120	
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 257, 617		3, 257, 617		3, 257, 617	
60.00	06000 LABORATORY	13, 358, 926		13, 358, 926		13, 358, 926	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 316, 268		1, 316, 268	1	1, 316, 268	1
65. 00	06500 RESPI RATORY THERAPY	4, 560, 807	0	., ,	1	4, 560, 807	1
66. 00	06600 PHYSI CAL THERAPY	2, 584, 081	0		1	2, 584, 081	1
67. 00	06700 OCCUPATI ONAL THERAPY	367, 922	0	00,,,22		367, 922	
68. 00	06800 SPEECH PATHOLOGY	477, 547	0	,		477, 547	
69. 00	06900 ELECTROCARDI OLOGY	1, 289, 394		1, 289, 394		1, 289, 394	
70.00	07000 ELECTROENCEPHALOGRAPHY	326, 206		326, 206		326, 206	
70. 01	07001 SLEEP LAB	311, 651		311, 651		311, 651	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	21, 954, 246 14, 690, 263		21, 954, 24 <i>6</i> 14, 690, 263		21, 954, 246 14, 690, 263	
72.00	07300 DRUGS CHARGED TO PATIENTS	31, 942, 308		31, 942, 308		31, 942, 308	
74. 00	07400 RENAL DIALYSIS	2, 925, 305		2, 925, 305		2, 925, 305	
76. 97	07697 CARDIAC REHABILITATION	470, 880		470, 880		470, 880	
70. 77	OUTPATIENT SERVICE COST CENTERS	470,000		470,000	ή σ	470,000	70.77
90. 00	09000 CLINIC	2, 167, 738		2, 167, 738	0	2, 167, 738	90.00
90. 01	09001 WOUND CARE CENTER	2, 346, 286		2, 346, 286		2, 346, 286	
90. 02	09002 CLINIC - BARIATRIC	595, 437		595, 437		595, 437	
90. 03	09004 VACCINATION CENTER	66, 166		66, 166	1	66, 166	1
90. 22	09003 SAFE HOUSE	1, 879, 311		1, 879, 311		1, 879, 311	
91.00	09100 EMERGENCY	24, 434, 627		24, 434, 627		24, 434, 627	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	151, 094		151, 094		151, 094	92. 00
92.01	09201 OBSERVATION BEDS-DISTINCT	4, 419, 829		4, 419, 829	0	4, 419, 829	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	606, 177		606, 177	0	606, 177	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
200.00		303, 577, 844	0			303, 577, 844	
201.00	l	151, 094	_	151, 094		151, 094	
202.00	Total (see instructions)	303, 426, 750	0	303, 426, 750	0	303, 426, 750	J202. 00

From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/25/2022 1:03 pm Title XIX Hospi tal TEFRA Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 530, 932, 161 530, 932, 161 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 87, 331, 264 87, 331, 264 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 43.00 04300 NURSERY 20, 901, 473 20, 901, 473 43.00 04400 SKILLED NURSING FACILITY 44.00 12, 629, 862 12, 629, 862 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 28, 936, 800 94, 882, 098 123, 818, 898 0.196355 0 196355 50.00 05100 RECOVERY ROOM 16, 928, 485 23, 357, 370 0.162813 0.162813 51.00 6, 428, 885 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 16, 744, 868 7, 215, 194 23, 960, 062 0.231015 0.231015 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 37, 569, 392 49, 792, 853 87, 362, 245 0.101743 0.101743 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 866, 212 23, 544, 320 24, 410, 532 0. 201549 0.201549 55.00 05600 RADI OI SOTOPE 4, 381, 715 10, 239, 332 56,00 14, 621, 047 0.161701 0.161701 56,00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 7, 563, 644 3, 519, 047 11, 082, 691 0.053969 0.053969 58.00 59.00 05900 CARDIAC CATHETERIZATION 14, 267, 652 11, 103, 414 25, 371, 066 0. 128399 0. 128399 59.00 60.00 06000 LABORATORY 66, 017, 168 56, 629, 407 122, 646, 575 0.108922 0.108922 60.00 2, 184, 578 06300 BLOOD STORING, PROCESSING & TRANS. 13.845.659 16, 030, 237 0.082112 63.00 0.082112 63.00 65.00 06500 RESPIRATORY THERAPY 18, 052, 097 833,000 18, 885, 097 0. 241503 0.241503 65.00 06600 PHYSI CAL THERAPY 14, 035, 939 66.00 6,000,572 8, 035, 367 0.184105 0.184105 66.00 06700 OCCUPATIONAL THERAPY 1, 085, 357 953, 884 2, 039, 241 0.180421 0.180421 67.00 67.00 06800 SPEECH PATHOLOGY 1, 541, 371 68.00 96, 421 1, 637, 792 0. 291580 0.291580 68.00 69.00 06900 ELECTROCARDI OLOGY 14, 345, 225 10, 555, 260 24, 900, 485 0.051782 0.051782 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 593, 130 294, 752 2, 887, 882 0.112957 0.112957 70.00 70 01 07001 SLEEP LAB 1, 787, 096 1 787 096 0 174390 0 174390 70 01 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 8, 813, 530 17, 620, 157 26, 433, 687 0.830540 0.830540 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 7, 059, 793 8, 734, 504 15, 794, 297 0. 930099 0.930099 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 33, 330, 372 17, 435, 356 50, 765, 728 0.629210 0.629210 73.00 07400 RENAL DIALYSIS 74.00 8, 049, 786 552, 888 8, 602, 674 0.340046 0.340046 74.00 76.97 07697 CARDIAC REHABILITATION 1, 238, 091 1, 238, 091 0.380327 0.380327 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 35 559 5, 148, 684 5 184 243 0 418140 0 418140 90 00 09001 WOUND CARE CENTER 90.01 1, 108, 484 12, 284, 785 13, 393, 269 0. 175184 0.175184 90.01 09002 CLINIC - BARIATRIC 687, 431 687, 431 0.866177 0.866177 90.02 90.02 09004 VACCINATION CENTER 700, 297 90.03 3, 183 697, 114 0.094483 0.094483 90.03 09003 SAFE HOUSE 0.000000 0 000000 90 22 r C 90 22 0.104004 91.00 09100 EMERGENCY 63, 698, 179 171, 240, 605 234, 938, 784 0.104004 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.264961 92.00 24, 150 546, 100 570, 250 0. 264961 92.00 92.01 09201 OBSERVATION BEDS-DISTINCT 9, 949, 900 52, 741, 950 62, 691, 850 0.070501 0.070501 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 66, 905 66, 905 9.060265 9. 060265 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 587, 589, 078 1, 611, 696, 521 Subtotal (see instructions) 1, 024, 107, 443 200. 00 201.00 Less Observation Beds 201.00

1, 024, 107, 443

587, 589, 078 1, 611, 696, 521

202.00

202.00

Total (see instructions)

Heal th Financial Systems

CLARA MAASS MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0009

Period:
From 01/01/2021
To 12/31/2021
Date/Time Prepared:
5/25/2022 1:03 pm

				5/25/2022 1:03 pm
		Title XIX	Hospi tal	TEFRA
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00   04000   SUBPROVI DER - 1 PF				40.00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS	<u> </u>			
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
51. 00   05100   RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 000000			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00   05600   RADI OI SOTOPE	0. 000000			56. 00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0. 000000			58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00   06000   LABORATORY	0. 000000			60.00
	0. 000000 0. 000000			63. 00 65. 00
65. 00 06500 RESPI RATORY THERAPY				
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
70. 01   07001   SLEEP LAB	0. 000000			70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00   07400   RENAL DI ALYSI S	0. 000000			74. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00  09000   CLI NI C	0. 000000			90.00
90. 01 09001 WOUND CARE CENTER	0. 000000			90. 01
90. 02   09002   CLI NI C - BARI ATRI C	0. 000000			90. 02
90. 03 09004 VACCINATION CENTER	0. 000000			90. 03
90. 22   09003   SAFE HOUSE	0. 000000			90. 22
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
92. 01 09201 OBSERVATI ON BEDS-DI STI NCT	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS	,			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300   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
[1044] (300 11134 404 0113)	ı			1202.00

Health Financial Systems	h Financial Systems CLARA MAASS MEDICAL CEN			u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE REDUCTIONS FOR MEDICALD ONLY	COST TO CHARGE RATIOS NET OF	Provider CCN: 31-0009	From 01/01/2021	Worksheet C Part II Date/Time Prepared:

			10	12/31/2021	5/25/2022 1:0	
		Ti tl	e XIX	Hospi tal	TEFRA	o piii
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
•	(Wkst. B, Part			Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			col . 2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATI NG ROOM	24, 312, 429	3, 476, 197	20, 836, 232	347, 620	1, 208, 501	
51.00  05100 RECOVERY ROOM	3, 802, 880	245, 176		24, 518	206, 347	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 535, 128	329, 652		32, 965	301, 918	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	8, 888, 492	1, 148, 594		114, 859	448, 914	
55. 00   05500   RADI OLOGY-THERAPEUTI C	4, 919, 918	1, 244, 693		124, 469	213, 163	55. 00
56. 00   05600   RADI OI SOTOPE	2, 364, 232	412, 651		41, 265	113, 192	56. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	598, 120	11, 220		1, 122	34, 040	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	3, 257, 617	289, 465		28, 947	172, 153	59. 00
60. 00  06000   LABORATORY	13, 358, 926	470, 475		47, 048		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 316, 268	22, 376		2, 238	75, 046	63. 00
65. 00 06500 RESPI RATORY THERAPY	4, 560, 807	281, 198		28, 120	248, 217	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 584, 081	162, 164		16, 216	140, 471	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	367, 922	10, 676		1, 068		67. 00
68.00 06800 SPEECH PATHOLOGY	477, 547	26, 763		2, 676	26, 145	•
69. 00 06900 ELECTROCARDI OLOGY	1, 289, 394	206, 212		20, 621	62, 825	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	326, 206	30, 296		3, 030	17, 163	70. 00
70. 01   07001   SLEEP LAB	311, 651	55, 030		5, 503	14, 884	70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 954, 246	566, 089		56, 609	1, 240, 513	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	14, 690, 263	378, 765		37, 877	830, 067	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	31, 942, 308	672, 922		67, 292	1, 813, 624	73. 00
74. 00   07400   RENAL DIALYSIS	2, 925, 305	218, 470		21, 847	156, 996	74. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	470, 880	42, 562	428, 318	4, 256	24, 842	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	2, 167, 738	230, 226		23, 023	112, 376	90.00
90. 01   09001   WOUND CARE CENTER	2, 346, 286	251, 681	2, 094, 605	25, 168	121, 487	90. 01
90. 02   09002   CLI NI C - BARI ATRI C	595, 437	73, 011	522, 426	7, 301	30, 301	90. 02
90. 03   09004   VACCI NATI ON CENTER	66, 166	1, 312		131	3, 762	90. 03
90. 22   09003   SAFE HOUSE	1, 879, 311	42, 136		4, 214	106, 556	90. 22
91. 00   09100   EMERGENCY	24, 434, 627	1, 454, 721		145, 472	1, 332, 835	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	151, 094	9, 337		934	8, 222	92.00
92. 01   09201   0BSERVATI ON BEDS-DI STI NCT	4, 419, 829	584, 377	3, 835, 452	58, 438	222, 456	92. 01
OTHER REIMBURSABLE COST CENTERS		40.07/		4 000	0.4.57.4	
95. 00 09500 AMBULANCE SERVI CES	606, 177	10, 076	596, 101	1, 008	34, 574	95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE	404 004 005	40.050.500	470 0/0 7/0	4 005 055	40.000.010	113.00
200.00 Subtotal (sum of lines 50 thru 199)	186, 921, 285	12, 958, 523		1, 295, 855		
201.00 Less Observation Beds	151, 094	9, 337		934		201. 00
202.00   Total (line 200 minus line 201)	186, 770, 191	12, 949, 186	173, 821, 005	1, 294, 921	10, 081, 618	J202. 00

Health Financial Systems	CLARA MAASS MEDIC	CAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COS REDUCTIONS FOR MEDICALD ONLY	ST TO CHARGE RATIOS NET OF	Provider CCN: 31-0009		Worksheet C Part II Date/Time Prepared: 5/25/2022 1:03 pm

							5/25/2022 1:	O3 pm
			Ti tl	e XIX	ı	Hospi tal	TEFRA	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent				
		Capital and	(Worksheet C,	Cost to Charg	jе			
		Operating Cost	Part I, column	Ratio (col.	6			
		Reduction	8)	/ col. 7)				
		6.00	7. 00	8. 00				
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	22, 756, 308	123, 818, 898	0. 18378	37			50. 00
51.00	05100 RECOVERY ROOM	3, 572, 015	23, 357, 370	0. 15292	29			51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 200, 245		0. 21703	38			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 324, 719	87, 362, 245	0. 09529	90			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	4, 582, 286	24, 410, 532	0. 18771	18			55. 00
56.00	05600 RADI OI SOTOPE	2, 209, 775	14, 621, 047	0. 15113	37			56. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	562, 958	11, 082, 691	0. 05079	96			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 056, 517	25, 371, 066	0. 12047	73			59. 00
60.00	06000 LABORATORY	12, 564, 348	122, 646, 575	0. 10244	14			60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 238, 984	16, 030, 237	0. 07729	90			63. 00
65.00	06500 RESPI RATORY THERAPY	4, 284, 470	18, 885, 097	0. 22687	70			65. 00
66.00	06600 PHYSI CAL THERAPY	2, 427, 394	14, 035, 939	0. 17294	11			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	346, 134			37			67. 00
68.00	06800 SPEECH PATHOLOGY	448, 726	1, 637, 792	0. 27398	32			68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 205, 948			31			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	306, 013		0. 10596	55			70. 00
70. 01	07001 SLEEP LAB	291, 264						70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 657, 124						71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 822, 319						72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	30, 061, 392						73. 00
74.00	07400 RENAL DIALYSIS	2, 746, 462						74.00
	07697 CARDI AC REHABI LI TATI ON	441, 782						76. 97
	OUTPATIENT SERVICE COST CENTERS		, , , , , ,					
90.00	09000 CLI NI C	2, 032, 339	5, 184, 243	0. 39202	22			90.00
90. 01	09001 WOUND CARE CENTER	2, 199, 631						90. 01
90. 02	09002 CLINIC - BARIATRIC	557, 835						90. 02
90. 03	09004 VACCINATION CENTER	62, 273	700, 297	0. 08892	24			90. 03
90. 22	09003 SAFE HOUSE	1, 768, 541						90, 22
91.00	09100 EMERGENCY	22, 956, 320	ł	•				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	141, 938						92.00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	4, 138, 935						92. 01
	OTHER REIMBURSABLE COST CENTERS	.,	, , , , , , , , , , , , , , , , , , , ,					
95. 00		570, 595	66, 905	8. 52843	36			95. 00
	SPECIAL PURPOSE COST CENTERS	, 3 , 0						
113. 00	11300 INTEREST EXPENSE							113. 00
200.00		175, 535, 590	959, 901, 761					200. 00
201.00		141, 938		1				201. 00
202.00		175, 393, 652						202. 00
		1 ., ,	,	'	1			

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/25/2022 1:0	pared:
		Title	XVIII	Hospi tal	PPS	
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, 613, 857	0	5, 613, 85	7 73, 956	75. 91	30.00
31.00 INTENSIVE CARE UNIT	1, 260, 033		1, 260, 03	3 8, 553	147. 32	31.00
40. 00 SUBPROVIDER - IPF	0	l o		0 0	0.00	40.00
43. 00 NURSERY	184, 453		184, 45	3 4, 113	44. 85	43.00
44.00 SKILLED NURSING FACILITY	453, 917		453, 91			
200.00 Total (lines 30 through 199)	7, 512, 260		7, 512, 26	-		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	19, 894	1, 510, 154				30.00
31. 00   INTENSIVE CARE UNIT	1, 471	216, 708				31. 00
40. 00 SUBPROVI DER - I PF	1 ., , , ,	1 2.5,700				40.00
43. 00 NURSERY		١				43. 00
44.00 SKILLED NURSING FACILITY	2, 255	218, 848				44. 00
200. 00 Total (lines 30 through 199)	23, 620					200.00
200. 00 Total (TITIES 30 till ough 199)	23, 020	1, 943, 710	'1			1200.00

Heal th F	Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	u of Form CMS-	2552-10
	ONMENT OF INPATIENT ANCILLARY SERVICE CAPIT		Provi der C	CN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/25/2022 1:0	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 476, 197				210, 631	50.00
	05100 RECOVERY ROOM	245, 176				16, 578	
	D5200 DELIVERY ROOM & LABOR ROOM	329, 652			0 8	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	1, 148, 594				142, 785	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 244, 693	24, 410, 532	0. 05099	252, 745	12, 887	55. 00
	05600 RADI OI SOTOPE	412, 651			1, 161, 341	32, 777	56. 00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	11, 220	11, 082, 691	0.0010	1, 994, 202	2, 018	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	289, 465	25, 371, 066	0. 01140	3, 357, 038	38, 300	59. 00
60.00	06000 LABORATORY	470, 475	122, 646, 575	0. 00383	18, 613, 354	71, 401	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	22, 376	16, 030, 237	0. 00139	2, 683, 920	3, 747	63.00
65.00	06500 RESPI RATORY THERAPY	281, 198	18, 885, 097	0. 01489	4, 607, 257	68, 602	65.00
66.00	06600 PHYSI CAL THERAPY	162, 164	14, 035, 939	0. 0115	1, 997, 554	23, 078	66.00
67.00	06700 OCCUPATIONAL THERAPY	10, 676	2, 039, 241	0.00523	389, 228	2, 038	67.00
68.00	06800 SPEECH PATHOLOGY	26, 763	1, 637, 792	0. 01634	400, 306	6, 541	68. 00
69.00	06900 ELECTROCARDI OLOGY	206, 212	24, 900, 485	0. 00828	3, 296, 136	27, 295	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	30, 296	2, 887, 882	0. 01049	738, 271	7, 745	70.00
70. 01	07001 SLEEP LAB	55, 030	1, 787, 096	0. 03079	93 0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	566, 089	26, 433, 687	0. 0214	1, 681, 007	35, 999	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	378, 765	15, 794, 297	0. 02398	2, 253, 887	54, 050	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	672, 922	50, 765, 728	0. 0132	7, 733, 710	102, 510	73.00
74.00	07400 RENAL DIALYSIS	218, 470	8, 602, 674	0. 02539	2, 981, 646	75, 722	74.00
76. 97	07697 CARDIAC REHABILITATION	42, 562	1, 238, 091	0.0343	77 0	0	76. 97
C	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	230, 226	5, 184, 243	0.04440	09 6, 212	276	90.00
90. 01	09001 WOUND CARE CENTER	251, 681	13, 393, 269	0. 01879	22, 785	428	90. 01
90. 02	09002 CLINIC - BARIATRIC	73, 011				0	90. 02
90. 03	09004 VACCINATION CENTER	1, 312	700, 297	0.0018	73 0	0	90. 03
	09003 SAFE HOUSE	42, 136	0	0.00000	00	0	90. 22
91.00	09100 EMERGENCY	1, 454, 721		l .		50, 756	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 337		l .		0	1
	09201 OBSERVATION BEDS-DISTINCT	584, 377				25, 684	92. 01
	THER REIMBURSABLE COST CENTERS			•			1
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	12, 948, 447	959, 834, 856	1	85, 065, 591	1, 011, 848	1

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		S Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/25/2022 1:0	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
30.00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	
31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF	0 0	0		0 0	0	31. 00 40. 00
43. 00   04300   NURSERY 44. 00   04400   SKI LLED NURSI NG FACI LI TY	0 0	0		0 0	0	44. 00
200.00 Total (lines 30 through 199)	0	0		0 0		200. 00
Cost Center Description	Swing-Bed Adjustment	Total Costs (sum of cols.	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		1 through 3, minus col. 4)				
INDATIONE DOUTING CERVILOE COST CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	O	0	73, 95	6 0.00	19, 894	30.00
31. 00   03100   NTENSIVE CARE UNIT	١	0	8, 55			
40. 00   04000   SUBPROVI DER -   PF	0	0		0.00	0	1
43. 00   04300   NURSERY		0	4, 11		0	43. 00
44. 00 04400 SKI LLED NURSING FACILITY		0	1		2, 255	
200.00 Total (lines 30 through 199)		0				200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00				==, ==	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF	0 0					30. 00 31. 00 40. 00
43.00   04300   NURSERY 44.00   04400   SKI LLED NURSI NG FACI LI TY 200.00   Total (lines 30 through 199)	0 0					43. 00 44. 00 200. 00

Health Financial Systems	n Financial Systems CLARA MAASS MEDICAL CENTER In I				
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 31-0009		Worksheet D Part IV Date/Time Prepared: 5/25/2022 1:03 pm	

THROUGH GOOTS				То	12/31/2021	Date/Time Prep 5/25/2022 1:03	pared: 3 pm
		Title	XVIII		Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
	Anestheti st	Program	Program		ost-Stepdown		
		ost-Stepdown		4	Adjustments		
		Adjustments					
	1.00	2A	2. 00		3A	3. 00	
ANCI LLARY SERVI CE 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
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
58. 00   05800   MAGNETIC RESONANCE I MAGING (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 RESPI RATORY THERAPY	0	0		0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
70. 01 07001 SLEEP LAB	0	0		0	0	ŭ,	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	71. 00 72. 00
	0	0		0	0	425 007	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	U	425, 097	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0		0	0	0	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	U U	0		0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC		0		0	ol	0	90. 00
90. 00   09000   CETNIC 90. 01   09001   WOUND CARE CENTER		0		0	U O	0	90.00
90. 01   09001   WOUND CARE CENTER 90. 02   09002   CLI NI C		0		0	0	0	90.01
90. 03   09004   VACCI NATI ON CENTER		0		0	0	0	90. 02
90. 03   09004   VACCINATION CENTER 90. 22   09003   SAFE HOUSE		0		0	0	0	90. 03
91. 00   09100   EMERGENCY		0		0	0	0	91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART		U		0	٩	0	91.00
92. 00 09200 OBSERVATION BEDS-DISTINCT PART		0		0	o	0	92. 00 92. 01
OTHER REIMBURSABLE COST CENTERS	<u> </u>	0		U	υ	U	72. U I
95. 00 09500 AMBULANCE SERVI CES					T		95. 00
200.00 Total (lines 50 through 199)	0	0		0	0	425, 097	
200.00   10tal (111163 30 till ough 199)	١	U	I	U	Ч	423, 077	200.00

