This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 31-0041 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/20/2024 2:35 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/20/2024 2:35 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, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY MEDICAL CENTER (31-0041) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-3, 385, 599	2, 357, 720	0	-2, 207, 305	1. 00
2.00	SUBPROVIDER - IPF	0	0	0		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, 045	-868		0	7. 00
200. 00 TOTAL		0	-3, 384, 554	2, 356, 852	0	-2, 207, 305	200. 00
The al	pove amounts represent "due to" or "due from"	the applicable	program for th	a alament of t	he above comply	ev indicated	

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

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

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

22.04

yes or "N" for no.

22.04 Did this hospital receive a geographic reclassification from urban to

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

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

Ν

58.00

Health Financial Systems COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0041 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/20/2024 2: 35 pm XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 instructions) IME Direct GME IME Direct GME 1.00 2.00 3. 00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 61.00 0.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61 04 Enter the number of unweighted primary care/or 61 04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year' primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)
61.06 Enter the amount of ACA §5503 award that is being 61 06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Unweighted IME Unweighted Program Name Program Code FTF Count Direct GME FTE Count 1.00 2. 00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents 0. 00 0.00 61.10 for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 0.00 62.00 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62. 01 0.00 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

Health Financial Systems	COMMUN	ITY MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI				eri od:	Worksheet S-2	
			To		5/20/2024 2: 3	
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Yea	r FTE Residents in N	onprovider Settings				
period that begins on or after J 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo	yes, or your facili ber of unweighted nor tations occurring in number of unweighted	ty trained residents n-primary care all nonprovider d non-primary care	0.00	0. 00	0. 000000	64. 00
of (column 1 divided by (column						
(50 (50 500)	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4.00	5.00	
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	0.000000 Ratio (col. 1/	65.00
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te			
	V 575 B 11 1 1		1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settings	sEffective fo	r cost reporti	ng periods	
66.00 Enter in column 1 the number of		rv care resident	0. 62	39. 39	0. 015496	66. 00
FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-prima al. Enter in column (	ry care resident 3 the ratio of				
(column 1 divided by (column 1 +	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
1 1 3 1	INTERNAL MEDICINE	1400	0. 38	28. 35		67. 00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

117. 00

118. 00

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems COMMUNITY MEDIC	AL CENTER		In lie	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 31-0041	Peri od: From 01/01/2023	Worksheet S	
			To 12/31/2023	Date/Time F	
		Premi ums	Losses	5/20/2024 2 Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 4, 256, 5	2. 00	3.00	0118.01
110. UTLIST alliquitts of marpractice premi ums and pard rosses.		4, 230, 3			0116.01
118.02 Are mal practice premiums and paid losses reported in a cost c	ontor other t	han the	1. 00 N	2.00	118. 02
Administrative and General? If yes, submit supporting schedu and amounts contained therein.			IN.		118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold   §3121 and applicable amendments? (see instructions) Enter in   "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment	column 1, "Y" lifies for th	for yes or ne Outpatient		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implan	·	,	Y		121. 00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1					122. 00
the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purc services, e.g., legal, accounting, tax preparation, bookkeepi management/consulting services, from an unrelated organizatio	ng, payroll,	and/or	Y	N	123. 00
for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from u located in a CBSA outside of the main hospital CBSA? In colum "N" for no.	greater than nrelated orga	50% of total anizations			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant ce	nter? Enter "	Y" for ves	N		125. 00
and "N" for no. If yes, enter certification date(s) (mm/dd/yy 126.00  f this is a Medicare-certified kidney transplant program, en	yy) below.	,			126. 00
in column 1 and termination date, if applicable, in column 2.					
127.00  f this is a Medicare-certified heart transplant program, enting in column 1 and termination date, if applicable, in column 2.	er the certif	cation date			127. 00
128.00  f this is a Medicare-certified liver transplant program, ent- in column 1 and termination date, if applicable, in column 2.	er the certif	ication date	•		128. 00
129.00 If this is a Medicare-certified lung transplant program, ente in column 1 and termination date, if applicable, in column 2.	r the certifi	cation date			129. 00
130.00 If this is a Medicare-certified pancreas transplant program,		ti fi cati on			130. 00
date in column 1 and termination date, if applicable, in column 131.00 of this is a Medicare-certified intestinal transplant program		erti fi cati on	,		131. 00
date in column 1 and termination date, if applicable, in column 132.00 of this is a Medicare-certified islet transplant program, ent	mn 2.				132. 00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved					133. 00
134.00 If this is a hospital-based organ procurement organization (0 in column 1 and termination date, if applicable, in column 2.	PO), enter th	ne OPO number	•		134. 00
All Providers  140.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y	es, and home	office costs	Y	H53560	140. 00
are claimed, enter in column 2 the home office chain number.  1.00 2.00			3. 00		
If this facility is part of a chain organization, enter on li home office and enter the home office contractor name and con			name and address	of the	
141.00 Name: RWJBARNABAS HEALTH Contractor's Name: NOVI			or's Number: 1200	)1	141. 00
142.00 Street: 95 OLD SHORT HILLS ROAD PO Box: 143.00 City: WEST ORANGE State: NJ		Zi p Code	: 0705	52	142. 00 143. 00
110. 00 of ty. West of the second sec		21 p 0000	. 0700		110.00
144.00 Are provider based physicians' costs included in Worksheet A?				1. 00 Y	144. 00
This sophic provider based physicians sosts their adea in horizonest in					111.00
145.00  f costs for renal services are claimed on Wkst. A, line 74,	are the costs	s for	1.00	2.00	145. 00
inpatient services only? Enter "Y" for yes or "N" for no in cono, does the dialysis facility include Medicare utilization fiperiod? Enter "Y" for yes or "N" for no in column 2.	olumn 1. If o	column 1 is			
146.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15 yes, enter the approval date (mm/dd/yyyy) in column 2.			- N		146. 00
David and a state of the state			ı	•	1

Health Financial Systems	COMMUNI TY	MEDI CAL	CENTER			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provi der CC	N: 31-0041		ri od: om 01/01/2023 12/31/2023	Worksheet S- Part I Date/Time Pr 5/20/2024 2:	epared:
							1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" f	for ves	or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order of							N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method	d? Enter	"Y" for ye	s or "N"	for no.		N	149. 00
			Part A	Part		Title V	Title XIX	
			1. 00	2.00		3. 00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or '			for Part A	and Part		e 42 CFR §413	3. 13)	
155. 00 Hospi tal			N	N		N	N	155. 00
156.00 Subprovi der - I PF			N	N		N	N	156. 00
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER			N	N		N	N	157. 00 158. 00
158. 00 S0BPROVI DER 159. 00 SNF			N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY			N	N N		N	N N	160.00
161. OO CMHC			IV	N		N	N N	161. 00
		l l					1.00	101100
Mul ti campus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or	more campu	ses in di	fferen	t CBSAs?	N	165. 00
	Name	С	ounty	State	Zip Co	ode CBSA	FTE/Campus	
	0		1. 00	2. 00	3.00	0 4.00	5. 00	
166.00 If line 165 is yes, for each							O. C	0 166. 00
campus enter the name in column								
O, county in column 1, state in column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
cordinar 5 (See Tristractions)								
							1.00	
Health Information Technology (HI 167.00 Is this provider a meaningful user						ct	N	167. 00
168.00 If this provider is a CAH (line 10						nter the	IN IN	168. 00
reasonable cost incurred for the			user (Title	107 13	1 ), 61	inter the		100.00
168.01 If this provider is a CAH and is n	•	,	is provider	qualify .	for a h	hardshi p		168. 01
exception under §413.70(a)(6)(ii)	PEnter "Y" for yes or	"N" for	no. (see i	nstructi o	ns)			
169.00 If this provider is a meaningful u		and is	not a CAH (	line 105	is "N")	), enter the	0.0	00169.00
transition factor. (see instruction	ons)					5	- "	
					_	Begi nni ng 1, 00	Endi ng 2. 00	_
170.00 Enter in columns 1 and 2 the EHR b	ogi ppi ng dato and ondi	na data	for the re	porting		1.00	2.00	170. 00
period respectively (mm/dd/yyyy)		ing date	TOI THE FE	portring				170.00
						1. 00	2.00	
171.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans i "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I,	line 2, col	. 6? Ente	r tion	N		0 171. 00

Health Financial Systems COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 31-0041 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/20/2024 2:35 pm Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1 00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 04/30/2022 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Ν 15.00 Part B Y/N Y/N Date Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N Ν 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/03/2023 04/03/2023 17 00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν N 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems COMMUNITY MED	DI CAL CENTER		In Lie	u of Form CM	IS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 31-0041	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time F 5/20/2024 2	Prepared:			
		Descr	ipti on	Y/N	Y/N				
	1.2.1	(	)	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			
	report data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date				
		1.00	2.00	3. 00	4. 00				
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00			
					1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	FPT CHILDRENS H	OSPLTALS)		1.00				
	Capi tal Related Cost		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00 23. 00			
23. 00	reporting period? If yes, see instructions.								
24. 00	Were new leases and/or amendments to existing leases entered of the second of the seco	· ·				24. 00			
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	rir yes, see		25. 00			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he cost reporti	ng period? I	f yes, see		26. 00			
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	g period? If	yes, submit		27. 00			
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into dur	ing the cost	reporting		28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (De	bt Service F	Reserve Fund)		29. 00			
30. 00	treated as a funded depreciation account? If yes, see insti Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see		30.00			
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see		31.00			
	instructions. Purchased Services								
32. 00	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru	uctions.				32. 00			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appno, see instructions.	plied pertainir	g to competi	tive bidding? If		33. 00			
34. 00	Provider-Based Physicians Were services furnished at the provider facility under an a	arrangement wit	h provider-h	pased physicians?		34.00			
	If yes, see instructions.	Ü		. ,		35. 00			
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		its with the	provider-based		35.00			
				Y/N	Date				
	lu			1. 00	2. 00				
36. 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 pullf 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 of the provider? If yes, enter in column 2 the fiscal year end			-		38. 00			
39. 00	1 1			5,		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								
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	respectively. Enter the employer/company name of the cost report	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.	732-923-8074		RI CH. HENWOOD@R\	NJBH. ORG	43. 00			
	proport proparor in conditions raile 2, respectivery.	I		T.		II			

Heal th	Financial Systems COMMUNITY MED	DICAL CENTER	In Lie	In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 31-0041	Peri od: From 01/01/2023			
			To 12/31/2023	Date/Time Pre 5/20/2024 2:3	pared: 5 pm	
		3. 00				
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	VP OF CORPORATE			41.00	
	held by the cost report preparer in columns 1, 2, and 3,	REIMBURSEMENT				
	respecti vel y.					
42.00	Enter the employer/company name of the cost report				42.00	
	preparer.					
43.00	Enter the telephone number and email address of the cost				43.00	
	report preparer in columns 1 and 2, respectively.					

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Health Financial Systems COMMUNI
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 31-0041

				Т	o 12/31/2023	Date/Time Prep 5/20/2024 2:3	
						I/P Days / 0/P	J pili
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	235	85, 775	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		235	85, 775	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	163	59, 495	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00	12	4, 380	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43. 00				0	13. 00
14.00	Total (see instructions)		410	149, 650	0.00	0	14. 00
15. 00	CAH visits					0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER	44.00	25	0.105		0	18. 00
19.00	SKILLED NURSING FACILITY	44. 00	25	9, 125		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
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						24. 00
24. 00		30. 00					24. 00
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					25. 00
26. 00							26. 00
26. 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 00
27. 00	Total (sum of lines 14-26)	69.00	435			U	27. 00
28. 00	Observation Bed Days		433			0	28. 00
29. 00	Ambul ance Trips					U	29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see l'istruction)						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32. 00
32. 00	Total ancillary labor & delivery room		١				32. 00
JZ. U1	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	c		0	
2 20	The state of the s		'	'	1	٠ - ١	

Provider CCN: 31-0041

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/20/2024 2:35 pm	

Component							5/20/2024 2:3	5 pm
Part   Start			I/P Days	o / O/P Visits	/ Trips	Full Time E	Equi val ents	
PART I - SIATISTICAL DATA		Component	Title XVIII	Title XIX				
PART I - STATISTICAL DATA			6.00	7 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)   12.002   2.00   13.00   14.00   15.00   15.00   16.00		PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
Hospice days)(see instructions for col. 2   7	1.00		46, 606	565	65, 794			1.00
For the portion of LDP room available beds)   2.00   Hold and others (see instructions)   35,524   12,002   3.00   0   0   0   0   0   0   0   0   0		8 exclude Swing Bed, Observation Bed and						
2.00 HM0 and other (see instructions)								
MNO IPF Subprovi der								
A.00   HMO IRF Subprovi der		` ,						
5.00		•	-	-				
6.00   Hospi tal Adult s & Peds. Swing Bed NF   Total Adult s & Peds. (exclude observation beds) (see instructions)   17   17   18   18   19   19   19   19   19   19				- 1	_			
Total Adults and Peds. (exclude observation beds)   Case			O	-	C			
beds) (see instructions)   8.00   17KSI VE CARE UNIT   2,974   574   48,180   8.00   9.00   10.00   BURN INTENSI VE CARE UNIT   1,541   0   3,566   11.00   10.00			47 707	- 1	(F 704			
8. 00   INTENSIVE CARE UNIT	7.00	· ·	46, 606	565	65, 794			7.00
9.00   CORONARY CARE UNIT   9.00   DURN INTENSIVE CARE UNIT   1,541   0   3,566   11.00   11.0	8 00		2 074	574	/Q 190			8 00
10. 00   BURN INTENSIVE CARE UNIT		l e	2, 7/4	374	40, 100			
11.00   SURGICAL INTENSIVE CARE UNIT   1,541   0   3,566   12.00   12.00   13.00   14.00   14.00   15.00   15.00   16.00   16.40   15.10   16.00   1								
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 1.829 3, 946 121, 486 68.74 1, 986.05 14.00 15.00 CAH visits 0 0 0 0 15.10 REH hours and visits 0 0 0 0 15.10 REH hours and visits 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1 541	0	3 566			
13.00   NuRSERY     1,829   3,946     13.00   14.00   15.10   15.00   15.10   16.40   15.00   15.10   16.40   15.00   15.10   16.00   15.10   16.00			1,011	Ŭ	0,000			
14. 00		· · ·		1, 829	3. 946	,		
15. 00 CAH visits		· ·	51, 121		·		1, 986, 05	
15. 10 REH hours and visits 0 0 0 0 0 0 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 00 NMSING FACILITY 20. 00 OTHER LONG TERM CARE 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 22. 00 HOSPICE 22. 00 HOME CONTROL OF THE CO			0	0	,	)	.,	
17. 00   SUBPROVI DER - IRF   17. 00   18. 00   SUBPROVI DER   18. 00   19. 00   19.		· ·	O	0	C	)	•	
18. 00   SUBPROVI DER   18. 00   19. 00   SKILLED NURSING FACILITY   3,680   0   5,975   0. 00   34. 26   19. 00   21. 00   21. 00   22. 00   22. 00   23. 00   24. 10   24. 10   25. 00   24. 10   25. 00   26. 25   27. 00   28. 00   29. 00   28. 00   29.	16.00	SUBPROVIDER - IPF						16.00
19. 00   SKILLED NURSING FACILITY   3,680   0   5,975   0.00   34.26   19.00   20.00   20.00   20.00   21.00   21.00   21.00   21.00   22.00	17.00	SUBPROVIDER - IRF						17. 00
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   22.00   22.00   23.00   24.00   22.00   24.00   24.00   24.00   24.00   24.10   25.00   24.00   25.00   24.00   25.00   26.00   26.25   26.00   26.25   27.00   26.25   27.00   28.00   29.00   28.00   29.	18.00	SUBPROVI DER						18. 00
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 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount 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  21. 00 22. 00 22. 00 22. 00 22. 00 23. 00 0 O O O O O O O O O O O O O O O O O	19. 00	SKILLED NURSING FACILITY	3, 680	0	5, 975	0.00	34. 26	19. 00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount 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  22. 00 22. 00 22. 00 23. 00 24. 10 24. 10 24. 10 25. 00 0 0 0 0 0. 00	20.00	NURSING FACILITY						
23. 00		· ·						
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 30. 00 LTCH non-covered days and discharges  24. 00 24. 10 24. 10 24. 10 25. 00 26. 00 26. 00 0 0. 00 0.		· ·						
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 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 30. 01 LTCH site neutral days and discharges  24. 10 25. 00 26. 05 27. 00 0 0 0 0 0. 0								
25. 00   CMHC - CMHC					_			
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 29. 00 Labor & delivery days (see instructions) 31. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 30. 01 LTCH site neutral days and discharges  26. 00 O O O O O O. 00 O. 00 O. 26. 25 00 O O O O O O O O O O O O O O O O O O					C			
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 68. 74 2, 020. 31 27. 00 28. 00 0bservation Bed Days 0 371 28. 00 Ambulance Trips 0 29. 00 Employee discount days (see instruction) 1, 221 21 22. 00 29. 0		l e						
27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 31. 01 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days 31. 00 LTCH site neutral days and discharges  0 371			0	0	_	0.00	0.00	
28. 00   Observation Bed Days   0   371   28. 00   29. 00   30. 00   Employee discount days (see instruction)   31. 00   Employee discount days - IRF   0   31. 00   31. 00   29. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   32. 01   Total ancillary labor & delivery room outpatient days (see instructions)   0   0   32. 01   33. 00   LTCH non-covered days   0   33. 01   LTCH site neutral days and discharges   0   33. 01   33. 01   33. 01   CTCH site neutral days and discharges   0   371   28. 00   29. 00   30. 00   31. 00   31. 00   31. 00   32. 01   32. 01   33. 00   33. 01   CTCH site neutral days and discharges   0   371   30. 00   371   30. 00   371   30. 00   371   30. 00   31. 00   31. 00   31. 00   31. 00   31. 00   32. 01   32. 01   33. 00   33. 01   33. 01   33. 01   33. 01   33. 01   33. 01   33. 01   34. 01		l e	U	U	C			
29. 00 Ambulance Trips				0	271		2,020.31	
30. 00 Employee discount days (see instruction) 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  30. 00 31. 02 30. 00 31. 00 32. 00 33. 00 33. 01			0	U	371			
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  31.00 31.00 10 10 1,027 10 10 10 10 10 10 10 10 10 10 10 10 10			o o		1 221			
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 10 1,027 0 32.00 0 32.01					1, 221			1
32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  31.01 LTCH site neutral days and discharges  32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	10	1 027	,		
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01		, ,	Š		., 52,	)		1
33.00 LTCH non-covered days 0 33.00 LTCH site neutral days and discharges 0 33.01					_			
33.01 LTCH site neutral days and discharges 0 33.01	33.00		o					33.00
34.00   Temporary Expansion COVID-19 PHE Acute Care   0 0 0 0 34.00	33. 01							33. 01
	34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	C			34.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Health Financial Systems COMMUNI
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 31-0041

				To	12/31/2023	Date/Time Prep 5/20/2024 2:3	
		Full Time Equivalents		Di sch	arges	0,20,202,2.0	<u>Б.</u>
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	· · · · · · · · · · · · · · · · · · ·	Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(	8, 344	276	23, 416	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			5 544	2 500		0.00
2.00	HMO and other (see instructions)			5, 541	3, 528		2.00
3.00	HMO I PF Subprovi der				0		3. 00 4. 00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				٩		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	(	8, 344	276	23, 416	14. 00
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER	0.00					18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00 20. 00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions)						33. 00
33. 00	LTCH non-covered days LTCH site neutral days and discharges			0			33. 00
	Temporary Expansi on COVID-19 PHE Acute Care						34. 00
57.00	Transporting Expansion Covid-17 The Acute Cale	1		1	ı		J J 7. UU

Provider CCN: 31-0041

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5/20/2024 2:35 pm	

						12/31/2023	5/20/2024 2: 3	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		4 00		A-6)	3)	col . 4		
	PART II - WAGE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							1
1.00	Total salaries (see instructions)	200. 00	187, 928, 710	-3, 835, 139	184, 093, 571	4, 202, 261. 02	43. 81	1.00
2.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3. 00
4. 00	Physician-Part A - Administrative		76, 708	0	76, 708	359. 00	213. 67	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		286, 791 1, 189, 300	0		1, 094. 00 2, 080. 00	l e	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	5, 721, 009	5, 721, 009	159, 262. 00	35. 92	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	О	О	0.00	0.00	7. 01
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	3, 487, 887 387, 769	l		71, 263. 48 21, 771. 06		
	instructions)							
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient Care		6, 993, 017	0	6, 993, 017	59, 819. 00	116. 90	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		0	0	0	0. 00	0. 00	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		31, 916, 903	0	31, 916, 903	448, 369. 27	71 18	14. 01
14. 02	Related organization salaries		0 0	l e	0	0.00	l e	
15. 00	Home office: Physician Part A		0	ō	O	0. 00	<b>l</b>	
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0.00	0.00	16. 01
16. 02	- Teaching Home office contract		0	0	0	0. 00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							1
17. 00	Wage-related costs (core) (see instructions)		49, 385, 102	0	49, 385, 102			17. 00
18. 00	Wage-related costs (other) (see instructions)		0/0.040		0/0.040			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		260, 318 0	0	260, 318 0			19. 00 20. 00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		1, 237		1, 237			22. 00
22. 01 23. 00	Physician Part A - Teaching		3, 770		3, 770 47, 324			22. 01 23. 00
23.00	Physician Part B Wage-related costs (RHC/FQHC)		47, 324 0	0	47, 324			24.00
25. 00	Interns & residents (in an approved program)		548, 865	o o	548, 865			25. 00
25. 50	Home office wage-related (core)		5, 923, 545	0	5, 923, 545			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52
	wage=rerated (core)			ļ	1		ļ	1

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0041

Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared:

5/20/2024 2:35 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 2.00 5. 00 1.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 4 00 17, 889. 40 26.00 Employee Benefits Department 695, 755 695, 755 38.89 27.00 Administrative & General 5.00 13, 808, 060 -2, 604, 781 11, 203, 279 212, 828. 37 52.64 27.00 28.00 Administrative & General under 2, 430, 831 2, 430, 831 9, 798. 00 248.09 28.00 contract (see inst.) Maintenance & Repairs 6.00 29.00 184, 550 184, 550 4. 170. 29 44. 25 29.00 0 Operation of Plant 29. 10 30.00 7.00 4, 119, 192 0 4, 119, 192 141, 551. 32 30.00 31.00 Laundry & Linen Service 8.00 0 0.00 0.00 31.00 32.00 Housekeepi ng 9.00 0 3, 614, 617 182, 230. 12 19. 84 32.00 3, 614, 617 Housekeeping under contract 33.00 0.00 C 0.00 33.00 (see instructions) Di etary 34.00 10.00 3, 550, 061 -1, 424, 832 2, 125, 229 94, 035. 51 22. 60 34.00 Dietary under contract (see instructions) 0.00 35.00 0.00 35.00 60, 147. 00 36, 00 Cafeteri a 11.00 0 1, 424, 832 1, 424, 832 23.69 36.00 Maintenance of Personnel 0.00 37.00 12.00 0 0.00 37.00 38.00 Nursing Administration 13.00 4, 388, 809 4, 380, 185 68, 942. 59 63. 53 38.00 -8, 624 39.00 Central Services and Supply 14.00 2, 060, 682 2, 060, 682 74, 557. 25 27. 64 39.00 -61, 090 126, 378. 44 40.00 Pharmacy 15.00 6, 212, 705 6, 151, 615 48. 68 40.00 41.00 Medical Records & Medical 16.00 1, 284, 573 -37, 283 1, 247, 290 40, 455. 54 30. 83 41. 00 Records Library Social Service 17.00 62, 625. 83 48. 13 42. 00 42.00 3, 014, 899 -535 3, 014, 364 43.00 Other General Service 18 00 0 00 0.00 43.00

					T	o 12/31/2023	Date/Time Prep 5/20/2024 2:3	
		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 ± 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		188, 883, 450	-9, 556, 148	179, 327, 302	4, 049, 623. 02	44. 28	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 875, 656	348, 866	4, 224, 522	93, 034. 54	45. 41	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		185, 007, 794	-9, 905, 014	175, 102, 780	3, 956, 588. 48	44. 26	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		38, 909, 920	0	38, 909, 920	508, 188. 27	76. 57	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		55, 309, 884	0	55, 309, 884	0.00	31. 59	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		279, 227, 598	-9, 905, 014	269, 322, 584	4, 464, 776. 75	60. 32	6. 00
7.00	Total overhead cost (see		45, 364, 734	-2, 712, 313	42, 652, 421	1, 095, 609. 66	38. 93	7. 00
	instructions)							

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 31-0041	Peri od:	Worksheet S-3
		From 01/01/2023 To 12/31/2023	Part IV   Date/Time Prenared:

	To 12/31/20	23 Date/Time Pre 5/20/2024 2:3	
		Amount	D piii
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		İ
	RETI REMENT COST		1
1.00	401K Employer Contributions	7, 654, 715	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	304, 253	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	740, 640	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	1, 868, 710	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)	22, 660, 694	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	413, 736	
11. 00	Life Insurance (If employee is owner or beneficiary)	116, 116	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	796, 176	
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	225, 491	
15. 00	'Workers' Compensation Insurance	1, 376, 029	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
47.00	TAXES	11 150 010	1
17. 00	FICA-Employers Portion Only	11, 452, 240	
18. 00	Medicare Taxes - Employers Portion Only	1, 968, 665	
19. 00	Unemployment Insurance	265, 170	
20. 00	State or Federal Unemployment Taxes	0	20. 00
21 00	OTHER		01 00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (seinstructions))	ee 0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	403, 981	
24. 00		50, 246, 616	
24.00	Part B - Other than Core Related Cost	1 30, 240, 010	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
20.00	10E	1	0.00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od:	Worksheet S-3	
	F	rom 01/01/2023	Part V	
		o 12/31/2023	Date/Time Pre	oared:
			5/20/2024 2: 3	5 pm
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identif	fi cati on:			
1 00		/ 000 047	EO 047 747	4 00

	Cost Center Description	Contract Labor	Benefit Cost	
		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	6, 993, 017	50, 246, 616	1.00
2.00	Hospi tal	6, 993, 017	50, 246, 616	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY	0	0	8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18. 00	Other	0	0	18. 00

	Financial Systems	COMMUNITY MEDIC			In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der CC		Period: From 01/01/2023 To 12/31/2023		pared:
	DART I HOCKLIAL AND HOCKLIAL COMPLEY	DATA				1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX Uncompensated and Indigent Care Cost-to						+
1. 00	Cost to charge ratio (see instructions)					0. 178216	1.00
1.00	Medicaid (see instructions for each lin					0.170210	1.00
2.00	Net revenue from Medicaid	10)				41, 128, 401	2.00
3.00	Did you receive DSH or supplemental pay	vments from Medicaid?				Υ Υ	3. 00
4. 00	If line 3 is yes, does line 2 include a		ental payment	s from Medicai	d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or					3, 296, 836	5.00
6.00	Medicaid charges	11 1 3				321, 415, 593	1
7.00	Medicaid cost (line 1 times line 6)					57, 281, 401	
8.00	Difference between net revenue and cost	ts for Medicaid program	n (see instru	ctions)		12, 856, 164	8. 00
	Children's Health Insurance Program (Ch	HIP) (see instructions	for each lin	e)			
9.00	Net revenue from stand-alone CHIP					0	1
10.00	Stand-alone CHIP charges					0	1
11. 00	Stand-alone CHIP cost (line 1 times lin					0	1 00
12. 00	Difference between net revenue and cost					0	12. 00
40.00	Other state or local government indiger					100 (0)	40.00
13. 00 14. 00	Net revenue from state or local indiger Charges for patients covered under state					129, 636	1
14.00	10)	te or rocal indigent ca	ire program (	Not included i	n rines o or	3, 718, 058	14.00
15. 00	State or local indigent care program co	ost (line 1 times line	14)			662, 617	15. 00
16. 00	Difference between net revenue and cost			program (see	instructions)	532, 981	
	Grants, donations and total unreimburse	ed cost for Medicaid, C	HIP and state	e/local indige	ent care program	ns (see	
	instructions for each line)						
	Private grants, donations, or endowment					0	
18. 00	Government grants, appropriations or to					0	1
19. 00	Total unreimbursed cost for Medicaid, 8, 12 and 16)	CHIP and state and loc	al indigent	care programs	(sum of lines	13, 389, 145	19. 00
	[6, 12 dilu 10)			Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col . 2)	
				1. 00	2. 00	3.00	
	Uncompensated care cost (see instruction	ons for each line)					
20. 00	Charity care charges and uninsured disc	counts (see instruction	ıs)	59, 929, 63	6 873, 201	60, 802, 837	20.00
21.00	Cost of patients approved for charity (instructions)	care and uninsured disc	counts (see	10, 680, 420	873, 201	11, 553, 621	21. 00
	Payments received from patients for amo	ounts previously writte	n off as	(	0	0	22. 00
22. 00				·		1	1
22. 00	charity care					1	1
22. 00 23. 00	9	)		10, 680, 420	873, 201	11, 553, 621	23. 00
	charity care	)		10, 680, 420	873, 201	11, 553, 621	23. 00

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

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

Charges for insured patients' liability (see instructions)

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

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

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

0 25.00

22, 649, 391

1, 227, 629

1, 888, 661

20, 760, 730

15, 914, 547

4, 360, 926

29, 303, 692 31. 00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

25.00

25. 01

27.01

28.00

stay limit

	Financial Systems COMMUNITY MEDICAL C			u of Form CMS-2	
OSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 31-0041	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prep 5/20/2024 2:35	pared
			•	1. 00	
	PART II - HOSPITAL DATA			1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
00	Cost to charge ratio (see instructions)			0. 176515	1.
	Medicaid (see instructions for each line)		1		
00	Net revenue from Medicaid				2.
00	Did you receive DSH or supplemental payments from Medicaid?		: -10		3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental		card?		4.
00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges	medi cai d			5.
00	Medicaid charges Medicaid cost (line 1 times line 6)				6. 7.
00	Difference between net revenue and costs for Medicaid program (se	o instructions)			8.
00	Children's Health Insurance Program (CHIP) (see instructions for				0.
00	Net revenue from stand-alone CHIP	cacii i i iic)			9.
0. 00	Stand-allone CHIP charges				10.
. 00	Stand-alone CHIP cost (line 1 times line 10)				11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (se	e instructions)			12.
	Other state or local government indigent care program (see instru		e)		
. 00	Net revenue from state or local indigent care program (Not includ				13.
. 00	Charges for patients covered under state or local indigent care p	rogram (Not include	din lines 6 or	l	14.
	10)				l
5. 00	State or local indigent care program cost (line 1 times line 14)				15.
	Difference between net revenue and costs for state or local indig				16.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a	and state/local ind	gent care program	s (see	
	instructions for each line)				
	Private grants, donations, or endowment income restricted to fund	9			17.
3. 00	Government grants, appropriations or transfers for support of hos		(6 1:		18.
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)	ndigent care progra	ns (sum of lines		19.
	0, 12 and 10)	Uni nsured	I Insured	Total (col. 1	
		patients		+ col . 2)	
		1.00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)				
0. 00	Charity care charges and uninsured discounts (see instructions)	59, 929,		60, 778, 417	20.
. 00	Cost of patients approved for charity care and uninsured discount	s (see 10, 578,	480 848, 781	11, 427, 261	21.
	instructions)				
2. 00	Payments received from patients for amounts previously written of	f as	0 0	0	22.
	charity care	10 570	400 040 701	11 407 0/1	22
3. 00	Cost of charity care (see instructions)	10, 578,	480 848, 781	11, 427, 261	23.
				1. 00	
. 00	Does the amount on line 20 col. 2, include charges for patient da	vs hevond a Length	nf stav limit	N N	24.
r. 00	imposed on patients covered by Medicaid or other indigent care pr		Ji Stay IIIII t	14	27.
5. 00	If line 24 is yes, enter the charges for patient days beyond the		am's Lenath of	0	25.
	stay limit	50 ca. c pi ogi		ŭ	
5. 01	Charges for insured patients' liability (see instructions)			o	25.
. 00	Bad debt amount (see instructions)			22, 631, 422	
. 00	Medicare reimbursable bad debts (see instructions)			1, 227, 629	
7. 01	Medicare allowable bad debts (see instructions)			1, 888, 661	27.
'. UI	medicale di lowable bad debts (see l'isti detions)				

4, 322, 440 29. 00 15, 749, 701 30. 00 15, 749, 701 31. 00

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Cost Center Description		Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	COMMUNITY MEDI	_	^N: 21 0041 E	In Lie Period:	Worksheet A	2552-10
Desire Center Description	RECLAS	STRICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EAPENSES	Provider Co	F	rom 01/01/2023		
Cost Center Description					Τ	o 12/31/2023	Date/Time Pre	pared:
Company   Comp		Cost Center Description	Salaries	Other	Total (col 1	Reclassificati		5 piii
SEIERDL SERVICE COST CRITERS   1.00   2.00   3.00   4.00   5.00   1.00		2001 201101 20001   pt. 0.1	00.0.700	010.				
					ŕ			
CREADED SERVICE COST SERVERS   11,111,110,000   11,111,110,000   12,000   13,810,000   12,000   13,810,000   12,000   13,810,000   12,000   13,810,000   12,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,810,000   13,910,000								
1.00   001000 CAP REL COSTS-BLUE & FIRX   1,111, Yes   1,111, Yes   1,111, Yes   3,000, 753   9,300, 753   2,208, 702   2,208, 703   3,300, 703		CENEDAL CEDALCE COCT CENTEDS	1.00	2. 00	3.00	4. 00	5. 00	
2.00 000000   000000   000000   000000	1 00			11 111 968	11 111 968	2 698 092	13 810 060	1 00
3.00 DOUGNO FINE CAP BEL COSTS 3  5.00 DOUGNO FINE CAP BEL COSTS 3  6.00 DOUGNO FINE CAP BELD COSTS 3  6.00								1
5.00   DOSCOOL JARMIN INSTRATIVE A GENERAL   13,100,000   117,93,944   131,762,000   2,016,460   22,745,541   5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							1	1
6.00   000000   MAINTENANCE & REPAIRS   181, 500   517, 619   702, 169   -3, 122   909, 044   0.0								
0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.000000   0.00000000								
8.00   000000 LAURORY & LINEN SERVICE   0   0   0   1, 129, 806   2, 90, 70   000000 DISTARY   1, 1891, 1811   1, 1897, 181								
9.00   00000   MUSIEKEERI NG			4, 117, 172	0, 717, 747				1
11.00   01100  CAFFTERIA			3, 614, 617	1, 871, 181	5, 485, 798			
13.00 (0.3100) NIRSING ADMINISTRATION ( 4, 888, 899		1 1	3, 550, 061	3, 548, 778	7, 098, 839			
14 00 01 01400 CENTRAL SERVICES & SUPPLY		1 1		-	1			1
19.00   01500   PIAMBIACY   6, 212, 705   42, 420, 665   48, 633, 370   -42, 314, 906   6, 318, 864   15.0   0100   0100   01700   SOCIAL SERVICE   3, 144, 899   1, 627, 691   4, 642, 996   -67, 606   4, 575, 530   77.0   02, 200   1200   22100   128 SERVICES-OTHER PROW   5, 002, 429   3, 224, 551   11, 226, 880   -7, 077, 639   4, 149, 341   32.0   02, 200   188 SERVICES-SALARY & FRINGES APRIVO   5, 002, 429   3, 224, 551   11, 226, 880   -7, 077, 639   4, 149, 341   32.0   02, 200   188 SERVICES-SALARY & FRINGES APRIVO   5, 002, 429   3, 224, 551   11, 226, 880   -7, 077, 639   4, 149, 341   32.0   03, 300								
10.00   10.00   MEDICAL RECORDS & LIBRARY   1,284,573   438,405   1,722,978   0   1,722,978   10.00   1,722,978   10.00   1,700   1,								
17.00   01700   SOCIAL SERVICE   3,011,899   1,627,691   4,642,990   -67,000   4,575,530   77.0   72.10   02100   12010   128 SERVICES-SALARY & FRINCES APPRIVO   1,000,479   3,224,551   11,226,980   -7,077,639   4,149,341   22.0   02.00   0200   188 SERVICES-OTHER PROM. COSTS APPRIVO   1,456,020   3,234,551   11,226,980   -7,077,639   4,149,341   22.0   02.00   02		1 1						
22 00   02000   IAR SERVICES-OTHER PROM. COSTS APPRVD   8.002, 429   3.244, 654   311, 226, 980   -7, 077, 639   4, 149, 341   22 0 0 0 0 0000 (ADUITS & PEROM. (SPCIETY)   145, 656   36, 636   181, 992   61, 099   243, 082   23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
1.00   1.00		1 1	0	· ·				
IMPATI ENT ROUTINE SERVICE COST CENTERS   36, 403, 501   8, 995, 603   45, 389, 244   -4, 028, 116   41, 361, 128   30. 00   30.00   03.100   03.								
30.00   30000   ADULT S A PEDIATRICS   30.403,561   8, 985,683   45, 389,244   -4,028,116   41,361,128   30.0   30.0	23. 00		145, 626	36, 366	181, 992	2 61, 090	243, 082	23. 00
31.00 0 31000 INTENSIVE CARE UNIT	30 00		36 403 561	0 005 603	45 380 247	-4 028 116	/1 361 120	30 00
34 00 03400 NURSERY 0.0 04400								
43.00   04300   NURSERY   1.085,622   3.608   1.089,230   2.147,401   3.236,721   42.0								
## ANCILLARY SERVICE COST CENTERS    ANCILLARY SERVICE COST CENTERS		1 1						
50.00	44.00		3, 487, 887	1, 565, 110	5, 052, 997	-975, 094	4, 077, 903	44.00
51.00   05100   RECOVERY ROOM   ALBOR ROOM   1.689, 446   107, 252   1.796, 698   -78, 477   1.718, 221   51.00   5200   0611/EVERY ROOM   ALBOR ROOM   3.730, 136   533, 562   4.63, 698   -631, 550   3.632, 148   52.0   52.0   03190   0F1 INFUSION   1.773, 232   259, 491   2.032, 723   2.515, 237   1.817, 486   52.0   05400   RADI DLOGY-DI AGNOSTI C   7.149, 373   5.797, 183   12.946, 556   -2.547, 602   10.399, 594   54.0   05400   RADI DLOGY-DI AGNOSTI C   3.730, 885   2.798, 891   12.946, 556   -2.547, 602   10.399, 594   54.0   05.00   05500   RADI DLOGY-PHERAPEUTI C   3.730, 885   927, 599   1.481, 284   50.414   1.531, 698   56.0   05600   RADI DLOGY-DI HERAPEUTI C   3.730, 885   927, 599   1.481, 284   50.414   1.531, 698   56.0   05600   RADI DLOGY-DI AGNOSTI C   2.112, 862   927, 599   1.481, 284   50.414   1.531, 698   56.0   05600   RADI DLOGY-DI AGNOSTI C   2.112, 862   927, 599   1.481, 284   50.414   1.531, 698   56.0   05600   RADI DLOGY-DI AGNOSTI C   2.112, 862   927, 599   1.481, 284   50.414   1.531, 698   56.0   05600   RADI AGNOSTI C   2.128, 662   2.47, 218   1.113, 877   -2.67, 665   1.087, 112   86.0   05800   RADI AGNOSTI C   2.00   0.00	F0 00		10 547 704	0/ 444 /40	0, 000 070	00.470.404	40.004.400	F0 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   3,730,136   533,562   4,263,698   -6.31,550   3,632,148   52.0   03700   0   NHUSION   1,773,232   259,491   2,032,722   -2.15,237   1,817,486   52.0   03500   05500   AND STRYPHSIOLOGY   104,849   1,549,226   1,654,075   -5.47,124   1,100,951   53.0   05500   AND OLOGY-THERAPPUTIC   7,149,373   5,797,183   12,946,556   -2,647,602   10,399,954   54.0   05600   RADIOLOGY-THERAPPUTIC   3,730,885   2,418,289   6,149,174   661,146   6,810,320   55.0   05500   RADIOLOGY-THERAPPUTIC   538,685   927,599   1,481,284   50,414   1,531,698   55.0   05700   CT SCAN   2,112,862   979,724   3,092,586   -126,398   2,966,188   57.0   05700   CT SCAN   866,659   247,218   1,138,977   -26,765   1,087,112   59.0   05900   CARDIA C CATHETERI ZATI ON   3,572,256   7,230,706   10,802,962   -6,596,461   4,206,501   59.0   05000   CARDIA C CATHETERI ZATI ON   3,572,256   7,230,706   10,802,962   -6,596,461   4,206,501   59.0   06000   LABORATORY   63.00   05800   RESPIRATORY THERAPY   3,088,770   12,110,464   2,337,867   273,153   2,611,020   66.00   06600   PHYSI CAL THERAPY   2,226,821   111,046   2,337,867   273,153   2,611,020   66.00   06600   PHYSI CAL THERAPY   1,286,761   4,876,188   0   1,882,281   0   1,882,281   0   0   0   0   0   0   0   0   0		1 1	1					1
1.03190   OP INFUSION			1					1
53.00   05300   ANESTHESI OLOGY   104, 849   1.549, 226   1.664, 075   -547, 124   1.106, 951   53.00   05500   RADI OLOGY-THERAPEUTI C   3, 730, 885   2.418, 289   6, 149, 174   661, 146   6, 810, 320   55.00   05500   RADI OLOGY-THERAPEUTI C   3, 730, 885   2.418, 289   6, 149, 174   661, 146   6, 810, 320   55.00   05500   RADI OLOGY-THERAPEUTI C   3, 730, 885   2.418, 289   6, 149, 174   661, 146   6, 810, 320   55.00   05500   RADI OLOGY-THERAPEUTI C   3, 730, 885   2.418, 289   6, 149, 174   661, 146   6, 810, 320   55.00   05500   RADI OLOGY-THERAPEUTI C   3, 730, 885   2.418, 289   6, 149, 174   661, 146   6, 810, 320   55.00   05500   RADI OLOGY-THERAPEUTI C   3, 730, 885   2.418, 289   6, 149, 174   661, 146   6, 810, 320   57.00   67.0			1					
55.00   OSDOO   RADIO LOGY-THERAPEUTIC   3, 730, 885   2, 418, 289   6, 149, 174   661, 146   6, 810, 320   55.0   65.00   OSDOO   CT SCAN   2, 112, 862   979, 724   3, 092, 586   -126, 398   2, 966, 188   57.0   67.00   05700   CT SCAN   2, 112, 862   979, 724   3, 092, 586   -126, 398   2, 966, 188   57.0   67.00   05900   CARDIAC CATHETERIZATION   3, 572, 256   7, 230, 706   10, 802, 962   -6, 596, 461   4, 206, 501   59.0   05900   CARDIAC CATHETERIZATION   3, 572, 256   7, 230, 706   10, 802, 962   -6, 596, 461   4, 206, 501   59.0   05900   CARDIAC CATHETERIZATION   3, 572, 256   7, 230, 706   10, 802, 962   -6, 596, 461   4, 206, 501   59.0   05900   CARDIAC CATHETERIZATION   3, 588, 477   1, 287, 671   4, 876, 148   -471, 610   4, 404, 538   65.0   06500   RESPIRATIONY THERAPY   2, 226, 821   1111, 046   2, 337, 867   273, 153   2, 611, 202   66.0   06600   PHYSI CAT HERAPY   2, 226, 821   111, 046   2, 337, 867   273, 153   2, 611, 202   66.0   06600   PHYSI CAT HERAPY   1, 186, 702   1, 536   1, 188, 238   0   1, 188, 238   67.0   06700   05000   SPECCH PATHOLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 773   3, 790, 446   69.0   06900   ELECTROCARDIOLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 773   3, 790, 446   69.0   070, 00   07000   ELECTROCARDIOLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 373   3, 790, 446   69.0   070, 00   07000   ELECTROCARDIOLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 373   3, 790, 446   69.0   070, 00   07000   ELECTROCARDIOLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 373   3, 790, 446   69.0   070, 00   07000   ELECTROCARDIOLOGY   2, 431, 549   1, 265, 661   525, 260   1, 790, 921   -35, 322   1, 755, 599   70.0   70.0   70.00		05300 ANESTHESI OLOGY	1					
56.00   OBGOO   RADIO I SOTOPE   553, 685   927, 599   1, 481, 284   50, 414   1, 531, 698   56. 0   70.00   570.00   TSCON   2, 112, 86.0   797, 724   1, 113, 877   -26, 765   10, 987, 112   88.0   798, 200   OBGOO   CARDIAC CATHETERI ZATI ON   3, 572, 256   7, 230, 706   10, 802, 962   -6, 596, 461   4, 606, 501   59   60.00   06000   LABORATORY   1, 287, 771   1, 287, 671   4, 287, 1171   125, 680   19, 298, 851   60.00   06000   RADIRATORY   1, 287, 671   4, 407, 148   4-47, 101   4, 404, 538   65.00   06500   RESPI RATORY THERAPY   2, 226, 821   111, 046   2, 337, 867   273, 153   2, 611, 020   66.00   06600   PSPI SCAL THERAPY   1, 186, 702   1, 536   1, 188, 238   0, 1			1					1
57.00   05700   CT SCAN   2,112,862   979,724   3,092,866   -126,398   2,966,188   57.00   59.00   05900   CARDIAC CATHETERIZATION   3,572,256   7,230,706   10,802,962   -6,596,461   4,206,501   59.00   06300   BODO STORING, PROCESSING & TRANS.   0   1,287,671   125,680   17,298,851   60.00   0600   08500   PRISTICAT HERAPY   3,588,477   1,287,671   4,876,148   -471,610   4,404,538   65.00   06500   PRISTICAT HERAPY   2,226,821   111,046   2,337,867   273,153   2,611,020   66.00   0600   PRISTICAT HERAPY   1,886,702   1,536   1,188,238   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,882,386   7.0   1,900   2.0   1,90			1					
58.00   OSBOO   MR    866, 659   247, 218   1, 113, 877   -26, 765   1, 087, 112   58.00   059, 00   05900   CARDIAC CATHETERI ZATION   3, 572, 256   7, 230, 706   10, 802, 962   -6, 596, 461   4, 206, 501   59.00   0500   06300   LABORATORY   HERAPY   3, 588, 477   1, 287, 671   4, 876, 148   -471, 610   4, 404, 538   65.00   06500   RESPIRATORY   HERAPY   2, 226, 821   111, 046   2, 337, 867   273, 153   2, 611, 020   66.00   06500   OSCOO   OCCUPATIONAL THERAPY   2, 226, 821   111, 046   2, 337, 867   273, 153   2, 611, 020   66.00   0600   OSCOO   OCCUPATIONAL THERAPY   1, 186, 702   1, 156   1, 188, 238   00   1, 188, 238   67.00   0800   SPECH PATHOLOGY   339, 797   2, 210   342, 007   0 342, 007   0 342, 007   0 400, 00   0900   LECTROCARDIOLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 773   3, 790, 446   69.00   0900   OSCOO   ELECTROCARDIOLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 773   3, 790, 446   69.00   0700   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			i i					
59, 00   05900   CARDI AC CATHETERI ZATION   3,572,256   7,230,706   10,802,962   -6,596,461   4,206,501   59,00   06000   CABORATORY   30,084   71,111   125,680   19,276,880   19,173,171   125,680   19,288,851   60.0   0   0   0   0   0   0   0   0   0								
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0								
65 00   06500   RESPI RATORY THERAPY   3, 588, 477   1, 287, 671   4, 876, 148   -471, 610   4, 404, 538   65. 0		1 1	30, 084	19, 143, 087	19, 173, 171	125, 680	19, 298, 851	
66.00   06600   PHYSI CAL THERAPY   2, 226, 821   111, 046   2, 337, 867   273, 153   2, 611, 020   66, 06, 06, 00   06700   0CCUPATI ONAL THERAPY   1, 186, 702   1, 536   1, 188, 238   0   1, 188, 238   67. 06, 00   06800   SPEECH PATHOLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 773   3, 790, 446   69. 00   06, 00   00   00   00   00   00			1	0		0		
67.00   06700   05CUPATI ONAL THERAPY   1, 186, 702   1, 536   1, 188, 238   0   1, 188, 238   67. 0   06800   06800   SPEECH PATHOLOGY   339, 707   2, 210   342, 007   0. 0   342, 007   68. 00   06900   ELECTROCARDI OLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 773   3, 790, 446   69. 0   070		1 1						
68.00   06800   SPEECH PATHOLOGY   339, 797   2, 210   342, 007   0   342, 007   68, 00   06900   ELECTROCARDIOLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 773   3, 790, 446   69, 00   07000   ELECTROENCEPHALOGRAPHY   1, 265, 661   525, 260   1, 790, 921   -35, 322   1, 755, 599   70. 01   07001   SLEEP LAB   0   0   0   0   0   0   0   0   0								
69.00   06900   ELECTROCARDI OLOGY   2, 431, 549   1, 396, 670   3, 828, 219   -37, 773   3, 790, 446   69.00								1
70. 01   07001   SLEEP LAB								
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   20,617,901   20,617,901   71. 072. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   18,871,711   18,871,711   72. 0   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   44,840,108   44,840,108   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   44,840,108   44,840,108   73. 00   07697   CARDI AC REHABI LITATI ON   622,329   28,100   650,429   -4,309   646,120   76.98   76.98   07698   HYPERBARI C OXYGEN THERAPY   0   314,307   314,307   -16,016   298,291   76.99   77. 00   0700   ALLOGENEI C STEM CELL ACQUI SITI ON   0   0   0   0   0   0   0   0   0	70.00	1 1	1, 265, 661	525, 260	1, 790, 921	-35, 322	1, 755, 599	
72. 00 07200   MPL   DEV CHARGED TO PATIENTS   0   0   0   18,871,711   18,871,711   72. 0 73. 00 07300   DRUGS CHARGED TO PATIENTS   0   0   0   44,840,108   44,840,108   44,840,108   73. 0 76. 97   07697   CARDI AC REHABI LITATI ON   622,329   28,100   650,429   -4,309   646,120   76. 97 76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   314,307   314,307   -16,016   298,291   76. 97 77. 00   07700   ALLOGENEI C STEM CELL ACQUI SITI ON   0   0   0   0   0   0   0  78. 00   07800   CAR T-CELL I MUNINOTHERAPY   0   0   0   0   0   0   0  00   0   0		1 1	0	0	C	_		
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   44, 840, 108   44, 840, 108   73. 076. 97   07697   CARDI AC REHABI LI TATI ON   622, 329   28, 100   650, 429   -4, 309   646, 120   76. 97   76. 98   76. 98   76. 98   76. 98   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   0   0   0   0   0   0			0	0				
76. 97   07697   CARDI AC REHABI LITATION   622, 329   28, 100   650, 429   -4, 309   646, 120   76. 976. 98   07698   HYPERBARI C OXYGEN THERAPY   0   314, 307   314, 307   -16, 016   298, 291   76. 977. 00   0770   ALLOGENEI C STEM CELL ACQUI SITION   0   0   0   0   0   0   0   0   0				0				
76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   314, 307   314, 307   -16, 016   298, 291   76. 97. 00   07700   ALLOGENEIC STEM CELL ACQUI SI TI ON   0   0   0   0   0   0   0   0   0			622, 329	28. 100	650, 429			1
77. 00   07700   ALLOGENEI C STEM CELL ACQUISITION   0   0   0   0   0   0   0   77. 0   78. 0   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   78. 0   0   78. 0   0   0   0   0   78. 0   0   0   0   0   0   78. 0   0   0   0   0   0   0   0   0   78. 0   0   0   0   0   0   0   0   0   0			0					
OUTPATIENT SERVICE COST CENTERS   177, 999   1, 158, 041   1, 336, 040   -497, 424   838, 616   90. 09100   09100   EMERGENCY   14, 491, 324   8, 928, 990   23, 420, 314   -2, 469, 794   20, 950, 520   91. 09200   09200   095ERVATI ON BEDS (NON-DI STI NCT PART   92. 01   09201   095ERVATI ON BEDS-DI STI NCT   3, 871, 572   800, 523   4, 672, 095   -283, 139   4, 388, 956   92. 00   09500   AMBULANCE SERVI CES   0   1, 120, 361   1, 120, 361   0   1, 120, 361   95. 00   102.00   102.00   09101 D TREATMENT PROGRAM   0   0   0   0   0   0   102.00   SPECI AL PURPOSE COST CENTERS   4, 794, 960   4, 794, 960   -4, 794, 960   -4, 794, 960   113. 00   113.00   1300   INTEREST EXPENSE   4, 794, 960   4, 794, 960   4, 794, 960   -4, 794, 960   113. 00   113.00   1000   0			O	0			0	
90. 00	78. 00		0	0	(	0	0	78. 00
91. 00	00.00		177 000	1 150 041	1 22/ 04/	407.424	020 (1)	00.00
92. 00								
92. 01   09201   0BSERVATI ON BEDS-DI STI NCT   3,871,572   800,523   4,672,095   -283,139   4,388,956   92. 0			14, 471, 324	0, 720, 770	25, 420, 514	-2,407,774	20, 730, 320	92.00
95. 00			3, 871, 572	800, 523	4, 672, 095	-283, 139	4, 388, 956	
102.00   10200   OPI OI D TREATMENT PROGRAM   O   O   O   O   O   O   102.00								
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   4,794,960   4,794,960   -4,794,960   0   113.00   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   187,686,567   336,020,425   523,706,992   173   523,707,165   118.00   NONREI MBURSABLE COST CENTERS   194.00   07950   MI SCELLANEOUS   0   0   0   0   0   0   194.00   194.01   07951   PUBLIC RELATIONS   0   384   384   0   384   194.00   194.03   07952   LI GHTHOUSE   46,922   160   47,082   0   47,082   194.04   194.04   07953   KI DS & FAMILY   0   0   0   0   0   0   194.00   194.05   07954   OTHER NON REI MBURABLE   194,375   55,989   250,364   -173   250,191   194.05			l I					
113.00	102.00		0	0		0	0	102.00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   187, 686, 567   336, 020, 425   523, 706, 992   173   523, 707, 165   118. 0   NONREI MBURSABLE COST CENTERS   0	113 00			/ 70/ 06O	1 701 060			113 00
NONREI   MBURSABLE   COST   CENTERS     194. 00   07950   MI SCELLANEOUS   0   0   0   0   0   194. 00			187 686 567					
194. 00     07950     MI SCELLANEOUS     0     0     0     0     194. 0       194. 01     07951     PUBLI C RELATI ONS     0     384     384     0     384     194. 0       194. 03     07952     LI GHTHOUSE     46, 922     160     47, 082     0     47, 082     194. 0       194. 04     07953     KI DS & FAMI LY     0     0     0     0     0     194. 0       194. 05     07954     OTHER NON REI MBURABLE     194, 375     55, 989     250, 364     -173     250, 191     194. 0			, 300, 307	333, 320, 123	1 020, 700, 772		, 525,757,765	1
194. 03 07952 LI GHTHOUSE     46, 922     160     47, 082     0     47, 082     194. 0       194. 04 07953 KI DS & FAMI LY     0     0     0     0     0     0     194. 0       194. 05 07954 OTHER NON REIMBURABLE     194, 375     55, 989     250, 364     -173     250, 191 194. 0		07950 MI SCELLANEOUS	0	-			0	194. 00
194. 04 07953 KI DS & FAMI LY 0 0 0 0 0 194. 0 194. 05 07954 OTHER NON REIMBURABLE 194. 375 55, 989 250, 364 -173 250, 191 194. 0			0					
194. 05 07954 OTHER NON REIMBURABLE 194, 375 55, 989 250, 364 -173 250, 191 194. 0		1 1	46, 922					
			104 275	· ·		1		
		· · ·			., 550		., .,	