∐oal +h	Financial Systems	CLARA MAASS ME	DICAL CENTED		In lie	eu of Form CMS-2	2552 10
APPORT	TOMMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		S Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV	pared:
			Title	XVIII	Hospi tal	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						
50.00	05000 OPERATING ROOM	0	0		0 123, 818, 898	0.000000	50. 00
51.00	05100 RECOVERY ROOM	0	0		0 23, 357, 370	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 23, 960, 062	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 87, 362, 245	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 24, 410, 532	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0 14, 621, 047		56.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 11, 082, 691	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 25, 371, 066		
60. 00	06000 LABORATORY	0	0		0 122, 646, 575		
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 16, 030, 237		
65. 00	06500 RESPI RATORY THERAPY	0	0		0 18, 885, 097		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 14, 035, 939		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	•	0 2, 039, 241	0.000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 637, 792		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 24, 900, 485		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 2, 887, 882		
70. 00	07001 SLEEP LAB	0	0		0 1, 787, 096		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 26, 433, 687		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 15, 794, 297		
	07300 DRUGS CHARGED TO PATIENTS	0	425, 097				
74. 00	07400 RENAL DIALYSIS	0	0		0 8, 602, 674		1
	07697 CARDIAC REHABILITATION	0	0		0 1, 238, 091	0.00000	
70. 77	OUTPATIENT SERVICE COST CENTERS	1 0	0		0 1, 230, 091	0.000000	10.91
90. 00	09000 CLINIC	T 0	0		0 5, 184, 243	0. 000000	90.00
	09001 WOUND CARE CENTER	0	0		0 13, 393, 269		
90.01	09001 WOUND CARE CENTER				0 13, 393, 269	0.00000	
	09004 VACCINATION CENTER	0	0		0077 101		
90. 03 90. 22	09003 SAFE HOUSE				0 700, 297 0 0	0. 000000 0. 000000	
					ٽ -		
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				
			)   0				
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT		0		0 62, 691, 850	0. 000000	92. 01

425, 097

425, 097

959, 834, 856

95.00

200. 00

OTHER REIMBURSABLE COST CENTERS
95.00 O9500 AMBULANCE SERVICES
200.00 Total (lines 50 through 199)

	Financial Systems ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	CLARA MAASS MED	Provi der CO	N. 21 0000	Peri od:	eu of Form CMS-2 Worksheet D	2332-10
THROUGH		RVICE UTHER PASS	Provider Co		From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre 5/25/2022 1:0	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati 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						1
	05000 OPERATING ROOM	0. 000000	7, 502, 431		0 11, 577, 987	0	
	05100 RECOVERY ROOM	0. 000000	1, 579, 335		0 4, 823, 002	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	10, 860, 682		0 5, 604, 630	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	252, 745		0 4, 766, 332	0	55. 00
	05600 RADI OI SOTOPE	0. 000000	1, 161, 341		0 2, 165, 590	0	56. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 994, 202		0 463, 343	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 357, 038		0 2, 563, 803	0	59. 00
	06000 LABORATORY	0. 000000	18, 613, 354		0 4, 157, 658	0	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	2, 683, 920		0 286, 492	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	4, 607, 257		0 159, 918	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 997, 554		0 77, 160	0	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0. 000000	389, 228		0 19, 685	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	400, 306		0 14, 159	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	3, 296, 136		0 2, 079, 252	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	738, 271		0 220, 580	0	70.00
	07001 SLEEP LAB	0. 000000	0		0 0	0	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 681, 007		0 2, 324, 743	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 253, 887		0 2, 202, 401	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 008374	7, 733, 710	64, 76	2 3, 033, 494	25, 402	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	2, 981, 646		0 24, 134	0	74.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000			0 0	0	76, 97
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>		·	<u> </u>		1
	09000 CLI NI C	0.000000	6, 212		0 466, 353	0	90.00
90. 01	09001 WOUND CARE CENTER	0. 000000	22, 785		0 3, 178, 009	0	90. 01
90. 02	09002 CLINIC - BARIATRIC	0. 000000	. 0		0 0	0	90. 02
	09004 VACCINATION CENTER	0. 000000	0		0 417, 255	0	90. 03
	09003 SAFE HOUSE	0. 000000	0		0 0	Ō	90. 22
	09100 EMERGENCY	0. 000000	8, 197, 094		0 10, 364, 369	o o	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	Ō	92. 00
	09201 OBSERVATION BEDS-DISTINCT	0. 000000	2, 755, 450		0 6, 005, 150	o o	
	OTHER REIMBURSABLE COST CENTERS		, , , , , , , ,		1, 222, 100		1
	09500 AMBULANCE SERVICES						95. 00
	Total (lines 50 through 199)	1			1		1

Health Financial Systems	CLARA MAASS MEDIC	In Li	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL.	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 31-0009	Peri od:	Worksheet D	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider C	CN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	1 Date/Time Prepared: 5/25/2022 1:03 pm	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect 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. 196355			0	2, 273, 396	50. 00
51. 00   05100   RECOVERY ROOM	0. 162813			0	785, 247	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 231015	l .	)	0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 101743		)	0	570, 232	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 201549	4, 766, 332		0	960, 649	55. 00
56. 00   05600 RADI 0I SOTOPE	0. 161701	2, 165, 590	)	0 0	350, 178	56. 00
58.00   05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 053969	463, 343		0 0	25, 006	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 128399	2, 563, 803		0 0	329, 190	59. 00
60. 00   06000   LABORATORY	0. 108922	4, 157, 658	1, 10	1 0	452, 860	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 082112	286, 492		0 0	23, 524	63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 241503	159, 918		0 0	38, 621	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 184105	l	1	0 0	14, 206	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 180421	19, 685		o o	3, 552	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 291580		1	o o	4, 128	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 051782	· ·		0	107, 668	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 112957	220, 580	1	0	24, 916	70.00
70. 01   07001   SLEEP LAB	0. 174390	l	1	0 0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 830540			0	1, 930, 792	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 930099			0	2, 048, 451	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 629210			0 2, 118	1, 908, 705	73.00
74. 00 07400 RENAL DI ALYSI S	0. 340046		i	0 2,110	8, 207	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 380327	21,101	i	o o	0, 207	76. 97
OUTPATIENT SERVICE COST CENTERS	0.000027		1	<u> </u>		70.77
90. 00 09000 CLINIC	0. 418140	466, 353		0 0	195, 001	90.00
90. 01   09001   WOUND CARE CENTER	0. 175184	3, 178, 009	1	0 0	556, 736	90. 01
90. 02   09002   CLINI C - BARI ATRI C	0. 866177	0,1,0,00,	,	0 0	0	90. 02
90. 03   09004   VACCI NATI ON CENTER	0. 094483	417, 255		0 0	39, 424	
90. 22 09003 SAFE HOUSE	0. 000000			0	0,, 121	90. 22
91. 00 09100 EMERGENCY	0. 104004	10, 364, 369	63, 36	.0	1, 077, 936	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 264961	10, 304, 307	05, 50	0 0	1, 077, 730	92.00
92. 01   09201   OBSERVATION BEDS-DISTINCT	0. 070501	6, 005, 150		0 0	423, 369	92. 01
OTHER REIMBURSABLE COST CENTERS	0.070301	0,000,100	1	O O	423, 307	92.01
95. 00   09500   AMBULANCE SERVICES   9. 060265   0				95. 00		
200.00 Subtotal (see instructions)	7. 000203	66, 995, 499	64, 46	~	14, 151, 994	
201.00 Less PBP Clinic Lab. Services-Program		00, 775, 499	04, 40	2, 110	14, 151, 994	200.00
Only Charges			1			201.00
202.00 Net Charges (line 200 - line 201)		66, 995, 499	64, 46	2, 118	14, 151, 994	202. 00

Health Financial Systems CLARA MAASS MEDICAL CENTER
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider In Lieu of Form CMS-2552-10 Provi der CCN: 31-0009

Peri od: Worksheet D
From 01/01/2021
To 12/31/2021 Date/Time Prepared: 5/25/2022 1:03 pm

							5/25/2022 1:0	J3 PIII
				Title	: XVIII	Hospi tal	PPS	
Co				sts		<u> </u>		
	Cost Center Description	n n	Cost	Cost				
	cost center bescription	) i						
			Rei mbursed	Rei mbursed				
			Servi ces	Services Not				
			Subject To	Subject To				
			Ded. & Coins.	Ded. & Coins.				
			(see inst.)	(see inst.)				
			6.00	7.00				
	ANOLI LADV CEDVI OF COCT CENT	-DC	0.00	7.00	l			
	ANCI LLARY SERVI CE COST CENTI	EKS	_1	_	ı			
50. 00	05000 OPERATING ROOM		0	0				50. 00
51. 00	05100 RECOVERY ROOM		0	0				51. 00
52.00	05200 DELIVERY ROOM & LABOR	ROOM	0	0				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0	0				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0	0				55. 00
			0	_				1
56. 00	05600 RADI OI SOTOPE		U	0				56. 00
58.00	05800 MAGNETIC RESONANCE I MA		0	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI (	ON	0	0				59. 00
60.00	06000 LABORATORY		120	0				60.00
63.00	06300 BLOOD STORING, PROCESS	SING & TRANS	0	0				63.00
65. 00	06500 RESPIRATORY THERAPY	71110 a 1101110.	0	0				65.00
	l l		0	_				
66. 00	06600 PHYSI CAL THERAPY		0	0				66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0	0				67. 00
68.00	06800 SPEECH PATHOLOGY		0	0				68. 00
69.00	06900 ELECTROCARDI OLOGY		ol	0				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	/	0	0				70. 00
70. 01	07001 SLEEP LAB		0	0				70. 01
		SED TO DATI FAIT	0	_				
71. 00	07100 MEDICAL SUPPLIES CHARC		0	0				71. 00
72.00	07200 I MPL. DEV. CHARGED TO		0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIE	ENTS	0	1, 333				73.00
74.00	07400 RENAL DIALYSIS		0	0				74.00
76. 97	07697 CARDIAC REHABILITATION	J	o	0				76. 97
, 0. , ,	OUTPATIENT SERVICE COST CEN			Ü				1 / 0 / / /
90. 00	09000 CLINIC	ILNJ	0	0				1 00 00
			U	_				90.00
90. 01	09001 WOUND CARE CENTER		0	0				90. 01
90. 02	09002 CLINIC - BARIATRIC		0	0				90. 02
90. 03	09004 VACCINATION CENTER		0	0				90. 03
90. 22	09003 SAFE HOUSE		0	0				90. 22
91. 00	09100 EMERGENCY		6, 590	0				91.00
		DICTINCT DART	0, 370	_				
92. 00	09200 OBSERVATI ON BEDS (NON-		U	0				92. 00
92. 01				92. 01				
	OTHER REI MBURSABLE COST CENTERS							
95. 00   09500   AMBULANCE SERVI CES   0				95. 00				
200.00	Subtotal (see instruct	tions)	6, 710	1, 333				200. 00
201.00	,		2,7.0	., 000				201. 00
201.00		or vices ilogialli						201.00
Only Charges		/ 710	1 222				202 00	
202.00	Net Charges (line 200	- IINE 201)	6, 710	1, 333				202. 00

Heal th	Financial Systems	CLARA MAASS ME	EDICAL CENTER		In Lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der Co	CN: 31-0009	Peri od:	Worksheet D	
			Component	CCN: 31-S009	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/25/2022 1:0	pared: 3 pm
				: XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,	9	Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	3, 476, 197				1, 364	
51. 00	05100 RECOVERY ROOM	245, 176					
52. 00	05200 DELIVERY ROOM & LABOR ROOM	329, 652				0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 148, 594				1, 355	
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 244, 693				463	
56.00	05600 RADI OI SOTOPE	412, 651				0	56. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	11, 220			2 45, 522	46	
59.00	05900 CARDI AC CATHETERI ZATI ON	289, 465	25, 371, 066	0. 01140	0	0	59. 00
60.00	06000 LABORATORY	470, 475			355, 172	1, 362	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	22, 376			3, 437	5	63.00
65.00	06500 RESPI RATORY THERAPY	281, 198	18, 885, 097	0. 01489	20, 705	308	65.00
66.00	06600 PHYSI CAL THERAPY	162, 164	14, 035, 939	0. 01155	70, 365	813	66.00
67.00	06700 OCCUPATI ONAL THERAPY	10, 676	2, 039, 241	0.00523	5, 459	29	67.00
68.00	06800 SPEECH PATHOLOGY	26, 763	1, 637, 792	0. 01634	5, 333	87	68. 00
69.00	06900 ELECTROCARDI OLOGY	206, 212			34, 927	289	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	30, 296	2, 887, 882	0. 01049	3, 680	39	70.00
70. 01	07001 SLEEP LAB	55, 030	1, 787, 096	0. 03079	0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	566, 089	26, 433, 687	0. 02141	5 2, 607	56	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	378, 765	15, 794, 297	0. 02398	31 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	672, 922	50, 765, 728	0. 01325	75, 049	995	73. 00
74.00	07400 RENAL DIALYSIS	218, 470				0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	42, 562				0	76. 97
	OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
90.00	09000 CLI NI C	230, 226	5, 184, 243	0. 04440	0	0	90.00
90. 01	09001 WOUND CARE CENTER	251, 681				0	90. 01
90. 02	09002 CLINIC - BARIATRIC	73, 011				0	
90. 03	09004 VACCINATION CENTER	1, 312				0	90. 03
90. 22	09003 SAFE HOUSE	42, 136	1			o o	
91. 00	09100 EMERGENCY	1, 454, 721	1			2, 613	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 434, 721		l .		2,013	
92. 01	09201 OBSERVATION BEDS-DISTINCT	584, 377				88	
72.01	OTHER REIMBURSABLE COST CENTERS	304,377	02, 071, 030	0.00732	7,400		/2.01
95. 00	09500 AMBULANCE SERVICES						95.00
200.00		12, 939, 110	959, 834, 856		1, 249, 150	10, 276	

	_Financial_Systems FIONMENT OF INPATIENT/OUTPATIENT_ANCILLARY_SE	CLARA MAASS ME RVICE OTHER PASS		CN: 31-0009	Peri o	d:	u of Form CMS-: Worksheet D	2002 10
	SH COSTS			CCN: 31-S009	From (	01/01/2021 12/31/2021	Part IV Date/Time Pre	
			Title	XVIII	Subp	rovi der -	5/25/2022 1: 0 PPS	3 pm
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Alli		Allied Health	
		Anesthetist	Program	Program		-Stepdown		
		Cost	Post-Stepdown		Adj	ustments		
			Adjustments					
	ANGLILADY CERVICE COCT CENTERS	1.00	2A	2.00		3A	3. 00	
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	0	0	Γ	0	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0		0	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0		0	0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C		0		0	0	0	55.00
56. 00	05600 RADI OI SOTOPE	0	0		Ö	0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0		Ö	0	ő	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0		0	0	0	
60.00	06000 LABORATORY	o	0		0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0		0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	o	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	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	
70. 01	07001 SLEEP LAB	0	0		0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0	0	425, 097	73.00
74. 00 76. 97	07400 RENAL DIALTSIS	0	0		0	0	0	
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		U		U	70. 77
90. 00	09000 CLINI C	0	0		0	0	0	90.00
90. 01	09001 WOUND CARE CENTER	o	0		Ö	0	0	
90. 02	09002 CLINIC - BARIATRIC	o	0		Ö	0	o o	1
90. 03	09004 VACCI NATI ON CENTER	o	0		Ō	0	Ō	
90. 22	09003 SAFE HOUSE	o	0		0	0	0	1
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 OBSERVATI ON BEDS-DISTINCT	0	0		0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS							1
95. 00	09500 AMBULANCE SERVI CES							95. 00
200.00	Total (lines 50 through 199)	O	0		0	0	425, 097	[200, 00]

	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE OTHER PASS	Component	CCN: 31-S009	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/25/2022 1:0	pared: 3 pm
			Title	XVIII	Subprovi der  - I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3, and 4)	8)	7) (see	
				anu 4)		instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	1 0	0		0 123, 818, 898	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	0			0 23, 357, 370	0.00000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0 23, 960, 062	0.00000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 87, 362, 245	0.00000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 24, 410, 532	0.00000	
56. 00	05600 RADI OI SOTOPE	0	ĺ		0 14, 621, 047	0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 11, 082, 691	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	٥		0 25, 371, 066	0. 000000	
50.00	06000 LABORATORY	0	٥		0 122, 646, 575	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 16, 030, 237	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 18, 885, 097	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 14, 035, 939	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	l o		0 2, 039, 241	0.000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 637, 792	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 24, 900, 485	0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 2, 887, 882	0. 000000	70.0
70. 01	07001 SLEEP LAB	0	0		0 1, 787, 096	0. 000000	70.0
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 26, 433, 687	0.000000	71.0
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 15, 794, 297	0. 000000	72.0
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	425, 097	425, 09		0.008374	73.0
74. 00	07400 RENAL DIALYSIS	0	0		0 8, 602, 674	0.000000	74.0
76. 97	07697 CARDIAC REHABILITATION	0	0		0 1, 238, 091	0. 000000	76. 9
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0			0 5, 184, 243		
90. 01	09001 WOUND CARE CENTER	0	1		0 13, 393, 269	0. 000000	
	09002 CLINIC - BARIATRIC	0	0		0 687, 431	0. 000000	
90. 03	09004 VACCINATION CENTER	0	0		0 700, 297	0. 000000	
	09003 SAFE HOUSE	0	0		0	0. 000000	
91. 00	09100 EMERGENCY	0	0		0 234, 938, 784	0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 570, 250	0. 000000	
92. 01	09201 OBSERVATI ON BEDS-DISTINCT	0	0		0 62, 691, 850	0. 000000	92.0
	OTHER REIMBURSABLE COST CENTERS	1					
95. 00							95. 0
200.00	Total (lines 50 through 199)	0	425, 097	425, 09	959, 834, 856		200.0

	n Financial Systems	CLARA MAASS MEDI	ICAL CENTER		In Lie	u of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE GH COSTS	RVICE OTHER PASS	Provider CC Component C	CN: 31-0009 CCN: 31-S009	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre	pared:
			Title	XVIII	Subprovi der - I PF	5/25/2022 1:03 der - PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9.00	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATING ROOM	0. 000000	48, 594		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	34, 706		0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	34, 700		0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	103, 082		0 6, 234	0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	9, 086		0 154	0	
56. 00	05600 RADI OI SOTOPE	0. 000000	7, 000		0 0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	45, 522		0 3, 392	Ö	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0, 022		0 0,072	Ö	
60. 00	06000 LABORATORY	0. 000000	355, 172		0 620	Ö	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	3, 437		0 0	Ö	
65. 00	06500 RESPI RATORY THERAPY	0. 000000	20, 705		0 0	ő	
66. 00	06600 PHYSI CAL THERAPY	0. 000000	70, 365		0 0	ő	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	5, 459		0 0	ő	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	5, 333		0 0	ő	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	34, 927		0 512	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	3, 680		0 892	Ō	
70. 01	07001 SLEEP LAB	0. 000000	0, 220		0 0	Ō	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	2, 607		0 0	Ō	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 008374	75, 049	62	28 0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0. 000000	0		0 0	0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09001 WOUND CARE CENTER	0. 000000	0		0 0	0	90. 01
90. 02	09002 CLINIC - BARIATRIC	0. 000000	0		0 0	0	90. 02
90. 03	09004 VACCINATION CENTER	0. 000000	0		0 0	0	90. 03
90. 22	09003 SAFE HOUSE	0. 000000	0		0 0	0	90. 22
91.00	09100 EMERGENCY	0. 000000	422, 026		0 3, 846	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	
92. 01	09201 OBSERVATION BEDS-DISTINCT	0. 000000	9, 400		0 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00							95. 00
200.00	Total (lines 50 through 199)		1, 249, 150	62	15, 650	0	200. 00

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	Provi der CO		Peri od:	Worksheet D			
		Component (		From 01/01/2021 To 12/31/2021	Part V Date/Time Prep 5/25/2022 1:03		
				Subprovi der - I PF	PPS		
			Charges		Costs		
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services		
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)		
	Worksheet C,	inst.)	Servi ces	Services Not			
	Part I, col. 9		Subject To	Subject To			

				Ch		C+-	
				Charges		Costs	
Cost Center Descriptio	n Co		PPS Reimbursed		Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
	Pa	art I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTE	RS						
50. 00 05000 OPERATI NG ROOM		0. 196355	0	0	0	0	50.00
51. 00 05100 RECOVERY ROOM		0. 162813	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR	ROOM	0. 231015	0	0	0	0	52. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C		0. 101743	6, 234	0	0	634	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 201549	154		0	31	1
56. 00   05600 RADI OI SOTOPE		0. 161701	0	0	0	0	56. 00
58. 00 05800 MAGNETIC RESONANCE I MA	GING (MPI)	0. 053969	3, 392	0	0	183	
59. 00 05900 CARDI AC CATHETERI ZATI 0		0. 128399	3, 372	0	0	0	59.00
60. 00   06000   LABORATORY	IN .	0. 128344	620	_	0	68	
1 1	INC & TRANC		020		0		1
63. 00 06300 BLOOD STORING, PROCESS	ING & IRANS.	0. 082112	0		U	0	
65. 00 06500 RESPIRATORY THERAPY		0. 241503	0	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 184105	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 180421	0	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY		0. 291580	0		0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY		0. 051782	512		0	27	
70. 00   07000   ELECTROENCEPHALOGRAPHY		0. 112957	892		0	101	70. 00
70. 01  07001   SLEEP LAB		0. 174390	0	0	0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARG	ED TO PATIENT	0. 830540	0	0	0	0	71. 00
72.00 07200 I MPL. DEV. CHARGED TO	PATI ENTS	0. 930099	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIE		0. 629210	0	0	0	0	73. 00
74.00 07400 RENAL DIALYSIS		0. 340046	0	0	0	0	74. 00
76. 97 07697 CARDIAC REHABILITATION		0. 380327	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENT					-)		
90. 00 09000 CLI NI C		0. 418140	0	0	0	0	90.00
90. 01 09001 WOUND CARE CENTER		0. 175184	0	l o	0	0	90. 01
90. 02 09002 CLINIC - BARI ATRIC		0. 866177	0	0	0	0	90. 02
90. 03 09004 VACCINATION CENTER		0. 094483	n	l o	0	0	90. 03
90. 22 09003 SAFE HOUSE		0. 000000	n	l o	0	0	90. 22
91. 00 09100 EMERGENCY		0. 104004	3, 846	0	0	400	
92. 00   09200   OBSERVATI ON BEDS (NON-	DISTINCT DART	0. 264961	0,040		0	0	92.00
92. 01   09201   0BSERVATI ON BEDS - DI STI		0. 070501	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENT		0. 070301	U	0	U	U	92.01
95. 00 09500 AMBULANCE SERVICES	EKS	0.0(02/5					05 00
	:>	9. 060265	15 /50	0	0	1 444	95. 00
200.00 Subtotal (see instruct			15, 650	0	0		200. 00
201.00 Less PBP Clinic Lab. S	ervices-Program				0	  -	201. 00
Only Charges	1: 201)		15 (50	_		1 444	202 00
202.00 Net Charges (line 200	- IINE 201)		15, 650	0	0	1, 444	202. 00

Heal th	Financial Systems	CLARA MAASS ME	EDICAL CENTER		In Lie	u of Form CMS-	2552-10
	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der C	CN: 31-0009 CCN: 31-S009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/25/2022 1:0	epared:
			Ti tl e	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00	-			
	ANCILLARY SERVICE COST CENTERS						
70. 00 70. 01 71. 00 72. 00 73. 00 74. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM & LABOR ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTIC 05500 RADI OLOGY-THERAPEUTIC 05600 RADI OLOGY-THERAPEUTIC 05600 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY 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 PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS	000000000000000000000000000000000000000					50. 00 51. 00 52. 00 54. 00 55. 00 56. 00 58. 00 60. 00 63. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 01 71. 00 72. 00 73. 00 74. 00 76. 97
90. 01 90. 02 90. 03	09000 CLINIC 09001 WOUND CARE CENTER 09002 CLINIC - BARIATRIC 09004 VACCINATION CENTER 09003 SAFE HOUSE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS-DISTINCT OTHER REIMBURSABLE COST CENTERS	0 0 0 0 0 0					90. 00 90. 01 90. 02 90. 03 90. 22 91. 00 92. 00 92. 01

0

0

92. 01 95.00

200. 00

201. 00

202. 00

92. 01 09201 0BSERVATI ON BEDS-DI STI NCT OTHER REI MBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVI CES

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

200.00

201.00

202.00

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS		Provi der CCN: 31-0009		Worksheet D Part I Date/Time Prep 5/25/2022 1:03	
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 ADULTS & PEDIATRICS	5, 613, 857	l e	0,0.0,00	· ·	75. 91	30.00
31.00   INTENSIVE CARE UNIT	1, 260, 033		1, 260, 03	3 8, 553	147. 32	31.00
40. 00 SUBPROVI DER - I PF	0	0		0	0.00	40.00
43. 00 NURSERY	184, 453		184, 45	3 4, 113	44. 85	43.00
44.00 SKILLED NURSING FACILITY	453, 917		453, 91	7 4, 677	97. 05	44.00
200.00 Total (lines 30 through 199)	7, 512, 260		7, 512, 26	0 91, 299		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, 947		•			30.00
31.00   INTENSIVE CARE UNIT	1, 716	252, 801				31.00
40. 00 SUBPROVI DER - I PF	0	0				40.00
43. 00 NURSERY	3, 306	148, 274				43.00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (lines 30 through 199)	6, 969	548, 872				200. 00

Harlah Firansial Contant	CLADA MAACC ME	DICAL CENTED		1-1:-	6 F CMC	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	CLARA MAASS ME L COSTS	Provi der CO		Peri od: From 01/01/2021 To 12/31/2021	worksheet D Part II Date/Time Pre 5/25/2022 1:0	pared:
			e XIX	Hospi tal	TEFRA	
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   OPERATING ROOM	3, 476, 197				13, 931	50. 00
51.00   05100   RECOVERY ROOM	245, 176				879	
52.00 05200 DELIVERY ROOM & LABOR ROOM	329, 652		0. 01375		5, 511	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 148, 594		0. 01314		15, 117	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	1, 244, 693		0. 05099		0	55. 00
56. 00   05600   RADI 0I SOTOPE	412, 651		0. 02822	23 131, 531	3, 712	56. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	11, 220	11, 082, 691	0. 00101	12 249, 788	253	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	289, 465			09 562, 902	6, 422	59. 00
60. 00   06000   LABORATORY	470, 475	122, 646, 575	0.00383	36 2, 353, 193	9, 027	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	22, 376	16, 030, 237	0. 00139	96 174, 568	244	63.00
65. 00 06500 RESPIRATORY THERAPY	281, 198	18, 885, 097	0. 01489	90 524, 862	7, 815	65. 00
66. 00   06600 PHYSI CAL THERAPY	162, 164	14, 035, 939	0. 01155	148, 050	1, 710	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 676	2, 039, 241	0.00523	35 27, 522	144	67.00
68. 00 06800 SPEECH PATHOLOGY	26, 763	1, 637, 792	0. 01634	108, 970	1, 781	68. 00
69. 00 06900 ELECTROCARDI OLOGY	206, 212	24, 900, 485	0. 00828	31 421, 074	3, 487	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	30, 296	2, 887, 882	0. 01049	122, 343	1, 284	70. 00
70. 01 07001 SLEEP LAB	55, 030	1, 787, 096	0. 03079	93 0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	566, 089	26, 433, 687	0. 0214	116, 788	2, 501	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	378, 765	15, 794, 297	0. 02398	85, 310	2, 046	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	672, 922	50, 765, 728	0. 01325		10, 418	73. 00
74. 00 07400 RENAL DI ALYSI S	218, 470	8, 602, 674	0. 02539	88, 846	2, 256	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	42, 562		0. 03437		0	1
OUTPATIENT SERVICE COST CENTERS			<u>'</u>			1
90. 00 09000 CLI NI C	230, 226	5, 184, 243	0. 04440	09 2, 108	94	90.00
90. 01   09001   WOUND CARE CENTER	251, 681				439	1
90. 02   09002   CLI NI C - BARI ATRI C	73, 011		0. 10620		0	90. 02
90. 03 09004 VACCINATION CENTER	1, 312		0. 00187		0	90. 03
90. 22 09003 SAFE HOUSE	42, 136		0.00000		0	1
91. 00 09100 EMERGENCY	1, 454, 721					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 337				0	1
92. 01 09201 OBSERVATI ON BEDS-DI STI NCT	584, 377				2, 705	
OTHER REIMBURSABLE COST CENTERS	22.7077		2. 20701		,	1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	12, 948, 447	959, 834, 856		9, 554, 573	99, 249	200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, , , , , , , , , , , , , , , , , , , ,	,	'	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	,	

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		TS Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/25/2022 1:0	pared:
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Nursi ng	Nursi ng		h 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	)	0 0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
40. 00   04000   SUBPROVI DER - 1 PF	0			0 0	0	40.00
43. 00 04300 NURSERY	0	l o		0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44.00
200.00 Total (lines 30 through 199)	0	ĺ		0 0	l o	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	200.00
oost content boson per on	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	buys	0 . 661. 67	l rogram bays	
	instructions)	minus col. 4)				
	4. 00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	73, 95	0.00	1, 947	30.00
31. 00 03100 INTENSIVE CARE UNIT		0	8, 55			
40. 00   04000   SUBPROVI DER - I PF	0	0	)	0.00		1
43. 00   04300   NURSERY		0	4. 11			
44.00 04400 SKILLED NURSING FACILITY			1			
200.00 Total (lines 30 through 199)			1			200. 00
Cost Center Description	I npati ent		, , , , , , , , , , , , , , , , , , , ,		0, 707	200.00
oost content boson per on	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00   03100   NTENSI VE CARE UNI T	0	ŀ				31.00
40. 00   04000   SUBPROVI DER -   PF	0	l .				40.00
43. 00   04300   NURSERY	0					43.00
44. 00   04400   SKI LLED NURSI NG FACI LI TY	0	l .				44.00
200.00 Total (lines 30 through 199)	0	l .				200.00
200.00 [10tal (11165 30 till ough 199)	1	I				1200.00

Health Financial Systems	CLARA MAASS MED	DICAL CENTER	CAL CENTER		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CC	CN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prep 5/25/2022 1:03		
		Title	e XIX	Hospi tal	TEFRA		
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health		

					10 12/31/2021	5/25/2022 1:03	
			Ti tl	e XIX	Hospi tal	TEFRA	
	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	
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0	C	)	0	ή "	50. 00
	OO RECOVERY ROOM	0	C	)	0	0	51. 00
	DO DELIVERY ROOM & LABOR ROOM	0	C	)	0	0	52. 00
	OO RADI OLOGY-DI AGNOSTI C	0	C	)	0	0	54. 00
	OO RADI OLOGY-THERAPEUTI C	0	C	)	0	0	55. 00
	00 RADI OI SOTOPE	0	C		0	0	56. 00
	MAGNETIC RESONANCE IMAGING (MRI)	0	C	)	0	0	58. 00
	OO CARDI AC CATHETERI ZATI ON	0	C		0	0	59. 00
	OO LABORATORY	0	C	)	0	0	60.00
	DO BLOOD STORING, PROCESSING & TRANS.	0	C		0	0	63. 00
	OO RESPIRATORY THERAPY	0	C		0	0	65. 00
	OO PHYSI CAL THERAPY	0	C		0	0	66. 00
	OO OCCUPATIONAL THERAPY	0	C	)	0	0	67. 00
	OO SPEECH PATHOLOGY	0	C	)	0	0	68. 00
	OO ELECTROCARDI OLOGY	0	C	)	0	0	69. 00
	OO ELECTROENCEPHALOGRAPHY	0	C	)	0	0	70. 00
	O1 SLEEP LAB	0	C	)	0	0	70. 01
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	)	0	0	71. 00
	OO IMPL. DEV. CHARGED TO PATIENTS	0	C	)	0	0	72. 00
	DO DRUGS CHARGED TO PATIENTS	0	C	)	0	425, 097	73. 00
	OO RENAL DIALYSIS	0	C		0	-	74. 00
	7 CARDIAC REHABILITATION	0	C	)	0 0	0	76. 97
	PATIENT SERVICE COST CENTERS						
	OO CLI NI C	0	C	)	0 0	1	90. 00
	01 WOUND CARE CENTER	0	C	)	0 0	0	90. 01
	02 CLINIC - BARIATRIC	0	C	)	0	0	90. 02
	04 VACCINATION CENTER	0	C	)	0	0	90. 03
	3 SAFE HOUSE	0	C	)	0	0	90. 22
	OO EMERGENCY	0	C	)	0	0	91. 00
	OO OBSERVATION BEDS (NON-DISTINCT PART	0	_		0	0	92. 00
	01 OBSERVATI ON BEDS-DI STI NCT	0	C	יו	0 0	0	92. 01
	R REIMBURSABLE COST CENTERS	1					05.00
	OO AMBULANCE SERVICES		_			405 007	95. 00
200. 00	Total (lines 50 through 199)	0	C	ין	0 0	425, 097	J200. 00

llool +h	Financial Customs	CLADA MAACC ME	DICAL CENTED		la lie	u of Form CMC	2552 10
APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	CLARA MAASS ME EVICE OTHER PASS			Period: From 01/01/2021 To 12/31/2021	worksheet D Part IV Date/Time Pre 5/25/2022 1:0	pared:
			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
				,		instructions)	
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 123, 818, 898	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	)	0 23, 357, 370	0.000000	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	,	0 23, 960, 062		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 87, 362, 245		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0 24, 410, 532	l .	1
56. 00	05600 RADI OI SOTOPE	0	0		0 14, 621, 047		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 11, 082, 691	0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	1	0 25, 371, 066		1
60.00	06000 LABORATORY	0	0	1	0 122, 646, 575	l	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0	1	0 16, 030, 237	0.000000	
65. 00	06500 RESPIRATORY THERAPY		0	1	0 18, 885, 097		
66. 00	06600 PHYSI CAL THERAPY	0	0	1		l e	1
67. 00	06700 OCCUPATIONAL THERAPY	0	0		0 14, 035, 939 0 2, 039, 241	0. 000000 0. 000000	
	06800 SPEECH PATHOLOGY	0	0	1			
68. 00		0	0		,,	0.000000	
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0 24, 900, 485		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 2, 887, 882		
70. 01	07001 SLEEP LAB	0	0	1	0 1, 787, 096	l e	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 26, 433, 687	0.000000	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	405.007	1	0 15, 794, 297	0.000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	425, 097	1		l	1
74. 00	07400 RENAL DIALYSIS	0	0	1	0 8, 602, 674		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 1, 238, 091	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS			1		T	
90. 00	09000 CLI NI C	0	-	1	5, 184, 243		1
90. 01	09001 WOUND CARE CENTER	0	0		0 13, 393, 269	l	
90. 02	09002 CLINIC - BARIATRIC	0	0		0 687, 431	0. 000000	
90. 03	09004 VACCINATION CENTER	0	0		0 700, 297	0.000000	
90. 22	09003 SAFE HOUSE	0	0	1	0	0.000000	1
91.00	09100 EMERGENCY	0	0		0 234, 938, 784		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 570, 250	0.000000	
92.01	09201 OBSERVATI ON BEDS-DI STI NCT	0	0		0 62, 691, 850	0. 000000	92. 01

425, 097

425, 097

959, 834, 856

95.00

200.00

Total (lines 50 through 199)

95. 00 OTHER REIMBURSABLE COST CENTERS
O9500 AMBULANCE SERVICES

200.00

	Financial Systems	CLARA MAASS MED	_			u of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PASS	Provider CO	CN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/25/2022 1:0	
			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10)	8	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	TANGULLARY OFRICE COOT OFFITERS	9. 00	10. 00	11. 00	12. 00	13. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.000000	407.004	1			 
50. 00 51. 00	O5000   OPERATI NG ROOM   O5100   RECOVERY ROOM	0. 000000 0. 000000	496, 201 83, 772	l .	0 0	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	400, 561		0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 149, 822		0 0	0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	131, 531		0 0	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	249, 788		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	562, 902		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	2, 353, 193		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	174, 568		0 0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	524, 862		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	148, 050		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	27, 522		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	108, 970		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	421, 074		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	122, 343		0 0	0	70. 00
70. 01	07001 SLEEP LAB	0. 000000	0		0	0	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	116, 788		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	85, 310		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 008374	785, 990			0	
74.00	07400 RENAL DIALYSIS	0. 000000	88, 846	1	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			ı			
90.00	09000 CLI NI C	0. 000000	2, 108	1	0 0	0	
90. 01	09001 WOUND CARE CENTER	0. 000000	23, 344		0 0	0	
90. 02	09002 CLINIC - BARIATRIC	0. 000000	0		0	0	90. 02
90. 03	09004 VACCINATION CENTER	0.000000	0		0	0	90. 03
90. 22	09003 SAFE HOUSE	0.000000	1 20/ 212		0	0	90. 22
91.00	09100 EMERGENCY	0.000000	1, 206, 818		0 0	0	
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS-DISTINCT	0. 000000 0. 000000	0 290, 210	1	0 0	0	92. 00 92. 01
92. UT	OTHER DELMBRIDGARIE COST CENTERS	0.000000	290, 210	1	<u>U</u>	0	92.01

6, 582

9, 554, 573

0

95.00

0 200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-0009 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/25/2022 1:03 pm Title XIX Hospi tal TEFRA Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 183787 129, 870 0 50.00 51.00 05100 RECOVERY ROOM 0. 152929 24, 391 0 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 217038 0 426, 233 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.095290 0 587, 274 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 187718 125, 422 0 55.00 56.00 05600 RADI OI SOTOPE 0.151137 0 35, 081 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 56.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.050796 94, 891 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.120473 0 59.00 06000 LABORATORY 60.00 0.102444 0 200, 219 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 1, 203 0.077290 0 63 00 0 63 00 65.00 06500 RESPIRATORY THERAPY 0. 226870 4,840 0 65.00 06600 PHYSI CAL THERAPY 0. 172941 16, 204 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.169737 67.00 5. 627 0 68.00 06800 SPEECH PATHOLOGY 0 1, 506 0.273982 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.048431 0 78, 489 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 105965 70.00 70.00 70. 01 07001 SLEEP LAB 0. 162982 0 0 70. 01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 16, 516 71.00 71.00 0.781470 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.875146 10, 018 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.592159 71, 241 0 73.00 07400 RENAL DIALYSIS 74.00 0.319257 0 0 74.00 0 07697 CARDIAC REHABILITATION 0 O 76. 97 76.97 0.356825 Ω OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 392022 364, 719 0 90.00 09001 WOUND CARE CENTER 90.01 0 0 0 0 0 0 90. 01 0.164234 106, 741 0 09002 CLINIC - BARIATRIC 90.02 90.02 0.811478 0 303 0 09004 VACCINATION CENTER 0.088924 0 90.03 90.03 0 C 90. 22 09003 SAFE HOUSE 0.000000 0 0 0 90. 22 91 00 09100 EMERGENCY 0.097712 0 2, 328, 407 91.00 Ω 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0. 248905 C 20, 985 0 92.00 09201 OBSERVATION BEDS-DISTINCT o 92.01 0.066020 0 839, 689 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 8.528436 0 34.360 95.00 200.00 Subtotal (see instructions) 5, 524, 229 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program o 201.00

0

5, 524, 229

0

0 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems CLARA MAASS MEDICAL CENTER			In Lieu of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 31-0009	Peri od:	Worksheet D

From 01/01/2021 | Part V | Date/Time Prepared: 5/25/2022 1:03 pm Title XIX Hospi tal TEFRA Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 23, 868 0 50.00 51.00 05100 RECOVERY ROOM 3,730 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 92, 509 0 52 00 52 00 05400 RADI OLOGY-DI AGNOSTI C 55, 961 0 54.00 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 23, 544 55.00 56.00 05600 RADI OI SOTOPE 5.302 0 56.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 4,820 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 0 60.00 20, 511 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63 00 93 63 00 65.00 06500 RESPIRATORY THERAPY 1,098 0 65.00 66.00 06600 PHYSI CAL THERAPY 2,802 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 955 67.00 0 68.00 06800 SPEECH PATHOLOGY 413 68.00 69.00 06900 ELECTROCARDI OLOGY 3,801 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70. 01 07001 SLEEP LAB 0 70. 01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 12, 907 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8,767 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 42, 186 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07697 CARDIAC REHABILITATION 0 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 142, 978 90.00 90.00 09001 WOUND CARE CENTER 90.01 17,531 0 90.01 09002 CLINIC - BARIATRIC 0 90.02 246 90.02 90.03 09004 VACCINATION CENTER 0 90.03 0 0 90. 22 09003 SAFE HOUSE 0 90. 22 09100 EMERGENCY 91 00 227, 513 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 5, 223 0 92.00 09201 OBSERVATION BEDS-DISTINCT 0 92.01 55, 436 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 293.037 95.00 200.00 Subtotal (see instructions) 1,045,231 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 201. 00

1,045,231

0

202.00

Only Charges

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Li€	eu of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0009	Peri od: From 01/01/2021	Worksheet D-1	
		To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		T: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11: 4-1	5/25/2022 1:0	3 pm
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			73, 956	1
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day	3 /	vata room dave	73, 956 0	2. 00 3. 00
3.00	do not complete this line.	ys). It you have only pr	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		73, 833	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	" days) till bagil becelliber	or or the cost	· ·	7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 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	o the Program (excluding	swi ng-bed and	19, 894	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	alv (including private r	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc-		Join days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	X only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye			Ü	10.00
14. 00	Medically necessary private room days applicable to the Progra	am (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 XLX only) SWING BED ADJUSTMENT	0	16. 00		
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	0.00	17.00		
18. 00	Medicare rate for swing-bed SNF services applicable to service	0.00	18. 00		
40.00	reporting period		40.00		
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	tne cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			90, 848, 438	1
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost report	ng period (line	0	22. 00
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	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	poriod (line 0	0	25. 00
23.00	x line 20)	of the cost reporting	perrou (Trile 6	U	25.00
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, 848, 438	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	dd			20.00
28. 00 29. 00	Private room charges (excluding swing-bed charges)	a and observation bed ch	arges)	0	•
30. 00	Semi -pri vate 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	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 mil		tions)	0.00	1
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	IC 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	90, 848, 438	•
	27 minus line 36)		, , ,		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		1	1 220 44	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	*		1, 228. 41 24, 437, 989	•
40. 00	Medically necessary private room cost applicable to the Program	•		24, 437, 707	40.00
	Total Program general inpatient routine service cost (line 39	,		24, 437, 989	1

	Financial Systems	CLARA MAASS ME				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2021	Worksheet D-1	
					To 12/31/2021		
			Ti tl e	xVIII	Hospi tal	5/25/2022 1: 0 PPS	3 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	'	Inpatient Cost	Inpatient Days	Diem (col. 1		(col. 3 x col.	
		1 00	2.00	col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0	5.00	42. 00
.2. 00	Intensive Care Type Inpatient Hospital Units			0.0	<u> </u>		12.00
43. 00	INTENSIVE CARE UNIT	15, 975, 893	8, 553	1, 867. 8	7 1, 471	2, 747, 637	43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
40.00	Dragger innetient encillery complete eact (W/	o+ D 2 ool 2	Line 200)			1.00	40.00
48.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ine)		18, 207, 791 45, 393, 417	48. 00 49. 00
47.00	PASS THROUGH COST ADJUSTMENTS	+1 through +0)(	3cc matructro	113)		15, 575, 417	77.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	1, 726, 862	50.00
E1 00	Describerant costs applicable to Dragger in	ationt anaillan	v comileos (fr	om Wkot D o	um of Dorsto II	1 07/ /10	F1 00
51. 00	Pass through costs applicable to Program inpland IV)	attent ancitrar	y services (ii	OIII WKSt. D, S	um or Parts II	1, 076, 610	51.00
52.00	Total Program excludable cost (sum of lines					2, 803, 472	52. 00
53.00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	42, 589, 945	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	55. 00
56. 00	Target amount (line 54 x line 55)				50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (i	ine 56 minus	line 53)	0 0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996. u	pdated and co	mpounded by the		
	market basket			•	,		
60.00	Lesser of lines 53/54 or 55 from prior year				the emount by	0.00	1
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see		3 (TIMES OF X	00), 01 1% 01	the target		
	Relief payment (see instructions)					0	
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See					0	64. 00
	instructions) (title XVIII only)	Ü		·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	porting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
00.00	(line 13 x line 20)	0 00010 01101 0		0001 . 000	. cring por rou		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil		•			I	   70. 00
71. 00	Adjusted general inpatient routine service c	-					71.00
72. 00	Program routine service cost (line 9 x line			,			72. 00
73. 00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv	•			art II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient 26, line 45)	TOUTTHE SELVICE	CUSIS (II UIII V	OINSHEEL D, P	art II, COTUIIII		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	. *					76. 00
77. 00	Program capital -related costs (line 9 x line	,					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi den record	ls)			78. 00 79. 00
	Total Program routine service costs for comp				us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			•		81.00
82.00	Inpatient routine service cost limitation (I		•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PAS					100	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			123 1, 228. 41	1
	Observation bed cost (line 87 x line 88) (se		2)			151, 094	1