Heal th Financ	cial Systems	COMMUNITY MED	ICAL CENTER		In Lie	eu of Form CMS-	2552-10
RECLASSI FI CA	TION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Peri od:	Worksheet A	
				l -	rom 01/01/2023		
					lo 12/31/2023	Date/Time Pre	
						5/20/2024 2: 3	5 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
194. 07 07956	RETAIL PHARMACY	0	C	)	0	0	194. 07
200.00	TOTAL (SUM OF LINES 118 through 199)	187, 928, 710	336, 077, 470	524, 006, 180	0	524, 006, 180	200. 00

Heal th	Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN	l: 31-0041	Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
						5/20/2024 2:3	35 pm
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7. 00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	-837, 233	· · · · · · · · · · · · · · · · · · ·				1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS	-704, 534 0	10, 884, 360 0				2. 00 3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 813, 043					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-26, 682, 713					5. 00
6.00	00600 MAINTENANCE & REPAIRS	-17, 946					6.00
7.00	00700 OPERATION OF PLANT	-115, 734	12, 921, 060				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 219, 806				8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG	-671	5, 398, 756				9.00
11. 00	01000 DI ETARY 01100 CAFETERI A	-21, 122 -1, 380, 090	4, 217, 341 1, 454, 585				10.00
13. 00	01300 NURSING ADMINISTRATION	-70, 301	4, 782, 821				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-210, 333					14. 00
15. 00	01500 PHARMACY	-1, 989					15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-682	1, 722, 296				16. 00
17. 00	01700 SOCIAL SERVICE	-29, 629	4, 545, 901				17. 00
21. 00 22. 00	02100   L&R SERVICES-SALARY & FRINGES APPRVD   02200   L&R SERVICES-OTHER PRGM. COSTS APPRVD	0 -39, 739	5, 721, 009 4, 109, 602				21. 00 22. 00
23. 00	1	-685	242, 397				23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		212/0//				20.00
30.00	03000 ADULTS & PEDI ATRI CS	-3, 094, 693					30.00
31. 00	03100 INTENSIVE CARE UNIT	-59, 708	· · · · · · · · · · · · · · · · · · ·				31. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	-437	3, 848, 226				34.00
43.00	04300 NURSERY	-474	3, 236, 247				43. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	-7, 590	4, 070, 313				44. 00
50. 00		-131, 417	13, 690, 272				50.00
51.00	05100 RECOVERY ROOM	-1, 114	1, 717, 107				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-4, 835	3, 627, 313				52. 00
52. 01	03190 OP INFUSION	-6, 102	1, 811, 384				52. 01
53.00	05300 ANESTHESI OLOGY	-986, 955	119, 996				53. 00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	-2, 006, 158 -292, 234					54. 00 55. 00
56. 00	05600 RADI OLOGI - MERAPEUTI C	-242, 234	6, 518, 086 1, 531, 489				56.00
57. 00	05700 CT SCAN	-2, 653	2, 963, 535				57. 00
58. 00	05800 MRI	-8, 557	1, 078, 555				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-89, 231	4, 117, 270				59. 00
60.00	06000 LABORATORY	-877, 154	18, 421, 697				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-62, 542 -22, 184	4, 341, 996 2, 588, 836				65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-1, 443	· · · · · · · · · · · · · · · · · · ·				67. 00
68. 00	06800 SPEECH PATHOLOGY	-1, 723	· · · · · · · · · · · · · · · · · · ·				68.00
69. 00		-17, 384	3, 773, 062				69. 00
70. 00		-406, 769	1, 348, 830				70. 00
70. 01	07001 SLEEP LAB	0	0 (17, 007				70. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	-864 -1, 294	20, 617, 037 18, 870, 417				71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-1, 294	44, 837, 283				73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	-5, 734	640, 386				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	298, 291				76. 98
77. 00	1	0	0				77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
00 00	OUTPATIENT SERVICE COST CENTERS	20. 274	010 242				1 00 00
90. 00 91. 00	09000   CLI NI C   09100   EMERGENCY	-28, 274 -2, 550, 006					90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	-2, 330, 000	10, 400, 314				92. 00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	-10, 807	4, 378, 149				92. 01
	OTHER REIMBURSABLE COST CENTERS						
95. 00		20, 156	1, 140, 517				95. 00
102. 0	10200 OPIOID TREATMENT PROGRAM	0	0				102. 00
112 0	SPECIAL PURPOSE COST CENTERS						1112 00
113.0	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	0 -38, 961, 572					113. 00 118. 00
110.0	NONREI MBURSABLE COST CENTERS	-30, 701, 372	404, 743, 373				1110.00
194. 0	07950 MI SCELLANEOUS	0	0				194. 00
194.0	1 07951 PUBLIC RELATIONS	0	384				194. 01
	07952 LI GHTHOUSE	0	47, 082				194. 03
	4 07953 KIDS & FAMILY	0	0				194. 04
	5 07954 OTHER NON REIMBURABLE	0	250, 191				194. 05
	6 07955 GRANTS/TRIALS 7 07956 RETAIL PHARMACY	0	1, 358				194. 06 194. 07
200. 0		-38, 961, 572					200.00
		, .,, ., .,					

	Financial Systems		COMMUNITY MED				u of Form CMS	
RECLAS	SIFI CATIONS			Provider C	CN: 31-0041	Peri od: From 01/01/2023	Worksheet A-	
						To 12/31/2023	Date/Time Pr 5/20/2024 2:	
	Cost Center	Increases Line #	Salary	Other				
	2. 00	3.00	4. 00	5. 00				
1.00	A - MEDICAL SURGICAL SUPPLIES			00 (47 004				1 00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	20, 617, 901				1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	208				2. 00
3. 00 4. 00		0. 00 0. 00	0	0				3. 00 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	o				9. 00
10.00		0.00	0	0				10.00
11. 00 12. 00		0. 00 0. 00	0	0				11. 00 12. 00
13. 00		0.00	0	o				13. 00
14.00		0.00	0	0				14.00
15. 00 16. 00		0. 00 0. 00	0	0				15. 00 16. 00
17. 00		0. 00	0	Ō				17. 00
18. 00 19. 00		0. 00 0. 00	0	0				18. 00 19. 00
20. 00		0.00	0	0				20.00
21. 00		0.00	O	0				21. 00
22. 00 23. 00		0. 00 0. 00	0	0				22. 00 23. 00
24. 00		0. 00	0	Ö				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	0	0				28. 00
29. 00 30. 00		0. 00 0. 00	0	0				29. 00 30. 00
31. 00		0.00	0	o				31.00
32. 00			0	<u>20,</u> 61 <u>8,</u> 109				32. 00
	B - I MPLANTABLES		<u> </u>					
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	18, 871, 711				1. 00
2. 00	PATI ENTS	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	Ö	Ö				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 12. 00		0. 00 0. 00	0	0				11. 00 12. 00
13.00		0.00	O	Ö				13. 00
14. 00			0	0 18, 871, 711				14. 00
	C - DRUGS AND IV SOLUTIONS		O[	10, 0/1, /11				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	44, 840, 108				1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	52, 160 0				2. 00 3. 00
4.00		0.00	0	0				4. 00
5. 00 6. 00		0. 00 0. 00	0	0				5. 00 6. 00
7. 00		0.00	0	o				7. 00
8.00		0.00	0	0				8. 00
9. 00 10. 00		0. 00 0. 00	0	0				9. 00 10. 00
11.00		0.00	0	0				11. 00
12. 00 13. 00		0. 00 0. 00	0	0				12. 00 13. 00
14. 00		0.00	0	0				14. 00
15.00		0.00	0	0				15.00
16. 00 17. 00		0. 00 0. 00	0	0				16. 00 17. 00
18.00		0. 00	0	0				18. 00
19. 00 20. 00		0. 00 0. 00	0	0				19. 00 20. 00
21. 00		0.00	0	o				21. 00

					12/31/2023	5/20/2024 2:35 pm
		Increases		0.11		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
22. 00	2. 00	0.00	4.00	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	•	0		24. 00
	0 D - BL00D		0	44, 892, 268		
1. 00	LABORATORY	60.00	0	125, 191		1.00
2. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	26		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4.00
5. 00 6. 00	+	0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	o	0		7. 00
8.00		0.00	O	0		8. 00
9.00	<u> </u>	0.00		0		9. 00
	E - INTEREST EXPENSE		0	125, 217		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	2, 603, 830		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2.00	Ö	2, 191, 130		2. 00
	0 — — — — —		0	4, 794, 960		
1 00	F - PROPERTY INSURANCE	1 00		04.242		1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	94, 262 47, 011		1. 00 2. 00
2.00	0			141, 273		2.00
	G - RADIOLOGY RNS		-	, =		
1.00	RADI OLOGY-THERAPEUTI C	55.00	594, 234	4, 203		1.00
2.00	RADI OI SOTOPE	56.00	61, 274	433		2. 00
	H - DIETARY		655, 508	4, 636		
1.00	CAFETERI A	11.00	1, 424, 832	1, 409, 843		1.00
	0		1, 424, 832	1, 409, 843		
1 00	J - LINEN	0.00		1 210 007		1 00
1. 00 2. 00	LAUNDRY & LINEN SERVICE PHARMACY	8. 00 15. 00		1, 219, 806 34		1. 00 2. 00
3.00		0.00	О	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0.00	0	0		6. 00 7. 00
8. 00		0.00	o	0		8.00
9. 00		0.00	o	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00 12. 00
12. 00 13. 00	+	0. 00 0. 00	0	0		13. 00
14. 00		0.00	ő	Ö		14. 00
15.00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
19. 00		0.00	0	0		19. 00
20. 00		0.00	Ö	Ö		20. 00
21. 00		0.00	0	0		21. 00
22. 00 23. 00		0. 00 0. 00	0	0		22. 00 23. 00
23. 00 24. 00		0.00	0	0		23.00
25. 00		0.00	ő	Ö		25. 00
26. 00		0.00	O	0		26. 00
27. 00		0.00	O	0		27. 00
28. 00 29. 00		0. 00 0. 00	0	0		28. 00 29. 00
30. 00		0.00	0	0		30.00
31. 00	L	0.00	0	0		31. 00
	0		0	1, 219, 840		
1. 00	K - MOTHER BABY NURSERY	43.00	1, 923, 024	225, 234		1.00
1.00	0	43.00	1, 923, 024 1, 923, 024	22 <u>5, 234</u> 225, 234		1.00
	M - MALPRACTICE		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	220, 20 7		
1.00	SKILLED NURSING FACILITY	44.00	0	10, 817		1. 00
2.00	RADI OLOGY-THERAPEUTI C	55.00	0	53, 704		2.00
3. 00 4. 00	CARDIAC CATHETERIZATION RESPIRATORY THERAPY	59. 00 65. 00	0	13, 327 19, 072		3. 00 4. 00
5. 00	ELECTROCARDI OLOGY	69.00	0	18, 174		5. 00
	0	+		115, 094		
		•				•

					5/20/2024	2:35 pm
		Increases				
	Cost Center	Li ne #	Salary	Other 5.00		
	2.00 N - BENEFITS DIRECTLY ASSIGNED	3.00	4. 00	5. 00	 	
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 764, 269		1.0
2. 00	Ziiii Zarez Beneri ra Berrintiment	0.00	o	0		2. 0
3.00		0.00	o	O		3. 0
4.00		0.00	О	0		4. 0
5.00		0.00	o	0		5. 0
6.00		000	0	0		6. 0
	0		0	2, 764, 269		
	Q - TRANSPORT			T		
1.00	ADULTS & PEDIATRICS	30.00	323, 583	3, 974		1. 0
2.00	INTENSIVE CARE UNIT	31.00	240, 671	2, 956		2. 00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	18, 407	226		3. 00
4. 00 5. 00	DELIVERY ROOM & LABOR ROOM	50. 00 52. 00	16, 131 8, 223	198 101		4. 00 5. 00
6. 00	RADI OLOGY-THERAPEUTI C	55. 00 55. 00	40, 033	492		6. 0
7. 00	CARDI AC CATHETERI ZATI ON	59. 00	5, 063	62		7. 0
8. 00	PHYSICAL THERAPY	66.00	306, 510	3, 764		8. 0
9. 00	ELECTROCARDI OLOGY	69.00	237, 688	2, 919		9. 0
10. 00	ELECTROENCEPHALOGRAPHY	70. 00	8, 811	108		10. 0
11. 00	EMERGENCY	91. 00	88, 996	1, 093		11. 0
	0 -		1, 294, 116	15, 893		
	R - PHARMACY RESIDENTS	<u>'</u>				
1.00	PARAMED ED PRGM-(SPECIFY)	23. 00	61, 090	0		1.00
	0		61, 090			
	W - WAGE INDEX					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 310, 665		1.00
2.00	NURSING ADMINISTRATION	13. 00	0	8, 624		2. 0
3.00	MEDICAL RECORDS & LIBRARY	16. 00	0	37, 283		3. 0
4.00	SOCI AL SERVI CE	17. 00	0	535		4. 0
5.00	I &R SERVICES-OTHER PRGM.	22. 00	0	1, 697, 984		5. 0
	COSTS APPRVD	20.00		240.042		
6.00	ADULTS & PEDIATRICS	30.00	0	348, 062		6. 0
7.00	INTENSIVE CARE UNIT	31.00	0	49, 963		7. 0
8. 00 9. 00	SURGICAL INTENSIVE CARE UNIT	34. 00 44. 00	0	93, 260 65, 790		8. 00 9. 00
10.00	OPERATING ROOM	50.00	0	9, 425		10. 0
11. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	53, 689		11. 0
12. 00	OP INFUSION	52. 00	0	60, 466		12. 0
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	32, 393		13. 0
14. 00	RADI OLOGY-THERAPEUTI C	55.00	0	89, 476		14. 0
15. 00	CT SCAN	57.00	Ö	204		15. 0
16. 00	CARDIAC CATHETERIZATION	59.00	Ö	44, 586		16. 0
17. 00	RESPIRATORY THERAPY	65. 00	o	14, 185		17. 0
18. 00	PHYSI CAL THERAPY	66. 00	o	1, 876		18. 0
19.00	CARDIAC REHABILITATION	76. 97	o	857		19. 0
20.00	EMERGENCY	91.00	o	239, 298		20. 0
21.00	OTHER NON REIMBURABLE	194.05	353, 566	0		21. 0
22.00	LABORATORY	60.00	O	30, 084		22. 0
	0		353, 566	4, 188, 705		
	X - OB SUPPORT					
1. 00	ADULTS & PEDIATRICS	3000	21 <u>0, 2</u> 74	<u>3, 7</u> 88		1. 0
	0		210, 274	3, 788		_
1 00	Y - INTERN & RESIDENT SALARY I		F 701 000			
1. 00	I &R SERVI CES-SALARY & FRI NGES APPRVD	21. 00	5, 721, 009	0		1. 00
	n NGES AFFRVD	<del> </del>	5, 721, 009	<sub>0</sub>		
	Z - COVI D-19- CONTRACT LABOR		5, 721, 009	<u> </u>		
1. 00	ADULTS & PEDIATRICS	30.00	O	2, 672		1.00
	0			$=\frac{27672}{2,672}$		
	AA - CONTRACT LABOR		<u> </u>	2,0,2		
1.00	ADULTS & PEDIATRICS	30.00	0	67, 454		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	o	460		2. 0
3.00	LABORATORY	60.00	o	2, 193		3. 0
	TOTALS			70, 107	 	
	AB - HBP TEACH PART A					
1.00	I&R SERVICES-OTHER PRGM.	22. 00	5, 909	0	 	1.0
	COSTS APPRVD					
	TOTALS		5, 909	0		
	AC - RESIDENT MALPRACTICE					
1.00	I&R SERVICES-OTHER PRGM.	22. 00	0	439, 735		1. 0
	COSTS APPRVD					
E00 -:	TOTALS		0	439, 735		
PUU 00	Grand Total: Increases		11, 649, 328	99, 903, 354		500.00

						5/20/2024 2:3	35 pm
	2 1 2 1	Decreases	6.1	011	MI . A 7 D C l		
	Cost Center	Li ne # 7.00	Sal ary		Wkst. A-7 Ref.		
	6. 00 A - MEDI CAL SURGI CAL SUPPLI ES		8. 00	9. 00	10. 00		
1. 00	MAINTENANCE & REPAIRS	6. 00	0	3, 125	0		1.00
2.00	OPERATION OF PLANT	7. 00	0	1, 951	Ö		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	65, 961	0		3. 00
4.00	DI ETARY	10. 00	0	4, 107	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	4, 995	0		5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	830, 525	0		6. 00
7.00	PHARMACY	15. 00	0	55, 509	0		7. 00
8. 00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22. 00	0	758	U		8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0	1, 621, 694	О		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	1, 564, 168	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	162, 122	0		11. 00
12.00	NURSERY	43.00	0	767	0		12. 00
13.00	SKILLED NURSING FACILITY	44. 00	0	88, 210	0		13. 00
14.00	OPERATING ROOM	50.00	0	9, 309, 584	0		14. 00
15. 00	RECOVERY ROOM	51.00	0	55, 085	0		15.00
16. 00 17. 00	DELIVERY ROOM & LABOR ROOM OP INFUSION	52. 00 52. 01	0	342, 413 70, 033	0		16. 00 17. 00
18. 00	ANESTHESI OLOGY	53. 00	0	513, 707	0		18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 079, 220	O		19. 00
20.00	RADI OLOGY-THERAPEUTI C	55. 00	0	31, 311	0		20.00
21.00	RADI OI SOTOPE	56.00	0	807	0		21. 00
22. 00	CT SCAN	57. 00	0	121, 985	0		22. 00
23. 00	MRI	58. 00	0	14, 865	0		23. 00
24. 00	CARDI AC CATHETERI ZATI ON	59.00	0	2, 014, 261	0		24. 00
25. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00	0	408, 811	0		25. 00
26. 00 27. 00	ELECTROCARDI OLOGY	66. 00 69. 00	0	26, 923 123, 163	0		26. 00 27. 00
28. 00	ELECTROCARDI GLOGI ELECTROENCEPHALOGRAPHY	70.00	0	36, 715	0		28. 00
29. 00	CARDI AC REHABI LI TATI ON	76. 97	0	4, 309	o		29. 00
30.00	CLINIC	90.00	0	305, 314	0		30.00
31.00	EMERGENCY	91.00	0	1, 581, 101	0		31. 00
32.00	OBSERVATION_BEDS-DISTINCT	92.01	0				32. 00
	O LANDI ANTARI EC		0	20, 618, 109			
1. 00	B - IMPLANTABLES CENTRAL SERVICES & SUPPLY	14.00		8, 299	O		1. 00
2. 00	I &R SERVICES - OTHER PRGM.	22. 00		6, 299 10, 150	0		2.00
2.00	COSTS APPRVD	22.00		10, 130	٥		2.00
3.00	ADULTS & PEDIATRICS	30. 00		372	0		3. 00
4.00	INTENSIVE CARE UNIT	31. 00		3, 448	0		4. 00
5. 00	SURGICAL INTENSIVE CARE UNIT	34.00		3, 432	0		5. 00
6.00	OPERATING ROOM	50.00		13, 400, 828	0		6.00
7. 00 8. 00	RECOVERY ROOM ANESTHESIOLOGY	51. 00 53. 00		495 5, 201	0		7. 00 8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00		687, 282	0		9. 00
10. 00	CARDI AC CATHETERI ZATI ON	59.00		4, 557, 111	o		10.00
11. 00	ELECTROCARDI OLOGY	69.00		6, 336			11. 00
12.00	ELECTROENCEPHALOGRAPHY	70. 00		62	0		12. 00
13.00	CLINIC	90.00		186, 746			13. 00
14.00	EMERGENCY	<u>91.</u> 00		<u>1, 9</u> 49	0		14. 00
	C DDUCE AND LV COLUTIONS		0	18, 871, 711			
1. 00	C - DRUGS AND IV SOLUTIONS EMPLOYEE BENEFITS DEPARTMENT	4.00		5, 559	0		1. 00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00		2, 732	0		2. 00
3.00	PHARMACY	15. 00		42, 197, 941	O		3. 00
4.00	ADULTS & PEDIATRICS	30.00		498, 659	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00		398, 300	0		5. 00
6.00	SURGICAL INTENSIVE CARE UNIT	34. 00		131, 312	0		6. 00
7.00	SKILLED NURSING FACILITY	44.00		5, 789	0		7. 00
8. 00	OPERATING ROOM	50.00		342, 469	0		8. 00
9. 00 10. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51. 00 52. 00		9, 054 40, 813	0		9. 00 10. 00
11. 00	OP INFUSION	52. 00 52. 01		87, 785	0		11.00
12. 00	ANESTHESI OLOGY	53. 00		28, 216	o		12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54. 00		77, 342	Ö		13. 00
14.00	RADI OLOGY-THERAPEUTI C	55. 00		183	o		14. 00
15. 00	RADI OI SOTOPE	56.00		535	0		15. 00
16.00	CT SCAN	57.00		4, 413	0		16.00
17. 00	MRI	58. 00		2, 746	0		17. 00
18. 00 19. 00	CARDI AC CATHETERI ZATI ON RESPI RATORY THERAPY	59. 00 65. 00		33, 252 81, 871	0		18. 00 19. 00
20. 00	ELECTROCARDI OLOGY	69.00		149, 156	0		20.00
21. 00	ELECTROENCEPHALOGRAPHY	70.00		308			21. 00
	1			300	ا م		

						5,	/20/2024 2:35 pm
		Decreases					
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.		
22.00	6.00	7. 00	8. 00	9. 00	10. 00		22, 00
22. 00 23. 00	CLI NI C EMERGENCY	91.00		4, 318 717, 965			23. 00
24. 00	OBSERVATION BEDS-DISTINCT	92. 01		71, 550			24. 00
24.00	OBSERVATION BEDS-DISTINCT						24.00
	D - BLOOD		<u> </u>	44, 092, 200			
1.00	NURSING ADMINISTRATION	13.00		26	0		1. 00
2. 00	I &R SERVI CES-OTHER PRGM.	22. 00		809	l .		2. 00
2.00	COSTS APPRVD	22.00		307			2.00
3.00	ADULTS & PEDIATRICS	30.00		3, 255	0		3. 00
4.00	INTENSIVE CARE UNIT	31.00		3, 760	0		4. 00
5.00	SURGICAL INTENSIVE CARE UNIT	34.00		6, 130	0		5. 00
6.00	OPERATING ROOM	50.00		64, 398	0		6. 00
7.00	OP INFUSION	52. 01		45, 232	0		7. 00
8.00	LABORATORY	60.00		1, 554	0		8. 00
9.00	EMERGENCY	<u>91.</u> 00		53	0		9. 00
	0		0	125, 217			
	E - INTEREST EXPENSE						
1. 00	INTEREST EXPENSE	113. 00	0	4, 794, 960			1. 00
2. 00		0.00	0	0			2. 00
	O		0	4, 794, 960			
4 00	F - PROPERTY INSURANCE	F 00		4.44 070	4.0		1.00
1.00	ADMINISTRATIVE & GENERAL	5.00	0	141, 273			1.00
2.00		0.00		<u> </u>			2. 00
	G - RADI OLOGY RNS		U	141, 2/3			
1. 00	RADI OLOGY - DI AGNOSTI C	54.00	655, 508	4, 636	0		1. 00
2. 00	RADI OLOGI - DI AGNOSTI C	0.00	055, 508	4, 030 0	0		2.00
2.00			655, 508	$- \frac{0}{4,636}$			2.00
	H - DI ETARY		033, 300	4, 030			
1.00	DI ETARY	10.00	1, 424, 832	1, 409, 843	0		1. 00
	0		1, 424, 832	1, 409, 843			
	J - LINEN		., .= .,	.,,			
1.00	ADMINISTRATIVE & GENERAL	5. 00		10, 616	0		1. 00
2.00	OPERATION OF PLANT	7. 00		194	0		2. 00
3.00	HOUSEKEEPI NG	9. 00		20, 410	0		3. 00
4.00	DI ETARY	10.00		21, 594	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00		341	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00		22, 082	0		6. 00
7.00	SOCI AL SERVI CE	17. 00		26	0		7. 00
8.00	I&R SERVICES-OTHER PRGM.	22. 00		2, 802	0		8. 00
	COSTS APPRVD						
9.00	ADULTS & PEDIATRICS	30.00		316, 684	0		9.00
10.00	INTENSIVE CARE UNIT	31.00		234, 234	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00		23, 771	0		11.00
12.00	SKILLED NURSING FACILITY	44.00		20, 369			12.00
13.00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00		69, 731	0		13. 00 14. 00
14. 00 15. 00	DELIVERY ROOM & LABOR ROOM	52.00		13, 843 42, 586			15. 00
16. 00	OP INFUSION	52. 00		12, 187	l .		16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00		44, 100	l .		17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55.00		26	o		18. 00
19. 00	RADI OI SOTOPE	56.00		9, 951	o		19. 00
20. 00	MRI	58.00		9, 154	o		20. 00
21. 00	CARDIAC CATHETERIZATION	59.00		10, 289	· ·		21. 00
22. 00	LABORATORY	60.00		150	l		22. 00
23. 00	PHYSI CAL THERAPY	66.00		10, 198	l .		23. 00
24.00	ELECTROCARDI OLOGY	69. 00		10, 388	o		24. 00
25.00	ELECTROCARDI OLOGY	69.00		1, 602	O		25. 00
26.00	ELECTROENCEPHALOGRAPHY	70.00		2, 381	O		26. 00
27.00	ELECTROENCEPHALOGRAPHY	70.00		4, 775	0		27. 00
28.00	HYPERBARIC OXYGEN THERAPY	76. 98		16, 016	0		28. 00
29. 00	CLINIC	90.00		1, 046	l .		29. 00
30.00	EMERGENCY	91. 00		251, 315			30. 00
31. 00	OBSERVATI ON BEDS-DISTINCT	92.01		3 <u>6, 9</u> 79			31. 00
	0		0	1, 219, 840			
	K - MOTHER BABY						
1.00	ADULTS & PEDIATRICS	3000	1, 923, 024	22 <u>5, 234</u>			1. 00
	U NAL PRACTICE		1, 923, 024	225, 234			
1 00	M - MALPRACTICE	F 00	اء	445 001			4.62
1.00	ADMINISTRATIVE & GENERAL	5.00	0	115, 094			1.00
2.00		0. 00 0. 00	0	0			2.00
3. 00 4. 00		0.00	0	0	l .		3.00
4. 00 5. 00		0.00	0	0			4. 00 5. 00
J. 00	1	0.00	Ч	0	ı V		1 5.00

COST Centrer							5/20/202	4 2: 35 pm
Columbridge								
Description								
No.   September   No.   September   No.		6. 00	7. 00			10.00		
DOC   ADMINISTRATIVE & CENERAL   5.00   4.0.356   0   1.000		N PENEELTS DIDECTLY ASSICNE	:n	U U	115, 094			
2.00 LOSS ARRIVES—OFFER PROUL  2.00 LOSS ARRIVES—OFFER PROUL  2.00 LOSS ARRIVES—OFFER PROUL  2.00 LOSS ARRIVES—OFFER PROUL  3.00 LOSS ARRIVES—OFFER PROUL	1 00				46 359	0		1 00
COSTS APPRIVED   COSTS AS APPRIVED   COSTS A						- 1		1
SAILLED MURSING FACILITY					., ,			
MINISTRATIVE & GENERAL	3.00	ADULTS & PEDIATRICS	30.00		50, 939	o		3. 00
0.00						_		1
Company						_		1
0 - TRAMSPORT	6.00	OTHER NON RETMBURABLE	194.05			9		6.00
1.00		O TRANSPORT		U]	2, 764, 269			
2.00   0.	1 00		5.00	1 204 116	15 903	0		1 00
3.00  4.00  5.00  0.00		ADMINISTRATIVE & GENERAL		1, 2, 4, 110				1
4.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00				ő				1
0.00				O				1
7. 00 9. 00	5.00		0.00	o	0	o		5. 00
8.00				0	- 1			1
9.00				0	0	0		1
10.00				0	0	0		1
11.00				0	ĭ	-		1
1, 294, 116				0	0			1
R - PHARMACY NESIDENTS	11.00			1 294 116	15_893			11.00
1.00		R - PHARMACY RESIDENTS		1, 2, 1, 110	10,070			
W - WAGE INDEX   1.00   ADMINISTRATIVE & GENERAL   5.00   1,310,665   0   0   0   1.00   ADMINISTRATION   13.00   8,624   0   0   0   2.00   3.30   ADMINISTRATION   13.00   8,624   0   0   0   0   2.00   3.30   ADMINISTRATION   13.00   8,624   0   0   0   0   3.30   ADMINISTRATION   13.00   8,624   0   0   0   0   3.30   ADMINISTRATION   13.00   8,624   0   0   0   0   0   0   0   0   0	1.00		15. 00	61, 090	0	0		1. 00
1.00   ADMIN INSTRATIVE & GENERAL   5.00   1,310,665   0   0   2.00   0   3.00   8.00   0   3.00   8.024   0   0   0   3.00   3.00   8.00   8.00   8.00   8.00   3.00   3.00   8.00   9.00   8.00   9.00   8.00   9.00		0		61, 090	0			
2. 00 NURSING ADMINISTRATION 13. 00 8, 624 0 0 0 3.30 0								
3.00								1
A 0.0   SOCI AL SERVICE		•						1
5.00   LAR SERVICES-OTHER PROM.   22.00   1,697,984   0   0   0   0   0   0   0   0   0						1		
COSTS APPRVD   COST				•				1
0.00   ADULTS & PEDIATRICS   30.00   348, 062   0   0   7.00     0.00   SURGICAL INTENSIVE CARE UNIT   31.00   49.963   0   0   0     0.00   SURGICAL INTENSIVE CARE UNIT   34.00   92.260   0   0   0     0.01   SURGICAL INTENSIVE CARE UNIT   34.00   92.260   0   0   0     0.00   SURGICAL INTENSIVE CARE UNIT   34.00   92.260   0   0   0     0.00   OPERATING ROOM   50.00   94.25   0   0   0     11.00   OPERATING ROOM   52.00   53.689   0   0   0     12.00   OPERATING ROOM   52.01   60.466   0   0   11.00     13.00   OPERATING ROOM   52.01   60.466   0   0   12.00     13.00   RADIOLOGY-DIAGNOSTIC   54.00   32.393   0   0   0     15.00   CT SCAN   57.00   204   0   0   0     15.00   CT SCAN   57.00   204   0   0   0     16.00   CARDIAC CATHETERIZATION   57.00   204   0   0   0     15.00   CT SCAN   57.00   204   0   0   0     16.00   CARDIAC CATHETERIZATION   59.00   44.586   0   0   0     17.00   CARDIAC CATHETERIZATION   76.97   857   0   0   0     19.00   CARDIAC CATHETERIZATION   76.97   857   0   0   0     19.00   CARDIAC REHABILITATION   76.97   857   0   0   0     10.00   OTHER NON REIMBURABLE   194.05   0   353.566   0   22.00     10.00   OTHER NON REIMBURABLE   194.05   0   353.566   0   22.00     10.00   OTHER NON REIMBURABLE   194.05   0   353.566   0   22.00     10.00   CARDIAC REHABILITATION   59.00   4.188.705   353.566   0   22.00     10.00   OTHER NON REIMBURABLE   194.05   0   25.720   0   0     2.00   OTHER NON REIMBURABLE   50.00   0   2.672   0   0     2.00   OTHER NON REIMBURABLE   50.00   0   2.672   0   0     2.00   OTHER NON REIMBURABLE   50.00   0   2.672   0   0     2.00   OTHER NON REIMBURABLE   50.00   0   2.672   0   0     2.00   OTHER NON REIMBURABLE   50.00   0   0   2.672   0   0     2.00   OTHER NON REIMBURABLE   50.00   0   0   0   0   0   0     2.00   OTHER NON REIMBURABLE   50.00   0   0   0   0   0   0   0   0     2.00   OTHER NON REIMBURABLE   50.00   0   0   0   0   0   0   0   0   0	3.00	1	22.00	1, 077, 704	J	٥		3.00
7. 00   INTENSIVE CARE UNIT   31. 00   49, 963   0   0   7. 00   8.00   SURICAL INTENSIVE CARE UNIT   34. 00   65, 790   0   0   9. 00   9. 00   SKILLED NURSING FACILITY   44. 00   65, 790   0   0   0   11. 00   DELIVERY ROOM & LABOR ROOM   52. 00   53, 689   0   0   11. 00   12. 00   OP INFUSION   52. 01   60, 466   0   0   12. 00   13. 00   RADIO LOGY-DIAGNOSTIC   54. 00   32, 393   0   0   13. 00   15. 00   CT SCAN   THERAPEUTIC   55. 00   89, 476   0   0   14. 00   16. 00   CARDIA C CATHETERIZATION   57. 00   204   0   0   15. 00   16. 00   CARDIA C CATHETERIZATION   59. 00   444, 586   0   0   17. 00   18. 00   PHYSICAL THERAPY   66. 00   1, 876   0   0   18. 00   19. 00   CARDIA C REHABILITATION   76. 97   857   0   0   19. 00   20. 00   EMERGENCY   91. 00   239, 298   0   0   20. 00   21. 00   THER NON REI IMBURBALE   194. 05   0   353, 566   0   22. 00   A. OB SUPPORT   CATHETERIZATION   55. 00   210, 274   3, 788   0   0   22. 00   A. OB SUPPORT   CATHETERIZATION   55. 00   210, 274   3, 788   0   0   20. 00   EMERGENCY   91. 00   239, 298   0   0   0   22. 00   20. 00   EMERGENCY   91. 00   239, 298   0   0   0   22. 00   21. 00   THER NON REI IMBURBALE   194. 05   0   353, 566   0   22. 00   22. 00   A. OB SUPPORT   CATHETERIZATION   55. 00   210, 274   3, 788   0   0   22. 00   20. 00   A. OB SUPPORT   CATHETERIZATION   55. 00   210, 274   3, 788   0   0   22. 00   20. 00   A. OB SUPPORT   CATHETERIZATION   55. 00   0   2, 672   0   0   20. 00   A. OB SUPPORT   CATHETERIZATION   55. 00   0   2, 672   0   0   20. 00   A. OB SUPPORT   CATHETERIZATION   75. 721, 009   0   0   0   0   20. 00   A. OB SUPPORT   CATHETERIZATION   75. 721, 009   0   0   0   0   0   0   0   20. 00   A. OB SUPPORT   CATHETERIZATION   75. 721, 009   0   0   0   0   0   0   0   0   0	6.00		30.00	348, 062	0	o		6, 00
9.00   0.00   OPERATING ROOM   0.00	7.00		31.00		0	o		1
10. 00   OPERATING ROOM   50. 00   9, 425   0   0   0   11. 00     11. 00   DELI VERY ROOM & LABOR ROOM   52. 00   53, 689   0   0   0   0     12. 00   OP   NFUSION   52. 01   60, 466   0   0   0     13. 00   RADIOLOGY-DIAGNOSTIC   54. 00   32, 393   0   0   0     15. 00   CT SCAN   57. 00   204   0   0   0     15. 00   CT SCAN   57. 00   204   0   0   0     17. 00   RESPIRATORY THERAPEUTIC   55. 00   89, 476   0   0   0     17. 00   RESPIRATORY THERAPEY   65. 00   14, 185   0   0   0     19. 00   CARDIAC CATHERRY   65. 00   14, 185   0   0   0     19. 00   CARDIAC REHABILITATION   76. 97   857   0   0   0     19. 00   CARDIAC REHABILITATION   76. 97   857   0   0   0     19. 00   CARDIAC REHABILITATION   76. 97   857   0   0   0     10. 00   EMERGENCY   91. 00   239, 298   0   0   20. 00     10. 00   THER NON REI MBURABLE   194, 05   0   353, 566   0     10. 00   LABORATORY   60. 00   30,084   0   0   0     22. 00   LABORATORY   60. 00   30,084   0   0   0     22. 00   LABORATORY   60. 00   30,084   0   0   0     22. 00   LABORATORY   60. 00   30,084   0   0   0     22. 00   LABORATORY   60. 00   57,721,009   0   0     24. 08 SUPPORT   70. 00   70. 00   70. 00     25. 00   COSTS APPRUD   70. 00   70. 00   70. 00     26. COVID-19- CONTRACT LABOR   70. 00   70. 107     27. 00   AMM INSTRATIVE & GENERAL   5. 00   0   2,672   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   0   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   0   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   0   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   0   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   0   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   439,735   0   0     20. 00   AMM INSTRATIVE & GENERAL   5. 00   0   0   439,735   0   0   0     20. 00   AMM INSTRATIVE &	8.00	SURGICAL INTENSIVE CARE UNIT	34.00	93, 260	0	0		8. 00
11. 00   DELIVERY ROOM & LABOR ROOM   52. 00   53. 689   0   0   0   11. 00     12. 00   PINFUSI ON   52. 01   60. 466   0   0   0     13. 00   RADI OLOGY-DI AGNOSTI C   54. 00   32, 393   0   0   0     14. 00   RADI OLOGY-THERAPEUTI C   55. 00   89, 476   0   0   0     15. 00   TO SCAN   57. 00   204   0   0   0     16. 00   CARDI AC CATHETERI ZATI ON   59. 00   44, 586   0   0   0     18. 00   PHYSI CAL THERAPY   66. 00   14, 185   0   0   0     19. 00   CARDI AC CATHETERI ZATI ON   76. 97   857   0   0   0     19. 00   CARDI AC CRAINETERI LITATI ON   76. 97   857   0   0   0     19. 00   CARDI AC CRAINETERI ZATI ON   76. 97   857   0   0   0     19. 00   CARDI AC CRAINETERI ZATI ON   76. 97   857   0   0   0     19. 00   CARDI AC CRAINETINO   76. 97   857   0   0   0     20. 00   EMERGENCY   91. 00   239, 298   0   0   0     21. 00   OTHER NON REIMBURABLE   194. 05   0   353, 566   0     22. 00   LABORATORY   66. 00   30. 084   0   0   0     22. 00   LABORATORY   66. 00   30. 084   0   0   0     23. 00   THER NON REIMBURABLE   194. 05   0   353, 566   0     24. 18B, 705   353, 566   0     25. 00   TO STAN RESIDENT SALARY RECLASS								1
12. 00		•						1
13. 00   RADI OLOGY-DI AGNOSTI C   54. 00   32, 393   0   0   14. 00   14. 00   14. 00   14. 00   14. 00   15. 00   15. 00   16. 00   16. 00   17. 00   15. 00   17								1
14. 00   RADI OLOCY-THERAPEUTI C   55. 00   89, 476   0   0   115. 00   15. 00   CT SCAN   57. 00   204   0   0   0   115. 0		•				_		1
15. 00   CT SCAN   57. 00   204   0   0   0   15. 00     16. 00   CARDIAC CATHETERIZATION   59. 00   44, 586   0   0   0     17. 00   RESPIRATORY THERAPY   65. 00   14, 185   0   0   0     18. 00   PHYSI CAL THERAPY   66. 00   1, 876   0   0   0     19. 00   CARDIAC CATHETERIZATION   76. 97   857   0   0   0     20. 00   EMERGENCY   91. 00   239, 298   0   0   0     21. 00   OTHER NON REIMBURABLE   194. 05   0   353, 566   0     22. 00   LABORATORY   66. 00   3.0, 084   0   0   0     0   A, 188, 705   353, 566   0     1. 00   DELI VERY ROOM & LABOR ROOM   52. 00   210, 274   3, 788   0   0     0   21. 00   THER NON RESIDENT SALARY RECLASS								1
16. 00 CARDI AC CATHETERI ZATI ON 59. 00 44,586 0 0 0 17. 00   RESPI RATORY THERAPY 66. 00 14,185 0 0 0 17. 00 18. 00 17. 00 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 18. 00 17. 00 0 17. 00 0 18. 00 17. 00 17. 00 0 18. 00 17						_		
17. 00						_		1
19.00   CARDIAC REHABILITATION   76.97   857   0   0   19.00   20.00	17.00		65.00	14, 185	0	o		17. 00
20. 00 EMERGENCY 91. 00 239, 298 0 0 0 21. 00 21. 00 01 HER NON REIMBURABLE 194. 05 0 353, 566 0 21. 00 22. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18.00	PHYSI CAL THERAPY	66.00	1, 876	0	0		18. 00
21.00	19. 00	CARDIAC REHABILITATION						
22.00   LABORATORY		1						
1.00   DELI VERY ROOM & LABOR ROOM   52.00   210,274   3,788   0   0   1.00					353, 566			
X - 08 SUPPORT   DEL VERY ROOM & LABOR ROOM   52.00   210,274   3,788   0   0   1.00   0   210,274   3,788   0   0   1.00   0   210,274   3,788   0   0   0   210,274   3,788   0   0   0   0   0   0   0   0   0	22. 00	LABORATORY			0	9		22.00
1. 00 DELI VERY ROOM & LABOR ROOM 52.00 210, 274 3, 788 0 0 210, 274 3, 788 0 1. 00 210, 274 3, 788 0 1. 00 210, 274 3, 788 0 1. 00 18R SERVI CES-OTHER PRGM. 22.00 5, 721, 009 0 0 5, 721, 009 0 1. 00 20, 672 0 1. 00 ADMI NI STRATI VE & GENERAL 5.00 0 2, 672 0 1. 00 ADMI NI STRATI VE & GENERAL 5.00 0 3, 073 0 1. 00 2. 00 ADMI NI STRATI VE & GENERAL 5.00 0 3, 073 0 2. 00 3. 00 TOTALS 0 70, 107  AB - HBP TEACH PART A 1. 00 ELECTROCARDI OLOGY 69.00 5, 909 0 0 1. 00 TOTALS 5, 909 0 1. 00 AC - RESI DENT MALPRACTI CE 1. 00 ADMI NI STRATI VE & GENERAL 5.00 0 439, 735 0 1. 00 TOTALS 5.00 0 439, 735 0 1. 00		U V OR SUDDODT		4, 188, 705	353, 566			
1.00   Large	1 00		52 00	210 274	3 788	0		1 00
1. 00	1.00	0		+				1.00
COSTS APPRVD		Y - INTERN & RESIDENT SALARY	RECLASS	210/2/1	37.33			
Totals   T	1.00	I&R SERVICES-OTHER PRGM.	22.00	5, 721, 009	0	0		1.00
Totals		COSTS APPRVD						
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 2, 672 0 1. 00 0 2, 672 1. 00 0 2, 672 1. 00 0 1. 00 0 2, 672 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 1. 00 0 0 0		0		5, 721, 009	0			
O			- aal	ما	0 (70	al		
AA - CONTRACT LABOR  1. 00 SOCI AL SERVI CE	1.00	ADMINISIRATIVE & GENERAL				9		1.00
1. 00		AA - CONTRACT LAROR		<u> </u>	2,072			
2. 00	1 00		17 00	٥	67 034	0		1 00
3.00				- 1				
TOTALS  AB - HBP TEACH PART A  1. 00 ELECTROCARDI OLOGY  TOTALS  AC - RESI DENT MALPRACTI CE  1. 00 ADMI NI STRATI VE & GENERAL  TOTALS  0 70, 107  69. 00 5, 909  0 0  1. 00  439, 735  0 439, 735  0 1. 00		A SELECTION		o	0	1		1
AB - HBP TEACH PART A  1.00 ELECTROCARDI OLOGY 69.00 5, 909 0 0 1.00 TOTALS 5, 909 0 1.00 ADMINISTRATI VE & GENERAL 5.00 0 439, 735 0 1.00 TOTALS 0 439, 735 0 1.00		TOTALS			70, 107			
TOTALS 5,909 0  AC - RESIDENT MALPRACTICE  1. 00 ADMINISTRATIVE & GENERAL 5.00 0 439,735 0 1.00  TOTALS 0 439,735 0 1.00		AB - HBP TEACH PART A						
AC - RESIDENT MALPRACTICE  1. 00 ADMINISTRATIVE & GENERAL 5. 00 439, 735 0 1. 00  TOTALS 0 439, 735	1.00		69.00	+	0	0		1.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 439, 735 0 1. 00 TOTALS 0 439, 735				5, 909	0			
TOTALS 0 439, 735	1 00		- 25		100 75-	-1		
	1.00			<u>_</u>				1.00
10, TOT, TOT, TOT, TOT, TOT, TOT, TOT, TO	500 00			15 484 467				500 00
	555.00		ı I	.5, 101, 707	.5,555,215	I		1 000.00

Provider CCN: 31-0041

					To 12/31/2023	Date/Time Pre 5/20/2024 2:3	pared:
				Acqui si ti ons		3/20/2024 2.3	5 pili
		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	T BALANCES					
1.00	Land	198, 713	0		0	0	1. 00
2.00	Land Improvements	3, 070, 534	0		0 0	0	2. 00
3.00	Buildings and Fixtures	289, 229, 993	28, 367, 966		0 28, 367, 966	0	3. 00
4.00	Building Improvements	17, 860, 652	0		0	0	4. 00
5.00	Fi xed Equipment	78, 755, 860	0		0	0	5. 00
6.00	Movable Equipment	200, 390, 619	7, 725, 241		0 7, 725, 241	6, 331	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	589, 506, 371	36, 093, 207		0 36, 093, 207	6, 331	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	589, 506, 371	36, 093, 207		0 36, 093, 207	6, 331	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	198, 713	0				1. 00
2.00	Land Improvements	3, 070, 534	1, 628, 159				2. 00
3.00	Buildings and Fixtures	317, 597, 959	57, 244, 879				3. 00
4.00	Building Improvements	17, 860, 652	5, 183, 612				4. 00
5.00	Fi xed Equipment	78, 755, 860	67, 348, 630				5. 00
6.00	Movable Equipment	208, 109, 529	98, 378, 455				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	625, 593, 247	229, 783, 735				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	625, 593, 247	229, 783, 735				10. 00

Heal th	n Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part II	pared:
			SL	JMMARY OF CAPI	TAL	072072021 2.0	Į į
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	11, 111, 968	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9, 350, 753	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	20, 462, 721	0		0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	11, 111, 968		·		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9, 350, 753				2. 00
	T 1 1 ( C1: 4 O)		00 4/0 704	I			1 2 22

0 0

11, 111, 968 9, 350, 753 20, 462, 721

1. 00 2. 00 3. 00

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

Heal th	n Financial Systems	COMMUNITY MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Pre 5/20/2024 2:3	pared:
		COM	PUTATION OF RA	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						
1.00	CAP REL COSTS-BLDG & FLXT	417, 483, 717	C	417, 483, 71	7 0. 667341	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	208, 109, 528					2. 00
3.00	Total (sum of lines 1-2)	625, 593, 245		625, 593, 24			3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONOLITATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS			0 11, 111, 968	0	1. 00
2.00	CAP REL COSTS-BLDG & FIXI	0			0 9, 350, 753		2.00
3.00	Total (sum of lines 1-2)	0			0 20, 462, 721		3.00
3.00	Total (Sail of Tries 1 2)		SI	JMMARY OF CAPI			3. 00
			0.		.,		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	11.00	12. 00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	1, 766, 597	94, 262		0 0	12, 972, 827	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 486, 596			o o		2.00
3.00	Total (sum of lines 1-2)	3, 253, 193		•	o o	, ,	
	,			'	•		•

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 31-0041

Suppose Classal Floation on North-Sheet A   \$7,00,000					T	01/01/2023		
Cost Center Description							3/20/2024 2.33	5 PIII
					To/From Which the Amount is	to be Adjusted		
1.00   Investment Income - CAP REL   B		Cost Center Description						
Investment income - CAP REL   S	1.00	II.						1. 00
0.00   0.00	2. 00		В	-704, 534	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
Chapter 2)  4. 00 Irides, quantity, and time of scannix (chapter 8)  5. 00 Indiscounts (chapter 8)  6. 00 Reatal of provider space by complete services (pays and passes)  8. 00 Irides (chapter 8)  9.	3 00			0		0.00	0	3 00
0   0   0   0   0   0   0   0   0   0		(chapter 2)		-				
Columbia	4.00	discounts (chapter 8)		0		0.00	O	4.00
Sentral or provider space by   0   0.00   0.6.00   0.00   0.6.00   0.0	5. 00			0		0. 00	0	5. 00
Telephone services (pay stations excluded) (chapter 21)   Stations excluded) (chapter 22)   Stations excluded) (chapter 23)   Stations excluded) (chapter 24)   Stations exclu	6.00	Rental of provider space by		0		0. 00	0	6. 00
8. 00 Television and radio service   8	7. 00		В	-59, 710	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
1.00   1.00								
Parking   of (chapter 21)	8.00	Television and radio service	В	-38, 235	OPERATION OF PLANT	7. 00	О	8. 00
adjustment		Parking Lot (chapter 21)		0		0. 00		
11.00   Saile of scrap, waste, etc. (Chapter 23)   12.00   Related organization   A-8-1   13,359,097   0   12.00   13.00   Laundry and I linen service   0   0   0.00   0   13.00   15.00	10. 00		A-8-2	-19, 034, 584			0	10. 00
12.00   Related organization   charactions (chapter 10)   13.00   Laundry and I linen service   0   0.00   0.13.00   15.00	11. 00	Sale of scrap, waste, etc.		0		0. 00	o	11. 00
13.00   Laundry and I linen service   0   0.00   0.13.00   15.00   1	12. 00	Related organization	A-8-1	13, 359, 097			0	12. 00
15.00   Rental of quarters to employee and others   0   0   0   15.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   17.00   0   17.00   0   18.00   0   19.00   0	13. 00			0		0. 00	0	13. 00
and others				-1, 380, 090	CAFETERI A			
Supplies to other than		and others		0				
17. 00   Sale of drugs to other than patients   0   0.00	16.00			0		0.00	0	16.00
patients	17. 00	1.		0		0. 00	0	17. 00
abstracts	10 00	pati ents		0		0.00	0	10 00
education (tuition, fees, books, etc.)		abstracts		0				
20. 00   Vending machines   Canada   Vending machines   Canada   Vending machines   Vending machines   Canada   Vending machines   Canada   Vending machines   Canada   Vending machines   Vending machines   Canada   Vending machines	19. 00			0		0.00	O	19.00
21.00	20. 00		В	-35. 388	OPERATION OF PLANT	7. 00	0	20. 00
Charges (chapter 21)   Canal		Income from imposition of		0			O	
overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 1.00 0 27.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 28.00 Non-physic ian Anesthetist 0 0 *** Cost Center Deleted *** 19.00 28.00 Non-physic ians' assistant 0 0.00 0 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) A-8-3 0 OCCUPATIONAL THERAPY 67.00 30.00 30.09 instructions) Adjustment for speech pathology costs in excess of limitation (chapter 14) CAP REL COSTS-MVBLE EQUIP 67.00 30.00 30.00 30.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) CAP REL COSTS-MVBLE EQUIP 67.00 30.00		charges (chapter 21)						
Page	22. 00			0		0. 00	0	22. 00
therapy costs in excess of limitation (chapter 14)  24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14)  25. 00 Utilization review - physicians' compensation (chapter 21)  26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT	22 00	repay Medicare overpayments		0	DESDI DATADV THEDADV	65.00		22 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	23.00	therapy costs in excess of	A-0-3	O	RESPIRATORY ITHERAFT	03.00		23.00
limitation (chapter 14)   Utilization review -   physicians' compensation (chapter 21)   26.00   Depreciation - CAP REL   OCAP REL COSTS-BLDG & FIXT   1.00   O 26.00   COSTS-BLDG & FIXT   T.00   O 27.00   COSTS-BLDG & FIXT   Depreciation - CAP REL   OCAP REL COSTS-MVBLE EQUIP   COSTS-MVBLE EQUIP   COSTS-MVBLE EQUIP   Depreciation and therapy costs in excess of limitation (chapter 14)   O ADULTS & PEDIATRICS   O ADULTS & O ADULTS	24. 00		A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25.00   Utilization review - physicians' compensation (chapter 21)   26.00   25.00   26.00   26.00   26.00   26.00   27.00   27.00   27.00   27.00   27.00   27.00   28.00   29.00								
Chapter 21)   Depreciation - CAP REL   OCAP REL COSTS-BLDG & FIXT   1.00   0 26.00	25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP  28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)  30. 99 Hospice (non-distinct) (see instructions)  31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32. 00 CAP REL COSTS-MVBLE EQUIP  0 CAP REL COSTS-MVBLE EQUIP  2. 00 0 27. 00 0 28. 00 0 29. 00 0 29. 00 0 0 29. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		(chapter 21)						
28. 00   Non-physician Anesthetist   O **** Cost Center Deleted ***   19. 00   28. 00   29. 00   Physicians' assistant   O   O   O   O   30. 00   Adjustment for occupational therapy costs in excess of limitation (chapter 14)   30. 99   Hospice (non-distinct) (see instructions)   A-8-3   O   O   O   O   31. 00   Adjustment for speech pathology costs in excess of limitation (chapter 14)   32. 00   CAH HIT Adjustment for Depreciation and Interest   O   O   O   32. 00   O   O   O   32. 00   O   O   O   32. 00   O   O   34. 00   O   O   35. 00   O   O   36. 00   O   37. 00   O   38. 00   O   39. 00   O   30. 00	26. 00			0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest  0 **** Cost Center Deleted **** 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	o	27. 00
30. 00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adj ustment for Depreciation and Interest  A-8-3  OCCUPATIONAL THERAPY  67. 00  30. 00  A-8-3  OSPEECH PATHOLOGY  68. 00  31. 00  32. 00		Non-physician Anesthetist		0	*** Cost Center Deleted ***			
limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest  O ADULTS & PEDIATRICS 30. 00 30. 99 31. 00 31. 00 31. 00 32. 00			A-8-3	0	OCCUPATI ONAL THERAPY		0	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest  OADULTS & PEDIATRICS 30. 00 30. 99 31. 00 SPEECH PATHOLOGY 68. 00 31. 00 0 0 0 0 32. 00								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  A-8-3 OSPEECH PATHOLOGY 68.00 31.00  O O O O O O O O O O O O O O O O O O	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
I i mi tation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest		pathology costs in excess of limitation (chapter 14)						
	32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
	33. 00		В	-170, 050	CENTRAL SERVICES & SUPPLY	14. 00	0	33. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 31-0041 

Depende Class   Traction on Nort-Sheet A					To	12/31/2023	Date/Time Prep 5/20/2024 2:3	
Court Centur Description								
1					IO/From Which the Amount IS	to be Adjusted		
1.00   2.00   3.00   3.00   4.00   5.00   5.00   3.00								
1.00   2.00   3.00   3.00   4.00   5.00   5.00   3.00								
33.01 GARNISHER SERVICE CHARGE BEV B3,775 BPLOVEE SERVETTS DEPARTMENT		Cost Center Description						
33.02 OUTREACH LAB 33.03 OTHER MI SCELLANEOUS REVENUE 33.04 OTHER MI SCELLANEOUS REVENUE 33.05 OTHER MI SCELLANEOUS REVENUE 33.06 OTHER MI SCELLANEOUS REVENUE 35.06 OTHER MI SCELLANEOUS REVENUE 36.10 OTHER MI SCELLANEOUS REVENUE 37.07 OTHER MI SCELLANEOUS REVENUE 38.11 OTHER MI SCELLANEOUS REVENUE 38.11 OTHER MI SCELLANEOUS REVENUE 38.11 OTHER MI SCELLANEOUS REVENUE 39.12 OTHER MI SCELLANEOUS REVENUE 39.13 OF OTHER MI SCELLANEOUS REVENUE 39.13 OF OTHER MI SCELLANEOUS REVENUE 39.14 OLD SCELLANEOUS REVENUE 39.15 OTHER MI SCELLANEOUS REVENUE 39.16 OTHER MI SCELLANEOUS REVENUE 39.17 OTHER MI SCELLANEOUS REVENUE 39.17 OTHER MI SCELLANEOUS REVENUE 39.18 OTHER MI SCELLANEOUS REVENUE 39.19 OTHER MI SCELLANEOUS REVENUE 39.10 OTHER MI SCELLANEOUS REVENUE 39.10 OTHER MI SCELLANEOUS REVENUE 39.11 OTHER MI SCELLANEOUS REVENUE 39.11 OTHER MI SCELLANEOUS REVENUE 39.11 OTHER MI SCELLANEOUS REVENUE 39.12 OTHER MI SCELLANEOUS REVENUE 39.13 OTHER MI SCELLANEOUS REVENUE 39.14 OTHER MI SCELLANEOUS REVENUE 39.15 OTHER MI SCELLANEOUS REVENUE 39.16 OTHER MI SCELLANEOUS REVENUE 39.17 OTHER MI SCELLANEOUS REVE	33 01	GARNISHEE SERVICE CHARGE REV						33 01
33.00		1						
33.05   OTHER MISCELLARGUS REVENUE   B			1	·	1		0	
Control   Cont		1	1					
0.01   0.01   0.02   0.03	33. 05	OTHER MISCELLANEOUS REVENUE	В	-1, 340		22.00	U	33.05
33.00   EMPLOYEE - HEALTH PAYMENTS   B   -10, 7004 DULL S & PEDIATRICS   30.00   0 33.00   33.00   SANDER - HEALTH PAYMENTS   B   -4, 7024 DULL S CARE UNIT   34.00   0 33.10   0 33.00   33.11   EMPLOYEE - HEALTH PAYMENTS   B   -375 DURL S CARE UNIT   34.00   0 33.11   SANDER - HEALTH PAYMENTS   B   -375 DURL S CARE UNIT   34.00   0 33.11   SANDER - HEALTH PAYMENTS   B   -325 DURL S CARE UNIT   34.00   0 33.11   SANDER - HEALTH PAYMENTS   B   -325 DURL S CARE UNIT   34.00   0 33.11   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.13   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.13   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.13   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.16   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.16   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.16   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.16   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.16   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.16   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.17   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.17   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.17   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.23   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.23   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.23   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.23   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.23   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.23   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.24   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.24   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTING ROOM   50.00   0 33.35   SANDER - HEALTH PAYMENTS   B   -75 OD FERNTI	33. 06	OTHER MI SCELLANEOUS REVENUE	В	-100, 800		50.00	0	33. 06
13.0   EMPLOYEE   HEALTH PAYMENTS   B   -4.029   NTENSIVE CARE HINT   31.00   0   33.00   33.10		1	1				0	
33.10   RAPLOYTE - HEALTH PAYMENTS   B   -373/SURGICAL INTENSIVE CARE UNIT   34.00   0.33.10   33.10   BAPLOYTE - HEALTH PAYMENTS   B   -526/SELED NUESTIG ROOM   50.00   0.33.12   33.12   BAPLOYTE - HEALTH PAYMENTS   B   -5.76/DOPERATING ROOM   50.00   0.33.12   33.13   BAPLOYTE - HEALTH PAYMENTS   B   -2.95/DOPERATING ROOM   50.00   0.33.13   33.15   BAPLOYTE - HEALTH PAYMENTS   B   -2.95/DOPERATING ROOM   50.00   0.33.13   33.16   BAPLOYTE - HEALTH PAYMENTS   B   -2.95/DOPERATING ROOM   50.00   0.33.13   33.16   BAPLOYTE - HEALTH PAYMENTS   B   -2.95/DOPERATING ROOM   50.00   0.33.17   33.17   33.17   BAPLOYTE - HEALTH PAYMENTS   B   -3.76/ADDICOST-HERAPITIT   55.00   0.33.18   33.17   33.17   BAPLOYTE - HEALTH PAYMENTS   B   -5.76/ADDICOST-HERAPITIT   55.00   0.33.18   33.18   BAPLOYTE - HEALTH PAYMENTS   B   -2.96/ADDICOST-HERAPITIT   55.00   0.33.19   33.17		1	1					
33.12   EMPLOYEE - HEALTH PAYMENTS   B   -5,762 PERATING ROOM   50.00   0.33.12			1					
33.13   BIPLOYEE - HEALTH PAYMENTS   B   -1,114 SCOVERY ROOM   51.00   0.33.13   33.15   BIPLOYEE - HEALTH PAYMENTS   B   -2,650 DELIVERY ROOM   62.00   0.33.15   33.15   BIPLOYEE - HEALTH PAYMENTS   B   -7,30 DP INFUSION   52.01   0.33.15   33.15   BIPLOYEE - HEALTH PAYMENTS   B   -7,30 DP INFUSION   52.01   0.33.15   33.17   BIPLOYEE - HEALTH PAYMENTS   B   -7,30 DP INFUSION   55.00   0.33.17   33.17   BIPLOYEE - HEALTH PAYMENTS   B   -2,00 MADIOLOSY-HIGHAPHITC   55.00   0.33.17   33.19   BIPLOYEE - HEALTH PAYMENTS   B   -2,00 MADIOLOSY-HIGHAPHITC   55.00   0.33.17   33.19   BIPLOYEE - HEALTH PAYMENTS   B   -2,00 MADIOLOSY-HIGHAPHITC   55.00   0.33.19   33.19   BIPLOYEE - HEALTH PAYMENTS   B   -2,00 MADIOLOSY-HIGHAPHITC   55.00   0.33.19   33.22   BIPLOYEE - HEALTH PAYMENTS   B   -2,00 MADIOLOSY-HIGHAPHITC   55.00   0.33.19   33.22   BIPLOYEE - HEALTH PAYMENTS   B   -2,00 MADIOLOSY-HIGHAPHITC   55.00   0.33.22   33.24   BIPLOYEE - HEALTH PAYMENTS   B   -3,00 MADIOLOSY-HIGHAPHITC   56.00   0.33.23   33.25   BIPLOYEE - HEALTH PAYMENTS   B   -3,00 MADIOLOSY-HIGHAPHITC   56.00   0.33.23   33.25   BIPLOYEE - HEALTH PAYMENTS   B   -3,00 MADIOLOSY-HIGHAPHITC   56.00   0.33.23   33.25   BIPLOYEE - HEALTH PAYMENTS   B   -3,00 MADIOLOSY-HIGHAPHITC   56.00   0.33.23   33.26   BIPLOYEE - HEALTH PAYMENTS   B   -3,00 MADIOLOSY-HIGHAPHITC   56.00   0.33.23   33.26   BIPLOYEE - HEALTH PAYMENTS   B   -3,00 MADIOLOSY-HIGHAPHITC   56.00   0.33.23   33.27   BIPLOYEE - HEALTH PAYMENTS   B   -3,00 MADIOLOSY-HIGHAPHITC   56.00   0.33.23   33.30   BIPLOYEE - HEALTH PAYMENTS   B   -3,00 MADIOLOSY-HIGHAPHITC   56.00   0.33.23   33.30   BIPLOYEE - HEALTH PAYMENTS   B   -3,00 MADIOLOSY-HIGHAPHITC   57.00   0.33.33   33.31   BIPLOYEE - HEALTH PAYMENTS   B   -2,70 MADIOLOSY-HIGHAPHITC   57.00   0.33.33   33.33   BIPLOYEE - HEALTH PAYMENTS   B   -2,70 MADIOLOSY-HIGHAPHITC   57.00   0.33.33   33.33   BIPLOYEE - HEALTH PAYMENTS   B   -2,70 MADIOLOSY-HIGHAPHITC   57.00   0.33.33   33.33   BIPLOYEE - HEALTH PAYMENTS   B   -2,70 MADIOLOSY-HIG		1	1				0	
SPECIFIC STATES   SPECIFIC S			1					
September   Sept		1	1				0	
Section   Sect			1	·			0	
33.18   MM_OVEE - HEALTH PAYMENTS   B			1				ŭ	
MM_OVEE - HEALTH PAYMENTS   B		1	1					
A		·		·	1			
33. 22 EMPLOYEE - HEALTH PAYMENTS B -9,380 (ABDRATORY) 60,00 0 33,22 3.2 24 3.3 24 EMPLOYEE - HEALTH PAYMENTS B -9,380 (ABDRATORY) 60,00 0 33,23 3.3 24 EMPLOYEE - HEALTH PAYMENTS B -337 (ESP) (ABDRATORY) 60,00 0 33,24 3.3 26 EMPLOYEE - HEALTH PAYMENTS B -337 (ESP) (ABDRATORY) 60,00 0 33,24 3.3 26 EMPLOYEE - HEALTH PAYMENTS B -50,00 (COUPATIONAL THERAPY) 66,00 0 33,26 3.3 26 EMPLOYEE - HEALTH PAYMENTS B -50,00 (COUPATIONAL THERAPY) 66,00 0 33,26 3.3 26 EMPLOYEE - HEALTH PAYMENTS B -50,00 (COUPATIONAL THERAPY) 66,00 0 33,26 3.3 26 EMPLOYEE - HEALTH PAYMENTS B -50,00 (COUPATIONAL THERAPY) 70,00 0 33,29 EMPLOYEE - HEALTH PAYMENTS B -54,00 (COUPATIONAL THERAPY) 70,00 0 33,29 EMPLOYEE - HEALTH PAYMENTS B -54,00 (COUPATIONAL THERAPY) 70,00 0 33,29 EMPLOYEE - HEALTH PAYMENTS B -54,00 (COUPATIONAL THERAPY) 70,00 0 33,30 (COUPATIONAL THERAPY) 70,00 0 33,40 (COUPATIONAL THERAPY) 70,00 0 33,40 (COUPATIONAL THERAPY) 70,00 0 33,40		1	1		1		0	
33. 22   EMPLOYEE - HEALTH PAYMENTS   B   -9.386/LABORATORY   F. FRALTH PAYMENTS   B   -3.378ESPIRATORY   THERAPY   66. 00   0.33. 24		1						
13.2   1		1	1	·	1			
33. 26		1	1	·	1			
13.2   EMPLOYEE - HEALTH PAYMENTS   B   -5-4  SPEECH PATHOLOGY   68.00   0   33.28			1					
13.2   EMPLOYEE - HEALTH PAYMENTS   B   -2,7772  ELECTROCARDIOLOGY   69, 00   0   33.29		1	1					
33. 30 EMPLOYEE - HEALTH PAYMENTS B -64MEDICAL SUPPLIES CHARGED TO PATIENT 71. 00 0 33. 30 PATIENT 72. 00 0 33. 30 PATIENT 72. 00 0 33. 30 PATIENT 73. 00 0 33. 30 PATIENT 75. 00 0 33. 30 PATIENT 75. 00 0 33. 30 PATIENT 75. 00 0 33. 31 PATIENTS 75. 00 0 33. 32 PATIENTS 75. 00 0 33. 34 PATIENTS 75. 00 0 33. 34 PATIENTS 75. 00 0 0 33. 35 PATIENTS 75. 00 0 0 33. 36 PATIENTS 75. 00 0 0 33. 37 PATIENTS 75. 00 0 0 33. 40			1					
PATIENT   PAYMENTS   B		1	1				0	
PATIENTS	33. 30	EMPLOYEE - HEALTH PAYMENTS			PATI ENT	71. 00	0	33. 30
33 33   EMPLOYEE   HEALTH PAYMENTS   B	33. 31	EMPLOYEE - HEALTH PAYMENTS	В	-1, 294		72. 00	0	33. 31
San San		1					0	
33.36   EMPLOYEE - HEALTH PAYMENTS		1	1				0	
33. 37   RMPLOYEE - HEALTH PAYMENTS   B   -2,095  OBSERVATION BEDS-DISTINCT   92.01   0   33. 37     RENTAL INCOME   B   -249,166  ADMINISTRATIVE & GENERAL   5.00   0   33. 38     33. 38   RENTAL INCOME   B   -27,008  RADIO LOGY-DIAGNOSTIC   54.00   0   33. 39     33. 40   RENTAL INCOME   B   -21,576  PHYSICAL THERAPY   66.00   0   33. 40     33. 41   FOUNDATION SUBSIDY   B   -51,183  EMPLOYEE BENEFITS DEPARTMENT   4.00   0   33. 41     33. 42   FOUNDATION SUBSIDY   B   -236,258  ADMINISTRATIVE & GENERAL   5.00   0   33. 42     33. 43   FOUNDATION SUBSIDY   B   -17,946  MAINTENANCE & REPAIRS   6.00   0   33. 43     33. 44   FOUNDATION SUBSIDY   B   -39,246  OPERATION OF PLANT   7.00   0   33. 43     33. 45   FOUNDATION SUBSIDY   B   -8,672  DIETARY   10.00   0   33. 45     33. 46   FOUNDATION SUBSIDY   B   -68,976  NURSING ADMINISTRATION   13.00   0   33. 47     33. 48   FOUNDATION SUBSIDY   B   -40,283 CENTRAL SERVICES & SUPPLY   14.00   0   33. 47     33. 48   FOUNDATION SUBSIDY   B   -30,909  & RESPRICES-OTHER PRGM.   22.00   0   33. 49     33. 50   FOUNDATION SUBSIDY   B   -99,070 ADULTS & PEDIATRICS   30.00   0   33. 50     33. 51   FOUNDATION SUBSIDY   B   -52,150  NUTENSIVE CARE UNIT   31.00   0   33. 50     33. 53   FOUNDATION SUBSIDY   B   -52,150  NUTENSIVE CARE UNIT   31.00   0   33. 50     33. 53   FOUNDATION SUBSIDY   B   -6,899  SILLED NURSING FACILITY   44.00   0   33. 51     33. 54   FOUNDATION SUBSIDY   B   -6,899  SILLED NURSING FACILITY   44.00   0   33. 53     33. 55   FOUNDATION SUBSIDY   B   -6,899  SILLED NURSING FACILITY   44.00   0   33. 53     33. 56   FOUNDATION SUBSIDY   B   -6,899  SILLED NURSING FACILITY   44.00   0   33. 53     33. 57   FOUNDATION SUBSIDY   B   -6,899  SILLED NURSING FACILITY   44.00   0   33. 53     33. 56   FOUNDATION SUBSIDY   B   -6,899  SILLED NURSING FACILITY   44.00   0   0   0   0     33. 57   FOUNDATION SUBSIDY   B   -6,899  SILLED NURSING FACILITY   44.00   0   0   0   0     33. 57   FOUNDATION SUBSIDY   B   -6,899  SILLED NURSING FACILITY   44.00   0		1	1					
33.38   RENTAL INCOME		1			1		0	
33. 39   RENTAL INCOME			1				0	
33. 40   RENTAL INCOME   B   -21,576 PHYSICAL THERAPY   66.00   0   33.40     33.41   FOUNDATI ON SUBSI DY   B   -51,183 EMPLOYEE BENEFITS DEPARTMENT   4.00   0   33.41     33.42   FOUNDATI ON SUBSI DY   B   -236,258 ADMI NI STRATI VE & GENERAL   5.00   0   33.42     33.43   FOUNDATI ON SUBSI DY   B   -79,246 DPERATI ON OF PLANT   7.00   0   33.43     33.44   FOUNDATI ON SUBSI DY   B   -8,672 DI ETARY   10.00   0   33.45     33.45   FOUNDATI ON SUBSI DY   B   -8,672 DI ETARY   10.00   0   33.45     33.46   FOUNDATI ON SUBSI DY   B   -68,976 NURSI NG ADMI NI STRATI ON   13.00   0   33.46     33.47   FOUNDATI ON SUBSI DY   B   -40,283 CENTRAL SERVI CES & SUPPLY   14.00   0   33.47     33.49   FOUNDATI ON SUBSI DY   B   -150 SOCI AL SERVI CE   17.00   0   33.49     33.50   FOUNDATI ON SUBSI DY   B   -99,070 ADULTS & PEDI ATRICS   30.00   0   33.50     33.51   FOUNDATI ON SUBSI DY   B   -99,070 ADULTS & PEDI ATRICS   30.00   0   33.51     33.52   FOUNDATI ON SUBSI DY   B   -474 NURSERY   44.00   0   33.51     33.54   FOUNDATI ON SUBSI DY   B   -474 NURSERY   44.00   0   33.53     33.55   FOUNDATI ON SUBSI DY   B   -474 NURSERY   44.00   0   33.55     33.55   FOUNDATI ON SUBSI DY   B   -474 NURSERY   44.00   0   33.55     33.55   FOUNDATI ON SUBSI DY   B   -474 NURSERY   44.00   0   33.55     33.56   FOUNDATI ON SUBSI DY   B   -474 NURSERY   44.00   0   33.55     33.56   FOUNDATI ON SUBSI DY   B   -4,6829 SKI LLED NURSI NG FACI LITY   44.00   0   33.55     33.56   FOUNDATI ON SUBSI DY   B   -4,6829 SKI LLED NURSI NG FACI LITY   44.00   0   33.55     33.57   FOUNDATI ON SUBSI DY   B   -4,6829 SKI LLED NURSI NG FACI LITY   44.00   0   33.55     33.56   FOUNDATI ON SUBSI DY   B   -4,6829 SKI LLED NURSI NG FACI LITY   44.00   0   33.55     33.57   FOUNDATI ON SUBSI DY   B   -4,6829 SKI LLED NURSI NG FACI LITY   44.00   0   33.55     33.58   FOUNDATI ON SUBSI DY   B   -4,6829 SKI LLED NURSI NG FACI LITY   44.00   0   33.56     33.58   FOUNDATI ON SUBSI DY   B   -4,6829 SKI LLED NURSI NG FACI LITY   44.00   0   33.56							0	
33. 42   FOUNDATI ON SUBSI DY   B   -236, 258   ADMIN IN STRATI VE & GENERAL   5. 00   0   33. 42		1	1	-21, 576	PHYSICAL THERAPY	66. 00	0	
33. 43   FOUNDATI ON SUBSI DY   B   -17, 946   MAI NTENANCE & REPAIRS   6. 00   0   33. 43     33. 44   FOUNDATI ON SUBSI DY   B   -39, 246   OPERATI ON OF PLANT   7. 00   0   33. 44     33. 45   FOUNDATI ON SUBSI DY   B   -8, 672   DIETARY   10. 00   0   33. 45     33. 46   FOUNDATI ON SUBSI DY   B   -68, 976   NURSI NG ADMI NI STRATI ON   13. 00   0   33. 45     33. 47   FOUNDATI ON SUBSI DY   B   -40, 283   CENTRAL SERVI CES & SUPPLY   14. 00   0   33. 47     33. 48   FOUNDATI ON SUBSI DY   B   -150   SOCI AL SERVI CE & SUPPLY   14. 00   0   33. 47     33. 49   FOUNDATI ON SUBSI DY   B   -150   SOCI AL SERVI CE & SUPPLY   14. 00   0   33. 48     33. 50   FOUNDATI ON SUBSI DY   B   -30, 999   & SERVI CES -0THER PRGM.   22. 00   0   33. 50     33. 51   FOUNDATI ON SUBSI DY   B   -99, 070   ADULTS & PEDI ATRI CS   30. 00   0   33. 51     33. 52   FOUNDATI ON SUBSI DY   B   -99, 070   ADULTS & PEDI ATRI CS   30. 00   0   33. 51     33. 53   FOUNDATI ON SUBSI DY   B   -474   NURSERY   43. 00   0   33. 52     33. 53   FOUNDATI ON SUBSI DY   B   -474   NURSERY   44. 00   0   33. 53     33. 54   FOUNDATI ON SUBSI DY   B   -1, 633   OPERATI NG ROOM   50. 00   0   33. 53     33. 55   FOUNDATI ON SUBSI DY   B   -1, 633   OPERATI NG ROOM   50. 00   0   33. 55     33. 55   FOUNDATI ON SUBSI DY   B   -2, 185   DELI VERY ROOM & LABOR ROOM   52. 00   0   33. 55     33. 55   FOUNDATI ON SUBSI DY   B   -3, 253   RADI OLOGY-DI AGNOSTI C   54. 00   0   33. 56     33. 58   FOUNDATI ON SUBSI DY   B   -5, 372   OP I NFUSI ON   59. 00   0   33. 58     33. 59   FOUNDATI ON SUBSI DY   B   -6, 69   PERATI ON CARTIFICITY   65. 00   0   33. 61     33. 61   FOUNDATI ON SUBSI DY   B   -6, 69   PERATI ON CARTIFICITY   65. 00   0   33. 61     33. 62   FOUNDATI ON SUBSI DY   B   -6, 69   PERATI ON CARTIFICITY   65. 00   0   33. 62     33. 64   FOUNDATI ON SUBSI DY   B   -1, 69   PERATI ON CARTIFICITY   65. 00   0   33. 63     33. 64   FOUNDATI ON SUBSI DY   B   -1, 69   PERATI ON CARTIFICITY   65. 00   0   33. 63     33. 64   FOUNDATI ON S								
33. 44 FOUNDATI ON SUBSI DY  33. 45 FOUNDATI ON SUBSI DY  33. 46 FOUNDATI ON SUBSI DY  33. 46 FOUNDATI ON SUBSI DY  33. 47 FOUNDATI ON SUBSI DY  34. 67 FOUNDATI ON SUBSI DY  35. 67 FOUNDATI ON SUBSI DY  36. 67. 68. 67. 69. 69. 69. 69. 69. 69. 69. 69. 69. 69		1					_	
33. 46   FOUNDATI ON SUBSI DY   B   -68, 976   NURSI NG ADMI NI STRATI ON   13. 00   0   33. 46		·		-39, 246	OPERATION OF PLANT			
33. 47   FOUNDATION SUBSIDY   B   -40, 283 CENTRAL SERVICES & SUPPLY   14. 00   0   33. 47		1	1					
33. 48   FOUNDATI ON SUBSI DY   B   -150   SOCI AL SERVI CE   17. 00   0   33. 48			1					
33. 49   FOUNDATI ON SUBSI DY   B   -30,909   &R SERVI CES-OTHER PRGM.   22.00   0   33.49		1	1	·	1		-	
33. 50 FOUNDATI ON SUBSIDY B -99, 070 ADULTS & PEDI ATRICS 30. 00 0 33. 50 33. 51 FOUNDATI ON SUBSIDY B -52, 150 INTENSIVE CARE UNIT 31. 00 0 33. 51 31. 52 FOUNDATI ON SUBSIDY B -474 NURSERY 43. 00 0 33. 52 33. 53 FOUNDATI ON SUBSIDY B -6, 829 SKI LLED NURSING FACILITY 44. 00 0 33. 53 33. 54 FOUNDATI ON SUBSIDY B -1, 633 OPERATING ROOM 50. 00 0 33. 55 FOUNDATI ON SUBSIDY B -2, 185 DELI VERY ROOM & LABOR ROOM 50. 00 0 33. 55 33. 56 FOUNDATI ON SUBSIDY B -5, 372 OP INFUSION 52. 01 0 33. 56 33. 57 FOUNDATI ON SUBSIDY B -3, 253 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 57 33. 58 FOUNDATI ON SUBSIDY B -61, 635 RADI OLOGY-THERAPEUTI C 55. 00 0 33. 58 33. 59 FOUNDATI ON SUBSIDY B -5, 949 MRI 58. 00 0 33. 59 33. 60 FOUNDATI ON SUBSIDY B -670 CARDI AC CATHETERI ZATI ON 59. 00 0 33. 60 33. 61 FOUNDATI ON SUBSIDY B -200 RESPIRATORY THERAPY 65. 00 0 33. 62 33. 63 FOUNDATI ON SUBSIDY B -1, 141 OCCUPATI ONAL THERAPY 67. 00 0 33. 63 33. 64 FOUNDATI ON SUBSIDY B -1, 669 SPEECH PATHOLOGY 69. 00 0 33. 64 FOUNDATI ON SUBSIDY B -1, 669 SPEECH PATHOLOGY 69. 00 0 33. 64		1			I&R SERVICES-OTHER PRGM.			
33. 52   FOUNDATI ON SUBSIDY   B   -474   NURSERY   43. 00   0   33. 52		1			ADULTS & PEDIATRICS		0	
33. 53 FOUNDATI ON SUBSIDY B -6,829 SKILLED NURSING FACILITY 44. 00 0 33. 53   33. 54 FOUNDATI ON SUBSIDY B -1,633 OPERATING ROOM 50. 00 0 33. 54   33. 55 FOUNDATI ON SUBSIDY B -2,185 DELI VERY ROOM & LABOR ROOM 52. 00 0 33. 55   33. 56 FOUNDATI ON SUBSIDY B -5,372 OP I NFUSI ON 52. 01 0 33. 56   33. 57 FOUNDATI ON SUBSIDY B -3,253 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 57   33. 58 FOUNDATI ON SUBSIDY B -61,635 RADI OLOGY-THERAPEUTI C 55. 00 0 33. 58   33. 59 FOUNDATI ON SUBSI DY B -5,949 MRI 58. 00 0 33. 59   33. 60 FOUNDATI ON SUBSI DY B -670 CARDI AC CATHETERI ZATI ON 59. 00 0 33. 61   33. 61 FOUNDATI ON SUBSI DY B -1,141 OCCUPATI ONAL THERAPY 65. 00 0 33. 61   33. 63 FOUNDATI ON SUBSI DY B -1,669 SPEECH PATHOLOGY 68. 00 0 33. 63   33. 64 FOUNDATI ON SUBSI DY B -350 ELECTROCARDI OLOGY 69. 00 0 33. 64		1						
33. 54 FOUNDATI ON SUBSIDY B -1, 633 OPERATI NG ROOM 50. 00 0 33. 54 33. 55 FOUNDATI ON SUBSIDY B -2, 185 DELI VERY ROOM & LABOR ROOM 52. 00 0 33. 55 33. 56 FOUNDATI ON SUBSIDY B -5, 372 OP I NFUSI ON 52. 01 0 33. 56 33. 57 FOUNDATI ON SUBSIDY B -3, 253 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 57 33. 58 FOUNDATI ON SUBSIDY B -61, 635 RADI OLOGY-THERAPEUTI C 55. 00 0 33. 58 33. 59 FOUNDATI ON SUBSI DY B -5, 949 MRI 58. 00 0 33. 59 33. 60 FOUNDATI ON SUBSI DY B -670 CARDI AC CATHETERI ZATI ON 59. 00 0 33. 60 33. 61 FOUNDATI ON SUBSI DY B -200 RESPI RATORY THERAPY 65. 00 0 33. 61 33. 62 FOUNDATI ON SUBSI DY B -1, 141 OCCUPATI ONAL THERAPY 67. 00 0 33. 62 33. 63 FOUNDATI ON SUBSI DY B -1, 669 SPEECH PATHOLOGY 68. 00 0 33. 63 33. 64 FOUNDATI ON SUBSI DY B -350 ELECTROCARDI OLOGY 69. 00 0 33. 64			1					
33. 56 FOUNDATI ON SUBSIDY B -5, 372 OP INFUSION 52. 01 0 33. 56 33. 57 FOUNDATI ON SUBSIDY B -3, 253 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 57 33. 58 FOUNDATI ON SUBSIDY B -61, 635 RADI OLOGY-THERAPEUTI C 55. 00 0 33. 58 33. 59 FOUNDATI ON SUBSIDY B -5, 949 MRI 58. 00 0 33. 59 33. 60 FOUNDATI ON SUBSIDY B -670 CARDI AC CATHETERI ZATI ON 59. 00 0 33. 60 33. 61 FOUNDATI ON SUBSI DY B -200 RESPI RATORY THERAPY 65. 00 0 33. 61 33. 62 FOUNDATI ON SUBSI DY B -1, 141 OCCUPATI ONAL THERAPY 67. 00 0 33. 62 33. 63 FOUNDATI ON SUBSI DY B -1, 669 SPEECH PATHOLOGY 68. 00 0 33. 63 33. 64 FOUNDATI ON SUBSI DY B -350 ELECTROCARDI OLOGY 69. 00 0 33. 64		·	В					
33. 57 33. 58 FOUNDATI ON SUBSI DY B -3, 253 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 57 33. 58 FOUNDATI ON SUBSI DY B -61, 635 RADI OLOGY-THERAPEUTI C 55. 00 0 33. 58 33. 59 FOUNDATI ON SUBSI DY B -5, 949 MRI 58. 00 0 33. 59 33. 60 FOUNDATI ON SUBSI DY B -670 CARDI AC CATHETERI ZATI ON 59. 00 0 33. 60 33. 61 FOUNDATI ON SUBSI DY B -200 RESPI RATORY THERAPY 65. 00 0 33. 61 33. 62 FOUNDATI ON SUBSI DY B -1, 141 OCCUPATI ONAL THERAPY 67. 00 0 33. 62 33. 63 FOUNDATI ON SUBSI DY B -1, 669 SPEECH PATHOLOGY 68. 00 0 33. 63 33. 64 FOUNDATI ON SUBSI DY B -350 ELECTROCARDI OLOGY 69. 00 0 33. 64		1						
33. 58 FOUNDATI ON SUBSIDY B -61, 635 RADI OLOGY-THERAPEUTI C 55. 00 0 33. 58 33. 59 FOUNDATI ON SUBSIDY B -5, 949 MRI 58. 00 0 33. 59 33. 60 FOUNDATI ON SUBSIDY B -670 CARDI AC CATHETERI ZATI ON 59. 00 0 33. 60 33. 61 FOUNDATI ON SUBSIDY B -200 RESPIRATORY THERAPY 65. 00 0 33. 61 33. 62 FOUNDATI ON SUBSIDY B -1, 141 OCCUPATI ONAL THERAPY 67. 00 0 33. 62 33. 63 FOUNDATI ON SUBSIDY B -1, 669 SPEECH PATHOLOGY 68. 00 0 33. 63 33. 64 FOUNDATI ON SUBSIDY B -350 ELECTROCARDI OLOGY 69. 00 0 33. 64		N. C.						
33. 59 FOUNDATI ON SUBSIDY B -5, 949 MRI 58. 00 0 33. 59 33. 60 FOUNDATI ON SUBSIDY B -670 CARDI AC CATHETERI ZATI ON 59. 00 0 33. 60 33. 61 FOUNDATI ON SUBSIDY B -200 RESPIRATORY THERAPY 65. 00 0 33. 61 33. 62 FOUNDATI ON SUBSIDY B -1, 141 OCCUPATI ONAL THERAPY 67. 00 0 33. 62 33. 63 FOUNDATI ON SUBSIDY B -1, 669 SPEECH PATHOLOGY 68. 00 0 33. 63 33. 64 FOUNDATI ON SUBSIDY B -350 ELECTROCARDI OLOGY 69. 00 0 33. 64		1						
33. 61 FOUNDATI ON SUBSIDY B -200 RESPIRATORY THERAPY 65. 00 0 33. 61 33. 62 FOUNDATI ON SUBSIDY B -1, 141 OCCUPATI ONAL THERAPY 67. 00 0 33. 62 33. 63 FOUNDATI ON SUBSIDY B -1, 669 SPEECH PATHOLOGY 68. 00 0 33. 63 33. 64 FOUNDATI ON SUBSIDY B -350 ELECTROCARDI OLOGY 69. 00 0 33. 64	33. 59	1	В	-5, 949	MRI		-	33. 59
33. 62 FOUNDATI ON SUBSIDY B -1, 141 OCCUPATI ONAL THERAPY 67. 00 0 33. 62 33. 63 FOUNDATI ON SUBSIDY B -1, 669 SPEECH PATHOLOGY 68. 00 0 33. 63 33. 64 FOUNDATI ON SUBSIDY B -350 ELECTROCARDI OLOGY 69. 00 0 33. 64		1					-	
33. 63 FOUNDATI ON SUBSIDY B -1, 669 SPEECH PATHOLOGY 68. 00 0 33. 63 33. 64 FOUNDATI ON SUBSIDY B -350 ELECTROCARDI OLOGY 69. 00 0 33. 64		1	1					
33. 64 FOUNDATION SUBSIDY B -350 ELECTROCARDIOLOGY 69. 00 0 33. 64		1	1					
33. 65   FUUNDATION SUBSIDY   B   -239, 915   ELECTROENCEPHALOGRAPHY   70. 00   0   33. 65	33. 64	FOUNDATION SUBSIDY	В	-350	ELECTROCARDI OLOGY	69. 00		33. 64
	33. 65	FOUNDATION SUBSIDY	B	-239, 915 	LLECTROENCEPHALOGRAPHY	70. 00	0	33. 65

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 31-0041

				To	12/31/2023	Date/Time Prep 5/20/2024 2:39	
				Expense Classification on		5/20/2024 2.3	5 PIII
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
33. 66	FOUNDATION SUBSLIDY	1. 00 B	2.00	3. 00 CARDI AC REHABI LI TATI ON	4. 00 76. 97	5. 00 0	33. 66
33. 67	FOUNDATION SUBSIDY FOUNDATION SUBSIDY	В	-3, 397 -28, 202	1	90.00	0	33. 67
33. 68	FOUNDATION SUBSIDY	В		EMERGENCY	91. 00	0	33. 68
33. 69 33. 70	FOUNDATION SUBSIDY INTERCOMPANY RENTAL INCOME	B B	·	OBSERVATION BEDS-DISTINCT ADMINISTRATIVE & GENERAL	92. 01 5. 00	0	33. 69 33. 70
33. 71	INTERCOMPANY RENTAL INCOME	В	-237, 966	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 71
33. 72 33. 73	NON ALLOWABLE ENTERTAINMENT NON ALLOWABLE ENTERTAINMENT	A A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	33. 72 33. 73
33. 74	NON ALLOWABLE ENTERTAINMENT	A		OPERATION OF PLANT	7. 00	Ö	33. 74
33. 75 33. 76	NON ALLOWABLE ENTERTAINMENT NON ALLOWABLE ENTERTAINMENT	A A		HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	33. 75 33. 76
33. 77	NON ALLOWABLE ENTERTAINMENT	A		NURSING ADMINISTRATION	13. 00	0	33. 77
33. 78 33. 79	NON ALLOWABLE ENTERTAINMENT NON ALLOWABLE ENTERTAINMENT	A A	· ·	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	33. 78 33. 79
33. 80	NON ALLOWABLE ENTERTAINMENT	A		SOCIAL SERVICE	17. 00	0	33. 79
33. 81	NON ALLOWABLE ENTERTAINMENT	A	-7, 490	I &R SERVICES-OTHER PRGM.	22. 00	0	33. 81
33. 82	NON ALLOWABLE ENTERTAINMENT	A	-685	COSTS APPRVD PARAMED ED PRGM-(SPECIFY)	23. 00	0	33. 82
33. 83	NON ALLOWABLE ENTERTAINMENT	A	-4, 062	ADULTS & PEDIATRICS	30.00	0	33. 83
33. 84 33. 85	NON ALLOWABLE ENTERTAINMENT NON ALLOWABLE ENTERTAINMENT	A A		INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	31. 00 34. 00	0	33. 84 33. 85
33. 86	NON ALLOWABLE ENTERTAINMENT	A	-437	SKILLED NURSING FACILITY	44.00	0	33. 86
33. 87 33. 88	NON ALLOWABLE ENTERTAINMENT NON ALLOWABLE ENTERTAINMENT	A A		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	33. 87 33. 88
33. 89	NON ALLOWABLE ENTERTAINMENT	A		RADI OLOGY-THERAPEUTI C	55. 00	0	33. 89
33. 90 33. 91	NON ALLOWABLE ENTERTAINMENT NON ALLOWABLE ENTERTAINMENT	A A		PHYSI CAL THERAPY ELECTROENCEPHALOGRAPHY	66. 00 70. 00	0	33. 90 33. 91
33. 92	NON ALLOWABLE ENTERTAINMENT	A		EMERGENCY	91. 00	0	33. 92
33. 93	NON ALLOWABLE ENTERTAINMENT	A		OBSERVATION BEDS-DISTINCT	92. 01	0	33. 93
33. 94 33. 95	COMMUNITY BENEFIT FQHC	A A		SOCIAL SERVICE ADMINISTRATIVE & GENERAL	17. 00 5. 00	0	33. 94 33. 95
33. 96	LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 96
33. 97 33. 98	BHMG/MMG NURSE PRACTIONERS (INCLUDES	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 97 33. 98
	FRI NGES)					_	
33. 99 34. 00	HBP   PENSION ADMINISTRATION COSTS	A A		DIETARY EMPLOYEE BENEFITS DEPARTMENT	10. 00 4. 00	0	33. 99 34. 00
34. 01	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 01
34. 02	(3) OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	34. 02
34. 03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34. 03
34. 04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	34. 04
34. 05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	
34. 06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	
34. 07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	
34. 08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	
34. 09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34. 09
34. 10 34. 11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	
	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		34. 11
34. 12 34. 13	OTHER ADJUSTMENTS (SPECIFY) (3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00 0. 00	0	
34. 13	(3)		0		0.00	0	
34. 14	OTHER ADJUSTMENTS (SPECIFY) (3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	
	(3)		20 041 570		0.00		
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-38, 961, 572				50. 00

Health Financial Systems		COMMUNITY MED	OLCAL CENTER	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Provider CCN: 31-0041	Peri od:	Worksheet A-8		
				From 01/01/2023		nanad.	
				To 12/31/2023	Date/Time Pre 5/20/2024 2:3		
			Expense Classification of	on Worksheet A			
			To/From Which the Amount i	s to be Adjusted			
0 1 0 1 5 11	D : (0   (0)	Δ 1		1.1 "	W . A 7 D C		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
	1. 00	2.00	3.00	4. 00	5. 00		

- (1) 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	lealth Financial Systems COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-						
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	3-1	
OFFICE	COSTS			From 01/01/2023 To 12/31/2023			
	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 ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED						
	HOME OFFICE COSTS:						
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	78, 627, 579	65, 288, 638	1.00	
2.00	0.00			0	0	2.00	
3.00	5. 00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL CENTER AUX	11, 031	11, 031	3. 00	
3. 01	5. 00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL CENTER FOU	100, 826	100, 826	3. 01	
3.02	5. 00	ADMINISTRATIVE & GENERAL	SAINT BARNABAS CORPORATION	585, 253	585, 253	3. 02	
3.03	95. 00	AMBULANCE SERVICES	AMBULANCE ADD ON	20, 156	0	3. 03	
4.00	0. 00			o	0	4.00	
5.00	TOTALS (sum of lines 1-4).			79, 344, 845	65, 985, 748	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/				
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00	A	0.00 RWJ BARNABAS HEALTH 100.0	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.
- $\hbox{E. Individual is director, of ficer, administrator, or key person of provider and related organization.}\\$
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems		COMMUNITY MEDIC	AL CENTER	In Lie	u of Form CMS-	2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED ORGA	NIZATIONS AND HOME	Provider CCN: 31-0041	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS					From 01/01/2023		
						To 12/31/2023	Date/Time Pro 5/20/2024 2::	
	Net	Wkst. A-7 Ref.				· .	3/20/2024 2.	) pili
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRE	D AS A RESULT OF TRA	ANSACTIONS WITH RELATED	ORGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:						
1.00	13, 338, 941	C	)					1. 00
2.00	0	C	)					2. 00
3.00	0	C	)					3. 00
3.01	0	C						3. 01
3.02	0	C	)					3. 02
3.03	20, 156	C	)					3. 03
4 00	0	۱ ،						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,	cordining 1 and/or 2, the amount arrowable should be find cated in cordinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	Comont under the Arrive		
	HEALTHCARE	6	6.00
7.00		7	7.00
8.00		8	8.00
7. 00 8. 00 9. 00		9	9.00
10. 00 100. 00		10	0.00
100.00		100	00.00