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Prep 5/25/2022 1:03	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 613, 857	90, 848, 438	0. 06179	4 151, 094	9, 337	90. 00
91.00 Nursing Program cost	o	90, 848, 438	0.00000	151, 094	0	91.00
92.00 Allied health cost	0	90, 848, 438	0.00000	151, 094	0	92. 00
93.00 All other Medical Education	0	90, 848, 438	0. 00000	151, 094	0	93. 00

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0009		Worksheet D-1
	Component CCN: 31-S009	From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/25/2022 1:03 pm
	Title XVIII	Subprovi der -	PPS
		IDE	

DART   ALL PROVIDER COMPONENTS    1.00			litle XVIII	Supprovider -	PPS	
NAMITION DAYS		Cost Center Description			1.00	
IMPATEENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpattent days (Including private room days, excluding swing-bed and newborn days)   0   1   1   1   1   1   1   1   1   1		I NPATI ENT DAYS				
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this I line.  4.00 Semi-private room days (excluding swing-bed and observation bed days)  5.01 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I line)  8.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this I line)  9.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I line)  1.00 Swing-bed NF type inpatient days applicable to title 2 vill only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days)  1.00 Swing-bed NF type inpatient days applicable to title 8 vior XIX only (including private room days)  1.01 Swing-bed NF type inpatient days applicable to title 8 vior XIX only (including private room days)  1.02 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.03 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days)  1.04 Swing-bed William Swing-bed SWF services applicable to services after December 31 of					-	1.00
do not complete this line.  5.00   Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total inpatient days including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total inpatient days including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total inpatient days including private room days)   Total inpatient days applicable to title XVIII only (including private room days)   Total December 31 of the cost reporting period (see instructions)   Total days   T				ivate room days	-	2. 00 3. 00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  7.00 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)  7.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  7.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  7.02 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  7.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  7.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  7.02 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  7.03 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  7.04 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  7.05 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  7.06 Swing-bed NF typ	3.00		ys). If you have only pr	i vate i oom days,	٥	3.00
reporting period  6. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed KF type inpatient days (including private room days) through December 31 of the cost reporting period  8. 00 Total swing-bed KF type inpatient days (including private room days) after December 31 of the cost reporting period  8. 00 Total inpatient days including private room days) after December 31 of the cost on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  18. 00 Medically necessary private room days applicable to services through December 31 of the cost  19. 00 Medical or rate for swing-bed SNF services applicable to services through December 31 of the cost  19. 00 Medical or rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical or rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x	4.00		ed days)		0	4. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line)  1.00 Intal swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Intal inpatient days 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 tille 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 tille 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 NF type inpatient days applicable to tille 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 NF type inpatient days applicable to tilles V or XIX only (including private room days) 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5.00		om days) through Decembe	r 31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total saying-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total saying-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 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 through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendary year, enter 0 on this line) 14.00 Modically necessary private room days applicable to title V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room period (including private room period (including private room p	6 00	1 91	om days) after December	31 of the cost	0	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after become of the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after become of the cost reporting period (see instructions)  13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  14. 00 Wedically necessary private room days applicable to titles V or XIX only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Wedically necessary private room days applicable to the Program (excluding swing-bed days)  17. 00 Wedically necessary private room days applicable to the Program (excluding swing-bed days)  18. 00 Wedical nursery days (title V or XIX only)  19. 00 Wedical nursery days (title V or XIX only)  19. 01 Wedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this ine)  19. 00 Wedical area for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this private room days)  19. 00 Wedical area for swing-bed SNF services applicable to services after December 31 of the cost reporting period (if calendary year, enter 0 on this private room days)  19. 00 Wedical area for swing-bed NF services applicable to services after December 31 of the cost reporting period (li	0.00		om days) arter becember	or the cost		0.00
1   10   10   10   10   10   10   10	7.00		m days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line)  10. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions)  12. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically inecessary private room days applicable to titles V or XIX only (including private room days)  15. 00 Italian unserv days (title V or XIX only)  16. 00 Nusrery days (title V or XIX only)  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 size)  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 size)  23. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 size)  24. 00 Swing-bed cost applicable to NF t	0.00	, , , , , , , , , , , , , , , , , , , ,	m daya) after December 2	1 of the cost		0.00
10.00   Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)   0.10   0.20	8.00		ili days) arter beceilber 3	i oi the cost	U	8. 00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Total nursery days (title V or XIX only)  17.00 More SPON AUSTENNT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (if the cost x i ine 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (if the cost x i ine 18)  24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (if the cost x i ine 18)  25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (if the cost x i ine 18)  26.00 Total sw	9.00		o the Program (excluding	swing-bed and	0	9. 00
through 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 Ilne)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient room days applicable to the Program (excluding swing-bed days)  1.01 Total nursery days (title V or XIX only)  1.02 Swing-bed SNF services applicable to services through December 31 of the cost reporting period  1.00 Swing BED ADJUSTMENT  1.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  1.00 On Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  1.00 On Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x ilne 17)  1.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x ilne 17)  1.01 Swing-bed Cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x ilne 17)  1.02 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x ilne 17)  1.01 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x ilne 18)  1.01 Swing-bed Cost applica					_	
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if call endar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  16.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  18.00 Including private room days applicable to the Program (excluding swing-bed days)  18.00 Including private room days applicable to the Program (excluding swing-bed days)  18.00 Including private room days applicable to the Program (excluding swing-bed days)  18.00 Including private room days applicable to the Program (excluding swing-bed days)  18.00 Including private room days applicable to services through December 31 of the cost  18.00 Including private room days applicable to services after December 31 of the cost  18.00 Including private room days applicable to services after December 31 of the cost  18.00 Including private room wing-bed SNF services applicable to services after December 31 of the cost  18.00 Including private room days applicable to services after December 31 of the cost  18.00 Including private room days applicable to services after December 31 of the cost  18.00 Including private room days applicable to services after December 31 of the cost  18.00 Including private room days applicable to services after December 31 of the cost reporting period (line 6 x line 17)  18.10 Including private room days applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  18.10 Including private room charges (excluding swing-bed cost (line 21 minus line 26)  18.10 Including private room charges (excluding swing-bed charges)  18.10 Including private room charges (exc	10.00			oom days)	0	10. 00
December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   0   11   12   10   13   10   15   10   10	11. 00			oom days) after	0	11. 00
through December 31 of the cost reporting period after December 31 of the cost reporting period (if call endar year, enter 0 on this line) after December 31 of the cost reporting period (if call endar year, enter 0 on this line)  14.00 Mick call y necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Mick care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Total general inpatient routine service cost (see instructions)  20.00 Total general inpatient routine service cost (see instructions)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6  21.10 X in 17)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6  22.10 X in 18.10  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6  24.11 ine 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8  26.10 X in 18.10  27.10 Mick Cost applicable to NF type services after December 31 of the cost reporting period (line 8  28.11 ine 19)  29.00 Verial swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8  29.11 ine 20)  29.00 Swing-bed cost ap		December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)			
3.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   1.10	12.00		X only (including privat	e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00  15.00  16.00  17.00  18.00  18.00  19.0	13 00		X only (including privat	e room days)	0	13. 00
14.00   Medically necessary private room 'days 'applicable to the Program (excluding swing-bed days)   0   1   15.00   Total nursery days (title V or XIX only)   0   1   16.00   Nursery days (title V or XIX only)   0   1   17.00   Nursery days (title V or XIX only)   0   1   18.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   0   1   18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   0   0   1   19.00   Medical drate for swing-bed SNF services applicable to services after December 31 of the cost   0   0   1   19.00   Medical drate for swing-bed SNF services applicable to services after December 31 of the cost   0   0   0   19.00   Medical drate for swing-bed NF services applicable to services after December 31 of the cost   0   0   0   19.00   Medical drate for swing-bed NF services applicable to services after December 31 of the cost   0   0   0   19.00   Medical drate for swing-bed NF services applicable to services after December 31 of the cost   0   0   0   19.00   Medical drate for swing-bed NF services applicable to services after December 31 of the cost   0   0   0   19.00   Medical drate for swing-bed NF services applicable to SNF type services through December 31 of the cost reporting period (line   0   2     2	10.00					10.00
16.00 Nursery days´(title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		, , , , , , , , , , , , , , , , , , , ,	am (excluding swing-bed	days)	-	14. 00
SWING BED ADJUSTMENT					-	15. 00
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 Total swing-bed cost (see instructions) 29. 00 Fivate room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room per diem charge (line 29 + line 3) 30. 00 Average per dem private room per diem charge (line 30 + line 4) 31. 00 Average per diem private room cost differential (line 3 x line 31) 31. 00 Average per diem private room cost differential (line 3 x line 31) 31. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 31) 31. 00 Average per diem private room cost differential (line 3 x line 31) 32. 01 Average per diem private room cost differential (line 3 x line 35) 33. 00 Average per diem p	16.00				U	16. 00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)  26.00 Total swing-bed cost spelicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per diem private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 32 minus line 33)  31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  32.01 Average per diem private room cost differential (line 32 minus line 33)  33.00 Average per diem private room cost differential (line 32 minus line 35)  34.00 Average per diem private room cost differential (line 32 minus line 35)  35.00 Average per di	17. 00		es through December 31 o	f the cost	0.00	17. 00
reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 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)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  33.00 Average per diem private room cost differential (line 32 minus line 33)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Pivate room cost differential adjustment (line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost di		1 91	<u> </u>			
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   21.00   Total general inpatient routine service cost (see instructions)   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)   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)   20.00   20	18. 00		0. 00	18. 00		
reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average period impatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average periode private room periode mcharge (line 29 + line 3)  31.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 32 minus line 33)  33.00 Average per diem private room cost differential (line 3 x line 35)  34.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)  35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)  38.00 Average per diem private room cost differential (line 3 x line 35)  39.00 General inpatient routine service cost net of swing-bed cost and private r	19. 00		0.00	19. 00		
reporting period Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost 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 Semi-private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 x line 36)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 x line 31)  38.00 Average per diem private room cost differential (line 34 x line 31)  39.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 x line 36)  39.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 x line 36)			cg			
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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 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 per diem private room charge differential (line 32 minus line 33)(see instructions)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 3 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  27. minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY	24 00		r 31 of the cost reporti	ng period (line	0	24. 00
x line 20)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  90. 00 Pri vate room charges (excluding swing-bed charges)  10. 00 Semi-private room charges (excluding swing-bed charges)  11. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  12. 00 Average pri vate room per diem charge (line 29 ÷ line 3)  13. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  13. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  13. 00 Average per diem private room cost differential (line 34 x line 31)  13. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY	2 00		. or or the dest repert.			2 00
Total swing-bed cost (see instructions)  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)  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 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	25. 00		31 of the cost reporting	period (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)  9.00 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 charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY	26 00				0	26. 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 charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY			(line 21 minus line 26)		-	
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 charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	·			
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) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY			d and observation bed ch	arges)	-	
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 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY			∸ line 28)		-	30. 00 31. 00
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 0 3 x line 35)  PART II - HOSPITAL AND SUBPROVIDERS ONLY			. 11116 20)			32. 00
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 0 3 x line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY						33. 00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY			ne 31)			35. 00 36. 00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			and private room cost di	fferential (line		37.00
	. ==	27 minus line 36)	,			
IDDOCDAM INDATIENT OPERATING COCT REFORE DACC TURQUOU COCT AR WICTHENTS			UCTMENTS			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  0.00 38	38 00				0.00	38 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40)	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		0	41. 00

	Financial Systems	CLARA MAASS MEDI				eu of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der CCN		Period: From 01/01/2021	Worksheet D-1	
			Component CC		Го 12/31/2021	5/25/2022 1:0	
			Title >		Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient CostIr		Average Per iem (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	ı	<u> </u>	0.00	5  0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00 44. 00
45. 00	1						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			1. 00 185, 599	48. 00
49. 00				5)		185, 599	
50. 00	Pass through costs applicable to Program inp.	atient routine se	ervices (from V	Vkst. D, sum	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (from	m Wkst. D, su	um of Parts II	10, 904	51.00
52.00	Total Program excludable cost (sum of lines		atad nan nhusi	oi on anaatha	atiot and	10, 904	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		atea, non-pnysi	cran anestne	etist, and	174, 695	53. 00
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57.00	Difference between adjusted inpatient operat	ng cost and targ	get amount (lir	ne 56 minus I	i ne 53)	0	1
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	oorting period er	ndi ng 1996, upo	dated and cor	npounded by the	_	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport und	ated by the mar	skot baskot		0.00	60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than	s 55, 59 or 60 er n expected costs	nter the Lesser	of 50% of t		0.00	1
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instruct	tions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	per 31 of the c	cost reportir	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cos	st reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 65)	)(title XVIII	only). For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing				•	0	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	cember 31 of th	ne cost repor	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil					Ι	70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (lin					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	*	(line 14 x line	e 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ce costs (line l	72 + line 73)	•			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service (	costs (from Wor	rksheet B, Pa	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	, ,						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.	·			us Line 70)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi		31 111111 (211011 )	(TITIE 70 IIIITI	23 TITLE 77)		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (	· · · · · · · · · · · · · · · · · · ·	<b>\</b>				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				1	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			0.00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•	•				89. 00

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (	CCN: 31-S009	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/25/2022 1:03	
		Title	: XVIII	Subprovi der  - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	0	0	0.00000	00	0	90. 00
91.00 Nursing Program cost	0	0	0. 00000	00	0	91. 00
92.00 Allied health cost	0	0	0. 00000	00	0	92. 00
93.00 All other Medical Education	0	0	0. 00000	00	0	93. 00

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0009		Worksheet D-1
	Component CCN: 31-5505	From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/25/2022 1:03 pm
	Title XVIII	Skilled Nursing	

		litle XVIII	Facility	PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 677	1. 00
2.00	Inpatient days (including private room days, excluding swing-	<i>3 1</i>	ivata maam daya	4, 677 0	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). It you have only pr	ivate room days,	U	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		4, 677	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber	or the cost	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ii days) arter becember 3	i or the cost		
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 255	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including privato r	oom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		dolli days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		o room days)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (frict during privat	e room days)	U	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 ye			0	14. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	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 service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
40.00	reporting period	0.00	40.00		
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	19. 00		
20. 00	Medicaid rate for swing-bed NF services applicable to services	0.00	20. 00		
21. 00	reporting period Total general inpatient routine service cost (see instructions	s)		5, 084, 384	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (Line 4	0	23. 00
23.00	x line 18)	31 of the cost reportin	g perrou (Trile 6	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) 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) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 5, 084, 384	26. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIC 21 IIII III as TITIC 20)		3, 004, 304	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 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	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	nuo lino 22) (ooo inotmuo	+: 000)	0.00	33.00
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li	, ,	LI ONS)	0. 00 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 di	fferential (line	5, 084, 384	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38.00	Adjusted general inpatient routine service cost per diem (see				38. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program				39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,			41. 00
			•		

Health Financial Systems CLARA MAASS MEDICAL CENTER In Li	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 31-0009 Period: From 01/01/202	Worksheet D-1	
Component CCN: 31-5505 To 12/31/202		
Title XVIII Skilled Nursin Facility		<u>o p</u>
Cost Center Description Total Total Average Per Program Days		
Inpati ent Cost Inpati ent Days Di em (col. 1 ÷ col. 2)	(col. 3 x col. 4)	
1.00 2.00 3.00 4.00 42.00 NURSERY (title V & XIX only)	5. 00	42.00
Intensive Care Type Inpatient Hospital Units		
43.00   INTENSIVE CARE UNIT 44.00   CORONARY CARE UNIT		43. 00 44. 00
45. 00 BURN INTENSIVE CARE UNIT 46. 00 SURGICAL INTENSIVE CARE UNIT		45. 00 46. 00
47. 00 OTHER SPECIAL CARE (SPECIFY)		47. 00
Cost Center Description	1. 00	
48.00   Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 49.00   Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		48. 00 49. 00
PASS THROUGH COST ADJUSTMENTS	. [	
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	d	50. 00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51. 00
52.00 Total Program excludable cost (sum of lines 50 and 51)		52. 00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53. 00
TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges		54. 00
55.00 Target amount per discharge		55. 00
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		56. 00 57. 00
58.00 Bonus payment (see instructions)	_	58. 00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59. 00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by		60. 00 61. 00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		01.00
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)		62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST		63. 00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See		64. 00
instructions)(title XVIII only) 65.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See		65. 00
instructions)(title XVIII only) 66.00  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For		66. 00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period		67. 00
(line 12 x line 19)		
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68. 00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		69. 00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	5, 084, 384	1
71.00   Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00   Program routine service cost (line 9 x line 71)	1, 087. 10 2, 451, 411	ı
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)	•	73.00
74.00   Total Program general inpatient routine service costs (line 72 + line 73) 75.00   Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column	2, 451, 411 0	1
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2)	0.00	76. 00
77.00 Program capital-related costs (line 9 x line 76)	0	77. 00
78.00   Inpatient routine service cost (line 74 minus line 77) 79.00   Aggregate charges to beneficiaries for excess costs (from provider records)	0	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation	0, 00	80. 00 81. 00
82.00 Inpatient routine service cost limitation (line 9 x line 81)	0	82. 00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions)	2, 451, 411 289, 658	1
85.00 Utilization review - physician compensation (see instructions)	0 2, 741, 069	85. 00
86.00   Total Program inpatient operating costs (sum of lines 83 through 85)   PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	1	
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		87. 00 88. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions)	1	89. 00

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2021	D 1 /T' D	
		Component	CCN: 31-5505	To 12/31/2021	Date/Time Prep 5/25/2022 1:03	
		Title	XVIII	Skilled Nursing		o piii
		11 11 0	7,4111	Facility	113	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	0	0.00000	0 0	0	90.00
91.00 Nursing Program cost	0	0	0.00000	0 0	0	91.00
92.00 Allied health cost	0	0	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93.00

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0009	Peri od: From 01/01/2021	Worksheet D-1	
		To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
	Title XIX	Hospi tal	TEFRA	
Cost Center Description				
			1. 00	

Dear 1 - ALL REPUTED COMPONENTS			Title XIX	Hospi tal	TEFRA	<u> </u>
IPART L - ALL PROVIDER COMPONENTS   IMPATENT MAY		Cost Center Description			1. 00	
Inpatient days (Including private room days, and swing-bed days, excluding newborn)   73,956   1,00   1,0				•		
Inpatient days (Including private room days, excluding swing-bed and newborn days)   17.90 have only private room days (cockuding swing-bed and observation bed days)   17.90 have only private room days (sectuding swing-bed and observation bed days)   17.90 have only private room days   3.00 do not complete this line.   3.00 do not complete th	1 00		e oveludina nowborn)		72 054	1 00
Private room days (excluding swing-bed and observation bed days)   If you have only private room days   0   3   0						
Semi-private room days (excluding swing-bed and observation bed days)   173,833   4.00				vate room days,		1
10.00   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of reporting period   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of reporting period (if cal endar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of reporting period (if cal endar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total swing-bed and inpatient days including private room days)   Total swing-bed AMF type inpatient days applicable to the Program (excluding private room days)   Total swing-bed AMF type inpatient days applicable to descent reporting period (if called period if called period (if called period period if called period (if called period period (if called period period if called period (if called period period if called period period (if called period period if called period period (if called period period if called period period (if called period period period (if called period period p	4 00	!	- d - d \		72 022	4 00
reporting period (1° cal endar year, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (1° cal endar year, enter 0 on this line)  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (1° cal endar year, enter 0 on this line)  9. 00 Total inpatient days including private room days after December 31 of the cost reporting period (1° cal endar year, enter 0 on this line)  10. 00 Swing-bed SNF type inpatient days applicable to this line)  10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (1° cal endar year)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (1° cal endar year)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (1° cal endar year, enter 0 on this line)  10. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  10. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days)  10. 01. 00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (1° cal endar year, enter 0 on this line)  10. 00 Swing-bed cost applicable to SNF services applicable to services through December 31 of the cost reporting period (1° cal endar year)  10. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (1° cal endar year)  10. 00 Swing-bed cost applic				31 of the cost		
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21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 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 per diem private room charge (line 29 ± line 3) 33.00 Average per diem private room charge (line 29 ± line 3) 33.00 Average per diem private room charge (line 30 ± line 4) 35.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 36.00 Private room cost differential (line 3 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 x line 31) 38.00 Average per diem private room cost differential (line 32 x line 31) 39.00 Average per diem private room cost differential (line 30 x line 31) 39.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 x line 31) 39.00 Average per diem private room cost differential (line 30 x line 31) 39.00 General inpatient routine service cost per diem (see instructions) 39.00 Average per diem private room cost differential (line 30 x line 31) 39.00 General inpatient routine service cost per diem (see instructions) 39.00 General inpatient routine service cost	20. 00		s after December 31 of th	ne cost	0.00	20. 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 v. 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)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service 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 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21. 00		s)		90, 848, 438	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 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average perivate room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 38 x line 31)  30.00 Average per diem private room cost differential (line 38 x line 31)  30.00 Average per diem private room cost differential (line 38 x line 31)  30.00 Average per diem private room cost differential (line 38 x line 31)  30.00 Average per diem private room cost differential (line 38 x line 31)  30.00 Average per diem private room cost differential (line 38 x line 31)  30	22. 00		er 31 of the cost reporti	ng 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)  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)  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 charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  36. 00 Average per diem private room cost differential (line 3 x line 31)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  24. 00 Average per diem private room cost applicable to the Program (line 14 x line 35)	23 00	,	31 of the cost reporting	neriod (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)  Comeral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Coeneral inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room charge differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40.00	20.00		or or the cost reporting	g perrou (rriie e	Ü	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 PRI VATE ROOM DIFFERENTI AL 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-private room charges (excluding swing-bed charges)  30.00 31.00 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 per diem private room charge differential (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  38.00 Algusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		r 31 of the cost reportion	ng period (line	0	24. 00
x line 20)  26.00 Total swing-bed cost (see instructions)  Ceneral 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)  Pri vate room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average per diem private room per diem charge (line 30 + line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  PRIVATE ROOM DIFFERENTIAL ADD SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Algusted general inpatient routine service cost (cost per diem (see instructions)  1, 228.41  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	25. 00		31 of the cost reporting	period (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  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instruction					_	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  O 28.00  29.00 Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  O 29.00  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  O 0.000000 31.00  32.00 Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  O 0.00 32.00  34.00 Average per diem private room cost differential (line 34 x line 31)  O 0.00 35.00  Average per diem private room cost differential (line 3 x line 35)  O 0 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  77.00 General inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general		, ,	(line 21 minus line 26)		0 90 848 438	1
29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  37. 00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29. 00 0 29. 00 0 30. 00 0 0 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.00		(TITIC 21 IIITIUS TITIC 20)		70, 040, 430	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) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0.00 000000 31.00 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00		,	d and observation bed cha	arges)		
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)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 000 32.00  0.00 32.00  30.00  31.00  0.00 32.00  32						1
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			+ line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,				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)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 35.00  0 36.00  37.00 27 minus line 36)  90,848,438 37.00  1,228.41 38.00  2,391,714 39.00  40.00			1: 00) (			1
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 90, 848, 438 and 9				tions)		ł
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 20, 848, 438 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37. 00  40. 00		, , ,	ie 31)			•
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			and private room cost di	fferential (line	-	•
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	57.00				,0,040,430	37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,228.41 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  2,391,714 39.00 40.00	00.05				4 000 ::	00.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
						1
		1 3 1	,			1