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

13, 359, 097

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 31-0041 

						0 12/31/2023	5/20/2024 2:3	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Provider Component	у рііі
	1. 00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	
1. 00		AGGREGATE-ADMINISTRATIVE &	10, 008, 744	9, 986, 307	22, 437	211, 500	103	1. 00
2.00		GENERAL AGGREGATE-ADULTS &	2, 966, 853		·	•		
3. 00		PEDIATRICS AGGREGATE-OPERATING ROOM	22, 800			0	0	3. 00
4. 00 5. 00		AGGREGATE-ANESTHESI OLOGY AGGREGATE-RADI OLOGY-DI AGNOST	985, 861 1, 731, 898	985, 861 1, 731, 898	0	0	0	4. 00 5. 00
6. 00		I C AGGREGATE-RADI OLOGY-THERAPEU	227, 643			0	0	6. 00
7. 00	59. 00	TI C AGGREGATE - CARDI AC CATHETERI ZATI ON	87, 013	87, 013	0	0	0	7. 00
8. 00	60.00	AGGREGATE-LABORATORY	238, 411	238, 411	0	0	0	8. 00
9. 00		AGGREGATE - RESPI RATORY THERAPY	62, 005	· ·	_	0	0	9. 00
10. 00 11. 00		AGGREGATE-ELECTROCARDI OLOGY AGGREGATE-ELECTROENCEPHALOGR	53, 179 164, 299		53, 179 0	211, 500 0	204 0	10. 00 11. 00
12. 00	91. 00	APHY AGGREGATE-EMERGENCY	2, 536, 044	2, 536, 044	0	0	0	12. 00
200.00			19, 084, 750					200. 00
	Wkst. A Line #	,	Unadjusted RCE		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 &	10, 473	524	0	0	346, 246	1. 00
2.00		GENERAL AGGREGATE-ADULTS &	0	0	0	0	0	
3. 00	50.00	PEDIATRICS AGGREGATE-OPERATING ROOM	0	0	0	0	0	3. 00
4. 00	1	AGGREGATE - ANESTHESI OLOGY	0	o o		0	o o	4. 00
5. 00	1	AGGREGATE-RADI OLOGY-DI AGNOST	o	0	0	0	0	5. 00
6.00	55. 00	AGGREGATE-RADI OLOGY-THERAPEU	0	0	0	0	53, 704	6. 00
7. 00	59. 00	AGGREGATE - CARDI AC CATHETERI ZATI ON	0	0	0	0	13, 327	7. 00
8. 00		AGGREGATE-LABORATORY	0	0	0	0	0	8. 00
9. 00	65.00	AGGREGATE-RESPI RATORY THERAPY	0	0	0	0	19, 072	9. 00
10. 00 11. 00		AGGREGATE-ELECTROCARDI OLOGY AGGREGATE-ELECTROENCEPHALOGR	20, 743 0	1, 037 0	0	0	18, 174 0	10. 00 11. 00
12.00	91. 00	APHY AGGREGATE-EMERGENCY	0	0	0	0	0	
200. 00	Wkst. A Line #	Cost Center/Physician	31, 216 Provi der	1, 561 Adjusted RCE	RCE	Adjustment	450, 523	200.00
	micse. A Erne "	I denti fi er	Component Share of col.	Li mi t	Di sal I owance	raj astiliert		
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		AGGREGATE-ADMINISTRATIVE &	776	11, 249		9, 997, 495		1. 00
2.00	30. 00	GENERAL AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2, 966, 853		2. 00
3.00	50. 00	AGGREGATE-OPERATING ROOM	0	0	0	22, 800		3. 00
4.00	53.00	AGGREGATE-ANESTHESI OLOGY	0	0	0	985, 861		4. 00
5. 00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	0	0	0	1, 731, 898		5. 00
6. 00	55. 00	AGGREGATE-RADI OLOGY-THERAPEU TI C	0	0	0	227, 643		6. 00
7. 00	59. 00	AGGREGATE-CARDI AC CATHETERI ZATI ON	0	0	0	87, 013		7. 00
8. 00	60.00	AGGREGATE-LABORATORY	0	0	0	238, 411		8. 00
9. 00	65. 00	AGGREGATE-RESPI RATORY THERAPY	0	0	0	62, 005		9. 00
10.00	1	AGGREGATE-ELECTROCARDI OLOGY	18, 174	38, 917		14, 262		10.00
11. 00		AGGREGATE-ELECTROENCEPHALOGR APHY	0	0	0	164, 299		11. 00
12. 00 200. 00	1	AGGREGATE-EMERGENCY	0 18, 950	0 50, 166	0 25, 450	2, 536, 044 19, 034, 584		12. 00 200. 00
	1	1						

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0041 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/20/2024 2:35 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFLTS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 12, 972, 827 12, 972, 827 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 10, 884, 360 10, 884, 360 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 35, 718, 932 133, 929 35, 852, 861 4.00 00500 ADMINISTRATIVE & GENERAL 103, 062, 828 4, 854, 781 2, 190, 151 5 00 667, 065 110, 774, 825 5 00 6.00 00600 MAINTENANCE & REPAIRS 681, 098 41, 222 3, 707 36, 078 762, 105 6.00 14, 645, 270 7.00 00700 OPERATION OF PLANT 12, 921, 060 206, 160 712, 781 805, 269 7.00 00800 LAUNDRY & LINEN SERVICE 1, 219, 806 1, 219, 806 8.00 8.00 C 00900 HOUSEKEEPI NG 9, 625 706, 629 9 00 5, 398, 756 151, 280 6, 266, 290 9 00 10.00 01000 DI ETARY 4, 217, 341 268, 601 60, 134 415, 465 4, 961, 541 10.00 01100 CAFETERI A 223, 537 278, 543 1, 960, 526 11.00 1, 454, 585 3, 861 11.00 01300 NURSING ADMINISTRATION 109, 339 856, 291 13.00 4.782.821 574.103 6. 322. 554 13.00 3, 913, 948 269, 636 14.00 01400 CENTRAL SERVICES & SUPPLY 513, 851 402.847 5, 100, 282 14 00 15.00 01500 PHARMACY 6, 316, 875 134, 152 135, 800 1, 202, 592 7, 789, 419 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 722, 296 16.00 198, 947 243, 835 2, 165, 078 16.00 01700 SOCIAL SERVICE 4, 545, 901 0 589, 284 5, 135, 185 17.00 17.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 5, 721, 009 C 0 1, 118, 411 6, 839, 420 21 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 4, 109, 602 0 115, 212 4, 224, 814 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 242, 397 40, 411 282, 808 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 38, 266, 435 2, 772, 195 77, 161 6, 777, 048 47, 892, 839 30.00 27, 875, 691 03100 INTENSIVE CARE UNIT 1, 526, 582 79, 341 5, 152, 906 34, 634, 520 31.00 31.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 3, 848, 226 117, 717 7, 272 649, 292 4, 622, 507 34.00 3, 996, 609 43.00 04300 NURSERY 3, 236, 247 165, 558 6,638 588, 166 43.00 04400 SKILLED NURSING FACILITY 44.00 4,070,313 213, 968 995 668, 993 4, 954, 269 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13, 690, 272 844, 223 1, 383, 905 2, 063, 306 17, 981, 706 50.00 51.00 05100 RECOVERY ROOM 1, 717, 107 120, 469 5, 801 330, 273 2, 173, 650 51.00 4, 741, 076 05200 DELIVERY ROOM & LABOR ROOM 3, 627, 313 387, 929 679, 217 52.00 46, 617 52.00 52.01 03190 OP INFUSION 1, 811, 384 207, 226 C 334, 832 2, 353, 442 52.01 05300 ANESTHESI OLOGY 119, 996 4, 930 20. 497 170, 211 53.00 24, 788 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 392, 796 537, 796 584, 330 1, 263, 166 10, 778, 088 54.00 05500 RADI OLOGY-THERAPEUTI C 835, 860 8, 279, 780 55.00 6, 518, 086 359, 522 566, 312 55.00 05600 RADI OI SOTOPE 120, 220 1, 700, 919 56.00 1,531,489 12, 394 56.00 36, 816 18, 591 05700 CT SCAN 2, 963, 535 413, 008 3, 395, 134 57.00 57.00 58.00 05800 MRI 1,078,555 73, 521 155, 494 169, 425 1, 476, 995 58.00 59.00 05900 CARDIAC CATHETERIZATION 4, 117, 270 523, 172 281, 829 690, 621 5, 612, 892 59.00 06000 LABORATORY 18, 421, 697 311, 485 60 00 329, 827 0 19, 063, 009 60 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. Λ 63.00 65.00 06500 RESPIRATORY THERAPY 4, 341, 996 46, 651 251, 229 698, 745 5, 338, 621 65.00 66.00 06600 PHYSI CAL THERAPY 2, 588, 836 132, 739 16, 517 494, 879 3, 232, 971 66.00 06700 OCCUPATIONAL THERAPY 1, 425, 429 231, 991 67 00 1, 186, 795 67 00 6, 643 68.00 06800 SPEECH PATHOLOGY 340, 284 20, 772 66, 428 427, 484 68.00 06900 ELECTROCARDI OLOGY 3, 773, 062 110, 182 92, 517 520, 659 4, 496, 420 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 348, 830 230.031 126, 851 249, 149 1, 954, 861 70.00 70.01 07001 SLEEP LAB 0 0 70 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 20, 617, 037 0 0 20, 617, 037 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 18, 870, 417 0 18, 870, 417 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 44, 837, 283 44, 837, 283 73.00 0 0 73.00 07697 CARDIAC REHABILITATION 76.97 640, 386 60, 631 1.872 121, 493 824, 382 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 298, 291 64, 448 362, 739 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77 00 0 0 Ω 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 810.342 34.797 845.139 90.00 09100 EMERGENCY 91.00 18, 400, 514 1, 417, 169 176.482 2, 803, 555 22, 797, 720 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 09201 OBSERVATION BEDS-DISTINCT 756, 861 5, 135, 010 92.01 92.01 4, 378, 149 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 1, 140, 517 1, 140, 517 95.00 95.00 0 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 484, 745, 593 12, 972, 827 10, 838, 822 35, 736, 405 484, 583, 599 118. 00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 0 194. 00 194. 01 07951 PUBLIC RELATIONS 384 0 0 384 194. 01 0 194. 03 07952 LI GHTHOUSE 0 0 56, 255 194. 03 47,082 9, 173 0 194. 04 07953 KIDS & FAMILY 0 0 194. 04

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B		
				From 01/01/2023 To 12/31/2023	Part     Date/Time Pre	nared:	
				12/31/2023	5/20/2024 2: 3		
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
	col . 7)	1.00	2.00	4.00	4.0		
		1.00	2.00	4. 00	4A		
194.05 07954 OTHER NON REIMBURABLE	250, 191	0	45, 53	8 107, 118		1	
194. 06 07955  GRANTS/TRI ALS	1, 358	0		0 165	1, 523	194. 06	
194. 07 07956 RETAIL PHARMACY	0	0		0 0	0	194. 07	
200.00 Cross Foot Adjustments					0	200. 00	
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	485, 044, 608	12, 972, 827	10, 884, 36	35, 852, 861	485, 044, 608	202. 00	

Provider CCN: 31-0041

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/20/2024 2:35 pm

Cost Centrol Description						0 12/31/2023	5/20/2024 2:3	
		Cost Center Description					HOUSEKEEPI NG	
STREAM STRVICE ORST CRITTESS							9 00	
2 00 00000 CAP NEL COSIS-AMPSILE EQUIP 4 00 000000 CARRIVER ERRORET SEPARTMENT 5 00 000000 CARRIVER ERRORET SEPARTMENT 5 00 000000 CARRIVER SEPARTMENT 6 10 000000 CARRIVER SEPARTMENT 7 00 0000000 CARRIVER SEPARTMENT 7 00 0000000 CARRIVER SEPARTMENT 7 00 000000000000000000000000000000000		GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7. 00	
4.00   0.000   D.000	1.00							
5.00   DODODO JAWNIN SIRATI VE. & CENERON.   110, 774, 925   987, 670   16, 906, 703   1, 580, 839   6, 70   7		I I						1
6.00   DOSCIDIAN NI HEMMISE & REPAILS   225, 568   997, 670   18, 996, 703   19, 905   19			440 774 005					1
0,000   0,00				007 (70				1
0.000   DOSOO   LAURDRY & LINEN SERVICE   5.61, 033   0   0   1,500, 830   8.374, 280   10.00   10.00   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10			1		1			
0.000   0.0000   INTERVENTING   1, 854, 677   12, 317   241, 000   0.8, 374, 280   9.0, 0.0   11.00   0.01000   INTERVENTING   1, 868, 407   18, 200, 386, 113   0.0   11.00   0.01000   INTERVENTING   1, 800, 249   18, 200, 386, 113   0.0   15.00   0.01000   INTERVENTING   1, 800, 241   18, 200   386, 113   0.0   11.00   15.00   0.0100   INTERVENTING   1, 800, 241   11, 200   386, 113   0.0   0.0   0.0   15.00   0.0100   INTERVENTING   1, 800, 241   11, 200   2, 21, 715   0.0   0.0   0.0   0.0   0.0   17.00   0.0100   INTERVENTING   1, 200, 241   1, 200   2, 200   0.0   0.0   0.0   0.0   0.0   17.00   0.0100   INTERVENTING   1, 200, 241   1, 200   0.0   0.0   0.0   0.0   0.0   0.0   0.0   17.00   0.0100   INTERVENTING   1, 200   0.0								
10.00   01000   DETARY			1	_	1	1, 300, 037	l	1
11.00   01100   CAFETERIA   580, 260   18, 200   356, 113   0   0   11.00		1 1			1	15. 806		
13.00   0300  MURSING ABUNIN STRATION   1,871,324   8,902   174,187   0   0   12,00   15.00   0500  PARAMACPU HIGHER SERVICE S. SUPPLY   1,509,561   10,022   213,715   10,031   10,001   15.00   0500  PARAMACPU HIGHER SERVICE S. SUPPLY   1,509,561   10,022   213,715   10,001   15.00   0500  PARAMACPU HIGHER SERVICE S. SUPPLY   1,509,561   10,022   213,715   10,001   17.00   0700  MAS SERVICE S. PORTER PROBLED SERVICE S. PORTER S. POR								
15.00   01500   PHABMACY   2.305, 481   10.923   213,715   0   0   15.00   16.00   17.00   01701   SOCIAL SERVICE   1.519, 892   0   0   0   0   0   17.00	13.00	01300 NURSING ADMINISTRATION	1, 871, 324	8, 902	174, 187	0	0	13. 00
16.00   01-00    MEDICAL PICKORES & LIBRARY   6.40, 811   16.198   316, 940   0   0   16.00   17.00   17.00   21.00   18.5EVID (SCIENTER)   20.00   20.01   17.00   21.00   20.00   20.01   18.5EVID (SCIENTER)   20.00   20	14.00	01400 CENTRAL SERVICES & SUPPLY	1, 509, 561	41, 838	818, 611	18, 531	0	14. 00
17.00   1700   SOCIAL SERVICE   1,519,892   0   0   0   0   17.00   22.00		I I	1		1		1	
21.00   02100   188 SERVICES-SALARY & FEN NEES APPRIVO   2, 024, 304   0   0   0   0   0   0   22.00   0220   188 SERVICES-SITER PREM. COSTS APPRIVO   83, 704   0   0   0   0   0   0   0   0   23.00   0300   DAMANED ED PROM. SPECIETY   83, 704   0   0   0   0   0   0   0   0   0			1	16, 198	316, 940	0		
22 00   02000   IAR SERVICES-OTHER PROM. COSTS APPRVD   1, 250, 444   0   0   0   0   0   22.00			1	C	0	0	1	1
23.00		1 1	1	C		0		
IMPATT   FILT ROUTT IN SERVICE COST CENTERS   14, 175, 084   225, 713   4, 416, 350   423, 826   3, 191, 243   30, 00   310, 00   30100   AULT SA PEDIATRICS   14, 175, 084   225, 713   4, 416, 350   423, 826   3, 191, 243   30, 00   314, 00   340000   340000   340000   340000   340000   340000   340000   340000   340000   340000   340000		1 1	1			0		
30.00	23.00		03, 704		<u>,                                    </u>	U	<u> </u>	23.00
31.00   03100   INTENSIVE CARE UNIT   10,280,987   124,294   2,431,980   314,537   1,683,083   31.00   34.00   03400   UNISCRIPT   1,182,900   13,480   263,748   0   153,005   43.00   44.00   44.00   0440	30. 00		14, 175, 084	225. 713	4, 416, 350	423, 826	3, 191, 243	30.00
43.00   04300 NURSERY   1, 182, 900   13, 490   263, 748   0   153, 005   44. 00   440.00		I I	1		1 ' '			1
44. 00   04400   SKILLED NURSING FACILITY   1,466,345   17,421   340,871   28,418   153,005   44. 00	34.00		1	9, 585	1			1
MAIL LLARY SERVICE COST CENTERS   50.00   GOOD OPERATING ROOM   5.322_153   68,736   1.344,922   97,288   218,578   50.00   510.00   6100 RECOVERY ROOM   643,348   9,899   191,917   19,313   0 51.00   52.	43.00	04300 NURSERY	1, 182, 900	13, 480	263, 748	0	153, 005	43. 00
50 00   050000   0FEATI NG ROOM   5, 322, 153   68, 736   1, 344, 922   97, 288   218, 578   50 .00   52 .00   052000   DELUYERY ROOM   643, 348   9, 809   191, 917   19, 313   05 .50 .00   52 .00   052000   DELLUYERY ROOM & LABOR ROOM   1, 403, 245   31, 585   618, 006   50, 392   153, 005   52, 00   05300   053000   NESTHESI OLOGY   50, 378   2, 018   39, 489   0   0   53, 00   55, 00   05300   ARESTHESI OLOGY   50, 378   2, 018   39, 489   0   0   053, 00   55, 00   05500   RADIOLOGY-THERAPEUTI C   2, 450, 616   29, 272   572, 751   0   0   0, 55, 00   05500   RADIOLOGY-THERAPEUTI C   2, 450, 616   29, 272   572, 751   0   0   0, 55, 00   05500   RADIOLOGY-THERAPEUTI C   2, 450, 616   29, 272   572, 751   0   0   0, 55, 00   05500   RADIOLOGY-THERAPEUTI C   2, 450, 616   29, 272   572, 751   0   0   0, 55, 00   05500   RADIOLOGY-THERAPEUTI C   2, 450, 616   29, 272   572, 751   0   0   0, 55, 00   05500   RADIOLOGY-THERAPEUTI C   2, 450, 616   29, 272   572, 751   0   0   0, 55, 00   05500   RADIOLOGY-THERAPEUTI C   2, 450, 616   29, 272   572, 751   0   0   0, 55, 00   05500   CARDARCORY RADIOLOGY RADIOLOGY-THERAPEUTI C   2, 450, 418   7, 1	44. 00		1, 466, 345	17, 421	340, 871	28, 418	153, 005	44. 00
51 00								
1. 00   05200   DELIVERY ROOM & LABOR ROOM   1. 403, 245   31, 585   616, 006   50, 392   153, 005   52, 00   03500   03500   ANESTHESI OLDGY   50, 378   2, 018   39, 489   0   0   53, 00   53, 00   54, 00   5400   RABIOLOGY   1.00   55, 00   55, 00   05500   RABIOLOGY   1.00   6000   75, 00   05500   RABIOLOGY   1.00		I I	1					1
10.00   0.00		I I	1		1		l e	
53.00   05300   ANSTHESIOLOCY   50.378					1			
54.00   OS400   RADIOLOGY-DIAGNOSTIC   3, 190, 055   43, 787   886, 757   61, 528   153, 005   54.00   55.00   OS500   RADIOLOGY-PIRERAPEUTIC   2, 486, 616   29, 272   2572, 751   0   0   0.5   0.0   55.00   0.5   0.0   0.0   0.0   0.5   0.0			1		1		l	
55.00   OSDO   RADIO LOCKY-THERAPEUTIC   2, 450, 616   29, 272   572, 751   0   0   55.00   0   56.00   OSDO   RADIO LOCKY-THERAPEUTIC   503, 431   1, 009   19, 745   13, 685   0   56.00   0   0   0   0   0   0   0   0   0			1					
50.0   0.5600   RADIO I SOTOPE					1			
SB. 00   OSBOO   MR		I I			1		0	1
99.00   0.00	57.00	05700 CT SCAN	1, 004, 878	1, 514	29, 617	0	0	57. 00
60.0   06000   LABORATORY		05800  MRI	437, 155	5, 986	117, 125	12, 771		
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0			1					
65.00   06500   RESPI RATORY THERAPY   1.580, 104   3,798   74, 319   0   0   65.00   65.00   66.00		I I		26, 854	1	2, 627		1
66.00   06600   PKYSI CAL THERAPY   956, 882   10, 808   211, 465   14, 228   51, 912   66, 00   67.00   06700   0CCUPATIONAL THERAPY   421, 893   541   10, 583   0   0   67, 00   68.00   06800   SPECH PATHOLOGY   126, 525   1, 691   33, 092   0   51, 912   69, 00   69.00   06900   ELECTROCARDIO LOGY   1, 330, 832   8, 971   175, 529   0   51, 912   69, 00   69.00   06900   ELECTROCARDIO LOGY   1, 330, 832   8, 971   175, 529   0   51, 912   69, 00   69.00   07000   10000   ELECTROENCEPHALOGRAPHY   578, 592   18, 729   366, 460   24, 306   218, 578   70. 00   69.00   07001   SLEEP LAB   0   0   0   0   0   0   0   69.00   07000   10000   10000   10000   10000   10000   10000   69.00   07000   10000   10000   10000   10000   10000   10000   69.00   07001   SLEEP LAB   0   0   0   0   0   0   0   69.00   07000   07001   SLEEP LAB   0   0   0   0   0   0   0   69.00   07000   07001   SLEEP LAB   0   0   0   0   0   0   0   69.00   07000   07001   SLEEP LAB   0   0   0   0   0   0   0   69.00   07000   07001   SLEEP LAB   0   0   0   0   0   0   69.00   07000   07001   07000   0   0   0   0   0   69.00   07000   07000   0   0   0   0   0			1	0.700	ή	0		
67.00   06700   OCCUPATI ONAL THERAPY   421,893   541   10,583   0   0 67,00   68.00   06800   SPECEN PATHOLOGY   126,525   1,691   33,092   0   0 68,00   69.00   06900   ELECTROCARDI OLOGY   1,330,832   8,971   175,529   0   51,912   69.00   0700   0700   ELECTROENCEPHALOGRAPHY   578,592   18,729   366,460   24,306   218,578   70.00   70.01   07001   SLEEP LAB   0   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   6,102,148   0   0   0   0   0   0   72.00   07200   IMPL. DEV CHARGED TO PATIENTS   13,270,760   0   0   0   0   0   0   76.97   07691   CARDI AC REHABILITATION   243,997   4,937   96,591   0   0   0   0   76.98   07698   HYPERABRIC OXYGEN THERAPY   107,362   5,247   102,672   22,345   0   76.97   77.00   07700   ALLOGENEI C STEM CELL ACQUISITION   0   0   0   0   0   0   0   78.00   07800   CART -ELEL L IMMUNOTHERAPY   0   0   0   0   0   0   0   79.00   09000   CLINIC   250,141   0   0   0   0   0   0   78.00   79.00   09000   CLINIC   250,141   0   0   0   0   0   131,147   79.00   09000   CLINIC   250,141   0   0   0   0   0   0   79.01   DEMERGENCY   5,747   5,788   115,385   2,257,675   401,517   1,683,053   91.00   79.00   09000   CLINIC   250,141   0   0   0   0   0   79.01   DEMERGENCY   5,747   5,748   115,385   2,257,675   401,517   1,683,053   91.00   79.00   09000   DEMERGENCY   5,749   5,749   5,749   5,749   5,749   79.00   09000   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   09000   79.00   090000   090000   090000   090000   09000   090000   090000   09000   09000   090000   0900000   090			1		1			
68.00   06.800   SPEECH PATHOLOGY   1.26, 525   1.691   33, 092   0   68.00   68.00   60.00			1		1			
69.00   06900   ELECTROCARDI OLOGY			1 ' 1		1			
70. 00   07000   ELECTROENCEPHALOGRAPHY   578, 592   18, 729   366, 460   24, 306   218, 578   70. 00   70. 01   07001   SLEEP LAB   0   0   0   0   0   0   0   0   0			1		1			
70. 01   07001   SLEEP LAB			1		1			
72.00   07200   MPL. DEV. CHARGED TO PATIENTS   5,585,191   0   0   0   0   0   72.00	70. 01				1	0		70. 01
73. 00   07300   DRUGS CHARGED TO PATIENTS   13, 270, 760   0   0   0   0   0   73. 00   76. 97   07697   CARDI AC REHABILITATI ON   243, 997   4, 937   96, 591   0   0   76. 97   77. 00   07698   MYPERBARIC OXYCEN THERAPY   107, 362   5, 247   102, 672   22, 345   0   76. 98   77. 00   07700   ALLOGENEI C STEM CELL ACQUISITION   0   0   0   0   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   79. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   79. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   79. 00   09000   CLI NI C   250, 141   0   0   0   0   131, 147   90. 00   79. 00   09000   CLI REGENCY   6, 747, 578   115, 385   2, 257, 675   401, 517   1, 683, 053   91. 00   79. 00   09000   DEMERGENCY   6, 747, 578   115, 385   2, 257, 675   401, 517   1, 683, 053   91. 00   70   09201   0BSERVATI ON BEDS -DI STI NCT   1, 519, 840   0   0   0   0   153, 005   70   09500   AMBULANCE SERVI CES   337, 566   0   0   0   0   0   0   713. 00   13000   DI TREATMENT PROGRAM   0   0   0   0   0   0   713. 00   13000   NTREEST EXPENSE   113. 00   713. 00   13000   NTREEST EXPENSE   113. 00   714. 01   07951   PUBLIC RELATI ONS   114   0   0   0   0   0   714. 01   07950   MI SCELLANCOUS   0   0   0   0   0   715. 02   07950   MI SCELLANCOUS   0   0   0   0   0   716. 98   YEARD   100   100   100   100   100   715. 00   00   00   00   00   00   716. 98   100   100   100   100   100   717. 00   00   00   00   00   00   718. 00   00   00   00   00   00   7194. 01   07950   VIBLIC RELATI ONS   114   0   0   0   0   0   7194. 01   07950   VIBLIC RELATIONS   114   0   0   0   0   0   7194. 01   07950   VIBLIC RELATIONS   114   0   0   0   0   0   7194. 02   07950   O7950   O795	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 102, 148	C	0	0	0	71.00
76. 97 07697 CARDI AC REHABILITATION 243, 997 4, 937 96, 591 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 107, 362 5, 247 102, 672 22, 345 0 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T - CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00  000 07800 CAR T - CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00  90. 00 09000 CLINIC 0 250, 141 0 0 0 0 131, 147 90. 00  91. 00 99000 EMERGENCY 6, 747, 578 115, 385 2, 257, 675 401, 517 1, 683, 053 91. 00  92. 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART 92. 01 09201 DESERVATI ON BEDS-DISTINCT 1, 519, 840 0 0 0 0 153, 005 92. 01  95. 00 09500 AMBULANCE SERVICES 337, 566 0 0 0 0 0 0 95. 00  102. 00 10200 OPI OI TREATMENT PROGRAM 0 0 0 0 0 0 102. 00  113. 00 11300 INTEREST EXPENSE  113. 00 11300 INTEREST EXPENSE  114. 00 07950 MI SCELLARIOUS 0 0 0 0 0 194. 01  194. 01 07951 PUBLIC RELATIONS 114 0 0 0 0 0 194. 01  194. 03 07952 LI GHTHOUSE 1 10NS 114 0 0 0 0 0 194. 01  194. 03 07952 LI GHTHOUSE 1 16, 650 0 0 0 0 0 194. 01  194. 04 07953 KIDS & FAMILY 0 0 0 0 0 194. 01  194. 05 07954 OTHER MON REI MBURABLE 1 19, 233 0 0 0 0 0 194. 03  194. 06 07955 GRANTS/TRIALS 1 PHARMACY 0 0 0 0 0 194. 07  194. 07 07956 RETAIL PHARMACY 0 0 0 0 0 0 194. 07  200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				C	0	0	0	72. 00
76. 98   07698   HYPERBARI C OXYGEN THERAPY   107, 362   5, 247   102, 672   22, 345   0   76. 98     77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0     78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0     78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0     78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   131, 147   90. 00     90. 00   09000   CLINIC   250, 141   0   0   0   0   131, 147   90. 00     91. 00   09000   CLINIC   0,747, 578   115, 385   2, 257, 675   401, 517   1, 683, 053   91. 00     92. 00   09200   08SERVATI ON BEDS   SININCT PART   1, 519, 840   0   0   0   0   153, 005     92. 01   09201   08SERVATI ON BEDS - DISTINCT   1, 519, 840   0   0   0   0   0     95. 00   09201   08SERVATI ON BEDS - DISTINCT   1, 519, 840   0   0   0   0   0     102. 00   09500   AMBULANCE SERVI CES   337, 566   0   0   0   0   0   0     102. 00   09500   AMBULANCE SERVI CES   337, 566   0   0   0   0   0   0     102. 00   09500   AMBULANCE SERVI CES   337, 566   0   0   0   0   0     102. 00   09500   AMBULANCE SERVI CES   337, 566   0   0   0   0   0     103. 00   01   01   TREATMENT PROGRAM   0   0   0   0   0     104. 00   07950   MISTERST EXPENSE   113. 00     108. 00   11300   INTEREST EXPENSE   110, 638, 377   987, 670   18, 996, 703   1, 580, 839   8, 374, 280     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0     109. 00   07950   MISTERST EXPENSE   114   0   0   0   0   0				C	0	0		
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 250, 141 0 0 0 0 131, 147 90. 00  91. 00 9100 EMERGENCY 6, 747, 578 115, 385 2, 257, 675 401, 517 1, 683, 053 91. 00  92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 01 09201) OBSERVATION BEDS-DISTINCT 1, 519, 840 0 0 0 0 153, 005 92. 01  OTHER REIMBURSABLE COST CENTERS  95. 00 09500  AMBULANCE SERVICES 337, 566 0 0 0 0 0 0 0 95. 00  102. 00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 0 0 0 102. 00  SPECIAL PURPOSE COST CENTERS  113. 00 11300  INTEREST EXPENSE 113. 00 11300  INTEREST EXPENSE 113. 00 1000 OPIOID TREATMENT PROGRAM 1140 0 0 0 0 194. 00  194. 00 07950  MISCELLANEOUS 0 0 0 0 0 0 194. 00  194. 01 07951  PUBLIC RELATIONS 114 0 0 0 0 0 0 194. 01  194. 02 07952  LI GHTHOUSE 1 THOUSE 1 19, 233 0 0 0 0 0 0 194. 03  194. 05 07954  OTHER NON REIMBURSABLE 119, 233 0 0 0 0 0 194. 05  194. 06 07955  GRANTS/TRIALS 451 0 0 0 0 0 194. 06  194. 06 07955  GRANTS/TRIALS 451 0 0 0 0 0 194. 06  194. 07 07956  RETAIL PHARMACY 0 0 0 0 0 0 194. 07  194. 07 07956  GRANTS/TRIALS 451 0 0 0 0 0 0 194. 07  194. 08 07956  GRANTS/TRIALS 451 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1	0	1	
78.00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   78.00		1 1	107, 362	5, 247	102, 672	22, 345		
90. 00   09000   CLI NI C   250, 141   0   0   0   131, 147   90. 00     91. 00   09100   EMERGENCY   6, 747, 578   115, 385   2, 257, 675   401, 517   1, 683, 053   91. 00     92. 01   09201   0BSERVATI ON BEDS (NON-DI STI NCT PART   92. 00     92. 01   09201   0BSERVATI ON BEDS-DI STI NCT   1, 519, 840   0   0   0   0   153, 005     92. 01   09201   0BSERVATI ON BEDS-DI STI NCT   1, 519, 840   0   0   0   0   0     07500   AMBULANCE SERVI CES   337, 566   0   0   0   0   0   0     102. 00   10200   0P1 0I D TREATMENT PROGRAM   0   0   0   0   0   0   0     102. 00   10300   INTEREST EXPENSE   113. 00     113. 00   1300   INTEREST EXPENSE   113. 00     194. 00   07950   MI SCELLANEOUS   0   0   0   0   0   0   194. 00     194. 01   07951   PUBLI C RELATI ONS   114   0   0   0   0   0   194. 01     194. 03   07952   LI GHTHOUSE   16,650   0   0   0   0   0   0   194. 01     194. 04   07953   KIDS & FAMILY   0   0   0   0   0   0   194. 03     194. 05   07954   OTHER NON REI MBURSABLE   119, 233   0   0   0   0   0   194. 05     194. 06   07955   GRANTS/TRI ALS   451   0   0   0   0   0   194. 06     194. 07   07956   RETAIL PHARMACY   0   0   0   0   0   194. 07     1900   00   00   00   00   00   00   0			0			0	•	
90. 00	76.00		l ol	C	<u>)                                    </u>	U		78.00
91. 00	90. 00		250, 141	C	0	0	131, 147	90.00
92. 00 92. 01 09200   OBSERVATI ON BEDS (NON-DISTINCT PART   OPEN OF ORDER   O				115. 385	_	_		
92. 01							,	
95. 00	92. 01	09201 OBSERVATION BEDS-DISTINCT	1, 519, 840	C	0	0	153, 005	92. 01
102. 00   10200   OPI 0I D TREATMENT PROGRAM   O   O   O   O   O   102. 00			,					
113.00   11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)   110,638,377   987,670   18,996,703   1,580,839   8,374,280   118.00   NONREI MBURSABLE COST CENTERS   10,000,000   0,00						-		
113. 00 118. 00 1194. 00 1194. 01 11	102.00		0	C	0	0	0	102. 00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   110, 638, 377   987, 670   18, 996, 703   1, 580, 839   8, 374, 280   118. 00   NONREI MBURSABLE COST CENTERS   0 0 0 0 0 0 0 194. 00 194. 01 194. 03 194. 03 07952   LI GHTHOUSE   16, 650 0 0 0 0 0 0 194. 03 194. 04 07953   KI DS & FAMI LY   0 0 0 0 0 0 0 194. 04 194. 05 07954   OTHER NON REI MBURABLE   119, 233   0 0 0 0 0 0 194. 06 194. 06 194. 06 194. 06 194. 07 07956   GRANTS/TRI ALS   451 0 0 0 0 0 0 194. 06 194. 07 07956   GRANTS/TRI ALS   451 0 0 0 0 0 0 194. 06 194. 07 07956   Cross Foot Adjustments   200. 00 0 0 0 0 194. 07 200. 00 0 0 0 0 194. 07 200. 00 0 0 0 0 194. 07 200. 00 0 0 0 0 0 0 0 194. 07 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	440.00						<u> </u>	
NONRE   MBURSABLE   COST   CENTERS     194. 00   07950   MI SCELLANEOUS   0   0   0   0   0   194. 00   194. 00   194. 01   194. 03   07951   PUBLI C   RELATI ONS   114   0   0   0   0   0   194. 01   194. 03   194. 04   07952   LI GHTHOUSE   16,650   0   0   0   0   194. 03   194. 04   07953   KI DS & FAMI LY   0   0   0   0   0   0   194. 04   194. 05   07954   OTHER   NON   REI MBURABLE   119, 233   0   0   0   0   194. 06   194. 05   GRANTS/TRI ALS   451   0   0   0   0   194. 06   194. 05   194. 07   07956   RETAI L   PHARMACY   0   0   0   0   194. 07   194. 05   Cross   Foot   Adjustments   200. 00   0   0   194. 07   194. 06   194. 07   1		I I	110 (20 277	007 (70	10.00/ 702	1 500 000	0 274 200	
194. 00   07950   MI SCELLANEOUS   0 0 0 0 0 194. 00 194. 00 194. 01 194. 01 194. 03 194. 03 194. 04 194. 05 07952   LI GHTHOUSE   16,650 0 0 0 0 194. 03 194. 04 194. 05 07954   OTHER NON REI MBURABLE   119, 233 0 0 0 0 0 194. 05 194. 06 1955   GRANTS/TRI ALS   451 0 0 0 0 0 194. 05 194. 06 1955   GRANTS/TRI ALS   451 0 0 0 0 0 194. 05 194. 06 1955   GRANTS/TRI ALS   194. 07 197956   RETAI L PHARMACY   0 0 0 0 0 194. 07 1955   OTHER NON REI MBURABLE   194. 07 197956   OTHER NON REI MBURABLE   194. 07 197956   OTHER NON REI MBURABLE   194. 06 1955   OTHER NON REI MBURABLE   194. 05 1955   OTHER NON REI MBURABLE   194. 05 1955   OTHER NON REI MBURABLE   195. 05 1955   OTHER NON R	118.00	, J	110, 638, 377	987, 670	18, 996, 703	1, 580, 839	8, 374, 280	]118.00
194. 01 07951 PUBLIC RELATIONS 114 0 0 0 0 0 194. 01 194. 03 07952 LI GHTHOUSE 16, 650 0 0 0 0 194. 03 194. 04 07953 KI DS & FAMI LY 0 0 0 0 0 0 194. 04 194. 05 07954 OTHER NON REIMBURABLE 1194. 06 07955 GRANTS/TRI ALS 194. 06 07955 GRANTS/TRI ALS 194. 07 07956 RETAI L PHARMACY 0 0 0 0 0 194. 06 194. 07 200. 00 Cross Foot Adjustments	104 00					0		104 00
194. 03 07952 LI GHTHOUSE 16, 650 0 0 0 0 194. 03 194. 04 07953 KI DS & FAMI LY 0 0 0 0 0 194. 05 194. 05 07954 OTHER NON REI MBURABLE 119, 233 0 0 0 0 194. 05 194. 06 07955 GRANTS/TRI ALS 451 0 0 0 0 194. 06 194. 07 07956 RETAI L PHARMACY 0 0 0 0 194. 07 200. 00 0 0 0 0 194. 07 200. 00						0		
194. 04 07953 KI DS & FAMI LY  194. 05 07954 OTHER NON REIMBURABLE  1194. 06 07955 GRANTS/TRI ALS  194. 07 07956 RETAIL PHARMACY  200. 00 Cross Foot Adjustments  0 0 0 0 0 194. 04  0 0 0 0 194. 05  194. 07  200. 00 0 0 0 0 194. 07  200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	,		n	<b>l</b>	
194. 05 07954 OTHER NON REIMBURABLE 119, 233 0 0 0 194. 05 194. 06 07955 GRANTS/TRIALS 451 0 0 0 0 194. 06 194. 07 07956 RETAIL PHARMACY 0 0 0 0 194. 07 200. 00 Cross Foot Adjustments			0	Č	ol o	Ö		
194. 06 07955 GRANTS/TRIALS 451 0 0 0 194. 06 194. 07 07956 RETAIL PHARMACY 0 0 0 0 194. 07 200. 00 Cross Foot Adjustments 200. 00			119, 233	C	o o	o	<b>l</b>	
200.00   Cross Foot Adjustments   200.00	194. 06	07955 GRANTS/TRI ALS		C	) o	0		
		1 1	0	C	0	0	0	
201.00    Negative Cost Centers   0  0  0  0  0  0 201.00								
	201.00	n   Negative Cost Centers	0	C	η <u>Ο</u>	0	1 0	1201.00

Health Financial Systems	COMMUNITY MEDI	ICAL CENTER		In Lie	In Lieu of Form CMS-2552-1		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Peri od:	Worksheet B		
				From 01/01/2023	Part I		
				To 12/31/2023	Date/Time Pre	pared:	
					5/20/2024 2: 3	5 pm	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE			
	5.00	6.00	7.00	8. 00	9. 00		
202.00 TOTAL (sum lines 118 through 201)	110, 774, 825	987, 670	18, 996, 70	1, 580, 839	8, 374, 280	202. 00	

Provider CCN: 31-0041

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/20/2024 2:35 pm

	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	5/20/2024 2: 3 PHARMACY	
				ADMI NI STRATI ON	SERVI CES & SUPPLY		
	CENEDAL CEDVICE COST CENTEDS	10. 00	11. 00	13. 00	14. 00	15. 00	
1. 00	GENERAL SERVICE COST CENTERS 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 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9.00
10. 00	01000 DI ETARY	6, 895, 618					10.00
11. 00	01100 CAFETERI A	0	2, 915, 108	3			11. 00
13. 00	01300 NURSING ADMINISTRATION	0	57, 604	8, 434, 571			13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	62, 278		7, 551, 101	40 407 7/0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	105, 581 33, 798		2, 649 33, 176	10, 427, 768 0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	52, 321		33, 176	0	17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	o	133, 054		o	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	О	7, 872		0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	5, 022	2 0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	0 700 044	700		000		
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 702, 341 2, 662, 059	666, 782 460, 119		36, 033 32, 452	0	30. 00 31. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	197, 399	49, 715		4, 906	0	34.00
43. 00	04300 NURSERY	0	40, 627		0	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	333, 819	59, 533		2, 133	0	44. 00
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATING ROOM	0	185, 671		33, 499	0	50.00
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	21, 808		130	0	51.00
52. 00 52. 01	03190 OP INFUSION	0	54, 146 31, 834		7, 095 1, 446	0	52. 00 52. 01
53. 00	05300 ANESTHESI OLOGY	o	3, 840		23	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	Ö	120, 404		8, 174	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	61, 722	57, 439	224	0	55. 00
56.00	05600 RADI OI SOTOPE	0	7, 767		33	0	56. 00
57. 00	05700 CT SCAN	0	31, 313		0	0	57. 00
58. 00 59. 00	05800 MRI   05900 CARDI AC CATHETERI ZATI ON	0	13, 849 48, 238		6, 597	0	58. 00 59. 00
60.00	06000 LABORATORY	0	40, 230	221,770	0, 347	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0	o o	Ö	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	59, 550	o	873	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	51, 435		104	0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	18, 593		0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	5, 491 55, 554		657	0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	23, 320		9, 076	0	70.00
70. 01	07001 SLEEP LAB	Ö	20, 020	0	0	0	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3, 830, 706	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	3, 506, 270	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	10, 427, 768	73.00
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	O O	8, 966	46, 568	68	0	76. 97 76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	Ö		o	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	-,			-1		
90.00	09000 CLI NI C	0	3, 632	8, 967	684	0	90. 00
91. 00	09100 EMERGENCY	0	290, 887	819, 467	30, 604	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		(0.400	204 454	2 400	0	92.00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT OTHER REI MBURSABLE COST CENTERS	0	69, 629	294, 456	3, 489	0	92. 01
95. 00	09500 AMBULANCE SERVICES	0	0	0	O	0	95. 00
	10200 OPIOID TREATMENT PROGRAM	o	0		Ö		102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
118. 00		6, 895, 618	2, 901, 955	8, 434, 507	7, 551, 101	10, 427, 768	118. 00
104.04	NONREI MBURSABLE COST CENTERS	٦		J 2	ام		104 00
	007950 MI SCELLANEOUS 107951 PUBLIC RELATIONS	0	0		O <sub>1</sub>		194. 00 194. 01
	3 07952 LI GHTHOUSE	0	0		0		194. 01
	4 07953 KIDS & FAMILY	ol	712		ol		194. 04
	07954 OTHER NON REIMBURABLE	o	12, 424		ō		194. 05
	5 07955 GRANTS/TRI ALS	O	17	64	О		194. 06
	7 07956 RETAIL PHARMACY	0	0		0		194. 07
200.00	Cross Foot Adjustments			1			200. 00

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 01/01/2023	Worksheet B Part I	
				To 12/31/2023		
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI OI	N SERVICES &		
				SUPPLY		
	10.00	11. 00	13.00	14. 00	15.00	
201.00 Negative Cost Centers	0	0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	6, 895, 618	2, 915, 108	8, 434, 57	7, 551, 101	10, 427, 768	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

Period: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Pre

Date/Time Prepared: 5/20/2024 2:35 pm INTERNS & RESIDENTS MEDI CAL SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description RECORDS & Y & FRINGES PRGM. COSTS **PRGM** LI BRARY 22.00 23.00 16.00 17.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 289, 049 16.00 01700 SOCIAL SERVICE 17.00 6, 901, 097 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21 00 8, 996, 778 21 00 0 22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 0 5, 483, 130 22.00 02300 PARAMED ED PRGM-(SPECIFY) 371, 534 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 1 099 874 30 00 1, 852, 948 4, 326, 571 2, 636, 850 0 31.00 03100 INTENSIVE CARE UNIT 105, 757 1,020,373 744, 159 453, 532 0 31.00 03400 SURGICAL INTENSIVE CARE UNIT 116, 333 34.00 78, 683 0 34.00 43.00 04300 NURSERY 338, 423 110, 659 0 o 0 43.00 04400 SKILLED NURSING FACILITY O 44.00 143, 017 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 317, 272 564, 282 540, 239 329, 251 0 50.00 05100 RECOVERY ROOM 51.00 80. 522 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 169, 212 52.00 259, 293 0 0 52.00 52.01 03190 OP INFUSION 138, 511 61, 209 37, 304 52.01 0 05300 ANESTHESI OLOGY 53 00 0 16, 568 164,001 99, 951 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 359, 465 67, 530 41, 156 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55 00 240, 306 C 0 0 55 00 05600 RADI OI SOTOPE 0 8, 284 56.00 56.00 57.00 05700 CT SCAN 0 0 12, 426 0 0 57.00 05800 MRI 58.00 49.141 0 58.00 0 0 05900 CARDIAC CATHETERIZATION 59.00 349, 690 0 59.00 60.00 06000 LABORATORY 0 0 220, 457 34, 597 21, 085 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 06500 RESPIRATORY THERAPY 140, 050 65.00 31, 181 85, 354 Λ 65.00 88, 723 66.00 06600 PHYSI CAL THERAPY 0000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 440 67.00 0 0 13, 884 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 73, 646 90, 816 55, 348 Ω 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 153, 754 70.00 07001 SLEEP LAB 0 0 70.01 70.01 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71 00 C Λ 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 0 371, 534 73.00 07697 CARDIAC REHABILITATION 76.97 40, 526 0 76.97 0 76.98 07698 HYPERBARIC OXYGEN THERAPY 43,077 0 0 0 76.98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 264, 393 767, 113 467, 521 0 90.00 09100 EMERGENCY 877, 785 947, 241 2, 060, 493 1, 255, 778 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 09201 OBSERVATION BEDS-DISTINCT 0 0 92.01 92.01 0 0 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 0 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 289, 049 6, 901, 097 8, 996, 778 5, 483, 130 371, 534 118. 00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 0 194. 00 194. 01 07951 PUBLIC RELATIONS 0 0 0 194. 01 0 0 0 194. 03 07952 LI GHTHOUSE 0 0 0 194. 03 194. 04 07953 KIDS & FAMILY 0 0 194. 04 0 0 194.05 07954 OTHER NON REIMBURABLE 0 0 0 194. 05

0

0 194.06

194. 06 07955 GRANTS/TRI ALS

Heal th Financial	Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-			
COST ALLOCATION	- GENERAL SERVICE COSTS	Provi de	r CCN: 31-0041	From 01/01/2023	Worksheet B Part I Date/Time Prepared:	

						5/20/2024 2: 3	5 pm
				INTERNS &	RESI DENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
	·	RECORDS &		Y & FRINGES	PRGM. COSTS	PRGM	
		LI BRARY					
		16. 00	17. 00	21. 00	22. 00	23. 00	
194. 07 07956	RETAIL PHARMACY	0	0	0	0	0	194. 07
200. 00	Cross Foot Adjustments			0	0	0	200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	3, 289, 049	6, 901, 097	8, 996, 778	5, 483, 130	371, 534	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Peri od: | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0041

				10	5/20/2024   Date/lime F 5/20/2024	
	Cost Center Description	Subtotal	Intern &	Total		, J
			Residents Cost			
			& Post			
			Stepdown			
		24.00	Adjustments 25.00	26. 00		
	GENERAL SERVICE COST CENTERS	24.00	25.00	20.00		
1.00	00100 CAP REL COSTS-BLDG & FLXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
6.00	00600 MAI NTENANCE & REPAI RS					6. 00
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	00900 HOUSEKEEPING					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSING ADMINISTRATION					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 21. 00	01700   SOCIAL SERVICE   02100   I&R SERVICES-SALARY & FRINGES APPRVD					17. 00 21. 00
21.00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD					22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)					23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	87, 509, 386	-6, 963, 421	80, 545, 965		30. 00
31.00	03100 INTENSIVE CARE UNIT	56, 887, 893	-1, 197, 691	55, 690, 202		31. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	6, 920, 822	0	6, 920, 822		34. 00
43. 00	04300 NURSERY	6, 184, 149	0	6, 184, 149		43. 00
44. 00	04400 SKILLED NURSING FACILITY	7, 650, 654	0	7, 650, 654		44. 00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	27, 686, 649	-869, 490	26, 817, 159		50.00
51. 00	05100 RECOVERY ROOM	3, 278, 991	-809, 490	3, 278, 991		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 755, 178	o	7, 755, 178		52. 00
52. 01	03190 OP INFUSION	3, 906, 361	-98, 513	3, 807, 848		52. 01
53.00	05300 ANESTHESI OLOGY	546, 479	-263, 952	282, 527		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 762, 068	-108, 686	15, 653, 382		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	11, 692, 110	0	11, 692, 110		55. 00
56. 00	05600 RADI OI SOTOPE	2, 254, 873	0	2, 254, 873		56. 00
57. 00 58. 00	05700   CT   SCAN   05800   MRI	4, 474, 882 2, 113, 022	0	4, 474, 882 2, 113, 022		57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	9, 009, 456	0	9, 009, 456		59.00
60. 00	06000 LABORATORY	25, 588, 177	-55, 682	25, 532, 495		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63. 00
65.00	06500 RESPIRATORY THERAPY	7, 313, 850	-225, 404	7, 088, 446		65. 00
66.00	06600 PHYSI CAL THERAPY	4, 618, 528	0	4, 618, 528		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 881, 479	0	1, 881, 479		67. 00
68. 00	06800 SPEECH PATHOLOGY	608, 167	0	608, 167		68. 00
69. 00	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY	6, 413, 878	-146, 164	6, 267, 714		69. 00
	07000 ELECTROENCEPHALOGRAPHY	3, 370, 859 0	0	3, 370, 859 0		70. 00 70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	30, 549, 891	0	30, 549, 891		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	27, 961, 878	o	27, 961, 878		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	68, 907, 345	o	68, 907, 345		73. 00
76. 97	07697 CARDIAC REHABILITATION	1, 266, 035	0	1, 266, 035		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	643, 442	0	643, 442		76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0		78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2, 738, 737	-1, 234, 634	1, 504, 103		90.00
91.00	09100 EMERGENCY	40, 285, 183	-3, 316, 271	36, 968, 912		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10,200,100	0	00,700,712		92. 00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	7, 175, 429	O	7, 175, 429		92. 01
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES	1, 478, 083	0	1, 478, 083		95. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0		102. 00
112 00	SPECIAL PURPOSE COST CENTERS					112.00
113.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	404 422 024	14 470 000	469, 954, 026		113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	484, 433, 934	-14, 479, 908	407, 704, 020		-110.00
194. 00	07950 MI SCELLANEOUS	ol	o	0		194. 00
	07951 PUBLIC RELATIONS	498	Ö	498		194. 01
	07952 LI GHTHOUSE	72, 905	o	72, 905		194. 03
	07953 KIDS & FAMILY	712	O	712		194. 04
	07954 OTHER NON REIMBURABLE	534, 504	0	534, 504		194. 05
194. 06	07955  GRANTS/TRI ALS	2, 055	0	2, 055		194. 06

Health Fina	ncial Systems	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der CC	N: 31-0041	Peri od: From 01/01/2023	Worksheet B		
					To 12/31/2023			
	Cost Center Description	Subtotal	Intern &	Total				
			Residents Cost					
			& Post					
			Stepdown					
			Adjustments					
		24.00	25.00	26.00				
194. 07 0795	6 RETAIL PHARMACY	0	0		0		194. 07	
200. 00	Cross Foot Adjustments	0	0		0		200. 00	
201. 00	Negative Cost Centers	0	0		0		201. 00	
202. 00	TOTAL (sum lines 118 through 201)	485, 044, 608	-14, 479, 908	470, 564, 7	00		202. 00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0041

				Io	12/31/2023	Date/lime Pre 5/20/2024 2:3	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	133, 929	1 1	133, 929		4. 00
5. 00 6. 00	OO5OO   ADMINISTRATIVE & GENERAL   OO6OO   MAINTENANCE & REPAIRS	0	667, 065 41, 222	1	5, 521, 846 44, 929		5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	0	206, 160	1	918, 941		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	l o	0		0		8. 00
9.00	00900 HOUSEKEEPI NG	0	151, 280	9, 625	160, 905	2, 639	9. 00
10.00	01000 DI ETARY	0	268, 601	1	328, 735		10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	223, 537 109, 339	1	227, 398 683, 442		11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY		513, 851	1	783, 487		14. 00
15.00	01500 PHARMACY	0	134, 152		269, 952		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	198, 947	1	198, 947		16. 00
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0	2, 200 4, 176	17. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0		0		•
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	i o	0	1	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	2, 772, 195	1	2, 849, 356		30.00
31. 00 34. 00	03100 INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	1, 526, 582 117, 717	1	1, 605, 923 124, 989		31. 00 34. 00
43. 00	04300 NURSERY		165, 558	1	172, 196		1
44.00	04400 SKILLED NURSING FACILITY	0	213, 968		214, 963		44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	O5000   OPERATI NG ROOM   O5100   RECOVERY ROOM	0	844, 223 120, 469		2, 228, 128		1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	387, 929		126, 270 434, 546		
52. 01	03190 OP INFUSION	l o	207, 226	1	207, 226		1
53.00	05300 ANESTHESI OLOGY	0	24, 788	1	29, 718		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	537, 796	1	1, 122, 126		54.00
55. 00 56. 00	O5500  RADI OLOGY-THERAPEUTI C   O5600  RADI OI SOTOPE	0	359, 522 12, 394	1 1	925, 834 49, 210		55. 00 56. 00
57. 00	05700 CT SCAN		18, 591	1	18, 591	1, 542	57.00
58.00	05800 MRI	0	73, 521	1 1	229, 015		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	523, 172		805, 001	2, 579	59. 00
60. 00 63. 00	O6000   LABORATORY   O6300   BLOOD STORING, PROCESSING & TRANS.	0	329, 827 0	1	641, 312 0	0	60. 00 63. 00
65. 00	06500 RESPIRATORY THERAPY	0	46, 651		297, 880	_	ł
66. 00	06600 PHYSI CAL THERAPY	0	132, 739	1	149, 256		•
67. 00	06700 OCCUPATI ONAL THERAPY	O	6, 643	1 1	6, 643		
68. 00	06800 SPEECH PATHOLOGY	0	20, 772		20, 772		68. 00
70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	110, 182 230, 031		202, 699 356, 882	930	69. 00 70. 00
70. 00	07001 SLEEP LAB	l o	230, 031	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	60, 631	1, 872	62, 503	0 454	73. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		64, 448	1	64, 448		76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	1	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	O	0	0	0	130	90. 00
91. 00	09100 EMERGENCY	0	1, 417, 169		1, 593, 651	10, 469	ı
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		.,,	1,	0		92. 00
92. 01	09201 OBSERVATION BEDS-DISTINCT	0	0	0	0	2, 826	92. 01
05.00	OTHER REIMBURSABLE COST CENTERS				0		05.00
	O9500   AMBULANCE SERVICES   10200   OPIOID TREATMENT PROGRAM	0	0		0		95. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	<u> </u>	0	0	102.00
113.00	11300 I NTEREST EXPENSE						113. 00
118. 00	3 7	0	12, 972, 827	10, 838, 822	23, 811, 649	133, 494	118. 00
104.00	NONREI MBURSABLE COST CENTERS		^			^	104 00
	07950 MISCELLANEOUS 07951 PUBLIC RELATIONS		0	0	0		194. 00 194. 01
194. 03	07952 LI GHTHOUSE		Ö	o o	0		194. 03
194. 04	07953 KIDS & FAMILY	0	0	0	0	0	194. 04
194. 05	07954 OTHER NON REIMBURABLE	0	0	45, 538	45, 538	400	194. 05

Heal th Finar	ncial Systems	COMMUNITY MED	COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10			
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der Co	Provider CCN: 31-0041		Worksheet B			
					From 01/01/2023 To 12/31/2023	Part II			
						Date/Time Pre 5/20/2024 2:3			
			CAPI TAL REI	LATED COSTS					
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE			
		Assigned New				BENEFITS			
		Capi tal				DEPARTMENT			
		Related Costs							
		0	1. 00	2.00	2A	4. 00			
194. 06 07955	GRANTS/TRI ALS	0	0		0	1	194. 06		
194. 07 07956	RETAIL PHARMACY	0	0		0	0	194. 07		
200.00	Cross Foot Adjustments				0		200. 00		
201.00	Negative Cost Centers		0		0	0	201.00		
202. 00	TOTAL (sum lines 118 through 201)	0	12, 972, 827	10, 884, 36	23, 857, 187	133, 929	202. 00		

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023

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5/20/2024 2:35 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 00500 ADMINISTRATIVE & GENERAL 5, 530, 024 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 11, 261 56, 325 6.00 00700 OPERATION OF PLANT 216, 399 957 1, 139, 304 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 18, 024 18, 024 8.00 00900 HOUSEKEEPI NG 271, 291 9.00 92, 591 702 14, 454 9 00 10.00 01000 DI ETARY 73, 312 1, 247 25, 663 180 10.00 0 11.00 01100 CAFETERI A 28, 969 1,038 21, 357 0 0 11.00 01300 NURSING ADMINISTRATION 13.00 93.422 13 00 508 10, 447 0 0 14.00 01400 CENTRAL SERVICES & SUPPLY 75, 362 2, 386 49,095 211 0 14.00 15.00 01500 PHARMACY 115,096 623 12, 817 0 0 15.00 01 01600 MEDICAL RECORDS & LIBRARY 31, 991 16, 00 924 19,008 16, 00 0 01700 SOCIAL SERVICE 75, 877 0 17.00 C 0 0 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 101, 059 0 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 22.00 62, 426 0 0 02300 PARAMED ED PRGM-(SPECIFY) 4, 179 0 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 707, 479 264, 867 4,832 103, 379 12,873 30.00 31.00 03100 INTENSIVE CARE UNIT 511, 760 7,088 145, 855 3, 586 54, 524 31.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 68.302 547 11.247 323 0 34.00 43.00 04300 NURSERY 59,054 769 15, 818 4.957 43.00 44.00 04400 SKILLED NURSING FACILITY 73, 204 994 20, 443 324 4, 957 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 265, 698 3, 920 80,660 1, 109 7,081 50.00 51.00 05100 RECOVERY ROOM 32, 118 559 11,510 220 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 70, 054 4, 957 52.00 1,801 37,064 575 52.00 03190 OP INFUSION 34.774 19, 799 194 52.01 962 3.541 52.01 05300 ANESTHESI OLOGY 53.00 2,515 115 2, 368 0 Ω 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 159, 257 2, 497 51, 383 702 4, 957 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 122, 342 1, 669 34, 350 0 0 55.00 56 00 05600 RADI OI SOTOPE 25 133 58 1 184 156 56 00 0 05700 CT SCAN 57.00 50, 166 86 1,776 0 0 57.00 58.00 05800 MRI 21, 824 341 7,024 146 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 82.936 2.429 49, 986 7.081 59.00 164 06000 LABORATORY 60.00 281, 675 1, 531 31, 513 30 1, 682 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS 0 0 63.00 06500 RESPIRATORY THERAPY 65.00 78,883 217 4, 457 0 0 65.00 66 00 06600 PHYSI CAL THERAPY 47, 770 1, 682 66 00 12, 682 616 162 06700 OCCUPATIONAL THERAPY 67.00 21,062 31 635 0 0 67.00 06800 SPEECH PATHOLOGY 6, 317 96 1, 985 0 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 66, 439 512 10, 527 0 1,682 69.00 07000 ELECTROENCEPHALOGRAPHY 277 7, 081 70 00 21, 978 70 00 28,885 1,068 70.01 07001 SLEEP LAB 0 0 0 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 304, 637 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 278, 829 0 72.00 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 662, 516 C 0 0 73.00 76. 97 07697 CARDIAC REHABILITATION 12, 181 282 5, 793 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76.98 5, 360 299 6, 158 255 0 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 0 0 C 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 12, 488 C 4, 249 90.00 09100 EMERGENCY 135, 401 54, 524 91.00 336, 859 6,580 4,578 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09201 OBSERVATION BEDS-DISTINCT 4, 957 75,875 0 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 16,852 0 0 0 95.00 0 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 5, 523, 212 56, 325 1, 139, 304 18, 024 271, 291 118. 00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 0 0 0 0 194. 00 194. 01 07951 PUBLIC RELATIONS 0 0 0 0 194, 01 6 C 194. 03 07952 LI GHTHOUSE 0 0 194. 03 831 0 194.04 07953 KIDS & FAMILY 0 0 194. 04 0 0 194.05 07954 OTHER NON REIMBURABLE 5, 952 0 0 0 194. 05 194. 06 07955 GRANTS/TRI ALS 0 0 194.06 C 23 194. 07 07956 RETAIL PHARMACY 0 C 0 0 0 194. 07 200.00 Cross Foot Adjustments 200.00 0 0 201.00

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Negative Cost Centers

201 00

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		eri od:	Worksheet B	
				rom 01/01/2023		
			T	o 12/31/2023	Date/Time Pre	
					5/20/2024 2:3	5 pm
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118 through 201)	5, 530, 024	56, 325	1, 139, 304	18, 024	271, 291	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

				) 12/31/2023	5/20/2024 2:3	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
OFNEDAL CEDIMOR COCT OFNEDO	10.00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS  1.00   OO100 CAP REL COSTS-BLDG & FIXT						1 1 00
						1.00
2. 00   00200   CAP REL COSTS-MVBLE EQUIP						2.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00   00500   ADMI NI STRATI VE & GENERAL						5.00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00   00700   OPERATION OF PLANT						7.00
8.00   00800   LAUNDRY & LI NEN SERVI CE 9.00   00900   HOUSEKEEPI NG						8. 00 9. 00
10. 00   01000 DI ETARY	120 400					10.00
11. 00   01100   CAFETERI A	430, 688	279, 802				11.00
13. 00   01100   CAFETERTA 13. 00   01300   NURSI NG   ADMI NI STRATI ON		279, 802 5, 529				13.00
14. 00   01400 CENTRAL SERVICES & SUPPLY		5, 978		918, 023		14.00
15. 00   01500   PHARMACY	0	10, 134	0	322	413, 435	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	3, 244	7, 843	4, 033	413, 433	16.00
17. 00 01700 SOCIAL SERVICE		5, 022		4, 033	0	17. 00
21. 00   02100   1&R SERVICES - SALARY & FRINGES APPRVD		12, 771	10, 293	0	0	21.00
22. 00   02200   &R SERVICES-OTHER PRGM. COSTS APPRVD		756	١	0	0	22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)		482		0	0	23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	UU	402	<u> </u>		0	23.00
30. 00 03000 ADULTS & PEDIATRICS	231, 242	63, 997	270, 342	4, 381	0	30.00
31. 00   03100   NTENSI VE CARE UNIT	166, 267	44, 164	186, 060	3, 945	0	31.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	12, 329	4, 772		597	0	34.00
43. 00   04300   NURSERY	12, 329	3, 900		397	0	43.00
44.00   04400   SKI LLED NURSING FACILITY	20, 850	5, 714		259	0	44.00
ANCI LLARY SERVICE COST CENTERS	20, 630	3, 714	14, 339	239	0	44.00
50. 00 05000 OPERATING ROOM	O	17. 821	64, 510	4. 073	0	50.00
51. 00   05100   RECOVERY   ROOM		2, 093		4, 073	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		5, 197		863	0	52.00
	0				0	
52. 01   03190   OP   INFUSION	0	3, 056		176		52. 01
53. 00 05300 ANESTHESI OLOGY	0	369		3	0	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	11, 557	7, 756	994	0	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	5, 924		27	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0	746		4	0	56. 00
57. 00   05700   CT   SCAN	0	3, 006		0	0	57. 00
58. 00   05800   MRI	0	1, 329		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	4, 630	20, 945	802	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	5, 716	0	106	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	0	4, 937		13	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	1, 785	0	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	527	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	5, 332	7, 007	80	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	2, 238	2, 190	1, 103	0	70.00
70. 01   07001   SLEEP LAB	O	0	0	0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	О	465, 716	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	О	426, 274	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	o	0	413, 435	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	o	861	4, 398	8	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	0	Ö	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0	ا	ő	0	78.00
OUTPATIENT SERVICE COST CENTERS	<u>ا</u>		·	<u> </u>		1 . 5. 55
90. 00 09000 CLINIC	ol	349	847	83	0	90.00
91. 00   09100   EMERGENCY		27, 920		3, 721	0	91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	١	21, 720	11, 373	3, 121	U	92.00
92. 01   09201   OBSERVATION   BEDS - DISTINCT   FART	o	6, 683	27, 809	424	0	92.00
OTHER REIMBURSABLE COST CENTERS	UU	0,003	27,009	424	0	72.01
95. 00 09500 AMBULANCE SERVICES	ol	0	O	o	0	95. 00
102.00 10200 OPLOID TREATMENT PROGRAM		0		ol		102.00
SPECIAL PURPOSE COST CENTERS	U U		l o	<u> </u>	0	102.00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	430, 688	278, 539	796, 540	918, 023	413, 435	
	430,000	270, 339	790, 340	910, 023	413, 433	1116.00
NONREI MBURSABLE COST CENTERS				٦	^	104 00
194. 00 07950 MI SCELLANEOUS		0	0	0		194. 00
194. 01 07951 PUBLI C RELATI ONS	0	0	0	0		194. 01
194. 03 07952 LI GHTHOUSE	0	0	0	0		194. 03
194. 04 07953 KIDS & FAMILY	0	68		0		194. 04
194. 05 07954 OTHER NON REIMBURABLE	0	1, 193	0	0		194. 05
194. 06 07955 GRANTS/TRI ALS	0	2	6	0		194. 06
194. 07 07956 RETAIL PHARMACY	0	0	0	0	0	194. 07
200.00 Cross Foot Adjustments	<u> </u>					200. 00

Health Financia	I Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF C	CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
					From 01/01/2023 To 12/31/2023		
Cos	st Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	J piii
	·			ADMINISTRATIO	N SERVICES &		
					SUPPLY		
		10.00	11. 00	13.00	14. 00	15. 00	
201. 00 Neg	gative Cost Centers	0	0		0 0	0	201. 00
202. 00 TO	TAL (sum lines 118 through 201)	430, 688	279, 802	796, 54	6 918, 023	413, 435	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/20/2024 2:35 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0041

					0 12/31/2023	5/20/2024 2:3	
				INTERNS &	RESI DENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES_OTHER	PARAMED ED	
	cost center bescription	RECORDS &	SOCIAL SERVICE	Y & FRINGES	PRGM. COSTS	PRGM	
		LI BRARY					
	T	16. 00	17. 00	21.00	22. 00	23. 00	
1 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT		ı				1 00
1. 00 2. 00	00200 CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE						8. 00 9. 00
10.00	00900  HOUSEKEEPI NG  01000  DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15.00	01500 PHARMACY	2// 001					15. 00
16. 00 17. 00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE	266, 901	101, 392				16. 00 17. 00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD	0	101, 342				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	Ō	l	63, 612		22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0			4, 812	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS	89, 254		1			30.00
34.00	03100   INTENSIVE CARE UNIT   03400   SURGICAL INTENSIVE CARE UNIT	8, 582 9, 440	14, 992 1, 156	1			31.00
43. 00	04300 NURSERY	27, 462		1			43. 00
44.00	04400 SKILLED NURSING FACILITY	0		1			44. 00
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATI NG ROOM	25, 746		1			50.00
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0 13, 731	1, 183 3, 810	1			51. 00 52. 00
52. 00	03190 OP INFUSION	13, 731	2, 035	1			52. 00
53. 00	05300 ANESTHESI OLOGY	Ō	243	1			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 281	1			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	3, 531	1			55. 00
56. 00 57. 00	05600	0	122 183	1			56. 00 57. 00
58. 00	05800 MRI	0	722	1			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	5, 138	1			59. 00
60.00	06000 LABORATORY	0	3, 239				60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
65. 00	06500 RESPI RATORY THERAPY	0	458				65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1, 304 65	1			66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	Ö	204	1			68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 082	1			69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	2, 259				70. 00
70. 01	07001 SLEEP LAB	0	0				70. 01
71. 00 72. 00	07100   MEDICAL SUPPLIES CHARGED TO PATIENT   07200   IMPL. DEV. CHARGED TO PATIENTS	0	0	•			71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		•			73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	Ö	595				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	633	1			76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0				78. 00
90. 00	09000 CLINIC	21, 455	0	1			90. 00
91. 00	09100 EMERGENCY	71, 231	13, 917				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
92. 01	09201 OBSERVATION BEDS-DISTINCT	0	0				92. 01
05 00	OTHER REIMBURSABLE COST CENTERS			ı			05.00
	09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM	0		•			95. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS			l .			102.00
113.00	11300   NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	266, 901	101, 392	0	0	C	118. 00
104 5	NONREI MBURSABLE COST CENTERS	=	-	ı			104.65
	07950 MISCELLANEOUS  07951 PUBLIC RELATIONS	0	0				194. 00 194. 01
	07951 PUBLIC RELATIONS 07952 LIGHTHOUSE	0	0				194. 01
	07953 KIDS & FAMILY	0					194. 04
194. 05	07954 OTHER NON REIMBURABLE	0	0				194. 05
194. 06	07955 GRANTS/TRI ALS	0	0	<u> </u>	<u> </u>	<u> </u>	194. 06

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 31-0041	From 01/01/2023	Worksheet B Part II Date/Time Prepared:

						5/20/2024 2:3	5 pm
				INTERNS &	RESI DENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
		RECORDS &		Y & FRINGES	PRGM. COSTS	PRGM	
		LI BRARY					
		16.00	17. 00	21.00	22. 00	23. 00	
194. 07 07956	RETAIL PHARMACY	0	0				194. 07
200.00	Cross Foot Adjustments			118, 006	63, 612	4, 812	200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	266, 901	101, 392	118, 006	63, 612	4, 812	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/20/2024 2:35 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0041

2 00 00000 CAP REL COSTS-AMBLE EQUIP						5/20/2024	2: 35 pm
S   Post   Steppons		Cost Center Description			Total		
Stephoon   Adjustedits   24.00   25.00   26.00							
AGUSTROPH   STATE							
OCT   CONTINUE   CON							
SAN INVESTIGATION   STRAYLE COSTS - MARKE EDUN			24. 00		26. 00		
2 00 DOZDOC AP ST. CISTS. WHILE FOULP		GENERAL SERVICE COST CENTERS		'	-		
0-0400   DIPLOYEE BENEFITS DEPARTMENT	1.00						1. 00
0.0500   AMM INTERRATE & CENERAL		1 1					2. 00
0.00   00000   IMITERANCE & REPAIRS   0   00000   IMITERANCE & REPAIRS   1   1   1   1   1   1   1   1   1		1 1					4.00
2.00		1 1					5. 00 6. 00
8.00   00800  CAURIDRY & LINEN SERVICE							7. 00
9.00   00900   00157EPF   10   11   10   00100   0157EPF   11   10   00100   0157EPF   11   11   10   00100   0157EPF   11   11   10   01100   0157EPF   11   11   10   01100   0157EPF   11   11   11   11   11   11   11							8.00
11-10.00   11-00   CAFETERIA     11-10.00		1 1					9. 00
13.00   01300   INIEST NO. ADMIN STRATION     115.00   01500   INIEST NO. ADMIN STRATION     115.00   115.00   INIEST NO. ADMIN STRATION     115.00   115.00   INIEST NO. ADMIN STRATION     115.00   115.00   INIEST NO. ADMIN STRATION     115.00   INIEST NO. ADMIN ST	10.00	01000 DI ETARY					10. 00
14.00   01400   CENTRAL SERVICES & SUPPLY   10.00   01600   MEDICAL RECORDS & LIBRARY   11.00   0170		1 1					11. 00
15.00   01500   PHARMACY   11   17   17   17   17   17   17   1		1 1					13.00
10.00   10.00   MEDICAL RECORDS & LIBRARY		1 1					14. 00 15. 00
17.00   01700   BAS SERVICES-SALARY & FRINCES APPRIVD   22.00   02200   BAS SERVICES-OTHER PROBL COSTS APPRIVD   22.00   02200   BAS SERVICES-OTHER PROBL COSTS APPRIVD   22.00   02200   BAS SERVICES-OTHER PROBL COSTS APPRIVD   22.00   02200   BAS SERVICES COST CENTERS   30.00   03200   03100   DAILITS & PERMIC (SPECLEY)   22.00   03200   DAILITS & PERMIC (SPECLEY)   22.00   03200   DAILITS & PERMIC (SPECLEY)   22.00   03200   DAILITS & PERMIC (SPECLEY)   22.00   03100   INTERSIVE CARE UNIT   20.00 4.00 0.00   03.00   03100   INTERSIVE CARE UNIT   20.00 4.00 0.00   03.00   03200   DAILISS & PERMISSIVE CARE UNIT   20.00 4.00 0.00   03.00   03200   DAILISS & PERMISSIVE CARE UNIT   20.00 4.00 0.00   03.00   03200   DAILISS & PERMISSIVE CARE UNIT   20.00 4.00 0.00   03.00   03200   DAILISS & PERMISSIVE CARE UNIT   20.00 4.00 0.00   03.00   03200   DAILISS & PERMISSIVE CARE UNIT   20.00 4.00 0.00   03		1					16. 00
21.00   02100   IAR SERVI CES-SALARY & FRINCES APPRIVD		1 1					17. 00
22 00   02200   RAY SERVICES-OTHER PROM COSTS APPRVD   22		1 1					21. 00
INPATE ENT ROUTINE SERVICE COST CENTERS   3.0.00   0.300   ADULTS & PEDID ATRICS   2.4,654,590   0.4,654,590   3.1.00   0.300   ADULTS & PEDID ATRICS   2.771,988   0.2,771,988   0.2,771,988   0.3,771,972   0.3,771,772   0.3,	22. 00						22. 00
30.00   03000   ADULTS & PEDIATRICS   4, 654, 580   0   4, 654, 580   3   3   3   3   3   3   0   03400   INTENSIVE CARE UNIT   2, 771, 988   3   3   3   3   0   03400   SURGICAL INTENSIVE CARE UNIT   250, 460   0   260, 460   3   3   3   3   3   0   03400   SURGICAL INTENSIVE CARE UNIT   250, 460   0   360, 646   4   4   3   3   3   3   3   3   3   3	23. 00						23. 00
31.00 03100 INTENSIVE CARE UNIT					. 1		
34.00   03400   SURGICAL INTENSIVE CARE UNIT   260.460   260.460   34.00   04300   NIRSERY   295.977   295.977   24.44.00   04400   SKILLED NIRSIN FACILITY   360.646   0   360.646   44.40   04400   SKILLED NIRSIN FACILITY   360.646   0   360.646   44.40   04400   SKILLED NIRSIN FACILITY   360.646   0   360.646   44.40   360.646   44.40   360.646   44.40   360.646   44.40   360.646   44.40   360.646   44.40   360.646   44.40   360.646   46.40   360.646   36				· •			30.00
43. 00 04300   NURSERY   295,977   0 295,977   4 44. 00 04400   SILLER NURSING FACILITY   360,646   0 360,646   4 80   1		1 1		· •			31.00
44. 00 04400   SKILLED NURSING FACILITY   300, 646   0   300, 646   4  RANCLEARY SERVIC COST CENTES   500, 00 05000   0FRATING ROOM   188, 282   51, 00 05000   0FRATING ROOM   188, 282   51, 00 05000   0FRATING ROOM   188, 282   52, 00 05200   0ELVERY ROOM   188, 282   52, 00 05200   0ELVERY ROOM   188, 282   53, 00 05300   0ELOWERY ROOM   180, 283, 662   53, 00 05300   0RSTHESI OLOGY   35, 408   0   35, 408   55, 400   05400   0ROI OLOGY - 0LAGOSTIC   1, 371, 227   0   1, 371, 227   55, 00 05300   ARISTHESI OLOGY   77, 062   57, 00 05500   RADI OLOGY - THERAPEUTI C   1, 102, 223   0   1, 102, 223   55, 00 05500   RADI OLOGY - THERAPEUTI C   1, 102, 223   0   1, 102, 223   55, 00 05500   RADI OLOGY - THERAPEUTI C   1, 102, 223   0   77, 062   55, 00 05500   RADI OLOGY - THERAPEUTI C   77, 062   57, 00 05700   CT SCAN   75, 350   0   75, 350   0   75, 350   0   55, 00   05500   RADI OLOGY - THERAPEUTI C   77, 062   57, 00 05700   CT SCAN   76, 350   0   75, 350   0   7				· •			34. 00 43. 00
ANCILLARY SERVICE COST CENTERS							44. 00
50.00     05000     05000   0FEATI NG ROOM   2, 714, 742   0 2, 714, 742   55   50   0500   0500   RECOVERY ROOM   18B, 282   0 18B, 282   55   50   00   5200   DELI VERY ROOM   4.1ABOR ROOM   600, 456   0 600, 456   55   50   00   530   00   1 NUSUS   0N   283, 662   0 283, 662   55   53   00   05300   AND STHESS   0.1 0340   0 PI NUSUS   0N   283, 662   0 283, 662   55   53   00   05300   AND STHESS   0.1 0340   0 ROOM	00		0007010	<u> </u>	000, 0.10		
Section   Continue	50.00		2, 714, 742	0	2, 714, 742		50.00
Section   1990   OP INFUSION   283, 662   35, 408   55   53   00   00   00   00   00   00	51.00	05100 RECOVERY ROOM	188, 282	0	188, 282		51.00
1.53		1 1					52. 00
54.00   05400   RADIOLOGY-DIAGNOSTIC   1,371,227   0   1,371,227   55.00   05500   RADIOLOGY-THERAPEUTIC   1,102,223   0   1,102,223   55.00   05500   RADIOLOGY-THERAPEUTIC   1,102,223   0   1,102,223   55.00   05500   RADIOLOGY-THERAPEUTIC   77,062   0   77,062   0   77,062   55.00   05900   RADIOLOGY-THERAPEUTIC   77,062   0   77,062   0   77,062   0   75,350   0		1 1					52. 01
55.00   05500   RADIO LOGY-THERAPEUTI C		1 1		i			53. 00 54. 00
56.00   05000   RADIOI SOTOPE   77, 062   0   77, 062   55.		1 1		1			55. 00
S7.00   05700   CT SCAN   75, 350   0   75, 350   55     S8.00   05800   MRI				0			56.00
S8.00   05800   MR    261,034   0 261,034   55				O			57. 00
60.00   06000   LABORATORY   960, 982   0   960, 982   0   63.00   06300   BLOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   65.00   06500   RESPIRATORY THERAPY   390, 326   0   390, 326   66.00   06600   PHYSI CAL THERAPY   220, 270   0   220, 270   66.00   06700   0CCUPATIONAL THERAPY   31, 087   0   31, 087   66.00   06700   0CCUPATIONAL THERAPY   31, 087   0   31, 087   66.00   06900   ELECTROCARDIOLOGY   30, 149   0   30, 149   0   66.00   06900   ELECTROCARDIOLOGY   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 304   0   297, 305   37, 300   0   30, 149   0   0   0   0   30, 149   0   30, 149   0   424, 891   77, 30, 300   70, 300   100,	58.00	05800 MRI	261, 034	0	261, 034		58. 00
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   65.00   06500   RESPI RATORY THERAPY   390, 326   0   390, 326   65.00   66.00   06600   PHYSI CAL THERAPY   220, 270   0   220, 270   06.00   06600   PHYSI CAL THERAPY   220, 270   0   220, 270   06.00   06600   PHYSI CAL THERAPY   31, 087   0   31, 087   0   66.00   06800   SPEECH PATHOLOGY   30, 149   0   30, 149   0   66.00   06900   ELECTROCARDI OLOGY   297, 304   0   297, 304   0   297, 304   0   66.00   06900   ELECTROCARDI OLOGY   297, 304   0   297, 304   2		1 1		_			59. 00
65.00   06500   RESPIRATORY THERAPY   390, 326   0   390, 326   66.00   06600   PHYSI CAL THERAPY   220, 270   0   220, 270   66.00   06600   PHYSI CAL THERAPY   31, 087   0   31, 087   0   66.00   066700   0CCUPATI ONAL THERAPY   31, 087   0   31, 087   0   66.00   06800   SPEECH PATHOLOGY   30, 149   0   30, 149   0   66.00   06900   ELECTROCARDI OLOGY   297, 304   0   297, 304   0   67.00   07.000   ELECTROENCEPHALOGRAPHY   424, 891   0   424, 891   0   424, 891   7.00   0   0   0   7.000   0.000   0   0   0   7.000   0.000   0   0   7.000   0.000   0.000   0   0   0   0   0		1		· · · · · · · · · · · · · · · · · · ·			60.00
66. 00 06600 PHYSI CAL THERAPY 220, 270 0 220, 270 660 06700 0CCUPATI ONAL THERAPY 31, 087 660 06700 0CCUPATI ONAL THERAPY 31, 087 0 31, 087 660 00 06800 SPEECH PATHOLOGY 30, 149 0 30, 149 0 660 00 06800 SPEECH PATHOLOGY 297, 304 0 297, 304 660 00 06900 ELECTROCARDI OLOGY 297, 304 0 297, 304 660 00 06900 ELECTROCARDI OLOGY 297, 304 0 297, 304 660 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0			_		-		63. 00 65. 00
67. 00 06700 OCCUPATI ONAL THERAPY 31, 087 0 31, 087 66 80. 00 66800 SPEECH PATHOLOGY 30, 149 66 80. 00 66800 SPEECH PATHOLOGY 297, 304 0 297, 304 66 90. 00 66900 ELECTROCARDI OLOGY 297, 304 0 297, 304 66 70. 00 07000 ELECTROENCEPHALOGRAPHY 424, 891 0 424, 891 0 77 70. 01 07001 SLEEP LAB 0 0 0 0 0 77 11. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 770, 353 0 770, 353 77 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 705, 103 0 705, 103 77 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 075, 951 0 1, 075, 951 77 76. 97 07697 CARDI AC REHABI LITATION 87, 075 0 87, 075 76 98 07698 HYPERBARI C 0XYGEN THERAPY 77, 153 0 77, 153 77 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77 80. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 77 80. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 77 80. 00 07800 CLINIC 39, 601 9900 OSSERVATI ON BEDS CINDATISTINCT PART 0 9900 OSSERVATI ON BEDS DISTINCT PART 0 9900 OSSERVATI ON BEDS DISTINCT PART 0 09201 OSSERVATI ON BEDS DISTINCT PART 0 09201 OSSERVATI ON BEDS COST CENTERS 9900 OSSOR ABBULANCE SERVICES 16, 852 0 16, 852 9900 OSSOR ABBULANCE SERVICES 16, 852 0 16, 852 9900 OSSOR ABBULANCE SERVICES 16, 852 0 0 16, 852 9900 OSSOR ABBULANCE SERVICES 16, 852 0 0 16, 852 9900 OSSOR ABBULANCE SERVICES 16, 852 0 0 0900 OSSOR ABBULANCE SERVICES 16, 852 0 0 16, 852 9900 OSSOR ABBULANCE SERVICES 16, 852 0 0 0900 OSSOR OSSOR ABBULANCE SERVICES 16, 852 0 0 0900 OSSOR OSSOR ABBULANCE SERVICES 16, 852 0 0 0900 OSSOR OSSO		1 1					66. 00
68.00 06800 SPEECH PATHOLOGY 30, 149 0 30, 149 66 69.00 06900 ELECTROCARDIOLOGY 297, 304 0 297, 304 66 70.00 07000 ELECTROENCEPHALOGRAPHY 424, 891 0 424, 891 77 70.01 07001 SLEEP LAB 0 0 0 0 0 77 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 770, 353 0 770, 353 77 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 705, 103 0 705, 103 77 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 075, 951 0 1, 075, 951 77 76.97 0797 CARDIA CREHABILITATION 87, 075 0 87, 075 77 76.98 07698 HYPERBARIC OXYGEN THERAPY 77, 153 0 77, 153 77 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77, 153 77 78.00 07300 CART -CELL IMMUNOTHERAPY 0 0 0 0 0 77 78.00 07300 CART -CELL IMMUNOTHERAPY 0 0 0 0 0 77 78.00 07900 CART -CELL IMMUNOTHERAPY 0 0 0 0 0 0 77 79.00 09000 CLINIC 39, 601 0 39, 601 99 92.00 09000 BSERVATION BEDS (NON-DISTINCT PART 0 0 118, 574 0 118, 574 97 92.01 09201 DSEERVATION BEDS (NON-DISTINCT PART 0 0 170 PRICE REIMBURSABLE COST CENTERS 99 95.00 09500 AMBULANCE SERVICES 16, 852 0 16, 852 99 102.00 1300 INFEREST EXPENSE 113.00 11300 INFEREST EXPENSE 113.00 INFEREST EXPENSE 113.00 INFEREST EXPENSE 114.00 07950 IM SCELLANEOUS 0 0 0 0 0 194 104.01 07951 PUBLIC RELATIONS 6 0 0 0 0 194 104.03 07952 LIGHTHOUSE 865 0 865 0 865 199		1 1					67. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY				0	·		68. 00
70. 01   07001   SLEEP LAB	69. 00	06900 ELECTROCARDI OLOGY	297, 304	0	297, 304		69. 00
71. 00			424, 891	0	424, 891		70. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 705, 103 0 705, 103 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 075, 951 0 1, 075, 951 75. 76. 77 07697 CARDIAC REHABILITATION 87, 075 0 87, 075 76. 98 07698 HYPERBARI C OXYGEN THERAPY 77, 153 0		1 1	0				70. 01
73. 00   07300   DRUGS CHARGED TO PATIENTS   1, 075, 951   0   1, 075, 951   76. 97   07697   CARDI AC REHABILITATION   87, 075   0   87, 075   76. 98   07698   MYPERBARI C OXYGEN THERAPY   77, 153   0   77, 153   76. 98   07698   MYPERBARI C OXYGEN THERAPY   77, 153   0   0   0   0   0   0   0   0   0					·		71. 00 72. 00
76. 97   07697   CARDI AC REHABILITATION   87, 075   0   87, 075   76, 98   07698   HYPERBARI C OXYGEN THERAPY   77, 153   0   77, 153   77, 153   0   77, 153   77, 153   0   77, 153   0   77, 153   0   77, 153   77, 153   0				0			73.00
76. 98    07698   HYPERBARI C OXYGEN THERAPY   77, 153				0			76. 97
78. 00				O			76. 98
OUTPATI ENT SERVICE COST CENTERS   90. 00   09000   CLI NI C   39, 601   0   39, 601   90. 00   91. 00   09100   EMERGENCY   2, 336, 244   0   2, 336, 244   97. 92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0   09201   0BSERVATI ON BEDS-DI STI NCT   118, 574   0   118, 574   97. 00   118, 574   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   118, 574   0   118, 574   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   118, 574   0   118, 574   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   118, 574   0   118, 574   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   118, 574   0   118, 574   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   118, 574   0   118, 574   0   118, 574   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   PART   97. 00   09201   0BSERVATI ON BEDS-DI STI NCT   97. 00   09201   0BSERVATI	77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77. 00
90. 00	78. 00		0	0	0		78. 00
91. 00				ا ما	20.104		
92. 00							90. 00 91. 00
92. 01			2, 330, 244	1	2, 330, 244		91.00
OTHER REI MBURSABLE COST CENTERS   16, 852   0   16, 852   99   102.00   10200   OPI OI D TREATMENT PROGRAM   0   0   0   0   0   102   0   0   0   0   0   0   0   0   0		,	118 574		118 574		92. 01
95. 00	, 2. 0.		110,071	<u> </u>	1107071		72.0.
SPECIAL PURPOSE COST CENTERS	95.00	09500 AMBULANCE SERVI CES	16, 852	0	16, 852		95. 00
113. 00	102.00		0	0	0		102. 00
118. 00     SUBTOTALS (SUM OF LINES 1 through 117)     23, 616, 703     0     23, 616, 703       NONREI MBURSABLE COST CENTERS       194. 00     07950     MI SCELLANEOUS     0     0     0     194       194. 01     07951     PUBLI C RELATIONS     6     0     6     194       194. 03     07952     LI GHTHOUSE     865     0     865     194							
NONREI MBURSABLE COST CENTERS   194. 00 07950 MI SCELLANEOUS   0 0 0 0 194. 01 07951 PUBLI C RELATI ONS   6 0 6 194. 03 07952 LI GHTHOUSE   865 0 865 194.		1 1	22 /1/ 702		22 /4/ 702		113. 00
194. 00     07950     MI SCELLANEOUS     0     0     194. 01       194. 01     07951     PUBLI C RELATI ONS     6     0     6     194. 03       194. 03     07952     LI GHTHOUSE     865     0     865     194. 03	118.00		23,616,703	0	23, 616, 703		118. 00
194. 01 07951 PUBLIC RELATIONS 6 0 6 194 194. 03 07952 LI GHTHOUSE 865 0 865	194 00		0	ام	O		194. 00
194. 03 07952 LI GHTHOUSE 865 0 865 194			-	-			194. 00
			_	o			194. 03
	194. 04	07953 KIDS & FAMILY	68	О	68		194. 04
				•			194. 05
194. 06 07955 GRANTS/TRI ALS   32  0  32   194	194.06	07955  GRANTS/TRI ALS	32	0	32		194. 06

Heal th Fina	ncial Systems	COMMUNITY MED	OLCAL CENTER		In Lie	eu of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der CC	CN: 31-0041	Peri od:	Worksheet B	
					From 01/01/2023 To 12/31/2023		nared:
					10 12/31/2020	5/20/2024 2: 3	
	Cost Center Description	Subtotal	Intern &	Total			
			Residents Cost				
			& Post				
			Stepdown				
			Adjustments				
		24.00	25. 00	26. 00			
194. 07 0795	6 RETAIL PHARMACY	0	0		0		194. 07
200. 00	Cross Foot Adjustments	186, 430	0	186, 43	30		200. 00
201. 00	Negative Cost Centers	0	0		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	23, 857, 187	0	23, 857, 18	87		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-0041 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/20/2024 2:35 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL DEPARTMENT (ACCUM COST) (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 523 355 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 9, 350, 751 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5, 403 183, 397, 816 4.00 00500 ADMINISTRATIVE & GENERAL 4, 170, 737 11, 203, 279 5 00 26, 911 -110, 774, 825 374, 269, 783 5 00 6.00 00600 MAINTENANCE & REPAIRS 1,663 3, 185 184, 550 762, 105 6.00 14, 645, 270 7.00 00700 OPERATION OF PLANT 8, 317 612, 350 4, 119, 192 7.00 00800 LAUNDRY & LINEN SERVICE 0 1, 219, 806 8.00 8.00 0 00900 HOUSEKEEPI NG 9 00 6.103 8, 269 3, 614, 617 6, 266, 290 9 00 10.00 01000 DI ETARY 10,836 51,661 2, 125, 229 0 4, 961, 541 10.00 01100 CAFETERI A 9,018 1, 424, 832 11.00 3, 317 0 1, 960, 526 11.00 01300 NURSING ADMINISTRATION 4, 411 493, 212 4, 380, 185 13.00 6. 322. 554 13.00 20, 730 231, 644 5, 100, 282 14.00 01400 CENTRAL SERVICES & SUPPLY 2,060,682 14 00 15.00 01500 PHARMACY 5, 412 116, 666 6, 151, 615 0 0 0 7, 789, 419 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 247, 290 16.00 8,026 2, 165, 078 16.00 01700 SOCIAL SERVICE 3, 014, 364 5, 135, 185 17.00 17.00 0 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 Ω 5.721.009 6, 839, 420 21 00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 589, 345 0 4, 224, 814 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 206, 716 282, 808 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 111, 837 66, 289 34, 666, 332 0 47, 892, 839 30.00 03100 INTENSIVE CARE UNIT 61,586 26, 358, 653 0 34, 634, 520 31.00 68, 162 31.00 o 34.00 03400 SURGICAL INTENSIVE CARE UNIT 4,749 6, 247 3, 321, 322 4, 622, 507 34.00 3, 008, 646 43.00 04300 NURSERY 6, 679 5, 703 0 3, 996, 609 43.00 04400 SKILLED NURSING FACILITY 44.00 8,632 855 3, 422, 097 4, 954, 269 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 34, 058 1, 188, 913 10, 554, 427 0 17, 981, 706 50.00 0 51.00 05100 RECOVERY ROOM 4,860 4, 984 1, 689, 446 2, 173, 650 51.00 4, 741, 076 05200 DELIVERY ROOM & LABOR ROOM 15,650 3, 474, 396 0 52.00 40, 049 52.00 52.01 03190 OP INFUSION 8, 360 1, 712, 766 0 2, 353, 442 52.01 05300 ANESTHESI OLOGY 1.000 104.849 170, 211 53 00 4.235 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 21, 696 501, 998 6, 461, 472 10, 778, 088 54.00 05500 RADI OLOGY-THERAPEUTI C 14, 504 4, 275, 676 8, 279, 780 55.00 486, 519 0 0 0 55.00 05600 RADI OI SOTOPE 31, 629 1, 700, 919 56.00 500 614, 959 56.00 05700 CT SCAN 2, 112, 658 3, 395, 134 57.00 750 57.00 58.00 05800 MRI 2,966 133, 585 866, 659 1, 476, 995 58.00 59.00 05900 CARDIAC CATHETERIZATION 21, 106 242, 119 3, 532, 733 0 0 0 5, 612, 892 59.00 06000 LABORATORY 13, 306 267, 597 60 00 0 19, 063, 009 60 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS.  $\cap$ 63.00 65.00 06500 RESPIRATORY THERAPY 1,882 215, 831 3, 574, 292 5, 338, 621 65.00 66.00 06600 PHYSI CAL THERAPY 5, 355 14, 190 2, 531, 455 0 3, 232, 971 66.00 06700 OCCUPATIONAL THERAPY 1, 186, 702 67 00 268 1, 425, 429 67 00 68.00 06800 SPEECH PATHOLOGY 838 339, 797 427, 484 68.00 06900 ELECTROCARDI OLOGY 79, 481 2, 663, 328 4, 496, 420 69.00 4.445 0 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 9.280 108, 978 1, 274, 472 1, 954, 861 70.00 70.01 07001 SLEEP LAB 0 0 0 70 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 20, 617, 037 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 0 18, 870, 417 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 44, 837, 283 73.00 n 73.00 0 07697 CARDIAC REHABILITATION 76.97 2.446 1.608 621, 472 824, 382 76.97 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 2,600 362, 739 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77 00 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 177.999 0 845.139 90.00 151, 616 14, 341, 022 91.00 09100 EMERGENCY 57.172 0 22, 797, 720 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 09201 OBSERVATION BEDS-DISTINCT 3, 871, 572 5, 135, 010 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 1, 140, 517 95.00 95.00 0 0 0 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 523, 355 9, 311, 629 182, 802, 107 -110, 774, 825 373, 808, 774 118. 00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MI SCELLANEOUS 0 0 194. 00 194. 01 07951 PUBLIC RELATIONS 0 0 384 194. 01 0 0 0 194. 03 07952 LI GHTHOUSE 56, 255 194. 03 0 0 46, 922 194. 04 07953 KIDS & FAMILY 0 0 0 194. 04

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 31-0041	Period: Worksheet B-1 From 01/01/2023
		F1 0III 01/01/2023

				T	o 12/31/2023	Date/Time Pre 5/20/2024 2:3	
		CAPITAL REI	LATED COSTS			372072024 2.3	5 piii
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
				DEPARTMENT		(ACCUM COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4. 00	5A	5. 00	
194. 05 07954	OTHER NON REIMBURABLE	0	39, 122	547, 941	0	402, 847	194. 05
194. 06 07955	GRANTS/TRI ALS	0	0	846	0	1, 523	194. 06
194. 07 07956	RETAIL PHARMACY	0	0	0	0	0	194. 07
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	12, 972, 827	10, 884, 360	35, 852, 861		110, 774, 825	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	24. 787815	1. 164009	0. 195492		0. 295976	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)			133, 929		5, 530, 024	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000730		0. 014776	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
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-0041

				T.	rom 01/01/2023 o 12/31/2023	Date/Time Prep 5/20/2024 2:3	
	Cost Center Description	MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5 piii
		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 EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	489, 378					6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	8, 317	481, 061	1			7.00
9. 00	00900 HOUSEKEEPI NG	6, 103	0 6, 103	.,	3, 065		8. 00 9. 00
10.00	01000 DI ETARY	10, 836	10, 836	19, 524	0	451, 640	10. 00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	9, 018 4, 411	9, 018 4, 411	1	0	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	20, 730		1	0	0	14. 00
15. 00	01500 PHARMACY	5, 412	5, 412	0	0	0	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	8, 026	8, 026 0	1	0	0	16. 00 17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0		0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0		22. 00
23. 00	02300   PARAMED ED PRGM-(SPECIFY)   INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	111, 837	111, 837	523, 534	1, 168	242, 491	30. 00
31. 00	03100 INTENSIVE CARE UNIT	61, 586			616		31. 00
34. 00 43. 00	03400 SURGICAL INTENSIVE CARE UNIT 04300 NURSERY	4, 749 6, 679			0 56		34. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	8, 632		1	56		44. 00
	ANCILLARY SERVICE COST CENTERS					_	
50. 00 51. 00	O5000   OPERATI NG ROOM   O5100   RECOVERY ROOM	34, 058 4, 860	1		80 0		50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	15, 650		l	56		52. 00
52. 01	03190 OP INFUSION	8, 360		l	40		52. 01
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	1, 000 21, 696		1	0 56		53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	14, 504	14, 504	1	0		55. 00
56.00	05600 RADI OI SOTOPE	500	ł .	1	0		56. 00
57. 00 58. 00	05700 CT SCAN 05800 MRI	750 2, 966	ł .	1	0		57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	21, 106		1	80		59. 00
60.00	06000 LABORATORY	13, 306		1	19		60.00
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	1, 882	0 1, 882	_	0		63. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 355		1	19		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	268		1	0		67. 00
68. 00 69. 00	O6800   SPEECH PATHOLOGY   O6900   ELECTROCARDI OLOGY	838 4, 445	838 4, 445	1	0 19		68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	9, 280		1	80		70. 00
70. 01 71. 00	07001 SLEEP LAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	_	70. 01
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 97 76. 98	O7697   CARDI AC REHABI LI TATI ON   O7698   HYPERBARI C OXYGEN THERAPY	2, 446 2, 600			0	0	76. 97 76. 98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	2,600	2, 800	27,602	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	1 0	l 0	0	48	0	90. 00
91.00	09100 EMERGENCY	57, 172			616		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
92. 01	O9201   OBSERVATI ON BEDS-DI STI NCT   OTHER REI MBURSABLE COST CENTERS	0	0	0	56	0	92. 01
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
113 00	SPECIAL PURPOSE COST CENTERS   11300   INTEREST EXPENSE			I			113. 00
118.00		489, 378	481, 061	1, 952, 740	3, 065	451, 640	
104 5	NONREI MBURSABLE COST CENTERS					-	104 66
	07950 MISCELLANEOUS 07951 PUBLIC RELATIONS	0	0	0	0		194. 00 194. 01
	07952 LI GHTHOUSE	0	0	Ö	0		194. 01
	07953 KIDS & FAMILY	0	0	0	0		194. 04
	07954 OTHER NON REIMBURABLE 07955 GRANTS/TRIALS	0	0	0	0		194. 05 194. 06
	07956 RETAIL PHARMACY	0	Ö		0		194. 07
						'	

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 31-0041	From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Prepared: 5/20/2024 2: 35 pm