Heal th	Financial Systems CLARA MAASS MEDICAL CENTER In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST  Provider CCN: 31-0009   Period:   From 01/01/2021   To 12/31/2021	Date/Time Pre	
	Title XIX Hospital	5/25/2022 1: 0 TEFRA	3 pm
	Cost Center Description  Total Total Average Per Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2)	Program Cost (col. 3 x col. 4)	
	1.00 2.00 3.00 4.00	5. 00	
42. 00	NURSERY (title V & XIX only) 4,747,844 4,113 1,154.35 3,306	3, 816, 281	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 15,975,893 8,553 1,867.87 1,716	3, 205, 265	43. 00
44. 00	CORONARY CARE UNIT	3, 203, 203	44. 00
45.00	BURN INTENSIVE CARE UNIT		45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT		46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description		47. 00
		1. 00	
48. 00		1, 776, 695	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)  PASS THROUGH COST ADJUSTMENTS	11, 189, 955	49.00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	548, 872	50. 00
E1 00	Describerance costs annicable to Descript innotions and large considers (from West D. cum of Desta II.	105 021	F1 00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	105, 831	51. 00
52. 00	Total Program excludable cost (sum of lines 50 and 51)	654, 703	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	10, 535, 252	53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program di scharges	673	54. 00
55. 00	1 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	4, 695. 45	
56. 00 57. 00	Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	3, 160, 038 -7, 375, 214	
58. 00	Bonus payment (see instructions)	-7, 375, 214	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00		0.00	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		
62. 00	amount (line 56), otherwise enter zero (see instructions)	316, 004	62. 00
63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions)	4, 130, 745	
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
	CAH (see instructions)		
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72. 00	Program routine service cost (line 9 x line 71)		72. 00
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75.00
	26, line 45)		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80. 00 81. 00
81.00	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)		81.00
83. 00	Reasonable inpatient routine service costs (see instructions)		83. 00
84.00	, , , , , , , , , , , , , , , , , , , ,		84.00
85. 00 86. 00	Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)		85. 00 86. 00
55. 60	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		33. 30
87.00		123	
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 228. 41 151, 094	

Health Financial Systems	CLARA MAASS ME	DICAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
		Ti tl	e XIX	Hospi tal	TEFRA	
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, 613, 857	90, 848, 438	0. 06179	4 151, 094	9, 337	90.00
91.00 Nursing Program cost	0	90, 848, 438	0.00000	151, 094	0	91.00
92.00 Allied health cost	0	90, 848, 438	0.00000	151, 094	0	92.00
93.00 All other Medical Education	0	90, 848, 438	0.00000	151, 094	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co	CN: 31-0009	Peri od:	Worksheet D-3	į.
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
	Title	XVIII	Hospi tal	PPS	<u>5 pi</u>
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		4.00	0.00	2)	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	-
. 00 03000 ADULTS & PEDIATRICS			141, 635, 144		30
. 00   03100   I NTENSI VE CARE UNI T			16, 916, 500		31
. 00   04000   SUBPROVI DER - I PF			0		40
. 00   04300   NURSERY					43
ANCILLARY SERVICE COST CENTERS		•			1
00 05000 OPERATING ROOM		0. 1963		1, 473, 140	
00   05100   RECOVERY ROOM		0. 1628		257, 136	
OO 05200 DELIVERY ROOM & LABOR ROOM		0. 2310°		0	
. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 10174		1, 104, 998	
. 00   05500   RADI OLOGY-THERAPEUTI C		0. 20154		50, 941	
. 00   05600   RADI OI SOTOPE		0. 16170		187, 790	
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.05396		107, 625	
. 00   05900   CARDI AC CATHETERI ZATI ON		0. 12839		431, 040	
.00   06000   LABORATORY .00   06300   BLOOD STORING, PROCESSING & TRANS.		0. 10892 0. 0821		2, 027, 404 220, 382	
00   06500   RESPIRATORY THERAPY		0. 0821		1, 112, 666	
. 00   06600   PHYSI CAL THERAPY		0. 18410		367, 760	
. 00 06700 OCCUPATI ONAL THERAPY		0. 18042		70, 225	
00 06800 SPEECH PATHOLOGY		0. 29158		116, 721	
. 00 06900 ELECTROCARDI OLOGY		0. 05178		170, 681	69
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1129!	57 738, 271	83, 393	
. 01   07001   SLEEP LAB		0. 1743	90 0	0	70
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 83054		1, 396, 144	7
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 9300		2, 096, 338	
.00 O7300 DRUGS CHARGED TO PATLENTS		0. 6292		4, 866, 128	
00 07400 RENAL DI ALYSI S		0. 34004		1, 013, 897	
97 O7697 CARDI AC REHABI LI TATI ON		0. 38032	27 0	0	70
OUTPATIENT SERVICE COST CENTERS OO O9000 CLINIC		0. 41814	40 6, 212	2, 597	90
.00   09000  CETNIC .01   09001  WOUND CARE CENTER		0. 41814		2, 597 3, 992	
. 02   09002   CLI NI C - BARI ATRI C		0. 17518		3, 442	
03 09004 VACCINATION CENTER		0. 09448		0	
22 09003 SAFE HOUSE		0. 00000		0	
00   09100   EMERGENCY		0. 10400		852, 531	
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 26496		0	1
01 09201 OBSERVATION BEDS-DISTINCT		0. 07050		194, 262	92
OTHER REIMBURSABLE COST CENTERS					
. 00 09500 AMBULANCE SERVICES					9!
0.00 Total (sum of lines 50 through 94 and 96 through 98)			85, 065, 591	18, 207, 791	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201
2.00 Net charges (line 200 minus line 201)			85, 065, 591		202

NPATIENT AND	ILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 31-0009	Peri od:	Worksheet D-3	į.
		Component	CCN: 31-S009	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
		Ti tl e	e XVIII	Subprovi der - I PF	PPS	
C	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	ENT ROUTINE SERVICE COST CENTERS					
	DULTS & PEDIATRICS					30.
	NTENSI VE CARE UNI T			_		31.
	SUBPROVI DER - I PF			0		40.
3. 00 04300 N	ARY SERVICE COST CENTERS					43.
	PERATING ROOM		0. 1963	55 48, 594	9, 542	50.
	RECOVERY ROOM		0. 1628		5, 651	
	DELIVERY ROOM & LABOR ROOM		0. 2310		0	
	RADI OLOGY-DI AGNOSTI C		0. 1017		10, 488	
5. 00 05500 F	RADI OLOGY-THERAPEUTI C		0. 2015	49 9, 086	1, 831	55
. 00 05600 F	RADI OI SOTOPE		0. 16170	01 0	0	56
.00 05800 M	MAGNETIC RESONANCE IMAGING (MRI)		0. 0539	69 45, 522	2, 457	
	CARDI AC CATHETERI ZATI ON		0. 1283		0	
	ABORATORY		0. 1089:		38, 686	
	SLOOD STORING, PROCESSING & TRANS.		0. 0821		282	
	RESPI RATORY THERAPY		0. 24150		5, 000	
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY		0. 18410		12, 955 985	
	SPEECH PATHOLOGY		0. 1804: 0. 29158		1, 555	
	ELECTROCARDI OLOGY		0. 05178		1, 809	
	ELECTROENCEPHALOGRAPHY		0. 1129			
	SLEEP LAB		0. 1743		0	
	IEDICAL SUPPLIES CHARGED TO PATIENT		0. 8305		2, 165	
	MPL. DEV. CHARGED TO PATIENTS		0. 9300	99 0	0	72
	DRUGS CHARGED TO PATIENTS		0. 6292		47, 222	73
	RENAL DIALYSIS		0. 3400		0	
	CARDI AC REHABI LI TATI ON		0. 3803	27 0	0	76
	ENT SERVICE COST CENTERS		0 4101	40	0	4
. 00   09000   0 . 01   09001   W	JUNIO CARE CENTER		0. 4181 0. 17518		0	
	CLINIC - BARIATRIC		0. 17516		0	
	ACCINATION CENTER		0. 09448		0	
1 1	SAFE HOUSE		0.0000		0	
	MERGENCY		0. 10400		_	
	DBSERVATION BEDS (NON-DISTINCT PART		0. 2649		0	
	DBSERVATION BEDS-DISTINCT		0. 07050		663	1
	REIMBURSABLE COST CENTERS					
	MBULANCE SERVICES					95
	otal (sum of lines 50 through 94 and 96 through 9			1, 249, 150	185, 599	
	ess PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201
02.00   N	let charges (line 200 minus line 201)			1, 249, 150		202

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 31-0009	Peri od:	Worksheet D-3	,
		Component	CCN: 31-5505	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/25/2022 1:0	
		Ti tl e	× XVIII	Skilled Nursing Facility		<u>o pii</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	
	INPATIENT ROUTINE SERVICE COST CENTERS			<u>'</u>		
0. 00	03000 ADULTS & PEDI ATRI CS					30
. 00	03100 INTENSIVE CARE UNIT					31
0. 00	04000 SUBPROVI DER - I PF					40
. 00	04300 NURSERY					43
	ANCILLARY SERVICE COST CENTERS					4
. 00	05000 OPERATING ROOM		0. 1963			
. 00	05100 RECOVERY ROOM		0. 1628			1 -
. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 2310		1	
. 00	05400 RADI OLOGY - DI AGNOSTI C		0. 1017		1	
. 00	05500 RADI OLOGY-THERAPEUTI C		0. 2015		1	1 -
. 00	05600 RADI OI SOTOPE		0. 1617			
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0539		1	
. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY		0. 1283		1	
. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 1089 0. 0821		1	
. 00	06500 RESPIRATORY THERAPY		0.0621			
. 00	06600 PHYSI CAL THERAPY		0. 2415		1	
. 00	06700 OCCUPATI ONAL THERAPY		0. 1841			
. 00	06800 SPEECH PATHOLOGY		0. 2915			
	06900 ELECTROCARDI OLOGY		0. 0517			
	07000 ELECTROENCEPHALOGRAPHY		0. 1129		1	
. 01	07001 SLEEP LAB		0. 1743		1	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 8305		1	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 9300		ol o	
	07300 DRUGS CHARGED TO PATIENTS		0. 6292		146, 724	1 7:
	07400 RENAL DIALYSIS		0. 3400			
. 97	07697 CARDI AC REHABI LI TATI ON		0. 3803	27 (	0	76
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		0. 4181	40 (	0	90
	09001 WOUND CARE CENTER		0. 1751		1	
	09002 CLINIC - BARI ATRI C		0. 8661			
	09004 VACCINATION CENTER		0. 0944		1	1
	09003 SAFE HOUSE		0.0000		7	
. 00	09100 EMERGENCY		0. 1040			
. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART		0. 2649		1	
. 01	09201 OBSERVATION BEDS-DISTINCT		0. 0705	01 (	0	92
	OTHER REIMBURSABLE COST CENTERS		1			4
	09500 AMBULANCE SERVICES					95
0.00		(1)		1, 013, 556	289, 658	
)1. 00		es (line 61)		4 242 ==	7	201
02.00	Net charges (line 200 minus line 201)		1	1, 013, 55 <i>6</i>	ol	202

	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	CLARA MAASS MEDICAL CENTE		N: 31-0009	Peri od:	eu of Form CMS-2 Worksheet D-3	
	2.1. 7.1.0. 22.1.1. 02.1.1.02 030. 7.1.1 01.1.1 01.1.1.0	110014	0. 00.	0. 0007	From 01/01/2021 To 12/31/2021		
					10 12/31/2021	5/25/2022 1:0	3 pm
			Title	XIX	Hospi tal	TEFRA	
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
			-	4 00	0.00	2)	
	INDATIENT DOUTINE CEDVICE COCT CENTEDS			1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS				11, 521, 850		30.00
31.00	03100   NTENSI VE CARE UNI T		1		15, 604, 632		31.00
40. 00	04000 SUBPROVI DER - I PF		ł		13, 004, 032		40.00
43. 00	04300 NURSERY				2, 800, 002		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS				2,000,002		10.00
50.00	05000 OPERATI NG ROOM			0. 19635	55 496, 201	97, 432	50.00
51. 00	05100 RECOVERY ROOM		i	0. 1628	·	13, 639	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		i	0. 2310	400, 561	92, 536	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 10174	1, 149, 822	116, 986	54.00
55.00	05500  RADI OLOGY-THERAPEUTI C		l	0. 20154	19 0	0	55. 00
56.00	05600  RADI 0I SOTOPE			0. 16170			
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 05396			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON			0. 12839			1
60. 00	06000 LABORATORY			0. 10892			
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.			0. 08211			
65. 00	06500 RESPI RATORY THERAPY			0. 24150	·		1
66.00	06600 PHYSI CAL THERAPY			0. 18410	•		1
67. 00	06700 OCCUPATIONAL THERAPY			0. 18042			1
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY			0. 29158			1
69. 00 70. 00	07000 ELECTROCARDI OLOGY		-	0. 05178			1
	07000 ELECTROENCEPHALOGRAPHY			0. 11295 0. 17439	•		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 1743		_	
	07200 I MPL. DEV. CHARGED TO PATIENTS			0. 93009			1
	07300 DRUGS CHARGED TO PATIENTS		1	0. 6292	·		1
74. 00	07400 RENAL DIALYSIS		ł	0. 34004			
	07697 CARDI AC REHABI LI TATI ON			0. 38032			1
70. 77	OUTPATIENT SERVICE COST CENTERS			0.00002			1 / 5. //
90.00	09000 CLI NI C			0. 41814	10 2, 108	881	90.00
	09001 WOUND CARE CENTER			0. 17518	·		1
	09002 CLINIC - BARIATRIC			0. 86617			90. 02
90. 03	09004 VACCINATION CENTER			0. 09448	33 0	0	90. 03
90. 22	09003 SAFE HOUSE			0.00000	00	0	90. 22
01 00	00100 EMEDGENCY		1	0 10100	1 20/ 010	105 514	01 00

0. 104004

0. 264961

0.070501

1, 206, 818

9, 554, 573

9, 554, 573

290, 210

91. 00 92. 00

92.01

20, 460

95. 00 1, 776, 695 200. 00 201. 00 202. 00

91. 00 09100 EMERGENCY

92.00

92.01

201. 00 202. 00

09200 OBSERVATION BEDS (NON-DISTINCT PART

95. 00 | 09500 | AMBULANCE SERVI CES | Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

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

09201 OBSERVATION BEDS-DISTINCT

OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0009		Worksheet E Part A Date/Time Prepared: 5/25/2022 1:03 pm

			Title XVIII	Hospi tal	5/25/2022 1: 0 PPS	3 pm
MRE A _ IMPAILIANT INSERTIAL SERVICES HOURS (1995)			TI LIE AVIII	nospi tai	113	
DBG Amounts Other than outlier Payments   0   1.00		DADT A LABATIENT HOCDITAL CEDVICES HADED LDDS			1. 00	
1.00   INSC amounts other than outlier payments for discharges occurring prior to October 1 (see   33.084.355   1.01	1 00				0	1 00
DRC amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)   1.02		DRG amounts other than outlier payments for discharges occurring pr	or to October 1 (s	see		
1.03   1.08	1. 02	DRG amounts other than outlier payments for discharges occurring on	8, 173, 316	1. 02		
1.04   Oktober 1 (see Instructions)   2.00	1. 03	DRG for federal specific operating payment for Model 4 BPCI for disc	0	1. 03		
2.00   Outlier payments for discharges. (see instructions)	1. 04	DRG for federal specific operating payment for Model 4 BPCI for disc	charges occurring o	on or after	0	1. 04
2.02   Outlier payment for discharges cocurring prior to October 1 (see Instructions)		Outlier payments for discharges. (see instructions)			0	
0.00   0.00						
20.4   Outlier payments for discharges occurring on or after October 1 (see instructions)   23.67   29.0		, , ,	netructions)		-	
Managed Care Simulated Payments   0   3.00		, , ,	· ·		•	
Bed days available divided by number of days in the cost reporting period (see instructions)   321.66   4.00		, , ,	5 Thistructrons)			
Indirect Medical Education Adjusteent Count for all lopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see Instructions) 6.00 FIE count for all lopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MM Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.01 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 0.00 7.01 cost report stradies July 1, 2011 then see instructions 8.00 Adjustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for application of increase in the program of the FIE count for all opathic and osteopathic programs for application of increase in the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report stradies July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$5506 of ACA. (see instructions) 8.02 Under \$5506 of ACA. (see instructions) 8.03 Under \$5506 of ACA. (see instructions) 9.00 Sun of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions) 9.01 Districtions of all opathic and osteopathic programs in the current year from your records 9.00 Districtions of all opathic and osteopathic programs in the current year from your records 9.00 Distriction of all opathic and osteopathic programs in the current year from your records 9.00 Distriction of all opathic and osteopathic programs in the current year from your records 9.00 Distriction of all opathic and osteopathic programs in the current year from your records 9.00 Distriction of all opathic and osteopathic programs in the current year resident of all opathic and your year. 9.00 Distriction of all opathic and osteopathic programs in the current year resident year year. 9.00 Distriction of year residents in initial years of			period (see instruc	ctions)	-	
or before 12/31/1996, (see instructions)  or before 12/31/31/31/31/31/31/31/31/31/31/31/31/31/		Indirect Medical Education Adjustment				
new programs in accordance with 42 CFR 413.79(e)   0.00   7.00   NA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the 0.00   7.01   ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the 0.00   7.01   ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the 0.00   7.01   ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the 0.00   7.01   ACA \$5503 reduction amount to increase if the hospital was earlied of 1.41   ACA   ATA   ACA   ACA   A	5.00		it cost reporting p	berroa enaring on	0.00	5.00
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	6. 00		teria for an add-or	n to the cap for	0. 00	6. 00
cost report straddles July 1, 2011 then see instructions.   8.00						
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		cost report straddles July 1, 2011 then see instructions.	,,,,,	, , , , ,		
8. 01   The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.   2. 01   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)   2. 00   Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)   2. 00   The count for all opathic and osteopathic programs in the current year from your records   2. 00   10,00   11.00   12.00   13.00   14.00   10.00   14.00   10.00   12.00   12.00   12.00   12.00   12.00   13.00   14.00   10.00   14.00   10.00   12.00   12.00   12.00   12.00   13.00   14.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00	8. 00	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(			0.00	8. 00
8. 02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots un	der § 5503 of the A	ACA. If the cost	0. 00	8. 01
9.00   Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see   0.00   9.00   10.00   FTE count for all opathic and osteopathic programs in the current year from your records   0.00   10.00   10.00   Current year all owable FTE (see instructions)   0.00   12.00   10.	8. 02	The amount of increase if the hospital was awarded FTE cap slots from	om a closed teachir	ng hospital	0. 00	8. 02
10.00   FTE count for allopathic and osteopathic programs in the current year from your records   0.00   10.00	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8,	8,01 and 8,02) (s	see	0. 00	9. 00
12.00   Current year allowable FTE (see instructions)   0.00   12.00   13.00   10.00   13.00   10.00		FTE count for allopathic and osteopathic programs in the current year	ar from your record	ds		
13.00   Total allowable FTE count for the prior year.   0.00   13.00   14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00   14.00   14.00   15.00   15.00   16.00   18.00		, , , ,				
14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.   0.00   14.00						
otherwise enter zero.         0.00         15.00         Sum of lines 12 through 14 divided by 3.         0.00         15.00           16.00         Adj ustment for residents in initial years of the program         0.00         16.00           17.00         Adj ustment for residents displaced by program or hospital closure         0.00         17.00           18.00         Adj usted rolling average FTE count         0.00         17.00           19.00         Current year resident to bed ratio (line 18 divided by line 4).         0.000000         19.00           20.00         Prior year resident to bed ratio (see instructions)         0.000000         19.00           21.00         Enter the lesser of lines 19 or 20 (see instructions)         0.000000         22.00           22.00         IME payment adjustment (see instructions)         0.000000         22.00           22.01         IME payment adjustment - Managed Care (see instructions)         0.000000         22.01           1 IME payment adjustment - Managed Care (see instructions)         0.000000         22.01           1 IME payment adjustment for the Add-on for § 422 of the MMA         0.000000         22.01           23.00         Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105         0.000         0.000           25.00         If the amount on line		. ,				
15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   16.00   16.00   17.00   Adjustment for residents in initial years of the program   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   18.00   19	14. 00		ed on or after Sept	tember 30, 1997,	0.00	14.00
16.00       Adjustment for residents in initial years of the program       0.00       16.00         17.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       21.00         21.00       Inter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.000000       22.00         22.01       IME payment adjustment - Managed Care (see instructions)       0.22.01         Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00         23.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0.000000         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       27.00         28.01       IME payments adjustment factor. (see instructions)       0.000000       27.00	15 00				0.00	15 00
17. 00						
18.00       Adjusted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.0000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.0000000       19.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.000000       22.00         1 ME payment adjustment - Managed Care (see instructions)       0.000000       22.01         1 Indirect Medical Education Adjustment For the Add-on For § 422 of the MMA       0.000000       22.01         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00       23.00         (f)(1)(iv)(C).       0.000000       24.00       25.00       1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.01       IME paymen		, ,				
19.00 Current year resident to bed ratio (line 18 divided by line 4).  20.00 Prior year resident to bed ratio (see instructions)  21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  22.01 IME payment adjustment - Managed Care (see instructions)  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 Iff the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see						
21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  22.01 IME payment adjustment - Managed Care (see instructions)  1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount (see instructions)  29.01 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (see instructions)  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.01 Allowable disproportionate share percentage (see instructions)  21.00 22.00 22.01 22.01 28.01 29.03 21.00 29.00						
22. 00 IME payment adjustment (see instructions) 0 22. 00 IME payment adjustment - Managed Care (see instructions) 0 22. 01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 0. 00 23. 00 (f) (1) (iv) (C).  24. 00 IME FTE Resident Count Over Cap (see instructions) 0. 00 24. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 Instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4) 0. 000000 27. 00 IME payments adjustment factor. (see instructions) 0. 000000 27. 00 IME payments adjustment amount (see instructions) 0. 000000 27. 00 IME add-on adjustment amount (see instructions) 0. 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0. 28. 01 IME payment (sum of lines 22 and 28) 0. 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0. 029. 01 Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 11. 82 30. 00 31. 00 Allowable disproportionate share percentage (see instructions) 21. 88 33. 00 Allowable disproportionate share percentage (see instructions) 21. 88 33. 00	20.00	Prior year resident to bed ratio (see instructions)			0.000000	20. 00
22. 01 IME payment adjustment - Managed Care (see instructions)  1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24. 00 IME FTE Resident Count Over Cap (see instructions)  25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	21. 00				0.000000	21. 00
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f) (1) (iv) (C).  24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 29.00 Total IME payment (sum of lines 22 and 28) 0.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 11.82 30.00 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 21.88 33.00 Allowable disproportionate share percentage (see instructions) 21.88 33.00						
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f) (1) (iv) (C).  24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 0.29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 11.82 30.00 31.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 21.88 33.00	22. 01				0	22. 01
24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME payments adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  21.88 33.00	23. 00	Number of additional allopathic and osteopathic IME FTE resident ca		FR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00 instructions)  Resident to bed ratio (divide line 25 by line 4)  1ME payments adjustment factor. (see instructions)  1ME add-on adjustment amount (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  10 28.00 IME payment (sum of lines 22 and 28)  29.01 Total IME payment (sum of lines 22 and 28)  10 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 isproportionate Share Adjustment  20.00 Sum of lines 30 and 31  30.00 Allowable disproportionate share percentage (see instructions)  21.88 33.00	24.00				0.00	24 00
26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  31.00 Allowable disproportionate share percentage (see instructions)  26.00  0.000000 27.00  0.000000  0.28.01  0.29.01		If the amount on line 24 is greater than -O-, then enter the lower	of line 23 or line	24 (see		
27. 00       IME payments adjustment factor. (see instructions)       0.000000       27. 00         28. 00       IME add-on adjustment amount (see instructions)       0 28. 00         28. 01       IME add-on adjustment amount - Managed Care (see instructions)       0 28. 01         29. 00       Total IME payment (sum of lines 22 and 28)       0 29. 00         29. 01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0 29. 01         Disproportionate Share Adjustment       90. 00         30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       11. 82       30. 00         31. 00       Sum of lines 30 and 31       41. 93       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       21. 88       33. 00	26 00				0 000000	26 00
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  20.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.01 Sum of lines 30 and 31  30.00 Allowable disproportionate share percentage (see instructions)  28.00  28.00  29.01  29.00  29.00  29.01  20.00						
28. 01 IME add-on adjustment amount - Managed Care (see instructions)  7 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  8 Disproportionate Share Adjustment  9 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  10. 00 Sum of lines 30 and 31  30. 00 Allowable disproportionate share percentage (see instructions)  28. 01  29. 00  29. 00  29. 01						
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  30.01 29.01  30.00 41.82 30.00  30.11 31.00  31.00 29.01		, ,				
Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  21.88 33.00	29.00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  30.00 41.82 30.00  41.93 32.00  21.88 33.00	29. 01				0	29. 01
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.11 31.00 41.93 32.00 21.88 33.00	30. 00		days (see instruct	tions)	11. 82	30.00
32.00 Sum of lines 30 and 31 41.93 32.00 33.00 Allowable disproportionate share percentage (see instructions) 21.88 33.00			J. (	- /		
33.00 Allowable disproportionate share percentage (see instructions) 21.88 33.00		, , , ,				
34.00   Disproportionate share adjustment (see instructions) 1,709,795   34.00					21.88	33. 00
	34. 00	Disproportionate share adjustment (see instructions)			1, 709, 795	34.00

35. 00 Total 35. 01 Facto 35. 02 Hospi instr 35. 03 Pro r 36. 00 Total Additi 40. 00 Total 41. 01 Total 41. 01 Total 42. 00 Ratio days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi no 64. 00 Al I ow 65. 00 Al I ow 65. 00 Al I ow 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 Outli 70. 00 Total 70. 50 Rural 70. 87 Demon	ompensated Care Adjustment	Provider CCN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/25/2022 1:03	pared:	
35. 00 Total 35. 01 Facto 35. 02 Hospi instr 35. 03 Pro r 36. 00 Total Additi 40. 00 Total 41. 00 Total 41. 01 Total 42. 00 Di vid 43. 00 Total 44. 00 Ratio days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi no 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 OTHER 70. 50 Rural 70. 50 Rural 70. 87 Demon		Title XVIII	Hospi tal	PPS	o piii	
35. 00 Total 35. 01 Facto 35. 02 Hospi instr 36. 00 Total Additi 40. 00 Total 41. 00 Total 41. 01 Total 42. 00 Di vid 43. 00 Total 44. 00 Ratio days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi no 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Ottler 70. 50 Rural 70. 50 Rural 70. 50 Rural 70. 87 Demon				On/After 10/1		
35. 00 Total 35. 01 Facto 35. 02 Hospi instr 36. 00 Total Additi 40. 00 Total 41. 00 Total 41. 01 Total 42. 00 Di vid 43. 00 Total 44. 00 Ratio days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi no 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Ottler 70. 50 Rural 70. 50 Rural 70. 50 Rural 70. 87 Demon			1. 00	2. 00		
35. 01 Facto 35. 02 Hospi instr 35. 03 Pro r 36. 00 Total Additi 40. 00 Total 41. 01 Total 42. 00 Di vi d 43. 00 Total 44. 00 Ratio days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Cost 65. 00 Adj us 66. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 50 Rural 70. 87 Demon						
35. 02 Hospi instr 35. 03 Pro r 36. 00 Total Additi 40. 00 Total 41. 01 Total 42. 00 Di vid 43. 00 Ratio days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y. 49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Ancil 59. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Cost 57. 00 Routi 58. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 Other 70. 50 Rural 70. 87 Demon	al uncompensated care amount (see instructions)		8, 290, 014, 521			
35. 03   Pro r r r r r r r r r r r r r r r r r r	ctor 3 (see instructions)	un zone en this line) (se	0. 000578474	0. 000848525	35. 01	
35. 03 Pro rada   Additi   40. 00 Total   41. 01 Total   42. 00 Di vi d   43. 00 Total   44. 00 Ratio   44. 00 Avera   46. 00 Total   47. 00 Subto   48. 00 Hospi   onl y.    49. 00 Total   50. 00 Payme   51. 00 Excep   52. 00 Di rec   53. 00 Nursi   54. 01 Islet   55. 00 Net   56. 00 Cost   57. 00 Routi   58. 00 Routi   59. 00 Total   60. 00 Pri ma   61. 00 Total   60. 00 Pri ma   61. 00 Total   62. 00 Deduc   63. 00 Coi no   64. 00 Al I ow   65. 00 Adj us   66. 00 Al I ow   67. 00 Subto   68. 00 Credi   69. 00 OTHER	spital uncompensated care payment (If line 34 is zero, ente structions)	er zero on this ime) (se	e 4, 795, 557	6, 102, 597	35. 02	
36. 00 Total Additi 40. 00 Total 1. 00 Total 1. 01 Total 1. 01 Total 1. 01 Total 1. 00 Tot	o rata share of the hospital uncompensated care payment amo	ount (see instructions)	3, 586, 813	1, 538, 190	35. 03	
40.00   Total   41.01   Total   42.00   Di vi d   43.00   Total   44.00   Ratio days)   45.00   Avera   46.00   Total   47.00   Subto   48.00   Hospi onl y.   49.00   Total   50.00   Payme   51.00   Excep   52.00   Di rec   53.00   Nursi   54.00   Speci   54.01   Islet   55.00   Routi   58.00   Anci I   59.00   Total   60.00   Pri ma   61.00   Total   62.00   Deduc   63.00   Coi ns   64.00   Al I ow   65.00   Al I ow   65.00   Al I ow   66.00   Al I ow   66.00   Al I ow   67.00   Subto   68.00   Credi   69.00   OTHER   70.50   Rural   7	al uncompensated care (sum of columns 1 and 2 on line 35.0		5, 125, 003		36. 00	
41. 00 Total 41. 01 Total 42. 00 Di vi d 43. 00 Total 44. 00 Rati o days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rotal 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Con 63. 00 Con 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 OTHER 70. 50 Rural 70. 50 Rural 70. 87 Demon	itional payment for high percentage of ESRD beneficiary di					
41. 01 Total 42. 00 Di vi d 43. 00 Total 44. 00 Rati o days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Ancil 59. 00 Total 60. 00 Pri ma 61. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 OTHER 70. 50 Rural 70. 50 Rural 70. 87 Demon	al Medicare discharges (see instructions)		0		40. 00	
42. 00 Di vi d 43. 00 Total 44. 00 Rati o days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Ancil 59. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Al I ow 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Utli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	al ESRD Medicare discharges (see instructions)		0		41. 00	
43. 00 Total 44. 00 Ratio days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi only.  49. 00 Total 50. 00 Payme 51. 00 Excep 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Al I ow 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 OTHER 70. 50 Rural 70. 87 Demon	cal ESRD Medicare covered and paid discharges (see instruct		0		41. 01	
44. 00 Ratio days) 45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi only.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Routi 58. 00 Ancil 59. 00 Total 60. 00 Prima 61. 00 Total 62. 00 Deduc 63. 00 Coins 64. 00 Allow 65. 00 Adjus 66. 00 Allow 67. 00 Subto 68. 00 Credi 69. 00 Ottli 70. 00 Ottler 70. 50 Rural 70. 87 Demon	vide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42.00	
45. 00 Avera 46. 00 Total 47. 00 Subto 48. 00 Hospi onl y.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Direc 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 OTHER 70. 50 Rural 70. 87 Demon	cal Medicare ESRD inpatient days (see instructions) cio 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 Avera 46. 00 Total 47. 00 Hospi only.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Routi 58. 00 Ancil 59. 00 Total 60. 00 Prima 61. 00 Prima 61. 00 Total 62. 00 Deduc 63. 00 Cost 63. 00 Cost 64. 00 Allow 65. 00 Adjus 66. 00 Allow 67. 00 Subto 68. 00 Credi 69. 00 Utli 70. 00 THER 70. 50 Rural 70. 87 Demon		by Title 41 divided by 7	0.00000		44.00	
46. 00 Total 47. 00 Subto 48. 00 Hospi only.  49. 00 Total 50. 00 Payme 51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Ancil 59. 00 Total 60. 00 Prima 61. 00 Total 62. 00 Deduc 63. 00 Cost 64. 00 Allow 65. 00 Adjus 66. 00 Allow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	erage weekly cost for dialysis treatments (see instructions	5)	0.00		45. 00	
47. 00 Subto 48. 00 Hospi only.  49. 00 Total 50. 00 Payme 51. 00 Excep 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 OTHER 70. 50 Rural 70. 87 Demon	al additional payment (line 45 times line 44 times line 41	•	0		46. 00	
Onl y.	ototal (see instructions)	•	38, 993, 133		47. 00	
49.00 Total 50.00 Payme 51.00 Excep 52.00 Direc 53.00 Nursi 54.00 Speci 54.01 Islet 55.00 Net o 56.00 Cost 57.00 Routi 58.00 Ancil 59.00 Total 60.00 Prima 61.00 Total 62.00 Deduc 63.00 Coins 64.00 Allow 65.00 Adjus 66.00 Allow 67.00 Subto 68.00 Credi 69.00 OTHER 70.50 Rural 70.50 Rural 70.87 Demon	spital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48. 00	
50.00 Payme 51.00 Excep 52.00 Di rec 53.00 Nursi 54.00 Speci 54.01 Islet 55.00 Net o 56.00 Cost 57.00 Routi 58.00 Ancil 59.00 Total 60.00 Pri ma 61.00 Total 62.00 Deduc 63.00 Coins 64.00 Allow 65.00 Adjus 66.00 Allow 67.00 Subto 68.00 Credi 69.00 OTHER 70.50 Rural 70.87 Demon	y. (see instructions)					
50.00 Payme 51.00 Excep 52.00 Di rec 53.00 Nursi 54.00 Speci 54.01 Islet 55.00 Net o 56.00 Cost 57.00 Routi 58.00 Ancil 59.00 Total 60.00 Pri ma 61.00 Total 62.00 Deduc 63.00 Coins 64.00 Allow 65.00 Adjus 66.00 Allow 67.00 Subto 68.00 Credi 69.00 OTHER 70.50 Rural 70.87 Demon				Amount		
50.00 Payme 51.00 Excep 52.00 Di rec 53.00 Nursi 54.00 Speci 54.01 Islet 55.00 Net o 56.00 Cost 57.00 Routi 58.00 Ancil 59.00 Total 60.00 Pri ma 61.00 Total 62.00 Deduc 63.00 Coins 64.00 Allow 65.00 Adjus 66.00 Allow 67.00 Subto 68.00 Credi 69.00 OTHER 70.50 Rural 70.87 Demon				1. 00	40.00	
51. 00 Excep 52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi ns 64. 00 Al Iow 65. 00 Adj us 66. 00 Al Iow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 THER 70. 50 Rural 70. 87 Demon	al payment for inpatient operating costs (see instructions ment for inpatient program capital (from Wkst. L, Pt. I an	•		38, 993, 133 2, 625, 672		
52. 00 Di rec 53. 00 Nursi 54. 00 Speci 54. 01 I sl et 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Utl i 70. 00 THER 70. 50 Rural 70. 87 Demon	ception payment for inpatient program capital (Wkst. L, Pt. 1 an			2, 625, 672	51.00	
53. 00 Nursi 54. 00 Speci 54. 01 Islet 55. 00 Net o 56. 00 Cost 57. 00 Routi 58. 00 Ancil 59. 00 Total 60. 00 Prima 61. 00 Total 62. 00 Deduc 63. 00 Coins 64. 00 Allow 65. 00 Adjus 66. 00 Allow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	rect graduate medical education payment (from Wkst. E-4, li			o o	52. 00	
54.00 Speci 54.01 Islet 55.00 Net o 56.00 Cost 57.00 Routi 58.00 Ancil 59.00 Total 60.00 Prima 61.00 Total 62.00 Deduc 63.00 Coi 63.00 Coi 64.00 Allow 65.00 Adjus 66.00 Allow 67.00 Subto 68.00 Credi 69.00 Outli 70.00 OTHER 70.50 Rural 70.87 Demon	rsing and Allied Health Managed Care payment	,		53, 714	53. 00	
55. 00 Net of 56. 00 Cost 57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	ecial add-on payments for new technologies			474, 198	54.00	
56. 00 Cost 57. 00 Routi 58. 00 Ancil 59. 00 Total 60. 00 Pri ma 61. 00 Deduc 63. 00 Coins 64. 00 Allow 65. 00 Adjus 66. 00 Allow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	et isolation add-on payment			0	54. 01	
57. 00 Routi 58. 00 Anci I 59. 00 Total 60. 00 Pri ma 61. 00 Deduce 63. 00 Coi ns 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6			0	55. 00	
58.00 Ancil 59.00 Total 60.00 Prima 61.00 Total 62.00 Deduc 63.00 Coins 64.00 Allow 65.00 Adjus 66.00 Allow 67.00 Subto 68.00 Credi 69.00 Other 70.00 OTHER 70.50 Rural 70.87 Demon	st of physicians' services in a teaching hospital (see intr	•		0	56. 00	
59.00 Total 60.00 Pri ma 61.00 Total 62.00 Deduc 63.00 Coil now 65.00 Adj us 66.00 All low 67.00 Subto 68.00 Credi 69.00 Outli 70.00 OTHER 70.50 Rural 70.87 Demon	itine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57. 00	
60. 00 Pri ma 61. 00 Total 62. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	cillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		64, 762		
61. 00 Total 62. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	ral (sum of amounts on lines 49 through 58) mary payer payments			42, 211, 479 17, 447		
62. 00 Deduc 63. 00 Coi ns 64. 00 Al I ow 65. 00 Adj us 66. 00 Al I ow 67. 00 Subto 68. 00 Credi 69. 00 Outl i 70. 00 OTHER 70. 50 Rural 70. 87 Demon	al amount payable for program beneficiaries (line 59 minus	line 60)		42, 194, 032		
63.00 Coins 64.00 Allow 65.00 Adjus 66.00 Allow 67.00 Subto 68.00 Credi 69.00 Outli 70.00 OTHER 70.50 Rural 70.87 Demon	ductibles billed to program beneficiaries	, , , , , , , , , , , , , , , , , , , ,		2, 501, 992		
64. 00 Allow 65. 00 Adjus 66. 00 Allow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	nsurance billed to program beneficiaries		428, 650	1		
66. 00 Allow 67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon				1, 116, 167	64. 00	
67. 00 Subto 68. 00 Credi 69. 00 Outli 70. 00 OTHER 70. 50 Rural 70. 87 Demon	owable bad debts (see instructions)	· · · · · · · · · · · · · · · · · · ·				
68.00 Credi 69.00 Outli 70.00 OTHER 70.50 Rural 70.87 Demon	· · · · · · · · · · · · · · · · · · ·	ructions)		436, 499	66. 00	
69.00 Outli 70.00 OTHER 70.50 Rural 70.87 Demon	· · · · · · · · · · · · · · · · · · ·			39, 988, 899 0	67. 00 68. 00	
70.00 OTHER 70.50 Rural 70.87 Demon	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see inst ototal (line 61 plus line 65 minus lines 62 and 63)					
70. 50 Rural 70. 87 Demon	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see inst btotal (line 61 plus line 65 minus lines 62 and 63) edits received from manufacturers for replaced devices for	(For SCH see instruction	s)	0	69.00	
70.87 Demon	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see instatotal (line 61 plus line 65 minus lines 62 and 63) edits received from manufacturers for replaced devices for clier payments reconciliation (sum of lines 93, 95 and 96).		i netrueti one)	0	70. 00 70. 50	
	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see instantial (line 61 plus line 65 minus lines 62 and 63) edits received from manufacturers for replaced devices for clier payments reconciliation (sum of lines 93, 95 and 96). HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ration) adjustment (see	i iisti ucti olis)	0	70. 30	
70.88 SCH o	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see instatotal (line 61 plus line 65 minus lines 62 and 63) edits received from manufacturers for replaced devices for clier payments reconciliation (sum of lines 93, 95 and 96). HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ral Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see			70.88	
	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see instatotal (line 61 plus line 65 minus lines 62 and 63) edits received from manufacturers for replaced devices for clier payments reconciliation (sum of lines 93, 95 and 96). HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ral Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration	ration) adjustment (see		l OI		
1	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see instatotal (line 61 plus line 65 minus lines 62 and 63) edits received from manufacturers for replaced devices for clier payments reconciliation (sum of lines 93, 95 and 96). HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ral Community Hospital Demonstration Project (§410A Demonst	, , ,		0	70. 89	
	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see instatotal (line 61 plus line 65 minus lines 62 and 63) edits received from manufacturers for replaced devices for clier payments reconciliation (sum of lines 93, 95 and 96). HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) and Community Hospital Demonstration Project (§410A Demonstation payment adjustment amount before sequestration or MDH volume decrease adjustment (contractor use only)	, , ,		0	70. 89 70. 90	
1	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see instatotal (line 61 plus line 65 minus lines 62 and 63) edits received from manufacturers for replaced devices for elier payments reconciliation (sum of lines 93, 95 and 96). HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) and Community Hospital Demonstration Project (§410A Demonst honstration payment adjustment amount before sequestration or MDH volume decrease adjustment (contractor use only) oneer ACO demonstration payment adjustment amount (see instatotal)	, , ,				
	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see instatotal (line 61 plus line 65 minus lines 62 and 63) ddits received from manufacturers for replaced devices for clier payments reconciliation (sum of lines 93, 95 and 96). HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) and Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration of or MDH volume decrease adjustment (contractor use only) oneer ACO demonstration payment adjustment amount (see instructions) of bonus payment HVBP adjustment amount (see instructions) and led Model 1 discount amount (see instructions)	, , ,		0 0 0	70. 90 70. 91 70. 92	
70. 94 HRR a 70. 95 Recov	usted reimbursable bad debts (see instructions) owable bad debts for dual eligible beneficiaries (see instatotal (line 61 plus line 65 minus lines 62 and 63) addits received from manufacturers for replaced devices for elier payments reconciliation (sum of lines 93, 95 and 96). HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) and Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration of or MDH volume decrease adjustment (contractor use only) oneer ACO demonstration payment adjustment amount (see instructions) of bonus payment HVBP adjustment amount (see instructions)	, , ,		0	70. 90 70. 91 70. 92 70. 93	

Heal th	Financial Systems	CLARA MAASS MEDIC	AL CENTER		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CO	CN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre 5/25/2022 1:03	
			Title	XVIII	Hospi tal	PPS	
				FFY	(yyyy)	Amount	
					0	1. 00	
70. 96	Low volume adjustment for federal fiscal year the corresponding federal year for the period		n column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year the corresponding federal year for the period				0	0	70. 97
70. 98	Low Volume Payment-3					0	70. 98
70. 99	HAC adjustment amount (see instructions)					308, 086	70. 99
71. 00	Amount due provider (line 67 minus lines 68	plus/minus lines 6	9 & 70)			39, 585, 967	71.00
71. 01	Sequestration adjustment (see instructions)					0	71. 01
	Demonstration payment adjustment amount after					0	71. 02

71.03 Sequestration adjustment-PARHM pass-throughs

(line 212 minus line 213) (see instructions)

73)

71.03 Sequestration adjustment-PARHM pass-throughs
72.01 Interim payments
72.01 Interim payments
73.00 Tentative settlement (for contractor use only)
73.01 Tentative settlement-PARHM (for contractor use only)
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)