				''	0 12/31/2023	5/20/2024 2: 3	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	
		REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVICE)		
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	987, 670	18, 996, 703	1, 580, 839	8, 374, 280	6, 895, 618	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	2. 018215	39. 489177	0.809549	2, 732. 228385	15. 267952	203. 00
204.00	Cost to be allocated (per Wkst. B,	56, 325	1, 139, 304	18, 024	271, 291	430, 688	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 115095	2. 368315	0.009230	88. 512561	0. 953609	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)						

	Financiai Systems	COMMUNITY MEL				u or form CMS	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: rom 01/01/2023 o 12/31/2023		pared:
	Cost Center Description	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON	SUPPLY	PHARMACY (COSTED REQUIS.)	5/20/2024 2: 3 MEDI CAL RECORDS & LI BRARY	5 pm
			(DIRECT NRSING HRS)	(COSTED REQUIS.)		(TIME SPENT)	
		11. 00	13.00	14.00	15. 00	16. 00	
4 00	GENERAL SERVICE COST CENTERS				T		4 00
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	167, 759					8. 00 9. 00 10. 00 11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	3, 315 3, 584		40, 642, 108			13. 00 14. 00
15. 00	01500 PHARMACY	6, 076	1	14, 260			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 945	1, 564, 900	178, 565	0	311	16. 00
17. 00	01700 SOCIAL SERVICE	3, 011		O	0	0	17. 00
21. 00 22. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD 02200   &R SERVICES-OTHER PRGM. COSTS APPRVD	7, 657 453	1	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	289		0	0		23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	207					20.00
30. 00	03000 ADULTS & PEDIATRICS	38, 372		193, 941			
31.00	03100 I NTENSI VE CARE UNI T	26, 479 2, 861		174, 664			1
34. 00 43. 00	03400 SURGICAL INTENSIVE CARE UNIT 04300 NURSERY	2, 338	.,	26, 408 0		11 32	34. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	3, 426		11, 480	_		44. 00
	ANCILLARY SERVICE COST CENTERS				1		
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	10, 685 1, 255	1	180, 300 700			50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 116	1	38, 186			1
52. 01	03190 OP INFUSION	1, 832	1	7, 782		0	
53. 00	05300 ANESTHESI OLOGY	221		126			53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	6, 929 3, 552		43, 997 1, 205		0	54. 00 55. 00
56. 00	05600 RADI OLOGY - THERAPEUTI C	3, 552		1, 203		0	56.00
57. 00	05700 CT SCAN	1, 802	1	C		0	57. 00
58. 00	05800 MRI	797	1	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	2, 776 C		35, 506 0		0	59. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.			O	0	0	63.00
65. 00	06500 RESPI RATORY THERAPY	3, 427	0	4, 697	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 960		562		0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 070 316		0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 197		3, 537	0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 342	436, 854	48, 852	0	0	70. 00
70. 01	07001 SLEEP LAB	C	1	20 (17 000	0	0	70. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	C	1	20, 617, 900 18, 871, 711		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	C	o	C		0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	516	877, 501	365	0	0	76. 97
76. 98 77. 00	07698 HYPERBARI C OXYGEN THERAPY 07700 ALLOGENEI C STEM CELL ACQUI SITION			0	0	0 0	76. 98 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		′I "I	0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	209		3, 683		25	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 740	15, 441, 531	164, 721	0	83	91. 00 92. 00
92. 01	09201 OBSERVATION BEDS-DISTINCT	4, 007	5, 548, 553	18, 780	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
102.00	09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	C	1	C C			102. 00
118. 00	NONREI MBURSABLE COST CENTERS	167, 002	158, 933, 479	40, 642, 108	44, 840, 109		113. 00 118. 00
	07950 MI SCELLANEOUS	C	1	C			194. 00
	07951 PUBLI C RELATI ONS 07952 LI GHTHOUSE	C		0	0		194. 01 194. 03
	107953 KIDS & FAMILY	41		a	0		194. 03
194.05	07954 OTHER NON REIMBURABLE	715	0	C	o	0	194. 05
194.06	07955 GRANTS/TRI ALS	1	1, 200	С	0	0	194. 06

Heal th 1	Financial Systems	COMMUNITY MED	OLCAL CENTER		In Lie	eu of Form CMS-	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der CO		Peri od: From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/20/2024 2:3	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTES)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
				SUPPLY	REQUIS.)	LI BRARY	
			(DIRECT NRSING	(COSTED		(TIME SPENT)	
			HRS)	REQUIS.)			
		11. 00	13.00	14. 00	15. 00	16.00	
194. 07 0	07956 RETAIL PHARMACY	0	0		0 0	0	194. 07
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 915, 108	8, 434, 571	7, 551, 10	10, 427, 768	3, 289, 049	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	17. 376761	0. 053069	0. 18579	0. 232554	10, 575. 720257	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	279, 802	796, 546	918, 02	413, 435	266, 901	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 667881	0. 005012	0. 02258	0. 009220	858. 202572	205. 00

206. 00

207. 00

11)

206.00

207.00

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

	Financial Systems LLOCATION – STATISTICAL BASIS	COMMUNITY MEDI	Provider CO	°N: 21 0041 D	In Lie eriod:	u of Form CMS-2552-10   Worksheet B-1
CO31 F	RELOCATION - STATISTICAL BASIS		Frovider Co		rom 01/01/2023	
				To	o 12/31/2023	Date/Time Prepared: 5/20/2024 2:35 pm
			I NTERNS &	RESI DENTS		372072024 2.33 piii
		_				
	Cost Center Description	SOCIAL SERVICES	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM	
		(SQUARE FEET)	(ASSI GNED	(ASSIGNED	(ASSI GNED	
		(SQUARE TEET)	TIME)	TI ME)	TIME)	
	T	17. 00	21. 00	22. 00	23. 00	
1.00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT					1 00
2.00	00200 CAP REL COSTS-BLDG & FTXT					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
6.00	00600 MAI NTENANCE & REPAI RS					6. 00
7. 00 8. 00	OO700   OPERATION OF PLANT   OO800   LAUNDRY & LINEN SERVICE					7. 00 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 NURSING ADMINISTRATION					13.00
14. 00 15. 00	O1400   CENTRAL SERVI CES & SUPPLY   O1500   PHARMACY					14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE	416, 525				17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	216, 360			21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0		216, 360	100	22. 00
23. 00	02300   PARAMED ED PRGM-(SPECIFY)   NPATIENT ROUTINE SERVICE COST CENTERS	0			100	23. 00
30. 00	03000 ADULTS & PEDI ATRI CS	111, 837	104, 048	104, 048	0	30.00
31.00	03100 INTENSIVE CARE UNIT	61, 586	17, 896		o	31.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	4, 749	0	0	0	34. 00
43.00	04300 NURSERY	6, 679	0	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	8, 632	0	0	0	44. 00
50. 00	05000 OPERATING ROOM	34, 058	12, 992	12, 992	0	50.00
51.00	05100 RECOVERY ROOM	4, 860	0	0	o	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	15, 650	0	0	0	52. 00
52. 01	03190   OP   INFUSION   05300   ANESTHESI OLOGY	8, 360	1, 472	1, 472	0	52. 01
53. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 000 21, 696	3, 944 1, 624		0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	14, 504	0	0	Ö	55. 00
56.00	05600 RADI OI SOTOPE	500	0	0	o	56. 00
57. 00	05700 CT SCAN	750	0	0	0	57. 00
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	2, 966 21, 106	0	0	0	58. 00 59. 00
60.00	06000 LABORATORY	13, 306	832	832	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	Ö	63. 00
65.00	06500 RESPIRATORY THERAPY	1, 882	3, 368	3, 368		65. 00
	06600 PHYSI CAL THERAPY	5, 355	0	_	0	66.00
67. 00 68. 00	O6700   OCCUPATI ONAL THERAPY   O6800   SPEECH PATHOLOGY	268 838	0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 445	2, 184	2, 184	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	9, 280	0	0	o	70. 00
70. 01	07001 SLEEP LAB	0	0	0	0	70. 01
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0	0	0 100	72. 00 73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 446	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 600	0	0	o	76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC		18, 448	18, 448	0	90.00
91. 00	09100 EMERGENCY	57, 172	49, 552			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	0	0	0	0	92. 01
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	l	0	0	0	95. 00
	10200 OPI OI D TREATMENT PROGRAM		0			102.00
102.00	SPECIAL PURPOSE COST CENTERS	9		<u> </u>	01	102.00
113.00	11300   NTEREST EXPENSE					113. 00
118.00	3 /	416, 525	216, 360	216, 360	100	118. 00
10/ 00	NONREI MBURSABLE COST CENTERS 07950 MI SCELLANEOUS		^	O	0	194. 00
	07950 MI SCELLANEOUS 07951 PUBLI C RELATI ONS		0	[ 0	0	194. 00
194.03	07952 LI GHTHOUSE		0	Ö	o o	194. 03
	07953 KIDS & FAMILY	0	0	0	o	194. 04
194. 05	07954 OTHER NON REIMBURABLE	0	0	0	0	194. 05

Heal th Finan	cial Systems	COMMUNITY MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCAT	ION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/20/2024 2:3	
			I NITERNS &	RESI DENTS		3/20/2024 2.3	5 piii
			TIVIERIUS &	RESIDENTS			
	Cost Center Description	SOCIAL SERVICE	SERVI CES-SALAR	SERVICES-OTHE	R PARAMED ED		
			Y & FRINGES	PRGM. COSTS	PRGM		
		(SQUARE FEET)	(ASSI GNED	(ASSI GNED	(ASSI GNED		
		,	TIME)	TIME)	TIME)		
		17. 00	21.00	22. 00	23. 00		
194.06 07955	GRANTS/TRI ALS	0	C		0		194. 06
194. 07 07956	RETAIL PHARMACY	0	C		0 0		194. 07
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	6, 901, 097	8, 996, 778	5, 483, 13	371, 534		202. 00
	Part I)						
	Unit cost multiplier (Wkst. B, Part I)	16. 568266		1			203. 00
004 00	0 1 1 1 1 1 1 1 C W 1 D	404 000	440 00/	(0 (4	1 040		1004 00

101, 392

0. 243424

118, 006

0. 545415

63, 612

0. 294010

4, 812

48. 120000

0.000000

204. 00

205. 00

206. 00

207. 00

204.00

205.00

206.00

207.00

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D, Parts III and IV)

NAHE adjustment amount to be allocated (per Wkst. B-2)

Part II)

11)

					To 12/31/2023	Date/Time Pre 5/20/2024 2:3	pared:
			Title	XVIII	Hospi tal	PPS	J pili
			11.11		Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00		0.00	
30.00	03000 ADULTS & PEDI ATRI CS	80, 545, 965		80, 545, 96	5 0	80, 545, 965	30. 00
31. 00	03100 INTENSIVE CARE UNIT	55, 690, 202		55, 690, 20:		55, 690, 202	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	6, 920, 822		6, 920, 82		6, 920, 822	34.00
43. 00	04300 NURSERY	6, 184, 149		6, 184, 14		6, 184, 149	
44. 00	04400 SKILLED NURSING FACILITY	7, 650, 654		7, 650, 65		7, 650, 654	1
	ANCILLARY SERVICE COST CENTERS				1	, , , , , , , , , , , , , , , , , , , ,	
50.00	05000 OPERATI NG ROOM	26, 817, 159		26, 817, 15	9 0	26, 817, 159	50.00
51.00	05100 RECOVERY ROOM	3, 278, 991		3, 278, 99	ıl ol	3, 278, 991	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 755, 178		7, 755, 178		7, 755, 178	52. 00
52. 01	03190 OP INFUSION	3, 807, 848		3, 807, 84		3, 807, 848	
53.00	05300 ANESTHESI OLOGY	282, 527		282, 52	7 ol	282, 527	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 653, 382		15, 653, 38	ol ol	15, 653, 382	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	11, 692, 110		11, 692, 110		11, 692, 110	
56.00	05600 RADI OI SOTOPE	2, 254, 873		2, 254, 87	s o	2, 254, 873	56. 00
57.00	05700 CT SCAN	4, 474, 882		4, 474, 88	2 0	4, 474, 882	57. 00
58.00	05800 MRI	2, 113, 022		2, 113, 02	2 0	2, 113, 022	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	9, 009, 456		9, 009, 45		9, 009, 456	
60.00	06000 LABORATORY	25, 532, 495		25, 532, 49	ol ol	25, 532, 495	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			o	0	63. 00
65.00	06500 RESPIRATORY THERAPY	7, 088, 446	0	7, 088, 44	6 0	7, 088, 446	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 618, 528	0	4, 618, 52	0	4, 618, 528	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 881, 479	0			1, 881, 479	67. 00
68.00	06800 SPEECH PATHOLOGY	608, 167	0	608, 16	7 o	608, 167	68. 00
69.00	06900 ELECTROCARDI OLOGY	6, 267, 714		6, 267, 71	14, 262	6, 281, 976	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 370, 859		3, 370, 85	o	3, 370, 859	70. 00
70. 01	07001 SLEEP LAB	0			ol ol	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	30, 549, 891		30, 549, 89	0	30, 549, 891	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	27, 961, 878		27, 961, 87	0	27, 961, 878	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	68, 907, 345		68, 907, 34	0	68, 907, 345	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 266, 035		1, 266, 03	5 o	1, 266, 035	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	643, 442		643, 442	0	643, 442	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		(	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	1, 504, 103		1, 504, 10	0	1, 504, 103	90. 00
91.00	09100 EMERGENCY	36, 968, 912		36, 968, 91	0	36, 968, 912	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	451, 637		451, 63	7	451, 637	92.00
92. 01	09201 OBSERVATION BEDS-DISTINCT	7, 175, 429		7, 175, 42	9 0	7, 175, 429	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	1, 478, 083		1, 478, 08	0	1, 478, 083	95. 00
102.00	10200 OPIOID TREATMENT PROGRAM	0		(		0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
200.00		470, 405, 663	0		1	470, 419, 925	
201.00	1 1	451, 637		451, 63		451, 637	
202.00	Total (see instructions)	469, 954, 026	0	469, 954, 02	5 14, 262	469, 968, 288	202. 00

Title XVII				Т	0 12/31/2023	Date/Time Pre 5/20/2024 2:3	pared:
Inpatient   Outpatient   Total (col. 6   Cost or Other Ratio			Title	XVIII	Hospi tal		<u> Э рііі</u>
Inpati ent				, , , , , , , , , , , , , , , , , , , ,	nospi tui	110	
INPATIENT ROUTINE SERVICE COST CENTERS   7,00   8,00   9,00   10,00   30,00	Cost Center Description	Inpatient		Total (col. 6	Cost or Other	TEFRA	
INPATIENT ROUTINE SERVICE COST CENTERS							
NPATIENT ROUTINE SERVICE COST CENTERS   502, 760, 634   502, 760, 634   30, 00   3				' ' ' ' ' ' '			
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7. 00	8.00	9. 00	10.00	
31 00   03100   INTERSIVE CARE UNIT   446, 788, 849   466, 788, 849   31 00   43.00   03400   SURGI CAL INTERSIVE CARE UNIT   43, 127, 435   43, 127, 435   44, 00   446, 00   440, 00   440, 00   540, 00   SURGI CAL INTERSIVE CARE UNIT   17, 934, 175   17, 934, 175   44, 00   44, 00   440, 00	INPATIENT ROUTINE SERVICE COST CENTERS						
34. 00   03400   SURGICAL INTENSIVE CARE UNIT   43, 127, 435   20, 126, 493   20, 126, 493   43, 00   430, 00   440, 00   04400   SKI LLED NUSSING FACILITY   17, 934, 175   17, 934, 175   17, 934, 175   17, 934, 175   17, 934, 175   17, 934, 175   17, 934, 175   17, 934, 175   17, 934, 175   17, 934, 175   17, 934, 175   17, 934, 175   18, 18, 16, 00   16,7994   0, 000000   51, 00   05100   06200   0FECOVERY ROW   8, 513, 004   11, 005, 512   19, 518, 516   0, 16,7994   0, 000000   51, 00   05100   06200   0FECOVERY ROW   8, 513, 004   11, 005, 512   19, 518, 516   0, 16,7994   0, 000000   52, 01   03190   09, 18151   00   08100	30. 00 03000 ADULTS & PEDIATRICS	502, 760, 634		502, 760, 634			30.00
43. 00   04300   NURSERY   20, 126, 493   20, 126, 493   44. 00	31.00 03100 INTENSIVE CARE UNIT	466, 788, 849		466, 788, 849			31.00
According to   Add   A	34.00 03400 SURGICAL INTENSIVE CARE UNIT	43, 127, 435		43, 127, 435			34.00
ANCILLARY SERVICE COST CENTERS	43. 00   04300 NURSERY	20, 126, 493		20, 126, 493			43.00
50.00   050000   0500000   05000   05000   05000000   05000000   05000000   050000000   0500000000	44.00 O4400 SKILLED NURSING FACILITY	17, 934, 175		17, 934, 175			44.00
51.00   05100   RECOVERY ROOM   18, 513, 004   11, 005, 512   19, 518, 516   0, 167994   0, 000000   52, 01	ANCILLARY SERVICE COST CENTERS						
S2.00   05200   DELLY VERY ROOM & LABOR ROOM   18, 333, 380   6, 888, 755   75, 222, 135   0, 307475   0, 000000   52, 00		47, 724, 306	55, 005, 187	102, 729, 493	0. 261046	0.000000	50.00
Section   03190   DP INFUSION   4.6, 039   18, 525, 170   18, 571, 209   0. 205040   0. 000000   52. 01   53. 00   05300   ARSTHESIOLOGY   8, 922, 420   9, 270, 205   18, 192, 625   0. 015530   0. 000000   53. 01   53. 00   05300   ARSTHESIOLOGY   0. 000000   54. 00   54. 00   05400   RADIOLOGY-THERAPEUTIC   2, 222, 192   77, 251, 280   8, 173, 472   0. 145835   0. 000000   55. 00   05600   RADIOLOGY-THERAPEUTIC   2, 222, 192   77, 251, 280   8, 173, 472   0. 145835   0. 000000   55. 00   05600   RADIOLOGY-THERAPEUTIC   2, 222, 192   77, 251, 280   6, 212, 440   0. 362961   0. 000000   55. 00   05600   RADIOLOGY-THERAPEUTIC   2, 222, 192   77, 251, 280   6, 212, 440   0. 362961   0. 000000   55. 00   05600   RADIOLOGY-THERAPEUTIC   2, 222, 192   77, 251, 280   68, 213, 400   0. 302079   0. 000000   55. 00   05600   RADIOLOGY-THERAPEUTIC   2, 222, 192   77, 251, 280   33, 666, 582   0. 062763   0. 000000   57. 00   057. 00   05900   CARDIOLOGY-TATORY   18, 293, 751   15, 372, 831   33, 666, 582   0. 062763   0. 000000   57. 00   05900   CARDIOLOGY-TORY   18, 293, 751   18, 293, 751   18, 293, 751   18, 293, 751   18, 293, 751   18, 293, 751   18, 293, 751   18, 293, 751   18, 293, 751   18, 293, 293   218, 782   0. 142512   0. 000000   59. 00   0. 000000	51.00   05100   RECOVERY ROOM	8, 513, 004	11, 005, 512	19, 518, 516	0. 167994	0.000000	51.00
53.00   05300   AINSTHESI OLOGY   8, 922, 420   9, 270, 205   18, 192, 625   0, 015530   0, 000000   53, 00   54, 00   05400   RADI OLOGY-THERAPEUTI C   2, 922, 192   77, 251, 280   80, 173, 472   0, 145835   0, 000000   55, 00   05600   RADI OLOGY-THERAPEUTI C   2, 922, 192   77, 251, 280   80, 173, 472   0, 145835   0, 000000   55, 00   55, 00   05600   RADI OLOGY-THERAPEUTI C   2, 922, 192   77, 251, 280   80, 173, 472   0, 145835   0, 000000   55, 00   55, 00   05600   RADI OLOGY-THERAPEUTI C   2, 922, 192   77, 251, 280   80, 173, 472   0, 362961   0, 000000   55, 00   55, 00   05600   RADI OLOGY-THERAPEUTI C   2, 922, 192   77, 251, 280   80, 173, 472   0, 362961   0, 000000   55, 00   56, 00   05600   RADI OLOGY-THERAPEUTI C   2, 923, 751   15, 372, 831   33, 666, 582   0, 062763   0, 000000   58, 00   059	52.00   05200   DELIVERY ROOM & LABOR ROOM	18, 333, 380	6, 888, 755	25, 222, 135	0. 307475	0.000000	52.00
SA 00   05400   RADI OLOGY-DI AGNOSTIC   33, 710, 587   45, 738, 447   79, 449, 034   0. 197024   0. 000000   55, 00   05500   05500   RADI OLOGY-THERAPEUTIC   2, 922, 192   77, 251, 280   80, 173, 472   0. 145835   0. 000000   55, 00   055, 00   05700   05700   CT SCAN   71, 459, 084   68, 038, 537   139, 497, 621   0. 0362961   0. 000000   56, 00   057, 00   05700   CT SCAN   71, 459, 084   68, 038, 537   139, 497, 621   0. 032079   0. 000000   57, 00   058, 00   05800   MRI OLOGO LABORATORY   138, 322, 575   15, 372, 831   33, 666, 582   0. 042763   0. 000000   58, 00   05900   CARDIATORY   138, 322, 575   78, 461, 435   216, 784, 101   0. 117778   0. 000000   60, 00   0. 0000	52. 01   03190   OP   NFUSI ON	46, 039	18, 525, 170	18, 571, 209	0. 205040	0.000000	52. 01
55.00   05500   RADIO LOCY-THERAPEUTIC   2, 922, 192   77, 251, 280   80, 173, 472   0, 145835   0, 000000   55.00   056.00   05600   RADIO I SOTOPE   2, 210, 133   4, 002, 307   6, 212, 440   0, 362941   0, 000000   56.00   057.00   05700   CT SCAN   71, 459, 084   68, 038, 537   139, 497, 621   0, 032079   0, 000000   57.00   058.00   05900   CARDI AC CATHETERI ZATI ON   34, 342, 700   28, 876, 682   63, 218, 782   0, 142512   0, 000000   59, 00   05900   06000   CABOIA C CATHETERI ZATI ON   34, 342, 700   28, 876, 682   63, 218, 782   0, 142512   0, 000000   59, 00   060, 00   06000   CABOIA C CATHETERI ZATI ON   34, 342, 700   28, 876, 682   63, 218, 782   0, 142512   0, 000000   69, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   06000   060, 00   060000   06000   06000   06000   06000   060000   06000   060000   060000   060000   060000   060000   060000   060000   060000   060000   060000   060000   060000   0600000   060000   060000   060000   0600000   0600000   0600000   0600000   0600000   06000000   06000000   0600000000	53. 00   05300   ANESTHESI OLOGY	8, 922, 420	9, 270, 205	18, 192, 625	0. 015530	0.000000	53.00
56.00   05600   RABIO I SOTOPE   2, 210, 133   4, 002, 307   6, 212, 440   0, 362961   0, 000000   57, 00   57, 00   05700   CT SCAN   71, 459, 084   68, 038, 537   139, 497, 621   0, 032079   0, 000000   58, 00   05900   CARDI AC CATHETERI ZATI ON   34, 342, 700   28, 876, 082   63, 218, 782   0, 142512   0, 000000   59, 00   06000   LABORATORY   0, 000000   138, 322, 575   78, 461, 435   216, 784, 010   0, 117778   0, 000000   60, 00   06000   LABORATORY   0, 0000000   0, 000000   0, 000000   0, 000000   0, 000000   0, 000000   0, 000000   0, 00000	54. 00   05400   RADI OLOGY-DI AGNOSTI C	33, 710, 587	45, 738, 447	79, 449, 034	0. 197024	0.000000	54.00
57.00   05700   CT SCAN   71, 459, 084   68, 038, 537   139, 497, 621   0.032079   0.000000   57.00	55. 00   05500 RADI OLOGY-THERAPEUTI C	2, 922, 192	77, 251, 280	80, 173, 472	0. 145835	0.000000	55.00
58. 00   05800   MR    18, 293, 751   15, 372, 831   33, 666, 582   0.062763   0.000000   58. 00   69. 00   05900   CARDIAC CATHETERIZATION   34, 342, 700   28, 876, 082   63, 218, 782   0.142512   0.000000   59. 00   0.000000   CABDRATORY   138, 322, 575   78, 461, 435   216, 784, 010   0.117778   0.000000   60. 00   0.000000   0.000000   63. 00   65. 00   0.000000   0.000000   65. 00   0.000000   0.000000   65. 00   65. 00   0.000000   0.000000   65. 00   66. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   66. 00   65. 00   66. 00   65. 00   66. 00   65. 00   65. 00   65. 00   66. 00   65. 00   66. 00   65. 00   65. 00   66. 00	56. 00   05600 RADI 0I SOTOPE	2, 210, 133	4, 002, 307	6, 212, 440	0. 362961	0.000000	56.00
59,00   05900   CARDI AC CATHETERI ZATION   34, 342, 700   28, 876, 082   63, 218, 782   0, 142512   0, 000000   59, 00	57. 00 05700 CT SCAN	71, 459, 084	68, 038, 537	139, 497, 621	0. 032079	0.000000	57.00
60. 00   06000   LABORATORY   138, 322, 575   78, 461, 435   216, 784, 010   0. 117778   0. 000000   60. 00   63. 00   63. 00   63. 00   63. 00   65. 00   06500   RESPIRATORY THERAPY   44, 949, 926   1, 917, 418   46, 867, 344   0. 151245   0. 000000   65. 00   66. 00   6600   PHYSI CAL THERAPY   13, 972, 897   2, 694, 518   16, 667, 415   0. 277099   0. 000000   66. 00   66. 00   6600   06800   SPEECH PATHOLOGY   2, 559, 732   629, 520   3, 189, 252   0. 190693   0. 000000   68. 00   69. 00	58. 00   05800   MRI	18, 293, 751	15, 372, 831	33, 666, 582	0. 062763	0.000000	58. 00
63.00   06300   BLODD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   0   0   0   0	59. 00 05900 CARDI AC CATHETERI ZATI ON	34, 342, 700	28, 876, 082	63, 218, 782	0. 142512	0.000000	59. 00
65.00   06500   RESPIRATORY THERAPY   44, 949, 926   1, 917, 418   46, 867, 344   0. 151245   0. 000000   65. 00   66. 00   06600   PHYSI CAL THERAPY   13, 972, 897   2, 694, 518   16, 667, 415   0. 277099   0. 000000   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   10, 178, 281   965, 302   11, 143, 583   0. 168840   0. 000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   2, 559, 732   629, 520   3, 189, 252   0. 190693   0. 000000   68. 00   69. 00   06900   ELECTROCARDIOLOGY   32, 464, 435   53, 764, 865   86, 229, 300   0. 072687   0. 000000   69. 00   70. 01   07001   SLEEP LAB   0   0   0   0. 000000   0. 000000   70. 01   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   13, 122, 097   10, 154, 512   23, 276, 609   1. 312472   0. 000000   70. 01   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   13, 137, 676   17, 811, 195   35, 948, 871   0. 777824   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   26, 122, 367   70, 115, 528   96, 237, 895   0. 716011   0. 000000   73. 00   76. 97   07597   CARDIA C REHABILITATION   1, 099   4, 149, 110   4, 150, 209   0. 305053   0. 000000   77. 00   77. 00   0700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0. 000000   0. 000000   77. 00   77. 00   07900   CALIDIGENEIC STEM CELL ACQUISITION   0   0   0   0. 000000   0. 000000   0. 000000   77. 00   78. 00   07900   CALIDIGENEIC STEM CELL ACQUISITION   0   0   0   0. 000000   0. 000000   0. 000000   77. 00   79. 00   07900   CALIDIGENEIC STEM CELL ACQUISITION   0   0   0   0. 0000000   0. 000000   0. 00000	60. 00   06000   LABORATORY	138, 322, 575	78, 461, 435	216, 784, 010	0. 117778	0.000000	60.00
65.00   06500   RESPIRATORY THERAPY   44, 949, 926   1, 917, 418   46, 867, 344   0. 151245   0. 000000   65. 00   66. 00   06600   PHYSI CAL THERAPY   13, 972, 897   2, 694, 518   16, 667, 415   0. 277099   0. 000000   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   10, 178, 281   965, 302   11, 143, 583   0. 168840   0. 000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   2, 559, 732   629, 520   3, 189, 252   0. 190693   0. 000000   68. 00   69. 00   06900   ELECTROCARDIOLOGY   32, 464, 435   53, 764, 865   86, 229, 300   0. 072687   0. 000000   69. 00   70. 01   07001   SLEEP LAB   0   0   0   0. 000000   0. 000000   70. 01   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   13, 122, 097   10, 154, 512   23, 276, 609   1. 312472   0. 000000   70. 01   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   13, 137, 676   17, 811, 195   35, 948, 871   0. 777824   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   26, 122, 367   70, 115, 528   96, 237, 895   0. 716011   0. 000000   73. 00   76. 97   07597   CARDIA C REHABILITATION   1, 099   4, 149, 110   4, 150, 209   0. 305053   0. 000000   77. 00   77. 00   0700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0. 000000   0. 000000   77. 00   77. 00   07900   CALIDIGENEIC STEM CELL ACQUISITION   0   0   0   0. 000000   0. 000000   0. 000000   77. 00   78. 00   07900   CALIDIGENEIC STEM CELL ACQUISITION   0   0   0   0. 000000   0. 000000   0. 000000   77. 00   79. 00   07900   CALIDIGENEIC STEM CELL ACQUISITION   0   0   0   0. 0000000   0. 000000   0. 00000	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	0	0	0. 000000	0.000000	63.00
67. 00 06700 OCCUPATIONAL THERAPY 10, 178, 281 965, 302 11, 143, 583 0. 168840 0. 000000 67. 00 68. 00 06800 SPECCH PATHOLOGY 2, 559, 732 629, 520 3, 189, 252 0. 190693 0. 000000 68. 00 69. 00 06900 ELECTROCARDIOLOGY 32, 464, 435 53, 764, 865 86, 229, 300 0. 072687 0. 000000 69. 00 00000 ELECTROCARDIOLOGY 2, 889, 189 8, 488, 263 11, 377, 452 0. 296275 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 70. 00 0. 000000 71. 00 0. 000000 0. 000000 71. 00 0. 000000 71. 00 0. 000000 71. 00 0. 000000 71. 00 0. 000000 0. 000000 71. 00 0. 000000 0. 000000 71. 00 0. 000000 0. 000000 71. 00 0. 000000 0. 000000 71. 00 0. 000000 0. 000000 71. 00 0. 000000 0. 000000 71. 00 0. 000000 0. 000000 72. 00 0. 000000 0. 000000 0. 000000 72. 00 0. 000000 0. 000000 0. 000000 72. 00 0. 000000 0. 000000 0. 000000 72. 00 0. 000000 0. 000000 0. 000000 0. 000000		44, 949, 926	1, 917, 418	46, 867, 344	0. 151245	0.000000	65.00
68.00   06800   SPEECH PATHOLOGY   2, 559, 732   629, 520   3, 189, 252   0, 190693   0, 000000   68.00   69.00   06900   ELECTROCARDI OLOGY   32, 464, 435   53, 764, 865   86, 229, 300   0, 072687   0, 0000000   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   2, 889, 189   8, 488, 263   11, 377, 452   0, 296275   0, 000000   70.00   70.01   07001   SLEEP LAB   0   0   0   0, 000000   0, 000000   70.00   71.00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENT   13, 122, 097   10, 154, 512   23, 276, 609   1, 312472   0, 000000   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   18, 137, 676   17, 811, 195   35, 948, 871   0, 777824   0, 000000   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   26, 122, 367   70, 115, 528   96, 237, 895   0, 716011   0, 000000   76. 97   76.97   07697   CARDI AC REHABI LI TATI ON   1, 099   4, 149, 110   4, 150, 209   0, 305053   0, 000000   76. 97   77.00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0, 000000   0, 000000   77.00   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0   0, 000000   0, 000000   78.00   79.00   09000   CLI NI C   95, 927   13, 095, 004   13, 190, 931   0, 114026   0, 000000   78.00   79.01   O9200   OBSERVATI ON BEDS (NON-DI STI NCT   22, 820, 998   52, 202, 830   3, 51, 300   0, 143318   0, 000000   92.00   79.02   O9200   OBSERVATI ON BEDS -DI STI NCT   22, 820, 998   52, 202, 830   75, 023, 828   0, 095642   0, 000000   79.00   OPECI AL PURPOSE COST CENTERS   0   80, 070   80, 070   18, 459885   0, 000000   79.00   ODE   DE   DE   TREATMENT PROGRAM   0   0   0   0   0   70.00   ODE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   COST CENTERS   0   0, 0000000   0, 000000   0, 000000   70.00   ODE   DE   COST CENTERS   0   0, 000000   0, 000000	66. 00   06600 PHYSI CAL THERAPY	13, 972, 897	2, 694, 518	16, 667, 415	0. 277099	0.000000	66. 00
68.00   06800   SPEECH PATHOLOGY   2, 559, 732   629, 520   3, 189, 252   0, 190693   0, 000000   68.00   69.00   06900   ELECTROCARDI OLOGY   32, 464, 435   53, 764, 865   86, 229, 300   0, 072687   0, 0000000   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   2, 889, 189   8, 488, 263   11, 377, 452   0, 296275   0, 000000   70.00   70.01   07001   SLEEP LAB   0   0   0   0, 000000   0, 000000   70.00   71.00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENT   13, 122, 097   10, 154, 512   23, 276, 609   1, 312472   0, 000000   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   18, 137, 676   17, 811, 195   35, 948, 871   0, 777824   0, 000000   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   26, 122, 367   70, 115, 528   96, 237, 895   0, 716011   0, 000000   76. 97   76.97   07697   CARDI AC REHABI LI TATI ON   1, 099   4, 149, 110   4, 150, 209   0, 305053   0, 000000   76. 97   77.00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0, 000000   0, 000000   77.00   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0   0, 000000   0, 000000   78.00   79.00   09000   CLI NI C   95, 927   13, 095, 004   13, 190, 931   0, 114026   0, 000000   78.00   79.01   O9200   OBSERVATI ON BEDS (NON-DI STI NCT   22, 820, 998   52, 202, 830   3, 51, 300   0, 143318   0, 000000   92.00   79.02   O9200   OBSERVATI ON BEDS -DI STI NCT   22, 820, 998   52, 202, 830   75, 023, 828   0, 095642   0, 000000   79.00   OPECI AL PURPOSE COST CENTERS   0   80, 070   80, 070   18, 459885   0, 000000   79.00   ODE   DE   DE   TREATMENT PROGRAM   0   0   0   0   0   70.00   ODE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   DE   COST CENTERS   0   0, 000000   0, 000000   70.00   ODE   DE   COST CENTERS   0   0, 0000000   0, 000000   0, 000000   70.00   ODE   DE   COST CENTERS   0   0, 000000   0, 000000	67. 00 06700 OCCUPATI ONAL THERAPY	10, 178, 281	965, 302	11, 143, 583	0. 168840	0.000000	67. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY   2, 889, 189   8, 488, 263   11, 377, 452   0. 296275   0. 000000   70. 00   70. 01   70. 01   SLEEP LAB   0   0   0   0. 0000000   70. 01   70. 01   70. 01   70. 01   70. 01   SLEEP LAB   0   0   0   0. 0000000   70. 01   70. 01   70. 01   70. 01   70. 01   70. 01   70. 01   70. 00   70. 01	68.00 06800 SPEECH PATHOLOGY		629, 520	3, 189, 252	0. 190693	0.000000	68. 00
70. 01   07001   SLEEP LAB	69. 00 06900 ELECTROCARDI OLOGY	32, 464, 435	53, 764, 865	86, 229, 300	0. 072687	0.000000	69. 00
71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   13,122,097   10,154,512   23,276,609   1.312472   0.000000   71.00   72	70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 889, 189	8, 488, 263	11, 377, 452	0. 296275	0.000000	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	70. 01   07001   SLEEP LAB	0	0	0	0.000000	0.000000	70. 01
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13, 122, 097	10, 154, 512	23, 276, 609	1. 312472	0.000000	71. 00
76. 97	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 137, 676	17, 811, 195	35, 948, 871	0. 777824	0.000000	72. 00
76. 98   07698   HYPERBARI C OXYGEN THERAPY   8, 969   3, 291, 628   3, 300, 597   0. 194947   0. 000000   76. 98   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   0. 0000000   0. 0000000   0. 0000000   0. 00000000	73.00 07300 DRUGS CHARGED TO PATIENTS	26, 122, 367	70, 115, 528	96, 237, 895	0. 716011	0.000000	73. 00
77. 00   07700   ALLOGENEI C STEM CELL ACQUI SITION   0   0   0   0   0   0   0   0   0	76. 97 07697 CARDIAC REHABILITATION	1, 099	4, 149, 110	4, 150, 209	0. 305053	0.000000	76. 97
78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   0   0	76. 98 07698 HYPERBARI C OXYGEN THERAPY	8, 969	3, 291, 628	3, 300, 597	0. 194947	0.000000	76. 98
OUTPATIENT SERVICE COST CENTERS  90. 00	77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	0	0	0. 000000	0.000000	77. 00
90. 00   90.00   CLI NI C   95, 927   13, 095, 004   13, 190, 931   0. 114026   0. 000000   90. 00   91. 00   91. 00   991. 00   991. 00   992. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   1, 848, 500   1, 302, 800   3, 151, 300   0. 143318   0. 000000   92. 00   92. 01   09201   0BSERVATI ON BEDS-DI STI NCT   22, 820, 998   52, 202, 830   75, 023, 828   0. 095642   0. 0000000   92. 01   09201   0BSERVATI ON BEDS-DI STI NCT   22, 820, 998   52, 202, 830   75, 023, 828   0. 095642   0. 0000000   92. 01   07HER REI MBURSABLE COST CENTERS   0   80, 070   80, 070   18. 459885   0. 0000000   95. 00   10200   0PI 0I D TREATMENT PROGRAM   0   0   0   0   0   0   0   0   0	78.00 07800 CAR T-CELL IMMUNOTHERAPY	o	0	0	0. 000000	0.000000	78. 00
91. 00   09100   EMERGENCY   135, 452, 723   217, 729, 876   353, 182, 599   0. 104674   0. 000000   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART   1, 848, 500   1, 302, 800   3, 151, 300   0. 143318   0. 000000   92. 00   09201   OBSERVATI ON BEDS-DI STINCT   22, 820, 998   52, 202, 830   75, 023, 828   0. 095642   0. 000000   92. 01   07HER REI MBURSABLE COST CENTERS   0   80, 070   80, 070   18. 459885   0. 000000   95. 00   10200   OPI OI D TREATMENT PROGRAM   0   0   0   0   0   0   0   0   0	OUTPATIENT SERVICE COST CENTERS						
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   1,848,500   1,302,800   3,151,300   0.143318   0.000000   92.00	90. 00 09000 CLI NI C	95, 927	13, 095, 004	13, 190, 931	0. 114026	0.000000	90.00
92. 01   09201   0BSERVATI ON BEDS-DISTINCT   22,820,998   52,202,830   75,023,828   0.095642   0.000000   92.01	91. 00 09100 EMERGENCY	135, 452, 723	217, 729, 876	353, 182, 599	0. 104674	0.000000	91.00
OTHER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   0   80, 070   80, 070   18. 45985   0. 000000   95. 00   102. 00   10200   OPI OI D TREATMENT PROGRAM   0   0   0   0   0   102. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   200. 00   Subtotal (see instructions)   1, 760, 162, 573   876, 828, 187   2, 636, 990, 760   200. 00   201. 00   Less Observation Beds   201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 848, 500	1, 302, 800	3, 151, 300	0. 143318	0.000000	92.00
95. 00   09500   AMBULANCE SERVI CES   0   80,070   80,070   18. 459885   0. 000000   95. 00   10200   0PI 0I D TREATMENT PROGRAM   0   0   0   0   0   0   0   0   0	92. 01   09201 OBSERVATI ON BEDS-DISTINCT	22, 820, 998	52, 202, 830	75, 023, 828	0. 095642	0.000000	92. 01
102. 00   10200   OPI 0I D TREATMENT PROGRAM   0   0   0   102. 00	OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (see instructions)   1,760,162,573   876,828,187   2,636,990,760   200.00   201.00   Less Observation Beds   201.00	95. 00 09500 AMBULANCE SERVICES		80, 070	80, 070	18. 459885	0.000000	95. 00
113. 00   11300   INTEREST EXPENSE		0	0	0			102. 00
200. 00       Subtotal (see instructions)       1,760,162,573       876,828,187       2,636,990,760       200.00         201. 00       Less Observation Beds       201.00							
201.00 Less Observation Beds 201.00							
		1, 760, 162, 573	876, 828, 187	2, 636, 990, 760			
202.00   Total (see instructions)   1,760,162,573  876,828,187  2,636,990,760    202.00							
	202.00   Total (see instructions)	1, 760, 162, 573	876, 828, 187	2, 636, 990, 760			202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041 From 01/01/2023 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/20/2024 2:35 pm

				5/20/2024 2:35 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00  03100 INTENSIVE CARE UNIT				31.00
34.00   03400   SURGI CAL INTENSIVE CARE UNIT				34.00
43. 00   04300   NURSERY				43. 00
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 261046			50.00
51.00   05100   RECOVERY ROOM	0. 167994			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 307475			52. 00
52. 01   03190   OP   INFUSION	0. 205040			52. 01
53. 00 05300 ANESTHESI OLOGY	0. 015530			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 197024			54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 145835			55. 00
56. 00   05600   RADI 0I SOTOPE	0. 362961			56.00
57. 00 05700 CT SCAN	0. 032079			57. 00
58. 00 05800 MRI	0. 062763			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 142512			59.00
60. 00 06000 LABORATORY	0. 117778			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 151245			65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 277099			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 168840			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 190693			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 072852			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 296275			70.00
70. 01   07001   SLEEP LAB	0. 000000			70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 312472			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 777824			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 716011			73. 00
76. 97 07697 CARDIAC REHABILITATION	0. 305053			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 194947			76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS	·			
90. 00 09000 CLI NI C	0. 114026			90.00
91. 00 09100 EMERGENCY	0. 104674			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 143318			92. 00
92. 01 09201 OBSERVATION BEDS-DISTINCT	0. 095642			92. 01
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	18. 459885			95. 00
102.00 10200 OPI OI D TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				. 52. 66
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
	1			1=32.00

				To 12/31/2023	Date/Time Pre 5/20/2024 2:3	pared:
		Ti +I	e XIX	Hospi tal	TEFRA	o piii
		11 (1	CAIA	Costs	TETRA	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	<u> </u>		
30. 00 03000 ADULTS & PEDIATRICS	80, 545, 965		80, 545, 96	5 0	80, 545, 965	30.00
31.00 03100 INTENSIVE CARE UNIT	55, 690, 202		55, 690, 202	2 0	55, 690, 202	31. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	6, 920, 822		6, 920, 822	2 0	6, 920, 822	34. 00
43. 00 04300 NURSERY	6, 184, 149		6, 184, 149	e o	6, 184, 149	43.00
44.00 04400 SKILLED NURSING FACILITY	7, 650, 654		7, 650, 654	1 0	7, 650, 654	44. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	26, 817, 159		26, 817, 159	9 0	26, 817, 159	50.00
51.00   05100   RECOVERY ROOM	3, 278, 991		3, 278, 99°	ı o	3, 278, 991	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 755, 178		7, 755, 178	3 o	7, 755, 178	52. 00
52. 01 03190 OP INFUSION	3, 807, 848		3, 807, 848	3 o	3, 807, 848	52. 01
53. 00 05300 ANESTHESI OLOGY	282, 527		282, 52 <sup>-</sup>	7 o	282, 527	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 653, 382		15, 653, 382	2 0	15, 653, 382	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	11, 692, 110		11, 692, 110		11, 692, 110	55. 00
56. 00   05600   RADI 0I SOTOPE	2, 254, 873		2, 254, 87	3 o	2, 254, 873	56. 00
57. 00   05700   CT   SCAN	4, 474, 882		4, 474, 882		4, 474, 882	57. 00
58. 00   05800   MRI	2, 113, 022		2, 113, 022	2 0	2, 113, 022	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 009, 456		9, 009, 456	6 0	9, 009, 456	59. 00
60. 00 06000 LABORATORY	25, 532, 495		25, 532, 49!	5 0	25, 532, 495	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			ol ol	0	63.00
65. 00 06500 RESPIRATORY THERAPY	7, 088, 446	0	7, 088, 446	ol ol	7, 088, 446	65. 00
66. 00   06600 PHYSI CAL THERAPY	4, 618, 528	0	4, 618, 528		4, 618, 528	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 881, 479	0			1, 881, 479	67.00
68. 00 06800 SPEECH PATHOLOGY	608, 167	0			608, 167	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 267, 714		6, 267, 714		6, 281, 976	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 370, 859		3, 370, 859		3, 370, 859	70.00
70. 01   07001   SLEEP LAB	0		(	1	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	30, 549, 891		30, 549, 89°	il ol	30, 549, 891	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	27, 961, 878		27, 961, 878	1	27, 961, 878	•
73.00 07300 DRUGS CHARGED TO PATIENTS	68, 907, 345		68, 907, 34!		68, 907, 345	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 266, 035		1, 266, 03!		1, 266, 035	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	643, 442		643, 442		643, 442	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			ol ol	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			ol ol	0	78. 00
OUTPATIENT SERVICE COST CENTERS			•	'		
90. 00 09000 CLI NI C	1, 504, 103		1, 504, 103	3 0	1, 504, 103	90.00
91. 00 09100 EMERGENCY	36, 968, 912		36, 968, 912	2 0	36, 968, 912	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	451, 637		451, 63 <sup>-</sup>		451, 637	92.00
92. 01 09201 OBSERVATION BEDS-DISTINCT	7, 175, 429		7, 175, 429		7, 175, 429	92. 01
OTHER REIMBURSABLE COST CENTERS	, , , , ,	ļ.		-1	, , ,	
95. 00 09500 AMBULANCE SERVICES	1, 478, 083		1, 478, 083	3 0	1, 478, 083	95. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0		(			102. 00
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300   NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	470, 405, 663	0	470, 405, 663	14, 262	470, 419, 925	1
201.00 Less Observation Beds	451, 637		451, 63	7	451, 637	201.00
202.00 Total (see instructions)	469, 954, 026	0			469, 968, 288	1
	•	-	•			•

			Т	o 12/31/2023	Date/Time Pre 5/20/2024 2:3	pared:
		Ti tl	e XIX	Hospi tal	TEFRA	<u> Э рііі</u>
		Charges	CAIA	nospi tui	121101	
Cost Center Description	Inpatient	Outpati ent	Total (col 6	Cost or Other	TEFRA	
oost denter beserretten	Impactiont	outputtent	+ col . 7)	Ratio	Inpatient	
			' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		Ratio	
	6.00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	502, 760, 634		502, 760, 634			30.00
31.00 03100 INTENSIVE CARE UNIT	466, 788, 849		466, 788, 849			31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	43, 127, 435		43, 127, 435			34.00
43. 00 04300 NURSERY	20, 126, 493		20, 126, 493			43.00
44.00 04400 SKILLED NURSING FACILITY	17, 934, 175		17, 934, 175			44. 00
ANCILLARY SERVICE COST CENTERS				<u>'</u>		
50. 00 05000 OPERATING ROOM	47, 724, 306	55, 005, 187	102, 729, 493	0. 261046	0. 261046	50.00
51. 00 05100 RECOVERY ROOM	8, 513, 004	11, 005, 512	19, 518, 516	0. 167994	0. 167994	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 333, 380	6, 888, 755	25, 222, 135	0. 307475	0. 307475	52. 00
52. 01 03190 OP INFUSION	46, 039	18, 525, 170		0. 205040	0. 205040	
53. 00 05300 ANESTHESI OLOGY	8, 922, 420	9, 270, 205		0. 015530	0. 015530	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	33, 710, 587	45, 738, 447	79, 449, 034	0. 197024	0. 197024	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 922, 192	77, 251, 280		0. 145835	0. 145835	55.00
56. 00 05600 RADI 0I SOTOPE	2, 210, 133	4, 002, 307		0. 362961	0. 362961	56.00
57. 00 05700 CT SCAN	71, 459, 084	68, 038, 537	139, 497, 621	0. 032079	0. 032079	
58. 00   05800 MRI	18, 293, 751	15, 372, 831		0. 062763	0.062763	
59. 00 05900 CARDI AC CATHETERI ZATI ON	34, 342, 700	28, 876, 082		0. 142512	0. 142512	59.00
60. 00 06000 LABORATORY	138, 322, 575	78, 461, 435		0. 117778	0. 117778	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0. 000000	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	44, 949, 926	1, 917, 418	46, 867, 344	0. 151245	0. 151245	65.00
66. 00 06600 PHYSI CAL THERAPY	13, 972, 897	2, 694, 518		0. 277099	0. 277099	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 178, 281	965, 302		0. 168840	0. 168840	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 559, 732	629, 520		0. 190693	0. 190693	68. 00
69. 00 06900 ELECTROCARDI OLOGY	32, 464, 435	53, 764, 865		0. 072687	0. 072687	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 889, 189	8, 488, 263		0. 296275	0. 296275	70.00
70. 01 07001 SLEEP LAB	0	0	0	0. 000000	0.000000	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13, 122, 097	10, 154, 512	23, 276, 609	1. 312472	1. 312472	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 137, 676	17, 811, 195		0. 777824	0. 777824	
73.00 07300 DRUGS CHARGED TO PATIENTS	26, 122, 367	70, 115, 528		0. 716011	0. 716011	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 099	4, 149, 110	4, 150, 209	0. 305053	0. 305053	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	8, 969	3, 291, 628	3, 300, 597	0. 194947	0. 194947	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0. 000000	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	o	0	0	0. 000000	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS				<u>'</u>		
90. 00 09000 CLI NI C	95, 927	13, 095, 004	13, 190, 931	0. 114026	0. 114026	90.00
91. 00 09100 EMERGENCY	135, 452, 723	217, 729, 876	353, 182, 599	0. 104674	0. 104674	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 848, 500	1, 302, 800	3, 151, 300	0. 143318	0. 143318	92.00
92. 01 09201 OBSERVATI ON BEDS-DISTINCT	22, 820, 998	52, 202, 830	75, 023, 828	0. 095642	0. 095642	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	80, 070	80, 070	18. 459885	18. 459885	95. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	o	O	0			102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	1, 760, 162, 573	876, 828, 187	2, 636, 990, 760			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	1, 760, 162, 573	876, 828, 187	2, 636, 990, 760			202. 00