71.03

72. 01 73. 00 73.01

74.00

37, 545, 045

2, 040, 922

	(73)							
74.01	Balance due provider/program-PARHM (see instructions)			74. 01				
75.00	Protested amounts (nonallowable cost report items) in accordance with		1, 037, 110	75. 00				
	CMS Pub. 15-2, chapter 1, §115.2							
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)							
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00				
	plus 2.04 (see instructions)							
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00				
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0	92. 00				
	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00				
	The rate used to calculate the time value of money (see instructions)		0.00					
95. 00	Time value of money for operating expenses (see instructions)		0.00	95. 00				
	Time value of money for capital related expenses (see instructions)		0	96.00				
96.00	Time varue of money for capital related expenses (see first uctions)	Dri or to 10/1	On/After 10/1	90.00				
		1.00	2.00					
	UCD Denus Doument Amount	1.00	2.00					
100.00	HSP Bonus Payment Amount			100.00				
100.00	HSP bonus amount (see instructions)	C	1 0	100. 00				
404.00	HVBP Adjustment for HSP Bonus Payment							
	HVBP adjustment factor (see instructions)	0.0000000000						
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	C	1 0	102. 00				
	HRR Adjustment for HSP Bonus Payment							
	HRR adjustment factor (see instructions)	0.0000						
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	C	) 0	104. 00				
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment							
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200. 00				
	Century Cures Act? Enter "Y" for yes or "N" for no.							
	Cost Reimbursement							
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00				
202.00	Medicare discharges (see instructions)			202. 00				
203.00	Case-mix adjustment factor (see instructions)			203. 00				
	Computation of Demonstration Target Amount Limitation (N/A in first year of the curi	rent 5-year demons	trati on					
	peri od)							
204.00	Medicare target amount			204. 00				
205.00	Case-mix adjusted target amount (line 203 times line 204)			205. 00				
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206. 00				
	Adjustment to Medicare Part A Inpatient Reimbursement							
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207. 00				
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00				
209.00	Adjustment to Medicare IPPS payments (see instructions)			209. 00				
	Reserved for future use			210.00				
	Total adjustment to Medicare IPPS payments (see instructions)			211. 00				
	Comparision of PPS versus Cost Reimbursement			1				
212.00	212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)							
	Low-volume adjustment (see instructions)			213. 00				
	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00				
	1	1	1					

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2021 Part A Exhibit 4
To 12/31/2021 Date/Time Prepared: 5/25/2022 1:03 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 31-0009

					'	0 12/31/2021	5/25/2022 1:0	
		W/S E Dort A	Amounts (from	Title Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	Amounts (from E. Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	23, 084, 355	0	23, 084, 355		23, 084, 355	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	8, 173, 316	0		8, 173, 316	8, 173, 316	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	O	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for	2. 00						2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2. 01
2. 02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	646, 085	0	646, 085		646, 085	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	254, 579	0		254, 579	254, 579	2. 03
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adju	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6.00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6. 01
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
10.00	Disproportionate Share Adjustme Allowable disproportionate	33. 00	0. 2188	0. 2188	0. 2188	0. 2188		10. 00
10.00	share percentage (see instructions)	33.00	0.2100	0.2100	0. 2100	0.2100		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	1, 709, 795	0	1, 262, 714	447, 081	1, 709, 795	11. 00
11. 01	Uncompensated care payments	36.00	5, 125, 003	0	3, 586, 813	1, 538, 190	5, 125, 003	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	46. 00	0 beneficiary	or scharges 0	0	0	0	12. 00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	38, 993, 133 0	0	28, 579, 967 0	10, 413, 166 0	38, 993, 133 0	
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	38, 993, 133	0	28, 579, 967	10, 413, 166	38, 993, 133	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	2, 625, 672	O	1, 935, 724	689, 948	2, 625, 672	16. 00

Date/Time Prepared: 5/25/2022 1:03 pm 12/31/2021 Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od Part A) to 10/01 On/After 10/01 line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 474, 198 387, 727 86, 471 474, 198 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 30, 903, 418 11, 189, 585 42, 093, 003 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 2, 349, 990 1, 733, 750 616, 240 2, 349, 990 20.00 Model 4 BPCI Capital DRG other 20.01 1 01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 67, 473 48, 364 19, 109 67, 473 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22.00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 0 0 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0886 0.0886 0.0886 0.0886 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 208.209 Ω 153, 610 54.599 208.209 25.00 adjustment (see instructions) 26.00 Total prospective capital 12.00 2, 625, 672 1, 935, 724 689, 948 2, 625, 672 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2. 00 5. 00 1.00 3.00 4.00 0 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) 29.00 Low volume adjustment 29.00 70.97 0 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/25/2022 1:0	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Peri od 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	23, 084, 355	23, 084, 35	5	23, 084, 355	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	8, 173, 316		8, 173, 316	8, 173, 316	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	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	646, 085	646, 08		646, 085	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	254, 579		254, 579		2. 03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0		0 0		
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0.00000	0.000000		5. 00
6. 00	(see instructions)  IME payment adjustment (see instructions)	22. 00	0		0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0		0		
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 00000			7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0		0 0	0	8. 00 8. 01
9. 00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0		0	0	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	0		0	Ö	
	lines 6.01 and 8.01)						ļ
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 2188	0. 218	0. 2188		10.00
	(see instructions)						
11. 00	Disproportionate share adjustment (see instructions)	34.00	1, 709, 795	1, 262, 71	4 447, 081	1, 709, 795	11. 00
11. 01	Uncompensated care payments	36.00	5, 125, 003	3, 586, 81	3 1, 538, 190	5, 125, 003	11. 01
12. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see instructions)	46. 00	di scharges 0		0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47. 00 48. 00	38, 993, 133 0	28, 579, 96	7 10, 413, 166 0 0	38, 993, 133 0	1
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	38, 993, 133	28, 579, 96	7 10, 413, 166	38, 993, 133	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	2, 625, 672	1, 935, 72	689, 948	2, 625, 672	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	474, 198	387, 72	86, 471	474, 198	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	1	0	0	1
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	1	0	0	18. 00
19. 00	SUBTOTAL			30, 903, 41	11, 189, 585	42, 093, 003	19. 00

Health Financial Systems	CLARA MAASS ME	EDICAL CENTER		In Lie	eu of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provi der CO	F	reriod: rom 01/01/2021 o 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/25/2022 1:0	pared:
			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	2, 349, 990	1, 733, 750	616, 240	2, 349, 990	
20.01   Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	67, 473	48, 364	19, 109	67, 473	
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	0.0000	0.0000	0.0000		22. 00
23.00   Indirect medical education adjustment (see instructions)	6. 00	0	C	0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0886	0. 0886	0. 0886		24. 00
25.00 Disproportionate share adjustment (see instructions)	11.00	208, 209	153, 610	54, 599	208, 209	25. 00
26.00 Total prospective capital payments (see instructions)	12.00	2, 625, 672	1, 935, 724	689, 948	2, 625, 672	26. 00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1. 00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0	0		0	
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	-85, 457	-85, 457	0	-85, 457	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	C	0	0	30. 01
31 00 HRR adjustment (see instructions)	70 94	_0 380	_0 380	0	_0 380	31 00

70.94

70. 91

0

70.99

-9, 389

1.00

Υ

-9, 389

308, 086

3.00

2.00

HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see

32.00 HAC Reduction Program adjustment (see

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

instructions)

instructions)

31.00

31.01

32.00

100. 00

-9, 389

308, 086

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

4.00

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0009	From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/25/2022 1:03 pm

		Title XVIII	Hospi tal	5/25/2022 1: 0 PPS	3 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			11.00	
1.00	Medical and other services (see instructions)			8, 043	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	ions)		14, 126, 592 14, 505, 583	2. 00 3. 00
4. 00	Outlier payment (see instructions)			9, 175	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		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 from Wkst. D, Pt. I	V. col. 13. line 200		25, 402	ı
10. 00	Organ acqui si ti ons	., 200		0	1
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			8, 043	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			66, 579	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		00, 377	1
	Total reasonable charges (sum of lines 12 and 13)	,		66, 579	1
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p	3	•	0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e	. 3	n a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			66, 579	1
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds lii	ne 11) (see	58, 536	19. 00
20.00	instructions)	v if line 11 evenede lie	20 10) (600	_	20.00
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	y II IThe II exceeds III	ie 18) (See	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			8, 043	21. 00
	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			14, 540, 160	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	)		12, 672	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line		uctions)	2, 342, 971	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			12, 192, 560	27. 00
00.00	instructions)	50)			00.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0 0	
	Subtotal (sum of lines 27 through 29)			12, 192, 560	1
31. 00	Primary payer payments			12, 836	1
32. 00	Subtotal (line 30 minus line 31)			12, 179, 724	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		0	1 22 00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 589, 928	
	Adjusted reimbursable bad debts (see instructions)			383, 453	1
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		273, 139	
	Subtotal (see instructions)			12, 563, 177	1
	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	`		0	39. 00 39. 50
39. 97	Demonstration payment adjustment amount before sequestration	)		0	ı
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruc	tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00	Subtotal (see instructions)			12, 563, 242	1
40. 01	Sequestration adjustment (see instructions)			0	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02 40. 03
	Interim payments			12, 154, 715	1
41. 01	Interim payments-PARHM				41. 01
	Tentative settlement (for contractors use only)			0	•
42. 01	Tentative settlement-PARHM (for contractor use only)			400 507	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			408, 527	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2.	chapter 1.	0	ı
55	§115. 2	23 27	· p · · · · · · · ·		
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	
93. 00	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94. 00

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0009	Peri od: From 01/01/2021	Worksheet E Part B
	Component CCN: 31-S009	To 12/31/2021	Date/Time Prepared: 5/25/2022 1:03 pm
	Title XVIII	Subprovi der -	PPS

Medical and other services (see instructions)		I Ti ti e XVIII Subpi ovi dei -	PFS	
APAT R . WENICA MAN OTHER HEATH SERVICES				
Medical and other services (see instructions)		PART R - MEDICAL AND OTHER HEALTH SERVICES	1.00	
	1.00		0	1.00
Dutilier payment (see instructions)		1	1, 444	2. 00
0.01   For record i lation amount (see Instructions)		1 ' '		•
Inter the hospital specific payment to cost ratio (see instructions)   0.000   0.00			1	
Line 2 Times   Line 5   0   0.00   7.00   8.00   8.00		1		
Transit forest corridor payment (see instructions)   0   0   0   0   0   0   0   0   0			1	
Accil lary service other pass through costs from West. D. Pt. IV, col. 13. Iline 200   0 9.00.	7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. 00
0 0 0 0rgan acquisitions		, , , , , , , , , , , , , , , , , , , ,		
Total coef. (sum of lines 1 and 10) (see instructions)				
Communitation for LESSER OF COST OR CHARGES   12.00   Ancil lary service charges   12.00   Ancil lary service charges   12.00   Ancil lary service charges   12.00   13.00   Organ acquisition charges (from West. 0.4, Pt. 111, col. 4, 11ne 69)   12.00   13.00   13.00   Organ acquisition charges (sum of lines 12 and 13)   14.00   14.		9		
12.00   Ancil larry service charges   0   12.00				1 00
13.00   Organ acquisition chargies (From Wists. D-4, Pt. 111, col. 4, line 69)		9		
14.00			1	•
Customary charges   Cust				
15.00   Aggregate amount actually collected from patients Halble for payment for services on a charge basis   0   15.00	14.00			14.00
had such payment been made In accordance with 42 CFR \$413.13(e)	15. 00		0	15. 00
17.00	16. 00		0	16. 00
Total customary charges (see instructions)   0   18.00   19.	17 00		0.000000	17 00
9, 00			1	
Instructions				
Instructions		instructions)		l
21.00   Lesser of cost or charges (see instructions)   0   21.00	20. 00		0	20. 00
22 00   Interns and residents (see instructions)   0 22 00	21 00		0	21 00
24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   1,758   24. 00   COMPUTATION OF REIMBURSEMENT SETTLEMENT     25. 00   Deductible sand coinsurance amounts (for CAH, see instructions)   237 26. 00   25. 00   26. 00   Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   237 26. 00   27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   1,521 27. 00   28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0 28. 00   28. 00   0   ESRD direct medical education costs (from Wkst. E-4, line 36)   0,29. 00   2			1	
COMPUTATION OF REI MBURSEMENT SETTLEMENT   0   25.00				
25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   25.00   27.00   Subtotal [(I] can amount on line 24 (for CAH, see instructions)   27.00   Subtotal [(I] can amount on line 24 (for CAH, see instructions)   27.00   Subtotal [(I] can amount on line 24 (for CAH, see instructions)   27.00   Subtotal (I] can amount on line 25 and 26) plus the sum of lines 22 and 23] (see   1,521   27.00   1.521   32.00   32.00   32.00   32.00   32.00   Subtotal (sum of lines 27 through 29)   1,521   30.00   32.00   3	24. 00		1, 758	24. 00
26. 00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   237   26. 00	25 00		0	25 00
27. 00   Subtotal   ([I ines 21 and 24 minus the sum of I ines 25 and 26) plus the sum of I ines 22 and 23] (see   1,521   27. 00   1   1,521   27. 00   1   1,521   27. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   29. 00				
28. 00   Direct graduate medical education payments (From Wkst. E-4, line 50)   0   28. 00   0   29. 00   29. 00   20.			1	
29.00   ESRD direct medical education costs (from Wist. E-4, line 36)   29.00   30.00   Subtotal (sum of lines 27 through 29)   1,521   30.00   30.00   30.00   Subtotal (sum of lines 27 through 29)   1,521   30.00   31.00   32.00   Subtotal (line 30 minus line 31)   1,521   30.00   31.00   AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   1,521   33.00   33.00   34.00   34.00   35.00   35.00   36.00	00.00			00.00
30. 00   Subtotal (sum of lines 27 through 29)   1,521   30. 00   31. 00				
31.00   Subtotal (line 30 minus line 31)   1,521   32.00   3				
ALLOWABLE RAD DEBTS (EXCLUDE RAD DEBTS FOR PROFESSIONAL SERVICES)   0   33.00   30.00   20.0		l ,	1	1
33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   34.00	32. 00	•	1, 521	32. 00
34.00   All lowable bad debts (see instructions)   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   35.00   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   1,521   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   91 oneer ACO demonstration payment adjustment (see instructions)   0   39.97   93.98   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.97   93.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   1,521   40.00   40.01   40.	22.00			22.00
35.00				•
37.00   Subtotal (see instructions)   1,521   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   39.97   Demonstration payment adjustment (see instructions)   0   39.95   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   1,521   40.00   40.01   Sequestration adjustment (see instructions)   0   40.01   40.02   Demonstration payment adjustment amount after sequestration   0   40.01   40.02   Demonstration payment adjustment amount after sequestration   0   40.02   40.03   Sequestration adjustment payment adjustment amount after sequestration   0   40.02   40.03				
38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00   39. 50   39. 50   39. 50   39. 97   0   0   0   0   0   0   0   0   0	36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   Pioneer ACO demonstration payment adjustment as equestration   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.99   40.00   Subtotal (see instructions)   0 40.01   Sequestration adjustment (see instructions)   0 40.01   40.02   Demonstration payment adjustment amount after sequestration   0 40.02   40.03   Sequestration adjustment amount after sequestration   0 40.02   40.03   Sequestration adjustment amount after sequestration   0 40.02   40.03   40.04   40.05   40				
39.50   Pi oneer ACO demonstration payment adjustment (see instructions)   39.50     39.97   Demonstration payment adjustment amount before sequestration   0 39.97     39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98     39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98     39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99     40.00   Subtotal (see instructions)   0 40.01     40.01   Demonstration adjustment (see instructions)   0 40.01     40.02   Demonstration payment adjustment amount after sequestration   0 40.02     40.03   Sequestration adjustment-PARHM pass-throughs   41.01     41.01   Interim payments   41.01     42.00   Interim payments-PARHM   (for contractors use only)   42.01     42.01   Tentative settlement (for contractor use only)   42.01     43.00   Balance due provider/program (see instructions)   43.01     44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,				
39.97   Demonstration payment adjustment amount before sequestration   0   39.97   39.98   8   8   8   8   8   8   8   8   9   8   8			١	
39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment adjustment exequestration 40. 03 Sequestration adjustment -PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Bal ance due provider/program (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2  TO BE COMPLETED BY CONTRACTOR  90. 00 Tiginal outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 O 93. 00			o	
40.00 Subtotal (see instructions) 40.01 Sequestration adj ustment (see instructions) 40.02 Demonstration payment adj ustment amount after sequestration 40.03 Sequestration adj ustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  41.01 To the complete of the contractor use only of		· · · · · · · · · · · · · · · · · · ·	0	
40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 1, 520 41. 01 Interim payments-PARHM 1, 520 41. 01 Tentative settlement (for contractors use only) 41. 01 42. 00 Tentative settlement (for contractor use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 1 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 1 43. 00 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 41. 01 42. 00 Tiginal outlier amount (see instructions) 0 90. 00 43. 01 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 44. 00 The rate used to calculate the Time Value of Money 10 93. 00 45. 01 Time Value of Money (see instructions) 0 93. 00			1	•
40. 02 Demonstration payment adjustment amount after sequestration  40. 03 Sequestration adjustment-PARHM pass-throughs  41. 00 Interim payments  41. 01 Interim payments-PARHM  42. 00 Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM (for contractor use only)  43. 00 Balance due provider/program (see instructions)  43. 01 Balance due provider/program-PARHM (see instructions)  43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  93. 00 Time Value of Money (see instructions)  94. 00 93. 00  95. 00 Time Value of Money (see instructions)  96. 00 97. 00  97. 00 Time Value of Money (see instructions)  98. 00 Time Value of Money (see instructions)  99. 00 Time Value of Money (see instructions)  90. 00 Time Value of Money (see instructions)				
40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments Interim payments Interim payments-PARHM Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00			1	
1.01   Interim payments-PARHM				•
Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)  43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Og 93.00			1, 520	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.01 Ag. 00 94.00 95.01 Ag. 00 96.01 Ag. 00 97.02 Og. 00 97.03 Og. 00 97.04 Og. 00 97.04 Og. 00 97.05 Og. 00 97.06 Og. 00 97.07 Og. 00 97.08 Og. 00 97.09 Og. 00 97.				
43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00   91.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Over the conciliation of Money (see instructions)  94.00 Over the conciliation adjustment amount (see instructions)  95.00 Over the conciliation adjustment amount (see instructions)  96.00 Over the conciliation adjustment amount (see instructions)  97.00 Over the conciliation adjustment amount (see instructions)  98.00 Over the conciliation adjustment amount (see instructions)  99.00 Over the conciliation adjustment amount (see instructions)			ا	
43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Og 93.00		,	1	
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00				
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 O 93.00	44. 00		o	44. 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions)				
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	90 00		0	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00		, ,	1	
	92.00	The rate used to calculate the Time Value of Money	0.00	92. 00
94.00   Total (sum of lines 91 and 93)   0   94.00			1	•
	94.00	TOTAL (SUIL OF TIMES 91 AND 93)	0	94.00

In Lieu of Form CMS-2552-10

Period:	Worksheet E-1
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/25/2022	1:03 pm

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 31-0009

Inj   mm/dd/\( \)	2.00	mm/dd/yyyy 3.00 1 0	PPS Tt B  Amount 4.00 12,154,715 0	1.00 2.00
1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	yyyy Amount ) 2.00 38,346,18	mm/dd/yyyy 3.00 1 0	Amount 4.00 12,154,715 0	2. 00
1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	2.00	3.00	4. 00 12, 154, 715 0	2. 00
1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	2.00	3.00	12, 154, 715 0	2. 00
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3.01 ADJUSTMENTS TO PROVIDER  3.50 ADJUSTMENTS TO PROGRAM  3.50 Provider to Program  ADJUSTMENTS TO PROGRAM  3.51 ADJUSTMENTS TO PROGRAM  12/16/3  3.51 ADJUSTMENTS TO PROGRAM  12/16/3  5.01 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  5.00 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  TENTATIVE TO PROVIDER		0 0	0	2. 00
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3.01 3.02 3.03 3.04 3.05  Provider to Program  ADJUSTMENTS TO PROGRAM  3.50 3.51 3.52 3.53 3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  5.01 TENTATIVE TO PROVIDER		000	0	
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  ADJUSTMENTS TO PROVIDER  3.01 3.02 3.03 3.04 3.05  Provider to Program  3.50 ADJUSTMENTS TO PROGRAM  12/16/2 3.51 3.52 3.53 3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR  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  TENTATIVE TO PROVIDER		O	1	3. 00
3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 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  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  5.01 TENTATIVE TO PROVIDER		O	1	
3.02 3.03 3.04 3.05  Provider to Program  3.50 3.51 3.52 3.53 3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  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  5.01 TENTATIVE TO PROVIDER		O	1	3. 01
3.03 3.04 3.05  Provider to Program  3.50 ADJUSTMENTS TO PROGRAM  12/16/2 3.51 3.52 3.53 3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  TENTATIVE TO PROVIDER		-	0	
3.04 3.05  Provider to Program  3.50 3.51 3.52 3.53 3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER		O	0	
3.05  Provider to Program  3.50 3.51 3.52 3.53 3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  5.01 TENTATIVE TO PROVIDER		o		3. 03
Provider to Program  3.50 ADJUSTMENTS TO PROGRAM  12/16/3  3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 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  5.00 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  5.01 TENTATIVE TO PROVIDER		0		
3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 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  5.00 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  5.01 TENTATIVE TO PROVIDER		o <sub>l</sub>		3.03
3.51 3.52 3.53 3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER	2021 801, 13	6	0	3.50
3.52 3.53 3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER		0		
3.53 3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER		0		
3.54 3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01  TENTATIVE TO PROVIDER		0		
3.99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER	·	0		0.00
3.50-3.98)  4.00 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  5.00 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  5.01 TENTATIVE TO PROVIDER	-801, 13	6	0	3. 99
4.00 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  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  5.01 TENTATIVE TO PROVIDER	-001, 13	0		3. 77
TO BE COMPLETED BY CONTRACTOR  5.00 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  5.01 TENTATIVE TO PROVIDER	37, 545, 04	5	12, 154, 715	4. 00
5.00 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  5.01 TENTATIVE TO PROVIDER  5.02				ł
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER  5.02				5. 00
5. 01 TENTATI VE TO PROVI DER 5. 02				5.00
5. 02		_		1
		0	0	
E 02		0	0	
		0	0	5. 03
Provider to Program		_		
5.50 TENTATIVE TO PROGRAM		0	0	
5. 51		0	0	5. 51
5. 52		0	0	0.02
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98)		0	0	5. 99
6.00 Determined net settlement amount (balance due) based on the cost report. (1)				6. 00
6. 01 SETTLEMENT TO PROVIDER	2, 040, 92	2	408, 527	6. 01
6.02 SETTLEMENT TO PROGRAM	_, _, ,_	ol	0	6. 02
7.00 Total Medicare program liability (see instructions)	39, 585, 96	7	12, 563, 242	
., (====================================	2:,222,70	Contractor Number	NPR Date (Mo/Day/Yr)	
		1. 00	2.00	
8.00 Name of Contractor	0			8. 00