Health Financial Systems COMMUNITY MEDICAL CENTER In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/20/2024 2:35 pm

					5/20/2024 2:35 pm
			Title XIX	Hospi tal	TEFRA
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
INF	PATIENT ROUTINE SERVICE COST CENTERS				
30.00 030	DOO ADULTS & PEDIATRICS				30.00
31.00 031	100 INTENSIVE CARE UNIT				31.00
34.00 034	400 SURGICAL INTENSIVE CARE UNIT				34.00
43. 00 043	300 NURSERY				43.00
	400 SKILLED NURSING FACILITY				44. 00
ANC	CILLARY SERVICE COST CENTERS				
50.00 050	OOO OPERATING ROOM	0. 000000			50.00
51.00 051	100 RECOVERY ROOM	0. 000000			51.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
52. 01   031	190 OP INFUSION	0. 000000			52. 01
53.00 053	300 ANESTHESI OLOGY	0. 000000			53.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 055	500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56.00 056	600 RADI OI SOTOPE	0. 000000			56. 00
57. 00 057	700 CT SCAN	0. 000000			57. 00
58. 00 058	800 MRI	0. 000000			58. 00
59. 00 059	900 CARDIAC CATHETERIZATION	0. 000000			59. 00
60.00 060	DOO LABORATORY	0. 000000			60.00
63.00 063	300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
65. 00 065	500 RESPI RATORY THERAPY	0. 000000			65. 00
66.00 066	600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 067	700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 068	BOO SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 069	900 ELECTROCARDI OLOGY	0. 000000			69. 00
70.00 070	DOO ELECTROENCEPHALOGRAPHY	0. 000000			70.00
70. 01 070	001 SLEEP LAB	0. 000000			70. 01
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00   073	300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	697 CARDIAC REHABILITATION	0. 000000			76. 97
1	698 HYPERBARIC OXYGEN THERAPY	0. 000000			76. 98
1	700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
	BOO CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
	TPATIENT SERVICE COST CENTERS				
	DOO CLI NI C	0. 000000			90.00
4	100 EMERGENCY	0. 000000			91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
	201 OBSERVATION BEDS-DISTINCT	0. 000000			92. 01
	HER REIMBURSABLE COST CENTERS				
	500 AMBULANCE SERVICES	0. 000000			95. 00
	200 OPIOID TREATMENT PROGRAM				102. 00
	ECLAL PURPOSE COST CENTERS				
4	300 I NTEREST EXPENSE				113. 00
200. 00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202. 00	Total (see instructions)				202. 00

	NEDOCTIONS FOR MEDICAND GIVE			Т	o 12/31/2023	Date/Time Pre 5/20/2024 2:3	
				e XIX	Hospi tal	TEFRA	
	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	1					
50.00	05000 OPERATING ROOM	26, 817, 159	2, 714, 742				1
51. 00	05100 RECOVERY ROOM	3, 278, 991	188, 282				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 755, 178	600, 456				52. 00
52. 01	03190 OP INFUSION	3, 807, 848	283, 662				52. 01
53.00	05300 ANESTHESI OLOGY	282, 527	35, 408				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	15, 653, 382	1, 371, 227				54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	11, 692, 110	1, 102, 223				55. 00
56.00	05600 RADI OI SOTOPE	2, 254, 873	77, 062				56. 00
57.00	05700 CT SCAN	4, 474, 882	75, 350				57. 00
58.00	05800  MRI	2, 113, 022	261, 034				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	9, 009, 456	981, 691	8, 027, 765	98, 169		
60.00	06000 LABORATORY	25, 532, 495	960, 982	24, 571, 513	96, 098	1, 425, 148	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	7, 088, 446	390, 326	6, 698, 120	39, 033	388, 491	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 618, 528	220, 270	4, 398, 258	22, 027	255, 099	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 881, 479	31, 087	1, 850, 392	3, 109	107, 323	67. 00
68.00	06800 SPEECH PATHOLOGY	608, 167	30, 149	578, 018	3, 015	33, 525	68. 00
69.00	06900 ELECTROCARDI OLOGY	6, 267, 714	297, 304	5, 970, 410	29, 730	346, 284	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 370, 859	424, 891	2, 945, 968	42, 489	170, 866	70. 00
70. 01	07001 SLEEP LAB	0	0	C	0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	30, 549, 891	770, 353	29, 779, 538	77, 035	1, 727, 213	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	27, 961, 878	705, 103	27, 256, 775	70, 510		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	68, 907, 345	1, 075, 951				73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 266, 035	87, 075				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	643, 442	77, 153				76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	o	0		0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	-1	-	-			
90.00	09000 CLI NI C	1, 504, 103	39, 601	1, 464, 502	3, 960	84, 941	90.00
91. 00	09100 EMERGENCY	36, 968, 912	2, 336, 244		•		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	451, 637	26, 099		•		92.00
	09201 OBSERVATI ON BEDS-DI STI NCT	7, 175, 429	118, 574			409, 298	92. 01
	OTHER REIMBURSABLE COST CENTERS	., ., ., ., ., .,		., .,	,		
95.00	09500 AMBULANCE SERVI CES	1, 478, 083	16, 852	1, 461, 231	1, 685	84, 751	95. 00
	10200 OPI OI D TREATMENT PROGRAM	0	0,002				102. 00
. 52. 50	SPECIAL PURPOSE COST CENTERS	, 9					1.02.00
113 00	11300   INTEREST EXPENSE						113. 00
200.00		313, 413, 871	15, 299, 151	298, 114, 720	1, 529, 913		1
201.00	· · · · · · · · · · · · · · · · · · ·	451, 637	26, 099				
202.00		312, 962, 234	15, 273, 052				
202.00	110101 (11110 200 11111103 11110 201)	312, 702, 234	15, 275, 052	277,007,102	1, 527, 505	17,200,770	1202.00

REDUCTIONS FOR MEDICALD ONLY

Title VIX   Hospital   TEFRA							5/20/2024 2:35 pm
Capi tal and   Ownersheet**   Capi tal and   Capi tal and   Capi tal and   Capi tal and   Ownersheet**   Capi tal and   Owne				Ti tl	e XIX	Hospi tal	TEFRA
Capi tal and   Ownersheet**   Capi tal and   Capi tal and   Capi tal and   Capi tal and   Ownersheet**   Capi tal and   Owne		Cost Center Description	Cost Net of	Total Charges	Outpatient		
ANCILLARY SERVICE COST CENTERS		F	Capital and				
Reduction							
ANOLILARY SERVICE COST CENTERS							
MACILLARY SERVICE COST CENTERS							
50.00		I	6.00	7.00	8.00		
51.00							
52.00   05200   DELIVERY ROOM & LABOR ROOM   7, 280, 158   25, 222, 125   0. 288642   52.00   1.0 1300   0. 191507   52.01   53.00   0.5300   ANESTHESI OLOGY   264, 653   18, 192, 625   0. 0. 14547   53.00   0.5300   ANESTHESI OLOGY   264, 653   18, 192, 625   0. 0. 14547   53.00   0.5500   RADI OLOGY-THERAPEUTI C   10, 967, 675   80, 173, 472   0. 136799   55.00   0.5500   RADI OLOGY-THERAPEUTI C   10, 967, 675   80, 173, 472   0. 136799   55.00   0.5500   RADI OLOGY-THERAPEUTI C   10, 967, 675   80, 173, 472   0. 136799   55.00   0.5500   RADI OLOGY-THERAPEUTI C   10, 967, 675   80, 173, 472   0. 136799   55.00   0.5500   RADI OLOGY-THERAPEUTI C   10, 967, 675   80, 173, 472   0. 136799   55.00   0.5500   RADI OLOGY-THERAPEUTI C   10, 967, 675   80, 173, 472   0. 136799   55.00   0.5500   RADI OLOGY-THERAPEUTI C   10, 967, 675   80, 173, 472   0. 136799   55.00   0.5500   RADI OLOGY-THERAPEUTI C   10, 967, 675   80, 173, 472   0. 136799   55.00   0.5500   RADI AC CATHETERI ZATI ON   8, 445, 677   63, 218, 782   0. 0.58979   58.00   0.5500   CARDI AC CATHETERI ZATI ON   8, 445, 677   63, 218, 782   0. 0. 133594   59.00   0.00000   0.6000   LABORATORY   66, 600, 922   46, 867, 344   0. 142123   65.00   0.6000   PASI CALT HERAPY   6, 660, 922   46, 867, 344   0. 142123   65.00   0.000000   9.7000   PASI CALT HERAPY   4, 341, 402   46, 667, 413   58930   67.00   0.000000   9.7000   0.000000   9.7000   0.000000   9.7000   0.000000   9.7000   0.000000   9.7000   0.000000   9.7000   0.000000   9.7000   0.000000   9.7000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		05000  OPERATI NG ROOM	25, 147, 745	102, 729, 493	0. 244796		l
52.01   03190   OP INFUSION   3,575,079   18,571,209   0,192507   52.01	51.00	05100 RECOVERY ROOM	3, 080, 902	19, 518, 516	0. 157845		51. 00
52.01   03190   OP INFUSION   3,575,079   18,571,209   0,192507   52.01	52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 280, 158	25, 222, 135	0. 288642		52.00
53.00   05300   ANESTHESI OLOGY   264, 653   18, 192, 625   0, 014547   53.00		i i	1				
54. 00   05400   RADI OLOGY-DIAGNOSTI C							
55.00   OSSOO   RADIO LOGY-THERAPEUTI C   10, 967, 675   80, 173, 472   0, 136799   55.00							
56. 00   05600   RADI DI SOTOPE   2, 120, 854   6, 212, 440   0, 341388   56, 00   5700   CT SCAN   4, 212, 174   139, 497, 621   0, 030195   55, 00   5800   MRI   1, 979, 504   33, 666, 582   0, 058797   58, 00   5800   MRI   1, 979, 504   33, 666, 582   0, 133594   59, 00   05900   CARDIAC CATHETERI ZATI ON   8, 445, 677   63, 218, 782   0, 133594   59, 00   06300   0.0000   LABORATORY   24, 011, 249   216, 784, 010   0, 110761   60, 00   063, 00   0.0000   0.00000   63, 00   0.00000   63, 00   0.00000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.000000   0.00000000							
57. 00   05700   CT SCAN   4, 212, 174   139, 497, 621   0. 030195   57. 00   05800   MRI   1, 979, 504   33, 666, 582   0. 058797   58. 00   05900   CARDIAC CATHETERI ZATION   8, 445, 647   63, 218, 782   0. 133594   59. 00   06000   06000   LABORATORY   24, 011, 249   216, 784, 010   0. 110761   60. 00   63. 00   06000   BLODD STORING, PROCESSING & TRANS.   0   0. 000000   63. 00   06000   BLODD STORING, PROCESSING & TRANS.   0   0. 000000   63. 00   06000   PHYSICAL THERAPY   4, 341, 402   141, 43, 583   0. 182930   67. 00   06000   PHYSICAL THERAPY   4, 341, 402   141, 43, 583   0. 18930   67. 00   06000   06000   PHYSICAL THERAPY   7, 771, 047   11, 143, 583   0. 18930   67. 00   06800   SPECCH PATHOLOGY   571, 627   3, 189, 252   0. 179235   68. 00   06800   SPEECH PATHOLOGY   5, 891, 700   86. 229, 300   0. 068326   69. 00   09000   LECETORORARIO LOGY   5, 891, 700   86. 229, 300   0. 068326   69. 00   0700   ELECTROENCEPHALOGRAPHY   3, 157, 504   11, 377, 452   0. 277523   70. 00   07001   ELECTROENCEPHALOGRAPHY   3, 157, 504   11, 377, 452   0. 277523   70. 00   07000   ELECTROENCEPHALOGRAPHY   3, 157, 504   11, 377, 452   0. 277523   70. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENT   28, 745, 643   23, 276, 609   1.234958   71. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENT   26, 310, 475   35, 948, 871   0. 731886   72. 00   07200   MPLD CAL SUPPLIES CHARGED TO PATI ENT   26, 310, 475   35, 948, 871   0. 731886   72. 00   0. 000000   77. 00   0. 000000   77. 00   0. 000000   77. 00   0. 000000   77. 00   0. 000000   77. 00   0. 000000   77. 00   0. 000000   77. 00   0. 000000   77. 00   0. 000000   77. 00   0. 000000   77. 00   0. 0000		1					
58. 00   05800   MR    1, 979, 504   33, 666, 582   0. 058797   58, 00   05900   CARDIAC CATHETERIZATION   8, 445, 677   63, 218, 782   0. 133594   59, 00   06000   LABORATORY   24, 011, 249   216, 784, 010   0. 110761   60, 00   063, 00   06300   RESPIRATORY THERAPY   6, 660, 922   46, 867, 344   0. 142123   65, 00   06000   CEVENTATORY THERAPY   4, 341, 402   16, 667, 415   0. 260472   66, 00   06700   0CCUPATIONAL THERAPY   1, 771, 047   11, 143, 583   0. 158930   67, 00   06900   ELECTROCARDIOLOGY   5, 891, 700   86, 229, 300   0. 068326   69, 00   06900   ELECTROCARDIOLOGY   5, 891, 700   86, 229, 300   0. 068326   69, 00   06900   ELECTROCARDIOLOGY   5, 891, 700   86, 229, 300   0. 068326   69, 00   07000   ELECTROCARDIOLOGY   5, 891, 700   86, 229, 300   0. 068326   69, 00   07000   ELECTROCARDIOLOGY   5, 891, 700   70, 01   07001   SLEEP LAB   0   0   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 00							
59.00   05900   CARDI AC CATHETERI ZATI ON   8, 445, 677   63, 218, 782   0. 133594   60. 00   06000   LABORATORY   24, 011, 249   216, 784, 010   0. 110761   60. 00   063. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0. 0000000   63. 00   06500   05500   RESPI RATORY THERAPY   0. 660, 9222   46, 867, 344   0. 142123   65. 00   06600   PHYSI CAL THERAPY   4, 341, 402   16. 667, 415   0. 260472   66. 00   06600   PHYSI CAL THERAPY   1, 771, 047   11, 143, 583   0. 158930   67. 00   06800   PECCH PATHOLOGY   571, 627   3, 189, 252   0. 179235   68. 00   06900   PECCH ROCARDI OLOGY   5, 891, 700   86, 229, 300   0. 068326   69. 00   070. 00   07000   ELECTROCARDI OLOGY   5, 891, 700   86, 229, 300   0. 068326   69. 00   070. 01   07010   SLEEP LAB   0   0   0   0   0. 000000   70. 01   07010   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   26, 310, 475   35, 948, 871   0. 731886   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   26, 310, 475   35, 948, 871   0. 731886   72. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   1, 188, 947   4, 150, 209   0. 286479   76. 98   07698   HYPERBARI C OXYGEN THERAPY   602, 882   3, 300, 597   0. 182658   76. 97   76. 98   07690   ALDIGENEIC STEM CELL ACQUI SI TI ON   0   0   0. 000000   77. 00   07000   ELECTROCEPHATE OR SERVICE COST CENTERS   90. 00   0. 000000   77. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 00000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 00000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 0000000   78. 00   0. 00000000   78. 00   0. 00000000   78. 00   0. 00000000   78. 00   0. 000000000   78. 00   0. 0000000000   78. 00   0. 0000000000   78. 00   0. 0000000000   78. 00   0. 00000000000000000000000000000							
60. 00   06000   LABORATORY   24, 011, 249   216, 784, 010   0. 110761   60. 00   63. 00   63. 00   63. 00   63. 00   63. 00   63. 00   65. 00   06500   RESPI RATORY THERAPY   6, 660, 922   46, 867, 344   0. 142123   65. 00   66. 00   06600   PKYSI CAL THERAPY   4, 341, 402   16, 667, 415   0. 260472   66. 00   66. 00   06000   PKYSI CAL THERAPY   1, 771, 047   11, 143, 583   0. 158930   67. 00   68. 00   06800   SPEECH PATHOLOGY   5, 891, 700   86, 229, 300   0. 068326   69. 00   069. 00   06900   ELECTROCARDI OLOGY   5, 891, 700   86, 229, 300   0. 068326   69. 00   07000   ELECTROCARDI OLOGY   5, 891, 700   86, 229, 300   0. 0068326   69. 00   07000   ELECTROCARDI OLOGY   5, 891, 700   80, 229, 300   0. 0068326   69. 00   07000   ELECTROCARDI OLOGY   3, 157, 504   11, 377, 452   0. 277523   70. 00	58.00	05800  MRI	1, 979, 504	33, 666, 582	0. 058797		58. 00
60. 00   06000   LABORATORY   24, 011, 249   216, 784, 010   0. 110761   60. 00   63. 00   63. 00   63. 00   63. 00   63. 00   63. 00   65. 00   06500   RESPI RATORY THERAPY   6, 660, 922   46, 867, 344   0. 142123   65. 00   66. 00   06600   PKYSI CAL THERAPY   4, 341, 402   16, 667, 415   0. 260472   66. 00   66. 00   06000   PKYSI CAL THERAPY   1, 771, 047   11, 143, 583   0. 158930   67. 00   68. 00   06800   SPEECH PATHOLOGY   5, 891, 700   86, 229, 300   0. 068326   69. 00   069. 00   06900   ELECTROCARDI OLOGY   5, 891, 700   86, 229, 300   0. 068326   69. 00   07000   ELECTROCARDI OLOGY   5, 891, 700   86, 229, 300   0. 0068326   69. 00   07000   ELECTROCARDI OLOGY   5, 891, 700   80, 229, 300   0. 0068326   69. 00   07000   ELECTROCARDI OLOGY   3, 157, 504   11, 377, 452   0. 277523   70. 00	59.00	05900 CARDI AC CATHETERI ZATI ON	8, 445, 677	63, 218, 782	0. 133594		59.00
63. 00   66300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0							
65. 00   06500   RSPJ RATORY THERAPY   6, 660, 922   46, 887, 344   0.142123   65. 00   66. 00   06600   PHYSI CAL THERAPY   4, 341, 402   16, 667, 415   0.260472   66. 00   06700   0CCUPATI ONAL THERAPY   1, 771, 047   11, 143, 583   0.158930   67. 00   08. 00   06800   SPEECH PATHOLOGY   571, 627   3, 189, 252   0.179235   68. 00   06900   ELECTROCARDI OLOGY   5, 891, 700   86, 229, 300   0.068326   69. 00   07000   ELECTROCARDI OLOGY   3, 157, 504   11, 377, 452   0.277523   70. 00   70. 01   07001   SLEEP LAB   0   0   0.000000   70. 01   07001   SLEEP LAB   0   0   0.000000   70. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   28, 745, 643   23, 276, 609   1.234958   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   26, 310, 475   35, 948, 871   0.731886   72. 00   73. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   26, 310, 475   35, 948, 871   0.731886   72. 00   73. 00   74. 07070   ALLOGENEI C STEM CELL ACQUI SI TION   002, 882   3, 300, 597   0.182658   76. 98   76. 98   76.98   76.99   76.99   76.99   76.99   76.99   76.99   76.90   0.000000   77. 00   0.000000   77. 00   0.000000   0.000000   77. 00   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000							
66.00   06600   PHYSI CAL THERAPY   4, 341, 402   16, 667, 415   0. 260472   66.00   0670 0   0CCUPATI ONAL THERAPY   1, 771, 047   11, 143, 583   0. 158930   67.00   68.00   06800   SPECH PATHOLOGY   5, 891, 700   86, 229, 300   0. 068326   69. 00   070.00   07000   ELECTROCARDI OLOGY   3, 157, 504   11, 377, 452   0. 277523   70. 00   070.01   07001   SLEEP LAB   0   0   0. 000000   70. 01   071.00   07010   MEDI CAL SUPPLIES CHARGED TO PATI ENT   28, 745, 643   23, 276, 609   1. 234958   71. 00   072.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   26, 310, 475   35, 948, 871   0. 731886   72. 00   076.97   07697   CARDI AC REHABI LI TATI ON   1, 188, 947   4, 150, 209   0. 286479   76. 97   076.98   07698   HYERBARI C OXYGEN THERAPY   602, 882   3, 300, 597   0. 182658   76. 98   078.00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0. 000000   0. 000000   078.00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0. 000000   0. 000000   079.00   09000   CINI C   0. 1, 415, 202   13, 190, 931   0. 107286   90. 00   09000   010   EMERGENCY   34, 726, 593   353, 182, 599   0. 098325   91. 00   092.01   08SERVATI ON BEDS ONS INICT   6, 754, 274   75, 023, 828   0. 090028   92. 01   071.02   O10   O10   TREATMENT PROGRAM   0   0   0. 000000   0. 000000   071.02   O10   TREATMENT PROGRAM   0   0   0. 000000   0. 000000   071.02   O10   O10   TREATMENT PROGRAM   0   0   0. 000000   0. 000000   071.00   CLINI ON TREATMENT PROGRAM   0   0   0. 000000   0. 000000   071.00   010   TREATMENT PROGRAM   0   0   0. 000000   0. 000000   071.00   010   TREATMENT PROGRAM   0   0   0. 0000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000							
67. 00   06700   06CUPATI ONAL THERAPY   1,771,047   11,143,583   0,158930   67. 00   68. 00   06800   SPEECH PATHOLOGY   571,627   3,189,252   0,179235   68. 00   06900   ELECTROCARDI OLOGY   5,891,700   86,229,300   0,68836   69. 00   07000   ELECTROENCEPHALOGRAPHY   3,157,504   11,377,452   0,277523   70. 00   0.000000   70. 01   07001   SLEEP LAB   0   0   0.000000   70. 01   07001   SLEEP LAB   0   0   0.000000   0.234958   71. 00   0.000000   70. 01   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   28,745,643   23,276,669   1,234958   71. 00   0.000000   0.7300   IMPL. DEV. CHARGED TO PATIENTS   26,310,475   35,948,871   0,731886   72. 00   0.7300   DRUGS CHARGED TO PATIENTS   64,865,529   96,237,895   0.674012   73. 00   0.7697   CARDIA C REHABI LITATI ON   1,188,947   4,150,209   0.286479   76. 97   76. 97   76. 97   76. 98   0.7698   HYPERBARI C OXYGEN THERAPY   602,882   3,300,597   0.182658   76. 98   77. 00   0.7000   ALLOGENEIC STEM CELL ACQUISITION   0   0   0.000000   77. 00   0.000000   77. 00   0.000000   0.000000   78. 00   0.000000   0.000000   78. 00   0.000000   0.000000   78. 00   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000							
68. 00   06800   SPEECH PATHOLOGY   571, 627   3, 189, 252   0. 179235   68. 00   69. 00   06900   ELECTROCARDI OLOGY   5, 891, 700   86, 229, 300   0. 068326   69. 00   0. 000000   0. 00000000							
69. 00   06900   ELECTROCARDIOLOGY   5, 891, 700   86, 229, 300   0.068326   69. 00   70. 00   70000   ELECTROENCEPHALOGRAPHY   3, 157, 504   11, 377, 452   0.277523   70. 00   70. 00   70. 01							
70. 00   70.00   70.00   ELECTROENCEPHALOGRAPHY   3, 157, 504   11, 377, 452   0. 277523   70. 00   70. 01			571, 627				
70. 01   07001   SLEEP LAB		06900  ELECTROCARDI OLOGY	5, 891, 700	86, 229, 300	0. 068326		69.00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   28, 745, 643   23, 276, 609   1.234958   71. 00   72. 00   72.00   IMPL. DEV. CHARGED TO PATI ENTS   26, 310, 475   35, 948, 871   0.731886   72. 00   73. 00   73. 00   0700   DRUGS CHARGED TO PATI ENTS   64, 865, 529   96, 237, 895   0. 674012   73. 00   73. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   1, 188, 947   4, 150, 209   0. 286479   76. 97   76. 98   07698   HYPERBARI C OXYGEN THERAPY   602, 882   3, 300, 597   0. 182658   76. 98   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0. 000000   0. 000000   77. 00   0. 000000   0. 000000   0. 0000000   0. 000000   0. 00000000	70.00	07000 ELECTROENCEPHALOGRAPHY	3, 157, 504	11, 377, 452	0. 277523		70.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   26, 310, 475   35, 948, 871   0. 731886   72. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   64, 865, 529   96, 237, 895   0. 674012   73. 00   76. 97   07697   07697   07697   07698   HYPERBARI C OXYGEN THERAPY   602, 882   3, 300, 597   0. 182658   76. 98   07698   HYPERBARI C OXYGEN THERAPY   602, 882   3, 300, 597   0. 182658   76. 98   07690   CAR T-CELL IMMUNOTHERAPY   0   0   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0	70. 01	07001 SLEEP LAB	0	0	0. 000000		70. 01
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   26, 310, 475   35, 948, 871   0. 731886   72. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   64, 865, 529   96, 237, 895   0. 674012   73. 00   76. 97   07697   07697   07697   07698   HYPERBARI C OXYGEN THERAPY   602, 882   3, 300, 597   0. 182658   76. 98   07698   HYPERBARI C OXYGEN THERAPY   602, 882   3, 300, 597   0. 182658   76. 98   07690   CAR T-CELL IMMUNOTHERAPY   0   0   0. 0000000   0. 0000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	71 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28 745 643	23 276 609	1 234958		71 00
73. 00							
76. 97							
76. 98							
77. 00		1					l -
78. 00							
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS     90. 00				·			
90. 00	78. 00		0	0	0.000000		78. 00
91. 00							
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   424, 346   3, 151, 300   0. 134657   92. 00   09201   0BSERVATI ON BEDS-DI STI NCT   6, 754, 274   75, 023, 828   0. 090028   92. 01   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   1, 391, 647   80, 070   17. 380380   95. 00   102.00   0PI 01D TREATMENT PROGRAM   0   0. 000000   102.00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   Subtotal (sum of lines 50 thru 199)   294, 593, 304   1, 586, 253, 174   200. 00   201. 00   Less Observation Beds   424, 346   0   201. 00	90.00	09000 CLI NI C	1, 415, 202	13, 190, 931	0. 107286		90.00
92. 01 09201 0BSERVATI ON BEDS-DI STI NCT 6, 754, 274 75, 023, 828 0. 090028 92. 01  OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 1, 391, 647 80, 070 17. 380380 95. 00  SPECI AL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (sum of lines 50 thru 199) 294, 593, 304 1, 586, 253, 174 200. 00  201. 00 Less Observation Beds 424, 346 0 201. 00	91.00	09100 EMERGENCY	34, 726, 593	353, 182, 599	0. 098325		91. 00
92. 01 09201 0BSERVATI ON BEDS-DI STI NCT 6, 754, 274 75, 023, 828 0. 090028 92. 01  OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 1, 391, 647 80, 070 17. 380380 95. 00  SPECI AL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (sum of lines 50 thru 199) 294, 593, 304 1, 586, 253, 174 200. 00  201. 00 Less Observation Beds 424, 346 0 201. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	424, 346	3, 151, 300	0. 134657		92.00
OTHER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   1,391,647   80,070   17. 380380   95. 00   102.00   102.00   091 01 D TREATMENT PROGRAM   0   0   0.000000   102. 00   SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200. 00   Subtotal (sum of lines 50 thru 199)   294,593,304   1,586,253,174   200. 00   201. 00   Less Observation Beds   424,346   0   201. 00			1				92 01
95. 00   09500   AMBULANCE SERVICES   1,391,647   80,070   17.380380   95. 00   102. 00   10200   OPI OI D TREATMENT PROGRAM   0   0   0.000000   102. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   Subtotal (sum of lines 50 thru 199)   294,593,304   1,586,253,174   200. 00   201. 00   Less Observation Beds   424,346   0   201. 00	, 2. 0.		0,701,271	7070207020	0.070020		72.01
102. 00 102.00 OPI 0I D TREATMENT PROGRAM 0 0 0.000000 102. 00 000000 102. 00 000000 102. 00 000000 102. 00 000000 102. 00 0000000 102. 00 0000000 102. 00 0000000 102. 00 00000000 102. 00 0000000000	05 00		1 301 647	80.070	17 390200		05.00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (sum of lines 50 thru 199)   294,593,304   1,586,253,174   200.00   201.00   424,346   0   201.00							
113.00	102.00		1 0		0.000000		102.00
200.00 Subtotal (sum of lines 50 thru 199) 294,593,304 1,586,253,174 200.00 201.00 Less Observation Beds 294,593,304 0 201.00			_		T		
201. 00 Less Observation Beds 424, 346 0 201. 00							
			294, 593, 304	1, 586, 253, 174			
202.00   Total (line 200 minus line 201)   294,168,958   1,586,253,174   202.00	201.00	Less Observation Beds	424, 346	0			
	202.00	Total (line 200 minus line 201)	294, 168, 958	1, 586, 253, 174			202. 00

Heal th	Financial Systems	COMMUNITY MED	ICAL CENTER		In Lieu of Form CMS-2552-10			
APPORT	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL			Provi der CCN: 31-0041		Worksheet D Part I Date/Time Pre 5/20/2024 2:3	pared: 5 pm	
				XVIII	Hospi tal	PPS		
	Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)		
		Part II, col. 26)		(col . 1 - col 2)				
		1.00	2.00	3.00	4. 00	5. 00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4, 654, 580	0	4, 654, 58				
31.00	INTENSIVE CARE UNIT	2, 771, 988		2, 771, 98			31. 00	
34.00	SURGICAL INTENSIVE CARE UNIT	260, 460	l e	260, 46				
43.00	NURSERY	295, 977	l e	295, 97			43. 00	
	SKILLED NURSING FACILITY	360, 646	l e	360, 64	•			
200.00	Total (lines 30 through 199)	8, 343, 651		8, 343, 65	1 127, 832		200. 00	
	Cost Center Description	I npati ent	Inpati ent					
		Program days	Program					
			Capital Cost					
			(col. 5 x col. 6)					
		6. 00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00					
30. 00	ADULTS & PEDIATRICS	46, 606	3, 278, 732				30.00	
31. 00	INTENSIVE CARE UNIT	2, 974					31. 00	
34. 00	SURGICAL INTENSIVE CARE UNIT	1, 541		•			34.00	
43.00	NURSERY	0	ľ	1			43.00	
	SKILLED NURSING FACILITY	3, 680	222, 125				44. 00	
200.00	Total (lines 30 through 199)	54, 801	3, 784, 506				200. 00	

Health Financial Systems	COMMUNITY MED	DICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/20/2024 2:3	pared: 5 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_					
50. 00   05000 OPERATI NG ROOM	2, 714, 742		1		474, 656	50.00
51. 00   05100   RECOVERY ROOM	188, 282				30, 018	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	600, 456				0	52. 00
52. 01  03190  OP   NFUSI ON	283, 662	18, 571, 209	0. 01527	'4 31, 017	474	52. 01
53. 00   05300   ANESTHESI OLOGY	35, 408	18, 192, 625	0. 00194	6 2, 781, 756	5, 413	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 371, 227	79, 449, 034	0. 01725	14, 642, 944	252, 723	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	1, 102, 223	80, 173, 472	0. 01374	8 1, 217, 090	16, 733	55. 00
56. 00   05600   RADI 0I SOTOPE	77, 062	6, 212, 440	0. 01240	962, 117	11, 934	56. 00
57. 00  05700 CT SCAN	75, 350	139, 497, 621	0.00054	0 31, 167, 905	16, 831	
58. 00   05800   MRI	261, 034	33, 666, 582	0.00775	7, 618, 862	59, 077	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	981, 691	63, 218, 782	0. 01552	13, 589, 722	211, 021	59. 00
60. 00   06000   LABORATORY	960, 982	216, 784, 010	0.00443	60, 069, 033	266, 286	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	390, 326	46, 867, 344	0. 00832		150, 992	65. 00
66. 00 06600 PHYSI CAL THERAPY	220, 270	16, 667, 415	0. 01321	6 6, 723, 102	88, 853	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	31, 087	11, 143, 583	0. 00279		12, 805	67.00
68.00 06800 SPEECH PATHOLOGY	30, 149	3, 189, 252	0.00945	1, 283, 413	12, 132	68. 00
69. 00 06900 ELECTROCARDI OLOGY	297, 304	86, 229, 300	0.00344	8 14, 418, 390	49, 715	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	424, 891	11, 377, 452	0. 03734	1, 032, 907	38, 574	70.00
70. 01 07001 SLEEP LAB	0	0	0. 00000	0 0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	770, 353	23, 276, 609	0. 03309	4, 664, 336	154, 371	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	705, 103				144, 220	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 075, 951			12, 327, 697	137, 824	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	87, 075				21	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	77, 153				209	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		1		0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0		0.00000		0	78. 00
OUTPATIENT SERVICE COST CENTERS	•					
00 00 00000 CLINIC	30 601	13 100 031	0 00300	2 84 670	25.4	l an nn

39, 601

2, 336, 244 26, 099

118, 574

15, 282, 299 1, 586, 173, 104

13, 190, 931

353, 182, 599 3, 151, 300

75, 023, 828

0.003002

0.006615

0.008282

0.001580

84, 679

37, 751, 318 571, 671

4, 664, 895

266, 759, 787

90.00

91. 00 92. 00

92.01

95.00

254

249, 725

4, 735

7, 371

2, 396, 967 200. 00

90.00

91.00

92.00

92.01

200.00

09000 CLI NI C

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

09201 OBSERVATION BEDS-DISTINCT

OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COST			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/20/2024 2:3	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 34. 00   03400   SURGICAL INTENSIVE CARE UNIT 43. 00   04300   NURSERY	0 0	0 0 0		0 0 0 0 0	0 0	31. 00 34. 00
44.00 04400 SKILLED NURSING FACILITY		0		0	Ĭ	44. 00
200.00 Total (lines 30 through 199)		0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	200.00
	Adjustment Amount (see	(sum of cols. 1 through 3, minus col. 4)	Days	5 ÷ col . 6)	Program Days	
	4.00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>					
30. 00 03000 ADULTS & PEDIATRICS	0	0	66, 16	5 0.00	46, 606	30.00
31.00 03100 INTENSIVE CARE UNIT		0	48, 18	0.00	2, 974	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	3, 56	0.00	1, 541	34.00
43. 00   04300 NURSERY		0	3, 94	6 0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	5, 97	5 0.00	3, 680	44.00
200.00 Total (lines 30 through 199)		0	127, 83	2	54, 801	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 34. 00   03400   SURGICAL   INTENSIVE CARE UNIT	0 0					30. 00 31. 00 34. 00
43. 00   04300   NURSERY	0					43.00
44.00   04400   SKILLED NURSING FACILITY 200.00   Total (lines 30 through 199)	0					44. 00 200. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 31-0041	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2023 Part IV

TTROOG	11 00313				To 12/31/2023	Date/Time Pre 5/20/2024 2:3	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0		0	0	00.00
51. 00	05100 RECOVERY ROOM	0	0		0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
52. 01	03190 OP INFUSION	0	0		0	0	52. 01
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MRI	0	0		0	0	58. 00
59. 00	05900  CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60. 00	06000 LABORATORY	0	0		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
	07001 SLEEP LAB	0	0		0	0	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	371, 534	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
92. 01	09201 OBSERVATION BEDS-DISTINCT	0	0		0 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0		0	371, 534	200. 00

Health Financial Systems		COMMUNITY MED	OL CA	I CENTER			In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SER			Provi der CC	CN: 31-0041		d: 01/01/2023	Worksheet D	pared:
				Title	XVIII	Н	spi tal	PPS	•
Cost Center Description		All Other	T	otal Cost	Total	Tot	al Charges	Ratio of Cost	
·		Medi cal	(sı	um of cols.	Outpati ent	(fro	m Wkst. C,	to Charges	
		Education Cost	1,	2, 3, and	Cost (sum of	f Par	t I, col.	(col. 5 ÷ col.	
				4)	col s. 2, 3,		8)	7)	
					and 4)			(see	
								instructions)	

				AVIII	nospi tai	FFJ	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(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		ı	T			
50. 00	05000 OPERATING ROOM	0	0	1	102, 729, 493		
	05100 RECOVERY ROOM	0	l ~	· ·	19, 518, 516		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	25, 222, 135		52. 00
	03190 OP INFUSION	0	0	0	18, 571, 209		
53.00	05300 ANESTHESI OLOGY	0	0	0	18, 192, 625		
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	0	79, 449, 034	0.000000	54.00
55.00	05500   RADI OLOGY-THERAPEUTI C	0	0	0	80, 173, 472	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	6, 212, 440	0.000000	56. 00
57. 00	05700 CT SCAN	0	0	0	139, 497, 621	0.000000	57. 00
58.00	05800 MRI	0	0	0	33, 666, 582	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	63, 218, 782	0.000000	59. 00
60.00	06000 LABORATORY	0	0	0	216, 784, 010	0. 000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0. 000000	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	46, 867, 344	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	16, 667, 415		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	11, 143, 583		67. 00
	06800 SPEECH PATHOLOGY	0	0	0	3, 189, 252		
	06900 ELECTROCARDI OLOGY	0	0	0	86, 229, 300		
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	11, 377, 452		
	07001 SLEEP LAB	0	0	0	0	0. 000000	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23, 276, 609		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35, 948, 871	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	0	371, 534	371, 534			73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0,1,001	0,1,001	4, 150, 209		
	07698 HYPERBARI C OXYGEN THERAPY	0	0	l o	3, 300, 597		
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	l o	0,000,077	0. 000000	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0. 000000	78. 00
70.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>		0	0.000000	70.00
90.00	09000 CLINI C	0	0	0	13, 190, 931	0.000000	90. 00
	09100 EMERGENCY	0	1	1	353, 182, 599		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-	ľ			
92. 00	09201 OBSERVATION BEDS-DISTINCT FART	0					
92. U I	OTHER REIMBURSABLE COST CENTERS		<u> </u>		10,023,828	0.000000	72.01
95 00	09500 AMBULANCE SERVICES						95. 00
200.00		0	371, 534	271 524	1, 586, 173, 104		200. 00
200.00	Trotal (Tries 30 till bugil 177)	1	3/1,334	3/1,334	1, 300, 173, 104	ı	<sub>1</sub> 200.00

	001111111111111111111111111111111111111				6.5	
Health Financial Systems  APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	COMMUNITY MEDI RVICE OTHER PASS	Provider Co		In Lie Period: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 000000	17, 961, 704		0 14, 976, 599		50.00
51.00   05100   RECOVERY ROOM	0. 000000	3, 111, 924		0 2, 849, 002	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
52. 01  03190  OP   NFUSI ON	0. 000000	31, 017		0 7, 200, 464		52. 01
53. 00   05300   ANESTHESI OLOGY	0. 000000	2, 781, 756		0 2, 568, 061		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	14, 642, 944		0 9, 773, 732	0	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 217, 090		0 27, 923, 298		55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000	962, 117		0 1, 057, 224		56. 00
57. 00   05700   CT   SCAN	0. 000000	31, 167, 905		0 20, 297, 752	0	57. 00
58. 00   05800   MRI	0. 000000	7, 618, 862		0 4, 211, 762		58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000	13, 589, 722		0 11, 804, 418	0	59. 00
60. 00   06000   LABORATORY	0. 000000	60, 069, 033		0 13, 904, 786	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	18, 130, 696		0 438, 652	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000	6, 723, 102		0 147, 198	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	4, 589, 771		0 37, 637	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	1, 283, 413		0 6, 224	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	14, 418, 390		0 19, 108, 561	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 032, 907		0 2, 189, 940	0	70. 00
70. 01   07001   SLEEP LAB	0. 000000	0		0 0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 664, 336		0 3, 023, 380	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	7, 352, 906		0 6, 552, 075	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 003861	12, 327, 697	47, 59	7 33, 594, 591	129, 709	73. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	998		0 2, 057, 786	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	8, 934		0 1, 102, 684	0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						1

0.000000

0. 000000

0.000000

0.000000

84, 679 37, 751, 318

571, 671

4, 664, 895

266, 759, 787

0

0

129, 709 200. 00

90.00

91. 00 92. 00

92.01

95.00

6, 288, 651

45, 094, 194 747, 257

13, 073, 939

250, 029, 867

0 0

47, 597

OUTPATIENT SERVICE COST CENTERS

09201 OBSERVATION BEDS-DISTINCT

OTHER REIMBURSABLE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

90.00

91.00

92.01

200.00

09000 CLI NI C

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

	Titianciai Systems	COMMUNICIALLY				u or rorm cws	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der C	CN: 31-0041	Period: From 01/01/2023 To 12/31/2023		narod:
					10 12/31/2023	5/20/2024 2: 3	
			Title	: XVIII	Hospi tal	PPS	<u>о р</u>
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(333	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 261046	14, 976, 599		0 0	3, 909, 581	50.00
51.00	05100 RECOVERY ROOM	0. 167994	2, 849, 002		0 0	478, 615	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 307475	0	)	0 0	0	52. 00
52. 01	03190 OP INFUSION	0. 205040	7, 200, 464		0 0	1, 476, 383	52. 01
53.00	05300 ANESTHESI OLOGY	0. 015530	2, 568, 061		0 0	39, 882	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 197024	9, 773, 732		0 0	1, 925, 660	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 145835	27, 923, 298		0 0	4, 072, 194	55. 00
56.00	05600 RADI OI SOTOPE	0. 362961	1, 057, 224		0 0	383, 731	56. 00
57.00	05700 CT SCAN	0. 032079			0 0	651, 132	1
58.00	05800 MRI	0. 062763		1	0 0	264, 343	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 142512			0 0	1, 682, 271	
60.00	06000 LABORATORY	0. 117778			0 0	1, 637, 678	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		,	0 0	0	1
65. 00	06500 RESPIRATORY THERAPY	0. 151245			0 0	66, 344	1
66. 00	06600 PHYSI CAL THERAPY	0. 277099		1	0 0	40, 788	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 168840		1	0 0	6, 355	1
68. 00	06800 SPEECH PATHOLOGY	0. 190693		1	0 0	1, 187	1
69. 00	06900 ELECTROCARDI OLOGY	0. 072687			0 0	1, 388, 944	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 296275		,	0 0	648, 824	
70. 01	07001 SLEEP LAB	0. 000000			0 0	0.0,021	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 312472			0 0	3, 968, 102	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 777824	6, 552, 075		0 0	5, 096, 361	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 716011			0 31, 168	24, 054, 097	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 305053			0 0	627, 734	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 194947			0 0	214, 965	
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0. 000000			0 0	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			0 0	0	1
70.00	OUTPATIENT SERVICE COST CENTERS	0.00000		1	0 0	0	70.00
90. 00	09000 CLINI C	0. 114026	6, 288, 651		0 0	717, 070	90.00
91. 00	09100 EMERGENCY	0. 104674			0 0	4, 720, 190	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 143318		1	0 0	107, 095	
92. 01	09201 OBSERVATION BEDS-DISTINCT	0. 095642		1	0 0	1, 250, 418	
72.01	OTHER REIMBURSABLE COST CENTERS	0.073042	13,073,737		0 0	1, 230, 410	72.01
95. 00	09500 AMBULANCE SERVICES	18. 459885		1	0		95. 00
200.00		10. 437003	250, 029, 867		0 31, 168	59, 429, 944	
200.00	,		250, 027, 007	1	0 31, 100	J7, 427, 744	201. 00
201.00	Only Charges						201.00
202.00			250, 029, 867		0 31, 168	59, 429, 944	202.00
00	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	,,	I .	3., 100	,,,	,

12/31/2023 Date/Time Prepared: 5/20/2024 2:35 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000000000000000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 03190 OP INFUSION 52.01 0 52.01 53. 00 | 05300 | ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56. 00 05600 RADI 0I SOTOPE 0 56.00 05700 CT SCAN 0 57.00 57.00 05800 MRI 0 58 00 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07001 SLEEP LAB 0 70.01 70.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 22, 317 73.00 07697 CARDIAC REHABILITATION 76. 97 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 76.98 0 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 90.00 0 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0 92.00 09201 OBSERVATION BEDS-DISTINCT 92.01 0 92.01 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 200.00 Subtotal (see instructions) 22, 317 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00

22, 317

202.00

Only Charges

Net Charges (line 200 - line 201)

APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SE	RVICE OTHER PAS		CN: 31-0041 CCN: 31-5490	Pe Fr To	eriod: com 01/01/2023 o 12/31/2023	Worksheet D Part IV Date/Time Pre 5/20/2024 2:3	pared: 5 pm
			Title	XVIII	Sk	killed Nursing Facility	PPS	
Cost Center Description		Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adjustments	Nursi ng Program		Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM		0	0		0	0	0	50.00
51.00   05100   RECOVERY ROOM		0	0		0	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROO	M	0	0		0	0	0	52.00
52.01   03190   OP   INFUSION		0	0		0	0	0	52. 01
3. 00   05300   ANESTHESI OLOGY		0	0		0	0	0	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0	0		0	0	0	54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C		0	0		0	0	0	55.00
6. 00   05600 RADI OI SOTOPE		0	0		0	0	0	56.00
7. 00 05700 CT SCAN		0	0		0	0	0	57.0
8. 00   05800 MRI		0	0		0	0	0	58.00
9. 00 05900 CARDIAC CATHETERIZATION		0	0		0	0	0	59.00
0. 00 06000 LABORATORY		0	0		0	0	0	60.00
3.00 06300 BLOOD STORING, PROCESSING	& TRANS.	0	0		0	0	0	63.00
5. 00 06500 RESPIRATORY THERAPY		0	0		0	0	0	65.0
6. 00 06600 PHYSI CAL THERAPY		0	0		0	0	0	66.0
7. 00 06700 OCCUPATIONAL THERAPY		0	0		0	0	0	67.0
8.00 06800 SPEECH PATHOLOGY		0	0		0	0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY		0	0		0	0	0	69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY		0	0		0	0	0	70.0
0. 01   07001   SLEEP LAB		0	0		0	0	0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENT	0	0		0	0	0	71.0
2.00 07200 IMPL. DEV. CHARGED TO PAT	I ENTS	0	0		0	0	0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	i	0	0		0	0	371, 534	73.0
6. 97 07697 CARDIAC REHABILITATION		0	0		0	0	0	76. 9
6.98 07698 HYPERBARIC OXYGEN THERAPY	•	0	0		0	0	0	76. 9
7.00 07700 ALLOGENEIC STEM CELL ACQU	ISITION	0	0		0	0	0	77.00
8.00 07800 CAR T-CELL IMMUNOTHERAPY		0	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS	5							]
0. 00 09000 CLINIC		0	0		0	0	0	90.00
1. 00 09100 EMERGENCY		0	0		0	0	0	91.00
2.00 09200 OBSERVATION BEDS (NON-DIS		0			0		0	92.0
2. 01 09201 OBSERVATION BEDS-DISTINCT	·	0	0		0	0	0	92.0
OTHER REIMBURSABLE COST CENTERS								]
5. 00 09500 AMBULANCE SERVICES								95.00
00.00 Total (lines 50 through 1	00)	0	0	1	0	0	371, 534	200

	Financial Systems		OI CAL CENTER	N 21 0041		eu of Form CMS-:	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE UTHER PAS	S Provider Co	JN: 31-0041	Peri od: From 01/01/2023	Worksheet D Part IV	
THRUUG	H C0313		Component	CCN: 31-5490	To 12/31/2023	Date/Time Pre	pared:
						5/20/2024 2:3	5 pm
			Title	XVIII	Skilled Nursing	PPS	
	Cost Center Description	All Other	Total Cost	Total	Facility Total Charges	Datio of Cost	
	cost center bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	,	Cost (sum of		(col . 5 ÷ col .	
		Ludouti on oost	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		0 102, 729, 493	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 19, 518, 516	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 25, 222, 135	0. 000000	52.00
52. 01	03190  OP   I NFUSI ON	0	0		0 18, 571, 209	0.000000	52. 01
53.00	05300 ANESTHESI OLOGY	0	0		0 18, 192, 625	0.000000	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0		0 79, 449, 034	0.000000	
55.00	05500  RADI OLOGY-THERAPEUTI C	0	0		0 80, 173, 472	0.000000	
56.00	05600  RADI 0I SOTOPE	0	0		0 6, 212, 440		
57.00	05700  CT SCAN	0	-		0 139, 497, 621	0. 000000	
58. 00	05800  MRI	0	0		0 33, 666, 582	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0 63, 218, 782		
60. 00	06000 LABORATORY	0	1		0 216, 784, 010		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	-		0	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 46, 867, 344		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 16, 667, 415	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 11, 143, 583		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 3, 189, 252	0.000000	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 86, 229, 300		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 11, 377, 452	0.000000	
70. 01	07001 SLEEP LAB	0	0		0 0	0.000000	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 23, 276, 609 0 35, 948, 871	1	
73.00	07300 DRUGS CHARGED TO PATIENTS		-			0.000000	
76. 97	07697 CARDI AC REHABI LI TATI ON		,	371, 53			
76. 97	07698 HYPERBARI C OXYGEN THERAPY	0	-		0 4, 150, 209 0 3, 300, 597	0.00000	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		1		0 3, 300, 597	0.00000	
78.00	07800 CAR T-CELL IMMUNOTHERAPY				0 0	0.00000	
76.00	OUTPATIENT SERVICE COST CENTERS				0 0	0.00000	76.00
90. 00	09000 CLINIC	0	0		0 13, 190, 931	0. 000000	90.00
91.00	09100 EMERGENCY				0 353, 182, 599	<b>l</b>	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 3, 151, 300	<b>l</b>	
92. 01	09201 OBSERVATION BEDS-DISTINCT TAKE	0			0 75, 023, 828	<b>l</b>	
, 2. 01	OTHER REIMBURSABLE COST CENTERS				75,025,020	0.00000	1 /2.01
95. 00	09500 AMBULANCE SERVICES						95. 00
	1	1	1	1	1	I	1