Component CCN: 31-S009

Subprovi der -Title XVIII

		Title	XVIII	Subprovi der – I PF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 399, 651		1, 520	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			I.		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program			T	_	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51 3. 52			0		0 0	3. 51 3. 52
3. 52			0			3. 52
3. 54			0			3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		o o	3. 99
0. ,,	3. 50-3. 98)		· ·			0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 399, 651		1, 520	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			1		
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	Cubtatal (aum af lines 5 01 5 40 minus aum af lines		0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	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		628		1	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 400, 279		1, 521	7. 00
				Contractor	NPR Date	
			1	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	C	)	1. 00	2.00	8. 00
0.00	name of softi actor			l	ı l	0.00

Component CCN: 31-5505 Title XVIII

		Title	XVIII	Skilled Nursing Facility	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 611, 686	5	0	1. 00
2.00	Interim payments payable on individual bills, either		(		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			<u>'</u>		
3.01	ADJUSTMENTS TO PROVIDER		(	)	0	3. 01
3.02			(		0	3. 02
3.03					0	3. 03
3.04			(		0	3. 04
3. 05			(	)	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		(	J	0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3. 51					0	3. 52
3. 53					Ö	3. 53
3. 54			-		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(		o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 611, 686	5	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after			1		5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5.02			(		0	5. 02
5.03			(		0	5. 03
	Provi der to Program			1		
5. 50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51 5. 52			(	)	0	5. 51 5. 52
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			)	0	5. 52 5. 99
5. 77	5. 50-5. 98)		(	΄	U	3. 77
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		(		0	6. 01
6.02	SETTLEMENT TO PROGRAM		•	ı	0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 611, 685		0	7. 00
				Contractor	NPR Date	
		(	1	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		)	1.00	2.00	8. 00
5.00	Indino of contractor			T .	!	0.00

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0009	Peri od: From 01/01/2021	Worksheet E-3
	Component CCN: 31-S009		
	Title XVIII	Subprovi der -	PPS
		I IPF	

	I PF		
		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2, 597, 364	1.00
2.00	Net IPF PPS Outlier Payments	3, 174	2.00
3.00	Net IPF PPS ECT Payments	11, 468	3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4. 00
	15, 2004. (see instructions)		
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	6. 00
7. 00	teaching program" (see instuctions)  Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
7.00	teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9.00	Average Daily Census (see instructions)	0.000000	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11. 00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2, 612, 006	12. 00
13.00		0	13.00
14. 00			14. 00
15. 00		0	15. 00
16.00		2, 612, 006	
17. 00		0	17. 00
18.00		2, 612, 006	
19. 00 20. 00		149, 656 2, 462, 350	
21. 00		62, 699	
22. 00		2, 399, 651	
23. 00		2, 377, 031	23. 00
24. 00		0	24.00
25. 00	· · · · · · · · · · · · · · · · · · ·	0	25. 00
26. 00		2, 399, 651	26. 00
27. 00	Direct graduate medical education payments (see instructions)	0	27. 00
28. 00	Other pass through costs (see instructions)	628	28. 00
29. 00	Outlier payments reconciliation	0	29. 00
30.00		0	30. 00
30. 50		0	30. 50
30. 98		0	30. 98
30. 99	1	0	30. 99
31.00		2, 400, 279	
31. 01		0	31. 01 31. 02
31. 02 32. 00		2, 399, 651	
33. 00		2, 344, 031	33.00
34. 00	3/	628	34.00
35. 00		0	35.00
00.00	S115. 2	١	00.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	3, 174	50. 00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	,	0.00	52. 00
53. 00		0	53. 00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1		
99. 00		0.000000	
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

	Financial Systems	CLARA MAASS MEDICAL CENTER	11 0000		u of Form CMS-1	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 3	31-0009	Peri od: From 01/01/2021	Worksheet E-3 Part VI	
		Component CCN:	31-5505	To 12/31/2021	Date/Time Pre	nared:
		Component Con.	01 0000	12,01,2021	5/25/2022 1:0	
		Title XVI	П	Skilled Nursing	PPS	•
				Facility		
					1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTL	EMEMENI - ALL OTHER HEALTH SERVIC	ES FOR I	TILE XVIII PARI A	A PPS SNF	
	SERVICES	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				1
1. 00	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS Resource Utilization Group Payment (RUGS)	)			1, 660, 101	1.00
2. 00	Routine service other pass through costs				1, 660, 101	1
3. 00	Ancillary service other pass through costs				0	
1. 00	Subtotal (sum of lines 1 through 3)				1, 660, 101	
. 00	COMPUTATION OF NET COST OF COVERED SERVICES				1,000,101	1
. 00	Medical and other services (Do not use this	line as vaccine costs are include	ed in line	e 1 of W/S E.		5.00
	Part B. This line is now shaded.)					
. 00	Deducti bl e				0	6.00
. 00	Coi nsurance				48, 416	7. 00
. 00	Allowable bad debts (see instructions)				0	8.00
. 00	Reimbursable bad debts for dual eligible ber				0	9.00
	Adjusted reimbursable bad debts (see instruc	ti ons)			0	
	Utilization review				0	1
	Subtotal (sum of lines 4, 5 minus lines 6 ar	d 7, plus lines 10 and 11)(see ir	nstructi o	ns)	1, 611, 685	
	Inpatient primary payer payments	_				13.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIF					14.00
	Pioneer ACO demonstration payment adjustment	(see instructions)				14. 50
	Recovery of accelerated depreciation.				-	14. 98
	Demonstration payment adjustment amount before	re sequestration			0	1
	Subtotal (see instructions				1, 611, 685	1
	Sequestration adjustment (see instructions)	r coguestration			0 0	
	Demonstration payment adjustment amount after Sequestration for non-claims based amounts (				)   0	
	Interim payments	SEE THISTI UCTI OHS)			1, 611, 686	
	Tentative settlement (for contractor use onl	w)			1, 011, 000	
		y) Lines 15.01, 15.02, 15.75, 16, ar			· · · · · · · · · · · · · · · · · · ·	18.00

18.00

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

Health Financial Systems	CLARA MAASS MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2022 1:03 pm

			Γο 12/31/2021	Date/Time Pre 5/25/2022 1:0	
		Title XIX	Hospi tal	TEFRA	о ріп
		THE XIX	I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	VIOLO FOR TITLES V OR XII	COLITYTOLO		
1.00	Inpatient hospital/SNF/NF services		4, 130, 745		1.00
2.00	Medical and other services		1, 100, 710	1, 045, 231	2. 00
3.00	Organ acquisition (certified transplant centers only)		0	1,010,201	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		4, 130, 745	1, 045, 231	4. 00
5. 00	Inpatient primary payer payments		0	.,	5. 00
6.00	Outpatient primary payer payments			0	6, 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		4, 130, 745	1, 045, 231	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8. 00
9.00	Ancillary service charges		9, 554, 573	5, 524, 229	9. 00
10.00	Organ acquisition charges, net of revenue		o		10.00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		9, 554, 573	5, 524, 229	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15. 00
16. 00	,	1611	9, 554, 573	5, 524, 229	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	5, 423, 828	4, 478, 998	17. 00
10.00	line 4) (see instructions)	vifling 4 avecade line	0	0	10 00
18. 00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y IT Time 4 exceeds Time	٥	0	18. 00
19. 00	Interns and Residents (see instructions)			0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		4, 130, 745	1, 045, 231	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			1, 043, 231	21.00
22. 00	Other than outlier payments	compreted for fis provide	0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	Ü	24. 00
	Capital exception payments (see instructions)		o		25. 00
26. 00	Routine and Ancillary service other pass through costs		o	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		o	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		4, 130, 745	1, 045, 231	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	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)		4, 130, 745	1, 045, 231	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		l 33)	4, 130, 745	1, 045, 231	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		4, 130, 745	1, 045, 231	
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)		4, 130, 745	1, 045, 231	40. 00
41.00	Interim payments		4, 914, 034	681, 363	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		-783, 289	363, 868	
43. 00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT EDUCATION COSTS	Provi der Co	CN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prep 5/25/2022 1:03	pared:
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
	Unweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.	programs for	cost reporti	ng peri ods	0. 00	1.00
. 00 L	Jnweighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	ructions)	0. 00	2.00
- 1	Amount of reduction to Direct GME cap under section 422 of MM. Direct GME cap reduction amount under ACA §5503 in accordance		8/12 70 (m)	(500	0. 00 0. 00	3. 00 3. 0°
	instructions for cost reporting periods straddling 7/1/2011)	WI til 42 CIK	. 9413.79 (111).	(366	0.00	3.0
	Adjustment (plus or minus) to the FTE cap for allopathic and of GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0. 00	4.0
	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng periods	0. 00	4. 0°
	straddling 7/1/2011)	_			0.00	4.00
	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0. 00	4. 02
	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 plus l	ines 4.01 and	0. 00	5.00
	4.02 plus applicable subscripts Jnweighted resident FTE count for allopathic and osteopathic	programs for	the current	vear from vour	0.00	6.00
r	records (see instructions)	F9		,		
. 00   E	Enter the lesser of line 5 or line 6		Primary Care	e Other	0. 00 Total	7. 00
			1.00	2. 00	3. 00	
	Weighted FTE count for physicians in an allopathic and osteop	athi c	0.0	0.00	0. 00	8. 00
00 i	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		0.0	0.00	0.00	9. 0
	5.	unt on time				
	Weighted dental and podiatric resident FTE count for the curry			0.00		10.0
	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	rrent year	0. (	0. 00 0. 00		10. 0°
2.00 1	Total weighted resident FTE count for the prior cost reporting nstructions)	g year (see	0.0	0.00		12. 0
3.00 1	Total weighted resident FTE count for the penultimate cost re	porti ng	0.0	0.00		13. 00
1 -	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0. (	0.00		14.0
	Adjustment for residents in initial years of new programs		0. (			15. 0
	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo		0. ( 0. (			15. 0 16. 0
	Jnweighted adjustment for residents displaced by program or h		0.0			16. 0
1	closure					47.00
4	Adjusted rolling average FTE count Per resident amount		0. ( 0. (			17. 00 18. 00
	Approved amount for resident costs			0 0	0	19. 0
					1. 00	
0.00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	ceived under 42		20.00
1	Sec. 413. 79(c)(4)		·			
1	Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instru				0. 00 0. 00	21. 0 22. 0
- 1	Enter the locality adjustment national average per resident a		nstructions)		0. 00	
- 1	Multiply line 22 time line 23		,		0	1
5. 00 1	Total direct GME amount (sum of lines 19 and 24)		 	at Managad Cana	0	25. 0
			inpatient Par	rt Managed Care	Total	
	DOMENTATION OF DECORAN DATIENT LOAD		1. 00	2. 00	3. 00	
6. 00 T	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part II 3.02, column 2)	X, line	21, 36	21, 333		26. 00
1	3.02, column 2) Fotal Inpatient Days (see instructions)		83, 65	83, 653		27. 0
3. 00 F	Ratio of inpatient days to total inpatient days		0. 25540	0. 255018		28.00
1	Program di rect GME amount			0 0	0	
9. 01   F	Percent reduction for MA DGME					29. 0°
- 1	Reduction for direct GME payments for Medicare Advantage			Ol	0	30.0

Heal th	Financial Systems CLARA MAASS MEDIO	CAL CENTER	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 31-0009	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2021 To 12/31/2021	Date/Time Prep 5/25/2022 1:03	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	E XVIII ONLY (NURSING PR	OGRAM AND PARAMED	OI CAL	
32.00	Renal dialysis direct medical education costs (from Wkst. B,	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
	and 94)				
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.		74 and 94)	8, 602, 674	
34. 00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0. 000000	1
	Medicare outpatient ESRD charges (see instructions)			0	
36. 00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
37. 00				49, 690, 528	1
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Primary payer payments (see instructions)			17, 447	1
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		49, 673, 081	41. 00
40.00	Part B Reasonable Cost			44 4/4 404	40.00
42. 00				14, 161, 481	1
43. 00	Primary payer payments (see instructions)			12, 836	1
	Total Part B reasonable cost (line 42 minus line 43)			14, 148, 645	1
	Total reasonable cost (sum of lines 41 and 44)	- 41   1: 45)		63, 821, 726	
	Ratio of Part A reasonable cost to total reasonable cost (lin			0. 778310	1
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin- ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAI			0. 221690	47.00
49.00	Total program GME payment (line 31)	KI D		0	48. 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		0	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			0	
50.00	Trail b medicale ome payment (Time 47 x 40) (title XVIII only)	(See HISH UCH OHS)	ı	U	J 50.00

Health Financial Systems

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

Provider CCN: 31-0009 Period: From 01/0

oni y)					5/25/2022 1:0	3 pm
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6, 442		0	0	1.00
2. 00 3. 00	Temporary investments	0			0	2. 00 3. 00
4.00	Notes recei vabl e Accounts recei vabl e	43, 402, 902	1		0	
5.00	Other recei vable	0			0	
6.00	Allowances for uncollectible notes and accounts receivable	-16, 508, 938	3	o o	0	
7.00	Inventory	5, 229, 786		0	0	7. 00
8.00	Prepai d expenses	2, 292, 868		0	0	
9.00	Other current assets	24, 444, 337		1	0	9.00
10.00	Due from other funds	89, 254, 598 148, 121, 995	l	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	140, 121, 993		<u>J</u>	0	11.00
12. 00	Land	458, 886		0	0	12. 00
13.00	Land improvements	2, 188, 133		0		
14.00	Accumulated depreciation	-2, 131, 156		0		14. 00
15. 00	Bui I di ngs	187, 714, 117	1	0	0	15. 00
16.00	Accumulated depreciation	-104, 369, 264	1	0	0	16.00
17. 00 18. 00	Leasehold improvements	336, 692	1	0	0	17. 00
19. 00	Accumulated depreciation Fixed equipment	-332, 268 24, 036, 290	1	-	0	18. 00 19. 00
20. 00	Accumulated depreciation	-22, 548, 489	1		0	20.00
21. 00	Automobiles and trucks	0	1	o o	o o	21.00
22.00	Accumul ated depreciation	0		0	0	22. 00
23.00	Major movable equipment	115, 477, 435	j (	0	0	23. 00
24.00	Accumul ated depreciation	-75, 202, 390	1	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	)	1	0	25. 00
26. 00	Accumulated depreciation	0		0	0	26. 00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0			0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e		1		0	
30.00	Total fixed assets (sum of lines 12-29)	125, 627, 986	1			30.00
	OTHER ASSETS			-		
31.00	Investments	1, 000	) (	0	-	31. 00
32. 00	Deposits on Leases	0	)	-	-	32. 00
33. 00	Due from owners/officers	0	1	0	0	33. 00
34. 00 35. 00	Other assets Total other assets (sum of Lines 21 24)	4, 695, 798	•	0	0	34. 00 35. 00
36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	4, 696, 798 278, 446, 779	1	-		36.00
30. 00	CURRENT LIABILITIES	270, 440, 777		91 0		30.00
37. 00	Accounts payable	23, 046, 464	. (	0	0	37. 00
38. 00	Salaries, wages, and fees payable	11, 446, 620	) (	0	0	38. 00
39. 00	Payroll taxes payable	3, 547, 038	3	0	0	39. 00
40.00	Notes and Loans payable (short term)	0		0	0	40.00
41.00	Deferred income	935, 739		0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	193, 829	0	0	0	42. 00 43. 00
44. 00	Other current liabilities	33, 880, 529				
45. 00	Total current liabilities (sum of lines 37 thru 44)	73, 050, 219		o o		
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	) (	٦	0	
47. 00	Notes payable	0	1	0		
48. 00	Unsecured Loans	140 244 100		0	1	48. 00 49. 00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	160, 266, 108 160, 266, 108		-		
51.00	Total liabilities (sum of lines 45 and 50)	233, 316, 327				
	CAPI TAL ACCOUNTS			-		
52.00	General fund balance	45, 130, 452	2			52. 00
53.00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00 57. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,		1		0 0	57. 00 58. 00
55. 00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	45, 130, 452		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	278, 446, 779		0	0	60.00
	[59]		1		l	l

CLARA MAASS MEDICAL CENTER

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 31-0009

					From 01/01/2021 To 12/31/2021	Date/Time Prep 5/25/2022 1:03	
		Genera	l Fund	Special P	urpose Fund	Endowment Fund	
	T	1.00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		41, 096, 391 3, 140, 482		0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		44, 236, 873	1	0		3. 00
4. 00	OTHER	1, 177, 228		l .	o	o	4. 00
5.00		0			o	0	5.00
6.00		0			0	0	6. 00
7.00		0		1	0	0	7. 00
8. 00 9. 00		0		1	0	0	8. 00 9. 00
10. 00	Total additions (sum of line 4-9)		1, 177, 228		0	- 1	10.00
11. 00	Subtotal (line 3 plus line 10)		45, 414, 101	l .	0		11. 00
12.00	NON-OPERATI NG REVENUE	283, 650			0	0	12.00
13. 00		0			0	0	13. 00
14. 00 15. 00		0			0	0 0	14. 00 15. 00
16. 00		0		•	0		16. 00
17. 00		0			o	Ö	17. 00
18. 00	Total deductions (sum of lines 12-17)		283, 650	)	0		18.00
19. 00	Fund balance at end of period per balance		45, 130, 451		0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	L : Fund			
		ZIIGOIIIIOITE T GIIG	11011				
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0			0		2. 00 3. 00
4. 00	OTHER		0	•			4. 00
5.00			0				5. 00
6.00			0				6.00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9. 00
10. 00	Total additions (sum of line 4-9)	0			o		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11.00
12. 00	NON-OPERATING REVENUE		0				12.00
13. 00 14. 00			0				13. 00 14. 00
15. 00			U				14.00
16. 00			Ö				16. 00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0		1	0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00
	Isheer (Tine II milius IIIIe 10)	1	I	I	1	l	

Health Financial Systems C STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 31-0009

		1	o 12/31/2021	Date/Time Prep 5/25/2022 1:03	
	Cost Center Description	I npati ent	Outpati ent	Total	5 piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	484, 652, 627		484, 652, 627	1. 00
2.00	SUBPROVI DER - I PF	69, 722, 400		69, 722, 400	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	12, 629, 862	2	12, 629, 862	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE	F/7 004 000		F/7 004 000	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)	567, 004, 889	<u>′</u>	567, 004, 889	10. 00
11. 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT	87, 931, 364	1	87, 931, 364	11. 00
12. 00	CORONARY CARE UNIT	07, 931, 302	•	07, 931, 304	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	87, 931, 364	ı	87, 931, 364	16. 00
	11-15)	0,7,0,700		0777017001	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	654, 936, 253	3	654, 936, 253	17. 00
18.00	Ancillary services	299, 931, 917	350, 274, 122	650, 206, 039	18. 00
19.00	Outpati ent servi ces	75, 227, 214	246, 022, 422	321, 249, 636	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 Wkst.	1, 030, 095, 384	596, 296, 544	1, 626, 391, 928	28. 00
	G-3, line 1)				
29. 00	PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200)		343, 973, 822		29. 00
30. 00	ADD (SPECIFY)				30.00
31. 00	ADD (SPECIFI)				31. 00
32. 00					32. 00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)	· ·	ĺ 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)(transfe	er	343, 973, 822		43.00
	to Wkst. G-3, line 4)				

	Financial Systems CLARA MAASS MEDI			u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 31-0009	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	nared:
			10 12/31/2021	5/25/2022 1:03	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ne 28)		1, 626, 391, 928	1.00
2.00	Less contractual allowances and discounts on patients' accoun	nts		1, 306, 588, 470	2.00
3.00	Net patient revenues (line 1 minus line 2)			319, 803, 458	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		343, 973, 822	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-24, 170, 364	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			o	23.00
24.00	OTHER OPERATING REVENUE			26, 361, 554	24.00
24. 50	COVI D-19 PHE Fundi ng			949, 292	
25. 00	Total other income (sum of lines 6-24)			27, 310, 846	25.00
26. 00	Total (line 5 plus line 25)			3, 140, 482	
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			3, 140, 482	29. 00
			'		

		MEDICAL CENTER		u of Form CMS-2	2552-10
CALCU	LATION OF CAPITAL PAYMENT	Provider CCN: 31-0009	Peri od: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/25/2022 1:0	
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			2, 349, 990	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 0
2.00	Capital DRG outlier payments			67, 473	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 0
3.00	Total inpatient days divided by number of days in the co	st reporting period (see inst	ructions)	230. 36	3.00
4.00	Number of interns & residents (see instructions)			0.00	4. 00
5. 00 6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by	withous most lines 1 and 1 01	columns 1 and	0. 00 0	5. 00 6. 00
8.00	1.01) (see instructions)	y the sum of filles I and I.O.	, corumns r and	U	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Par	t A patient days (Worksheet F	. part A line	11. 82	7. 00
	30) (see instructions)	- · · · pass sist and any of (incomment a	, par 1		
8. 00	Percentage of Medicaid patient days to total days (see in	nstructions)		30. 11	8.00
9. 00	Sum of lines 7 and 8			41. 93	9. 00
10. 00	Allowable disproportionate share percentage (see instruc	tions)		8. 86	10.00
11.00	, , , , , , , , , , , , , , , , , , , ,			208, 209	11.00
12. 00	Total prospective capital payments (see instructions)			2, 625, 672	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 instruction			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)	)		0	3.00
4.00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4.00
5. 00	Total Impatrent program capital cost (Time 3 x Time 4)			U	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)	,		0	2.00
3. 00 4. 00	Applicable exception percentage (see instructions)	)		0. 00	4. 00
5. 00	Capital cost for comparison to payments (line 3 x line 4)	)		0.00	5. 00
	Percentage adjustment for extraordinary circumstances (se			0.00	6. 00
6. 00	Adjustment to capital minimum payment level for extraordi		(line 6)	0	7. 00
		•	,	0	8.00
7. 00	Capital minimum payment level (line 5 plus line 7)			_	9.00
7. 00 8. 00	Current year capital payments (from Part I, line 12, as a			0	
7. 00 8. 00 9. 00 10. 00	Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level	to capital payments (line 8		0	
7. 00 8. 00 9. 00 10. 00 11. 00	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 or Worksheet L, Part III, line 14)	to capital payments (line 8 ver capital payment (from pri	or year	0	11. 00
7. 00 8. 00 9. 00 10. 00 11. 00	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 of Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital	to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus lin	or year ne 11)	0	11. 00 12. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	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 of Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, or	to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus line enter the amount on this line	or year ne 11)	0	11. 00 12. 00 13. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	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 ow Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level or	to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus line enter the amount on this line	or year ne 11)	0	11. 00 12. 00 13. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	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 or Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level or (if line 12 is negative, enter the amount on this line)	to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus line enter the amount on this line ver capital payment for the f	or year ne 11)	0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	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 or Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level or (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus line enter the amount on this line ver capital payment for the fe instructions)	or year ne 11)	0	11. 00 12. 00 13. 00