Provider CON: 31-0041   Prov	Heal th	Financial Systems	COMMUNITY MEDIC	CAL CENTER		In Lie	u of Form CMS-:	2552-10
Component CCN: 31-5490   To   12/31/2023   Date/Time Preparet   5/20/2024 2:35 pm   Title XVIII   Skilled Nursing   PPS   Facility   Program   P				_	CN: 31-0041			
Title XVIII   Skilled Nursing Facility   PPS Faci	THROUG	H COSTS						
Cost Center Description				Component	CN: 31-5490	10 12/31/2023		
Cost Center Description				Title	XVIII			
Ratio of Cost   Program   Program   Charges   Program   Charges   Program   Charges   Program	Cost Contor Description	Outpotiont	Innationt	Innationt		Outpoti opt		
NAMELILARY SERVICE COST CENTERS   Charges (col. 6 + col.)   Charges (col. 6 + col.)   Pass-Through (costs (col. 8 + col. 10)   Pass-Through (costs (col. 9 + col. 10)   Pass-Through (costs (col. 10)   Pass-Through (col.		cost center bescription						
Costs (col   8				J				
NO   NO   NO   NO   NO   NO   NO   NO				charges				
ANCILLARY SERVICE COST CENTERS						)		
ANCILLARY SERVICE COST CENTERS				10.00		12 00		
50, 00     05000     05000   05000   0   0		ANCILLARY SERVICE COST CENTERS	71.00	10.00	11100	12.00		
S1 00   05100   RECOVERY ROOM   0.000000   0.750   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	50.00		0. 000000	0		0 0	0	50.00
S2.00   OS200   DELIVERY ROOM & LABOR ROOM   0.000000   0   0   0   0   52.	51.00			1. 750		0	0	1
S2 01   03190   D   INFUSI ON   0 000000   0 0 0 0 0 52.			• • • • • • • • • • • • • • • • • • •				0	
S3.00   05300   AMBSTHESI OLOGY   0.000000   390   0   0   0   53.				0		0	0	
54.00   05.0			• • • • • • • • • • • • • • • • • • •	390		0	0	
55. 00         05500 RADI OLOGY-THERAPEUTI C         0.000000         0         0         0         0         55.           56. 00         05600 RADI OI SOTOPE         0.000000         0         0         0         55.           57. 00         05700 CT SCAN         0.000000         14, 363         0         0         0         57.           58. 00         05800 MRI         0.000000         3, 227         0         0         0         58.           59. 00         05900 CARDIAC CATHETERI ZATI ON         0.000000         0         0         0         0         58.           60. 00         06000 LABORATORY         0.000000         735, 975         0         0         66.         63.00         0         0         0         0         66.         66.         63.00         0         0         0         0         0         0         0         66.         66.         0         0         0         0         0         0         0         66.         66.         0         0         0         0         0         0         66.         66.         0         0         0         0         0         66.         66.         0         0								
56. 00         05600 RADI OI SOTOPE         0.000000         0         0         56.           57. 00         05700 CT SCAN         0.000000         14,363         0         0         0         57.           58. 00         05800 MRI         0.000000         3,227         0         0         0         57.           59. 00         05900 CARDI AC CATHETERI ZATI ON         0.000000         0         0         0         0         59.           60. 00         06000 LABORATORY         0.000000         0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>0</td><td></td><td></td></td<>						0		
57. 00         05700 CT SCAN         0.000000         14,363         0         0         0         57.80           58. 00         05800 MRI         0.000000         0         0         0         0         58.80           60. 00         05900 CARDI AC CATHETERI ZATI ON         0.000000         0         0         0         0         58.80           60. 00         06000 LABORATORY         0.000000         0			• • • • • • • • • • • • • • • • • • •			0		56. 00
58.00         05800 MRI         0.000000         3,227         0         0         0         58.           59.00         05900 CARDI AC CATHETERI ZATI ON         0.000000         0         0         0         0         59.           60.00         06000 LABORATORY         0.000000         735,975         0         0         0         0         63.           63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0.000000         0         0         0         0         0         63.           65.00         06500 RESPI RATORY THERAPY         0.000000         42,758         0         0         0         0         66.           66.00         06600 PHYSI CAL THERAPY         0.000000         2,042,067         0         0         0         66.           67.00         06700         0CCUPATI ONAL THERAPY         0.000000         1,346,778         0         0         0         67.           68.00         06800 SPEECH PATHOLOGY         0.000000         11,923         0         0         0         0         68.           69.00         06900 ELECTROCARDI OLOGY         0.000000         0         0         0         0         0         0         0			0. 000000	14, 363		0	0	57. 00
59.00         05900         CARDI AC CATHETERI ZATI ON         0.000000         0         0         0         59.           60.00         06000         LABORATORY         0.000000         63.         0         0         0         0         65.         0         06500         RESPI RATORY THERAPY         0.000000         2,042,067         0         0         0         0         0         65.         0	58. 00		- I			0	0	58.00
60. 00   06000   LABORATORY   0.000000   735, 975   0   0   0   60. 63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0.000000   42, 758   0   0   0   63. 65. 00   06500   RESPIRATORY THERAPY   0.000000   42, 758   0   0   0   65. 66. 00   06600   PHYSI CAL THERAPY   0.000000   2, 042, 067   0   0   0   66. 67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   1, 346, 778   0   0   0   0   67. 68. 00   06800   SPECH PATHOLOGY   0.000000   1, 346, 778   0   0   0   0   67. 68. 00   06800   SPECH PATHOLOGY   0.000000   1, 346, 778   0   0   0   0   0   69. 69. 00   06900   ELECTROCARDI OLOGY   0.000000   0, 752   0   0   0   0   0   0   0   0   0	59.00		ł			0	0	59.00
63. 00	60.00		0. 000000	735. 975		0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	63.00		ł			0 0	0	63.00
67. 00 06700 0CCUPATI ONAL THERAPY	65.00	· ·	0. 000000	42, 758		0 0	0	65.00
67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   1,346,778   0   0   0   67. 68. 00   06800   SPEECH PATHOLOGY   0.000000   11,923   0   0   0   68. 69. 00   06900   ELECTROCARDI OLOGY   0.000000   6,752   0   0   0   0   0   0   0   0   0	66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 042, 067		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 6, 752 0 0 0 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 0 0 0 0 0 70. 70. 01 7001 SLEEP LAB 0. 0. 000000 0 0 0 0 0 0 0 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 956 0 0 0 0 71. 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 000000 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000861 270, 601 1, 045 0 0 73. 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 0 0 0 0 0 0 75. 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0. 000000 0 0 0 0 0 0 76. 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 0 0 0 0 0 0 77. 78. 00 07300 CAR T -CELL I MMUNOTHERAPY 0. 000000 0 0 0 0 0 0 77. 78. 00 07300 CAR T -CELL I MMUNOTHERAPY 0. 000000 0 0 0 0 0 0 0 77. 79. 00 09000 CLI NI C 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68.00	06800 SPEECH PATHOLOGY	0. 000000	11, 923		0 0	0	68.00
70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   0   0   0   0   0   70.   70. 01   07001   SLEEP LAB   0. 000000   0   0   0   0   0   70.   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 000000   956   0   0   0   71.   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 000000   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 003861   270, 601   1, 045   0   0   73.   76. 97   07697   CARDI AC REHABI LI TATI ON   0. 000000   0   0   0   0   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0. 000000   0   0   0   0   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0. 000000   0   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0. 000000   0   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0. 000000   0   0   0   791. 00   09000   CLI NI C   0. 000000   0   0   0   0   792. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0. 000000   0   0   0   0   792. 01   09201   OBSERVATI ON BEDS -DI STI NCT   0. 000000   0   0   0   795. 00   09500   AMBULANCE SERVI CES	69.00	06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	69.00
71. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
72. 00	70. 01	07001 SLEEP LAB	0. 000000	0		0 0	0	70. 01
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	956		0 0	0	71. 00
76. 97   07697   CARDI AC REHABI LI TATI ON   0.000000   0   0   0   0   76. 76. 98   07698   HYPERBARI C 0XYGEN THERAPY   0.000000   0   0   0   0   76. 77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0   0   0   0   0   77. 78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0.000000   0   0   0   0   0   78.    00   07800   CAR T-CELL I IMMUNOTHERAPY   0.000000   0   0   0   0   0   78.    00   00   00   00   0   0   0   0	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
76. 98   07698   HYPERBARI C OXYGEN THERAPY   0. 000000   0   0   0   0   0   76.  77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0. 000000   0   0   0   0   0   77.  78. 00   07800   CAR T - CELL I IMMUNOTHERAPY   0. 000000   0   0   0   0   0   78.    00   00   07800   CAR T - CELL I IMMUNOTHERAPY   0. 000000   0   0   0   0   0   0   0	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 003861	270, 601	1, 04	5 0	0	73. 00
77. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	76. 97
78. 00	76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	76. 98
OUTPATIENT SERVICE COST CENTERS     O	77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
90. 00	78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
91. 00								
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   0   0   0   0   0   92.    0   0   0   0   0   0   0   0   0								
92. 01 09201 0BSERVATI ON BEDS-DI STI NCT 0. 000000 0 0 0 0 92. OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95.			• • • • • • • • • • • • • • • • • • •				-	
OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 95.							-	
95. 00 09500 AMBULANCE SERVICES 95.	92. 01		0. 000000	0		0 0	0	92. 01
			1					
200.00				4 544 557	4 2.	_	-	95. 00
	200. OC		1	4, 511, 356	1, 04	p  0	0	J200. 00

		T: +1 o	XVIII :	Ckilled Numeina	PPS	Орш
		IIIIe	XVIII	Skilled Nursing	PPS	
			Charges	Facility	Costs	
Cost Center Description	Cost to Charge	DDC Doimburcod		Cost	PPS Services	
COST CENTER DESCRIPTION	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
	Part I, col. 9	·	Subject To	Subject To		
	Part I, Cor. 9		Ded. & Coins.	Ded. & Coi ns.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	0. 261046	0		) 0	0	50.00
51. 00   05100   RECOVERY   ROOM	0. 261046		1		0	51.00
52. OO   05200   DELIVERY ROOM & LABOR ROOM	0. 107994	0	1		0	52.00
		0	1		0	52.00
52. 01   03190   OP   INFUSI ON	0. 205040	ł	1	٥		
53. 00   05300   ANESTHESI OLOGY	0. 015530	ł	1	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 197024	0		0	0	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 145835	0		0	0	55.00
56. 00   05600   RADI 01 SOTOPE	0. 362961	0	1	0	0	56. 00
57. 00   05700   CT   SCAN	0. 032079	0	1	0	0	57. 00
58. 00   05800   MRI	0. 062763	0	(	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 142512	0	(	0	0	
60. 00  06000 LAB0RAT0RY	0. 117778	l .	(	0	0	60. 00
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	(	0	0	63. 00
65. 00  06500 RESPI RATORY THERAPY	0. 151245	0	(	0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 277099	0	(	0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 168840	0	(	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 190693	0	(	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 072687	0	(	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 296275	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	1. 312472	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 777824	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 716011	0		3, 116	0	73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 305053	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 194947	0		0	0	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				0	78. 00
OUTPATIENT SERVICE COST CENTERS	0.00000		·	<u> </u>	<u> </u>	70.00
90. 00 09000 CLINIC	0. 114026	0		0	0	90.00
91. 00   09100   EMERGENCY	0. 104674	0	1		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 143318	1			0	92.00
92. 01 09201 OBSERVATION BEDS-DISTINCT PART	0. 095642	0			0	
OTHER REIMBURSABLE COST CENTERS	0. 093042	ı	1	J <sub>1</sub> 0	0	72.01
95. 00 09500 AMBULANCE SERVICES	18. 459885		1			95.00
	10. 409883	0	1		_	
200.00 Subtotal (see instructions)			]	3, 116	U	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges		_		2 444	_	202 00
202.00   Net Charges (line 200 - line 201)	Į.	0		3, 116	0	202. 00

Ith Financial Systems COMMUNITY MEDICAL CENTER In Lieu of Form CMS-							
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Peri od: From 01/01/2023			
		Component (	CCN: 31-5490	To 12/31/2023	Date/Time Prep 5/20/2024 2:35	pared pm	
		Title	XVIII	Skilled Nursing Facility	PPS		
	Co:	sts					
Cost Center Description	Cost	Cost					
	Rei mbursed	Rei mbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins.					
	(see inst.)	(see inst.)					
	6, 00	7. 00					

	Cost Center Description	Cost	Cost		
	·	Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
	ANOLLI ADV CEDIU OF COCT CENTERS	6. 00	7. 00		
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0	0		50.00
	05100 RECOVERY ROOM	0	0		51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
	03190 OP INFUSION	0	0		52. 01
	05300 ANESTHESI OLOGY	0	0		53.00
	05400 RADI OLOGY - DI AGNOSTI C	0	0		54. 00
	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
	05600 RADI OI SOTOPE	0	0		56. 00
	05700 CT SCAN	0	0		57. 00
	05800 MRI	0	0		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0			59.00
	06000 LABORATORY				60.00
	06300 BLOOD STORING, PROCESSING & TRANS.				63. 00
	06500 RESPIRATORY THERAPY				65. 00
	06600 PHYSI CAL THERAPY				66. 00
	06700 OCCUPATI ONAL THERAPY				67. 00
	06800 SPEECH PATHOLOGY				68. 00
	06900 ELECTROCARDI OLOGY	0			69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
	07001 SLEEP LAB	0	0		70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	2, 231		73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	•	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY		0	1	78. 00
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0		90.00
	09100 EMERGENCY			i e	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	09201 OBSERVATION BEDS-DISTINCT PART		0		92.00
	OTHER REIMBURSABLE COST CENTERS		<u>,                                     </u>		72.01
	09500 AMBULANCE SERVICES		)		95. 00
200.00	Subtotal (see instructions)		2, 231		200. 00
201.00			2, 231		201. 00
201.00	Only Charges				[
202. 00	, ,	0	2, 231		202. 00
	1 3.1 ( 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-		1	

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/20/2024 2:3	
			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	4, 654, 580	0	4, 654, 58	0 66, 165	70. 35	
31.00   INTENSIVE CARE UNIT	2, 771, 988		2, 771, 98	8 48, 180	57. 53	31. 00
34. 00 SURGICAL INTENSIVE CARE UNIT	260, 460		260, 46	0 3, 566	73. 04	34. 00
43. 00 NURSERY	295, 977		295, 97	7 3, 946	75. 01	43.00
44.00 SKILLED NURSING FACILITY	360, 646		360, 64	6 5, 975	60. 36	44.00
200.00 Total (lines 30 through 199)	8, 343, 651		8, 343, 65	1 127, 832		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	565					30. 00
31.00   INTENSIVE CARE UNIT	574	33, 022	1			31. 00
34. 00 SURGICAL INTENSIVE CARE UNIT	0	0	)			34. 00
43. 00 NURSERY	1, 829	137, 193				43.00
44.00 SKILLED NURSING FACILITY	0	0	)			44. 00
200.00 Total (lines 30 through 199)	2, 968	209, 963				200. 00

Health Financial Systems	COMMUNI	TY MEDI	CAL CENTER		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE				Provider CCN: 31-0041		Worksheet D Part II Date/Time Pre 5/20/2024 2:3	pared:
			Ti tl	e XIX	Hospi tal	TEFRA	•
Cost Center Description	Capi Relateo (from Wk	Cost (	Total Charges from Wkst. C, Part I, col.		Program Program	Capital Costs (column 3 x column 4)	
	Part II 26 1.0	)	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	'	'		•			
50. 00 05000 OPERATING ROOM	2, 7	14, 742	102, 729, 493	0. 02642	26 311, 214	8, 224	50.00
E1 00 OF100 DECOVEDY DOOM	1 4	00 202	40 540 547	0 000//	77 500	740	F4 00

			e xi x	ноѕрі таі	IEFKA	
Cost Center Description	Capi tal		Ratio of Cost	I npati ent	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	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	2, 714, 742	102, 729, 493	0. 026426	311, 214	8, 224	
51.00   05100   RECOVERY ROOM	188, 282	19, 518, 516	0. 009646	77, 593	748	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	600, 456	25, 222, 135	0. 023807	200, 452	4, 772	52.00
52. 01   03190   OP   I NFUSI ON	283, 662	18, 571, 209	0. 015274	0	0	52. 01
53. 00   05300   ANESTHESI OLOGY	35, 408	18, 192, 625	0. 001946	90, 130	175	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 371, 227	79, 449, 034	0. 017259	251, 074	4, 333	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	1, 102, 223	80, 173, 472	0. 013748	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	77, 062	6, 212, 440	0. 012404	31, 895	396	56. 00
57. 00  05700 CT SCAN	75, 350	139, 497, 621	0.000540	934, 208	504	57.00
58. 00 05800 MRI	261, 034			250, 962	1, 946	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	981, 691			328, 606		
60. 00   06000   LABORATORY	960, 982			1, 417, 592		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0. 000000	0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	390, 326			157, 949	1, 315	•
66. 00   06600   PHYSI CAL THERAPY	220, 270			65, 322		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	31, 087			40, 613		
68. 00 06800 SPEECH PATHOLOGY	30, 149			16, 237		
69. 00   06900   ELECTROCARDI OLOGY	297, 304			290, 557	1, 002	
70. 00 07000 ELECTROENCEPHALOGRAPHY	424, 891			21, 864		70.00
70. 01 07001 SLEEP LAB	0		0.000000	21,004	0 0	70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	770, 353			76, 091	2, 518	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	705, 103			82, 587	1, 620	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 075, 951			159, 129		
76. 97   07697   CARDI AC   REHABI LI TATI ON	87, 075			137, 127	1, 7/9	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	77, 153			0	0	76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	//, 155		l	0	0	77.00
	0		0.000000	0	0	78.00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	1 0		0.000000	U	0	78.00
	20 (01	12 100 021	0.002002	7 720	22	00 00
90. 00   09000   CLI NI C	39, 601			7, 739		90.00
91. 00 09100 EMERGENCY	2, 336, 244			1, 118, 127	7, 396	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	26, 099			21, 234		
92. 01 09201 OBSERVATI ON BEDS-DI STI NCT	118, 574	75, 023, 828	0. 001580	143, 401	227	92. 01
OTHER REI MBURSABLE COST CENTERS		<u> </u>				05.00
95. 00 09500 AMBULANCE SERVICES	45 000 000	4 50/ 470 10:			F0 :07	95.00
200.00   Total (lines 50 through 199)	15, 282, 299	1, 586, 173, 104	1	6, 094, 576	50, 487	J200. 00

Health Financial Systems	COMMUNITY MED		CN 21 0041		eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COST			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/20/2024 2:3	pared: 5 pm
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Healt Post-Stepdow Adjustments	h Allied Health Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 34. 00   03400   SURGICAL INTENSIVE CARE UNIT 43. 00   04300   NURSERY	0 0	0 0			0 0	31. 00 34. 00
44. 00   04400   SKI LLED NURSI NG FACI LI TY 200. 00   Total (lines 30 through 199)	0	0				44. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 34. 00   03400   SURGICAL INTENSIVE CARE UNIT 43. 00   04300   NURSERY	0	0 0 0	48, 18 3, 56 3, 94	0. 00 06 0. 00 06 0. 00	574 0 1, 829	31. 00 34. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)		0				44. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	0	127, 00	7.2	2,700	200. 00
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   31.00   03100   INTENSIVE CARE UNIT   34.00   03400   SURGICAL INTENSIVE CARE UNIT   43.00   04300   NURSERY   44.00   04400   SKILLED NURSING FACILITY   200.00   Total (lines 30 through 199)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					30. 00 31. 00 34. 00 43. 00 44. 00 200. 00

Health Financial Systems	COMMUNITY MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 31-0041	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

12/31/2023 Date/Time Prepared: To 5/20/2024 2:35 pm Title XIX Hospi tal TEFRA Cost Center Description Non Physician Nursi ng Allied Health Allied Health Nursi ng Post-Stepdown Anestheti st Program Program Cost Post-Stepdown Adjustments Adjustments 1.00 3. 00 2A 2.00 ЗА ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 0 0000000000000000000000000000000 0 05100 RECOVERY ROOM 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 03190 OP INFUSION 0 0 52.01 0 52.01 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 01 05700 CT SCAN 57.00 0 0 57.00 58.00 05800 MRI 0 0 58.00 59. 00 05900 CARDIAC CATHETERIZATION 59.00 06000 LABORATORY 0 0 60.00 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 63.00 0 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 67 00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07001 SLEEP LAB 0 0 70. 01 70 01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 371, 534 73 00 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77.00 77.00 0 o 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 0 0 09100 EMERGENCY 91.00 0 o 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 09201 OBSERVATION BEDS-DISTINCT 0 92.01 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 o 0 0 0 371, 534 200. 00 200.00 Total (lines 50 through 199)

Health Financial Systems	COMMUNI TY	MEDIC.	AL CENTER		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLATHROUGH COSTS			Provider Co		Period: From 01/01/2023	Worksheet D	pared:
			Ti tl	e XIX	Hospi tal	TEFRA	•
Cost Center Description	All Other	-	Total Cost	Total	Total Charges	Ratio of Cost	
·	Medi cal	(5	sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Co	ost 1	, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				1.43	1	, '	

				e xi x	ноѕрі таі	IEFRA	
	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)	
			ĺ	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	102, 729, 493	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0	0	0		0.000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		0. 000000	
52. 01	03190 OP I NFUSI ON	0	0	Ö			
53. 00	05300 ANESTHESI OLOGY	0	0	1	18, 192, 625	0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	79, 449, 034	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C		١	0		0. 000000	l
56. 00	05600 RADI OI SOTOPE				6, 212, 440		
57. 00	05700 CT SCAN				139, 497, 621	0. 000000	
58. 00	05800 MRI	0	0	0			1
59.00	05900  MRT   05900  CARDI AC   CATHETERI ZATI ON	0	0		,,	0. 000000 0. 000000	
		0	0	0	,,		
60.00	06000 LABORATORY	0	0	0	216, 784, 010		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	
65.00	06500 RESPIRATORY THERAPY	0	0	0	46, 867, 344	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0	0	16, 667, 415	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	1.11.101.000	0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	-, ,	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	86, 229, 300		
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	11, 377, 452		
70. 01	07001 SLEEP LAB	0	0	0	0	0.000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23, 276, 609	0.000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	35, 948, 871	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	371, 534	371, 534	96, 237, 895	0. 003861	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	4, 150, 209	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	3, 300, 597	0.000000	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS		•				
90.00	09000 CLI NI C	0	0	0	13, 190, 931	0.000000	90.00
91. 00	09100 EMERGENCY	0	0	0		0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0			l
92. 01	09201 OBSERVATI ON BEDS-DI STI NCT	0	0	0			1
72. 01	OTHER REIMBURSABLE COST CENTERS		·	·	70,020,020	3. 555000	72.01
95 00	09500 AMBULANCE SERVICES						95. 00
200.00		0	371, 534	371 534	1, 586, 173, 104		200. 00
200.00	1.5ta. (11165 55 th ough 177)	1	0,1,004	0,1,004	1 ., 555, 175, 104	l	_50.00

Health Financial Systems CO	DMMUNITY MEDICAL C	CENTER		In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE THROUGH COSTS	E OTHER PASS Pr	rovider CCN:		From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 2:35 pm
		Title >	XIX	Hospi tal	TEFRA

Tilkoodii 00010			To	12/31/2023	Date/Time Pre 5/20/2024 2:3	
		Ti tl	e XIX	Hospi tal	TEFRA	o piii
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0. 000000	311, 214	0	0	0	50.00
51.00   05100   RECOVERY ROOM	0. 000000	77, 593		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	200, 452		0	0	52.00
52.01 03190 OP INFUSION	0. 000000	0	0	0	0	52. 01
53. 00   05300   ANESTHESI OLOGY	0. 000000	90, 130		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	251, 074	0	0	0	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000	31, 895	0	0	0	56. 00
57.00  05700 CT SCAN	0. 000000	934, 208		0	0	57. 00
58. 00   05800   MRI	0. 000000	250, 962	0	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000	328, 606	0	0	0	59. 00
60. 00   06000   LABORATORY	0.000000	1, 417, 592	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	157, 949	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	65, 322	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	40, 613	o	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	16, 237	o	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	290, 557	o	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	21, 864	o	0	0	70. 00
70. 01 07001 SLEEP LAB	0. 000000	0	o	0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	76, 091	o	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	82, 587	o	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 003861	159, 129	614	0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	o	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	Ö	0	0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	Ö	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	0.00000		<u> </u>	<u> </u>		70.00
90. 00 09000 CLI NI C	0. 000000	7, 739	0	0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 118, 127	Ö	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	21, 234	Ö	0	0	92.00
92. 01   09201   0BSERVATI ON BEDS-DI STI NCT	0. 000000	143, 401	Ö	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS		,	<u> </u>			1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)		6, 094, 576	614	0	0	200. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	., ,		-1	•	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-0041 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/20/2024 2:35 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. 244796 119, 131 0 50.00 51.00 05100 RECOVERY ROOM 0. 157845 0 27, 418 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 288642 52 00 0 475, 893 52 00 0 03190 OP INFUSION 52.01 0.192507 0 29, 844 0 52.01 53.00 05300 ANESTHESI OLOGY 0.014547 23, 038 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.184872 0 281, 515 54.00 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.136799 97, 884 0 55.00 56.00 05600 RADI OI SOTOPE 0.341388 17, 622 0 56.00 05700 CT SCAN 57.00 0.030195 0 418, 672 0 57.00 05800 MRI 0.058797 0 58 00 58 00 77, 176 0 59.00 05900 CARDIAC CATHETERIZATION 0.133594 0 13, 226 0 59.00 06000 LABORATORY 0. 110761 0 13,060 0 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 63.00 0 06500 RESPIRATORY THERAPY 0 65.00 65 00 0.142123 7.725 0 66.00 06600 PHYSI CAL THERAPY 0.260472 0 8, 389 0 66.00 06700 OCCUPATI ONAL THERAPY 0. 158930 67.00 4, 162 67.00 06800 SPEECH PATHOLOGY 0. 179235 0 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 93.662 69.00 69 00 0.068326 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 277523 6, 283 0 70.00 07001 SLEEP LAB 0.000000 70.01 70.01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1. 234958 16,052 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0.731886 23. 247 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.674012 0 33, 729 0 73.00 73.00 07697 CARDIAC REHABILITATION 76. 97 0. 286479 0 C 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 76.98 0.182658 0 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 0.000000 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0. 107286 10, 723 0 0 0 0 91.00 09100 EMERGENCY 0.098325 0 3, 014, 389 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 134657 o 92.00 C 26, 285 0 92.00 09201 OBSERVATION BEDS-DISTINCT 92.01 0.090028 568, 130 92.01 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 17. 380380 95.00 200.00 Subtotal (see instructions) 5, 407, 255 0 0 200.00 Less PBP Clinic Lab. Services-Program 201.00  $\cap$ 201.00

0

5, 407, 255

0

0 202. 00

Only Charges

Net Charges (line 200 - line 201)

| Peri od: | Worksheet D | From 01/01/2023 | Part V | To | 12/31/2023 | Date/Time | Prepared:

					10 12/31/2023	5/20/2024 2: 3	
			Ti tl	e XIX	Hospi tal	TEFRA	9 10
		Cos					
	Cost Center Description	Cost	Cost				
	· · · · · · · · · · · · · · · · · · ·	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	29, 163	0				50.00
51. 00	05100 RECOVERY ROOM	4, 328	0				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	137, 363	Ö				52.00
52. 01	03190 OP I NFUSI ON	5, 745	0				52. 01
53. 00	05300 ANESTHESI OLOGY	335	Ö				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	52, 044	0				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	13, 390	0				55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	6, 016	0				56. 00
57. 00	05700 CT SCAN	12, 642	0				57. 00
	05800 MRI						
58. 00		4, 538	0				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 767	-				59.00
60.00	06000 LABORATORY	1, 447	0				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
65. 00	06500 RESPI RATORY THERAPY	1, 098	0				65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 185	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	661	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	6, 400	0	•			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 744	0				70. 00
70. 01	07001 SLEEP LAB	0	0				70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 824	0				71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	17, 014	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	22, 734	0				73.00
76. 97	07697 CARDIAC REHABILITATION	0	0				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	1, 150	0				90. 00
91.00	09100 EMERGENCY	296, 390	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 539	0				92.00
92. 01	09201 OBSERVATION BEDS-DISTINCT	51, 148	0	•			92. 01
	OTHER REIMBURSABLE COST CENTERS	2.7,710		·			1
95. 00	09500 AMBULANCE SERVICES	0					95. 00
200.00		692, 665	0				200.00
201.00	1 /	072,003					201.00
201.00	Only Charges						251.00
202.00		692, 665	0				202. 00
202.00	1.1.1 3.16. 955 (1.1.6 255 1.1.6 251)	3,2,000	Ĭ	1			1-32.00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0041	Peri od: From 01/01/2023	Worksheet D-1 Date/Time Prepared:
		10 12/31/2023	5/20/2024 2: 35 pm
	Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	5/20/2024 2: 3 PPS	5 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l	,		66, 165 66, 165	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days	00, 105	3.00
0.00	do not complete this line.	,e, yeuave e y p	tato toom dayo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation be			65, 794	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December :	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 .			
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	n davs) after December 3	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	46, 606	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private r	nom davs)	0	10. 00
	through December 31 of the cost reporting period (see instruc-				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Theraaring private	2 ( com days)	O	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 Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed to	lays)	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 of	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
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		80, 545, 965	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 of the east reporting	nominal (line (	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December   x line 18)	31 of the cost reporting	g period (iine o	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25.00	7 x line 19)	of the cost resenting	ported (line O	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	or the cost reporting	period (iine 8	Ü	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)		80, 545, 965	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Congral inpatient routing service charges (excluding swing-ber	d and observation had ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed ch	in ges)	0	29. 00
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	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	ne 31)		0.00	35. 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 a	and private room cost di	rrerential (line	80, 545, 965	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 217. 35	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		56, 735, 814	
40.00	Medically necessary private room cost applicable to the Progra	,		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		56, 735, 814	41.00

	Financial Systems	COMMUNITY MEDI				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 31-0041	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			Titl∈	· XVIII	Hospi tal	5/20/2024 2: 3 PPS	5 pm
	Cost Center Description	Total Inpatient Costl	Total Inpatient Days	Average Per 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) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00 0	0	42.00
43. 00	INTENSIVE CARE UNIT	55, 690, 202	48, 180	1, 155. 8	2, 974	3, 437, 587	43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT	6, 920, 822	3, 566	1, 940. 7	1, 541	2, 990, 742	1
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	<u> </u>					1.00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk: Program inpatient cellular therapy acquisition			III lino 10	column 1)	51, 302, 889 0	1
	Total Program inpatient costs (sum of lines				COLUMN 1)	114, 467, 032	1
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa	ationt routing	sorvices (from	Wks+ D sum	of Darts L and	2 542 201	50.00
50.00	III)	atrent routine :	services (IIoli	i wkst. D, Suii	TOT PALLS I ALIU	3, 562, 381	30.00
51.00	Pass through costs applicable to Program inpand IV)	,	y services (fr	om Wkst. D, s	um of Parts II	2, 444, 564	
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	lated, non-phy	rsician anesth	etist, and	6, 006, 945 108, 460, 087	1
54. 00	Program discharges					0	54. 00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	1
	Adjustment amount per discharge (contractor	use only)				0.00	1
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		ract amount (	ino E4 minus	lino E2)	0	
58. 00	Bonus payment (see instructions)	ing cost and tal	rget amount (i	THE 50 IIITHUS	111le 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	the cost repo	rting period	endi ng 1996,	0.00	59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	m prior year o	ost report, u	pdated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less	ser of 50% of tl	he amount by w	hich operatin	g costs (line	0	61.00
	53) are less than expected costs (lines 54 $\times$ enter zero. (see instructions)	60), 01 1 % 01	the target an	lount (Trine 5c	), otherwise		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (coo instru	ctions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistru	ctions)				03.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line o	64 plus line 6	5)(title XVII	l only). for	0	66. 00
	CAH, see instructions	·	·		3.		
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 c	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil					I	70. 00
71. 00	Adjusted general inpatient routine service co	ost per diem (li					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 1)		(lino 14 v li	no 25)			72. 00 73. 00
74. 00	Medically necessary private room cost applications. Total Program general inpatient routine services.						74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	lorksheet B, F	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
	Program capital -related costs (line 9 x line						77. 00 78. 00
79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	ls)			79. 00
	Total Program routine service costs for compa		ost limitation	(line 78 min	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (	see instruction	* .				83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					371	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 217. 35	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				451, 637	89. 00

Health Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/20/2024 2:3	
		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	4, 654, 580	80, 545, 965	0. 05778	8 451, 637	26, 099	90.00
91.00 Nursing Program cost	0	80, 545, 965	0.00000	0 451, 637	0	91.00
92.00 Allied health cost	0	80, 545, 965	0.00000	0 451, 637	0	92.00
93.00 All other Medical Education	0	80, 545, 965	0. 00000	0 451, 637	0	93. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0041	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 31-5490	To 12/31/2023	Date/Time Prepared: 5/20/2024 2:35 pm
	Title XVIII	Skilled Nursing	PPS
		Facility	

		Facility	FF3	
	Cost Center Description			
	PART I - ALL PROVIDER COMPONENTS		1.00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days		5, 975	
2.00	Inpatient days (including private room days, excluding swing-b		5, 975	1
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only private room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)	5, 975	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		0	5. 00
4 00	reporting period	om dovo) often December 21 of the cost		/ 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December 31 of the cost	0	7. 00
	reporting period		_	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding swing-bed and	3, 680	9. 00
	newborn days) (see instructions)			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye		Ĭ	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed days)	0	
15. 00	Total nursery days (title V or XIX only)		0	1
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 of the cost	0.00	17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of the cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of the cost	0.00	19. 00
	reporting period			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	3)	7, 650, 654	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December			1
	5 x line 17)		_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting period (line 6	0	23. 00
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 3 x line 20)	31 of the cost reporting period (line 8	0	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)	7, 650, 654	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed charges)	0	28. 00 29. 00
30. 00	Semi -private room charges (excluding swing-bed charges)		0	1
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 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instructions)	0. 00 0. 00	1
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	0.00	1
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 a	and private room cost differential (line	7, 650, 654	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		<u> </u>	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		38. 00
39.00	Program general inpatient routine service cost (line 9 x line			39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	·		40. 00 41. 00
	,	· ·-/	1	, 55

	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNITY MEDI		CN: 21 0041		u of Form CMS-	
COMPUTA	ATTON OF INPATTENT OPERATING COST			CCN: 31-0041	Peri od: From 01/01/2023	Worksheet D-1	
			· ·	CCN: 31-5490	To 12/31/2023	Date/Time Pre 5/20/2024 2:3	
			litle	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total Inpatient Costl		col . 2)	÷	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
	Intensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
1	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
171.00	Cost Center Description						171.00
48. 00	Program inpatient ancillary service cost (Wk:	st. D-3. col. 3.	line 200)			1. 00	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines of the costs)	on cost (Worksh	et D-6, Part		column 1)		48. 01 49. 00
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine s	services (from	m Wkst. D, sur	m of Parts I and		50.00
	<pre>III) Pass through costs applicable to Program inpa and IV)</pre>	atient ancillar	services (fi	rom Wkst. D, s	sum of Parts II		51. 00
52. 00	Total Program excludable cost (sum of lines!						52. 00
	Total Program inpatient operating cost exclude medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phy	ysician anestl	netist, and		53. 00
54. 00	Program discharges						54. 00
	Target amount per discharge Permanent adjustment amount per discharge						55. 00 55. 01
	Adjustment amount per discharge (contractor	use only)					55. 02
	Target amount (line 54 x sum of lines 55, 55.		cast amount (	lino E4 minus	lino E2)		56. 00 57. 00
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and tai	get amount (i	Time so minus	11 ne 53)		58.00
	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		·	0.			59. 00
	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	i prior year o	cost report, i	updated by the		60.00
	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of th	ne amount by w	which operatio	ng costs (line		61.00
62. 00	Relief payment (see instructions)						62.00
	Allowable Inpatient cost plus incentive paymo PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)				63.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	Ü		•			64. 00
	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the o	cost reportin	g period (See		65. 00
1	Total Medicare swing-bed SNF inpatient routin CAH, see instructions	ne costs (line d	64 plus line (	65)(title XVI	ll only); for		66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period		67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period		68. 00
	Total title V or XIX swing-bed NF inpatient of PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY			69. 00
1	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of	-			)	7, 650, 654 1, 280. 44	1
72. 00	Program routine service cost (line 9 x line		70 - 11110	_,		4, 712, 019	72. 00
1	Medically necessary private room cost application Total Program general inpatient routine servi					0 4, 712, 019	
1	Capital-related cost allocated to inpatient	•			Part II, column	4, 712, 019	1
1	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				0 00	76. 00
77. 00	Program capital-related costs (line 9 $\times$ line	76)				0.00	77. 00
1	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	ds)		0	
	Total Program routine service costs for compa				nus line 79)	0	1
81. 00	Inpatient routine service cost per diem limi	tati on				0.00	1
1	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (					0 4, 712, 019	
1	Program inpatient ancillary services (see in		-/			1, 091, 795	

1, 091, 795

0 85.00

5, 803, 814 86. 00

84.00

0 87.00 0.00 88.00

84.00 Program inpatient routine service costs (see instructions)
84.00 Program inpatient ancillary services (see instructions)
85.00 Utilization review - physician compensation (see instructions)
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST
87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (	CCN: 31-5490	From 01/01/2023 To 12/31/2023		
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	OST					
90.00 Capital -related cost	0	0	0.00000	0 0	0	90. 00
91.00 Nursing Program cost	0	o	0. 00000	00	0	91. 00
92.00 Allied health cost	0	o	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	o	0. 00000	00	0	93. 00

Health Financial Systems	th Financial Systems COMMUNITY MEDICAL CENTER In Lieu			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/20/2024 2:3	pared:
	Title XIX	Hospi tal	TEFRA	
C-+ C-++ Di-+i				

		Title XIX	Hospi tal	5/20/2024 2: 3: TEFRA	o pm
	Cost Center Description	TITLE XIX	nospi tai	TETRA	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	avaluding nawbarn)		// 1/5	1. 00
1. 00 2. 00	Inpatient days (including private room days, excluding swing-bed days)			66, 165 66, 165	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days.	00, 103	3. 00
	do not complete this line.	3			
4.00	Semi-private room days (excluding swing-bed and observation be			65, 794	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through December	31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December 3	R1 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
0.00	reporting period	daya) after December 21	of the cost	0	8. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember 3	of the cost	0	8.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	565	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		Join days) arter		11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15.00	Total nursery days (title V or XIX only)	, 3	,	3, 946	15.00
16. 00	Nursery days (title V or XIX only)			1, 829	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	as through December 21 of	- +ho ooo+	0.00	17 00
17.00	reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
20.00	reporting period	ditter becomber of or the	10 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			80, 545, 965	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	neriod (line 6	0	23. 00
20.00	x line 18)	or or the edet reporting	, por rou (11110 0	· ·	20.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
25 00	7 x line 19)	of the cost respecting	noriad (line O	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (iine 8	0	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)		80, 545, 965	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		```		00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	28. 00 29. 00
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	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		. ,	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x line		(ions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	ic 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	80, 545, 965	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 217. 35	38. 00
39. 00	Program general inpatient routine service cost per drem (see	,		687, 803	
40. 00	Medically necessary private room cost applicable to the Progra	,		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		687, 803	41. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNITY MEDICA	AL CENTER Provider CCN:	Fi	eriod: com 01/01/2023	u of Form CMS-2 Worksheet D-1	
				To	12/31/2023	Date/Time Pre 5/20/2024 2:3	
	Cook Cooking Doorselating	Tabal	Title		Hospi tal	TEFRA	
	Cost Center Description	Total Inpatient Cost[n		verage Per em (col. 1 ÷	Program Days	Program Cost (col. 3 x col.	
				col . 2)	4.00	4)	
42.00	NURSERY (title V & XIX only)	1. 00 6, 184, 149	2.00	3. 00 1, 567. 19	4. 00 1, 829	5. 00 2, 866, 391	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	55, 690, 202	48, 180	1, 155. 88	574	663, 475	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	6, 920, 822	3, 566	1, 940. 78	0	0	46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk:	et D 2 col 2	Lino 200)			1. 00 970, 128	48. 00
	Program inpatient cellular therapy acquisition			, line 10, d	column 1)	970, 120	1
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48.01)	(see instructio	ons)		5, 187, 797	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine se	rvices (from Wk	kst. D, sum (	of Parts I and	209, 963	50.00
51. 00	III) Pass through costs applicable to Program inpa	ationt and Harv	convices (from	Wks+ D sur	of Dorts II	51, 101	51.00
51.00	and IV)	attent and train	services (110m	WKSt. D, Sui	I OI PAILS II	51, 101	31.00
52.00	Total Program excludable cost (sum of lines		tad non nhuais	ion opeother	ict and	261, 064	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line !		tea, non-physic	an anestne	ist, and	4, 926, 733	53. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					276	54. 00
	Target amount per discharge					0.00	1
	Permanent adjustment amount per discharge					0.00	1
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0. 00 0	1
	Difference between adjusted inpatient operat	ng cost and targ	et amount (line	e 56 minus li	ne 53)	-4, 926, 733	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from t	he cost reporti	ng period er	ıdi ng 1996,	0 0. 00	
(0.00	updated and compounded by the market basket)		·	<b>.</b>		0.00	(0.00
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year cost	report, upo	lated by the	0.00	60.00
61. 00	Continuous improvement bonus payment (if line $55.01$ , or line $59$ , or line $60$ , enter the less $53$ ) are less than expected costs (lines $54 \times 10^{-2}$ ) are less than expected costs (lines $54 \times 10^{-2}$ ).	ser of 50% of the	amount by which	ch operating	costs (line	0	61.00
	enter zero. (see instructions)	00), 01 1 % 01 1	ne target amour	it (iiiic 50),	other wise		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)			0 261, 064	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST	,	,			·	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions) (title XVIII only)	ts through Decemb	er 31 of the co	ost reportino	period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cost	t reporting p	eriod (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line 64	plus line 65)(	title XVIII	only); for	0	66. 00
(7.00	CAH, see instructions	t- thb D					(7.00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through b	ecember 31 01 i	the cost repo	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	ember 31 of the	e cost report	ing 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						70.00
71. 00	Adjusted general inpatient routine service co	ost per diem (lin		. ( 37)			71. 00
	Program routine service cost (line 9 x line Medically necessary private room cost applications)		line 14 x line	35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ce costs (line 7	2 + line 73)				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service c	osts (from Work	ksheet B, Par	t II, column		75. 00
	Per diem capital-related costs (line 75 ÷ li	•					76. 00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus	•					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from pro					79. 00
	Total Program routine service costs for companient routine service cost per diem limi		t limitation (I	ine 78 minus	Fline 79)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (I	ne 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in:	· ·					83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructions					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ugn 85)				86. 00
	Total observation bed days (see instructions)	)				371	1
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see		rne 2)			1, 217. 35 451, 637	1
	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )					,	

Health Financial Systems	COMMUNITY MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	4, 654, 580	80, 545, 965	0. 05778	8 451, 637	26, 099	90.00
91.00 Nursing Program cost	0	80, 545, 965	0.00000	0 451, 637	0	91.00
92.00 Allied health cost	0	80, 545, 965	0.00000	0 451, 637	0	92.00
93.00 All other Medical Education	0	80, 545, 965	0.00000	0 451, 637	0	93. 00

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 31-0041	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/20/2024 2:3	pare
		Title	e XVIII	Hospi tal	PPS	
	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	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			415, 143, 889		30.
1. 00	03100 I NTENSI VE CARE UNIT			54, 623, 186		31.
4. 00	03400 SURGI CAL INTENSIVE CARE UNIT			70, 798		34.
3. 00	04300 NURSERY					43.
2 00	ANCILLARY SERVICE COST CENTERS		0.2/10	4/ 17 0/1 704	4 (00 001	
0. 00 1. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM		0. 2610 0. 1679			
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 1679			
	03190 OP INFUSION		0. 3074		6, 360	
3. 00	05300 ANESTHESI OLOGY		0. 2050			53.
1. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1970			
5. 00	05500 RADI OLOGY-THERAPEUTI C		0. 1458			
5. 00	05600 RADI OI SOTOPE		0. 3629			
7. 00	05700 CT SCAN		0. 0320			
3. 00	05800 MRI		0. 0627			1
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1425			
0. 00	06000 LABORATORY		0. 1177			60.
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0.0000	00	0	63.
5. 00	06500 RESPI RATORY THERAPY		0. 1512	45 18, 130, 696	2, 742, 177	65.
5. 00	06600 PHYSI CAL THERAPY		0. 2770	99 6, 723, 102	1, 862, 965	66.
7. 00	06700 OCCUPATI ONAL THERAPY		0. 1688	40 4, 589, 771	774, 937	67.
3. 00	06800 SPEECH PATHOLOGY		0. 1906	93 1, 283, 413	244, 738	68.
9. 00	06900 ELECTROCARDI OLOGY		0. 0728	52 14, 418, 390	1, 050, 409	69.
0. 00	07000 ELECTROENCEPHALOGRAPHY		0. 2962			1
0. 01	07001 SLEEP LAB		0.0000		ı	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 3124			
. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 7778			
	07300 DRUGS CHARGED TO PATIENTS		0. 7160			1
. 97	07697 CARDI AC REHABI LI TATI ON		0. 3050			1
	07698 HYPERBARI C OXYGEN THERAPY		0. 1949		1, 742	
	07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000			1
3. 00	07800 CAR T-CELL IMMUNOTHERAPY		0.0000	00 0	0	78.
	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC		0 1140	24 04 470	0 /5/	90.
	1091001 EMERGENCY		0. 1140 0. 1046			
	100200 OBSEDVATION REDS (NON DISTINCT DART		0. 1046			

0. 143318

0.095642

571, 671

4, 664, 895

266, 759, 787

266, 759, 787

81, 931

51, 302, 889 200. 00

446, 160

92.00

92.01

95.00

201. 00

202. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

09201 OBSERVATION BEDS-DISTINCT

OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

92.01

200.00

201.00

<u>Health Financia</u> INPATIENT ANCIL	I Systems COMMUNITY MEDIC  LARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 31-0041	Peri od:	wof Form CMS-2 Worksheet D-3	
		Component	CCN: 31-5490	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/20/2024 2:3	
		Title	e XVIII	Skilled Nursing Facility		о ріп
Cos	st Center Description		Ratio of Cos To Charges		Inpatient Program Costs	
			i o onargoo	Charges	(col . 1 x col . 2)	
			1.00	2. 00	3. 00	
	T ROUTINE SERVICE COST CENTERS					
	JLTS & PEDI ATRI CS					30.00
	ENSIVE CARE UNIT					31.00
	RGICAL INTENSIVE CARE UNIT					34.00
43. 00 04300 NUF						43. 0
	Y SERVICE COST CENTERS  ERATING ROOM		0. 26104	46 0	0	50.00
	COVERY ROOM		0. 26102		294	
	LIVERY ROOM & LABOR ROOM		0. 30747		0	1
52. 00 03200 DEI			0. 20504		0	
	ESTHESI OLOGY		0. 01553		6	
	DI OLOGY-DI AGNOSTI C		0. 19702			
55. 00 05500 RAI	OI OLOGY-THERAPEUTI C		0. 14583		0,000	
	OI OI SOTOPE		0. 36296		0	
57. 00 05700 CT			0. 03207		461	
58. 00   05800 MRI			0.06276		203	
59. 00 05900 CAF	RDI AC CATHETERI ZATI ON		0. 14251	12 0	0	59.0
60. 00 06000 LA	BORATORY		0. 11777	78 735, 975	86, 682	60.0
	OOD STORING, PROCESSING & TRANS.		0.00000	00	0	63.0
	SPI RATORY THERAPY		0. 15124	45 42, 758	6, 467	
1 1	'SI CAL THERAPY		0. 27709		565, 855	
1 1	CUPATI ONAL THERAPY		0. 16884		227, 390	
	ECH PATHOLOGY		0. 19069		2, 274	
	CCTROCARDI OLOGY		0. 07285		492	
	ECTROENCEPHALOGRAPHY		0. 29627		0	
70. 01   07001   SLE			0.00000		0	
	DI CAL SUPPLI ES CHARGED TO PATI ENT		1. 31247		1, 255	
	PL. DEV. CHARGED TO PATIENTS JGS CHARGED TO PATIENTS		0. 77782 0. 71601		0 193, 753	1
	RDIAC REHABILITATION		0. 7160		193, 753	
	PERBARI C OXYGEN THERAPY		0. 19494		0	
	OGENEIC STEM CELL ACQUISITION		0. 00000		0	
	R T-CELL IMMUNOTHERAPY		0. 00000		-	1
	NT SERVICE COST CENTERS		0.0000	30  0		70.0
90. 00 09000 CLI			0. 11402	26 0	0	90. 0
91. 00 09100 EME			0. 10467		ő	
	SERVATION BEDS (NON-DISTINCT PART		0. 14331		0	
	SERVATION BEDS-DISTINCT		0. 09564		0	
	MBURSABLE COST CENTERS					
95. 00 09500 AME	BULANCE SERVICES					95.0
	cal (sum of lines 50 through 94 and 96 through 98)			4, 511, 356	1, 091, 795	200. 0
	ss PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00 Net	charges (line 200 minus line 201)		1	4, 511, 356	1	202. 0

Health Financial Systems	COMMUNITY MEDICAL CEN	TER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi	der CC		Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/20/2024 2:3	pared:
		Ti tl e	e XIX	Hospi tal	TEFRA	
Cost Center Description			Ratio of Cos	Inpati ent	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS				4, 154, 807		30.00
31.00 03100 INTENSIVE CARE UNIT				5, 730, 347		31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				0		34.00
43. 00   04300   NURSERY				783, 977		43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	·		0. 26104	6 311, 214	81, 241	50.00

	Title XVIII Hospital	5/20/2024 2: 3 PPS	o piii
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1. 00	
1. 00	DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	66, 827, 832	1. 01
1. 02	Instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	23, 573, 276	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
	October 1 (see instructions)		
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)	897, 133	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	76, 131	2. 04
3. 00 4. 00	Managed Care Simulated Payments  Bed days available divided by number of days in the cost reporting period (see instructions)	60, 547, 903 408. 98	3. 00 4. 00
4.00	Indirect Medical Education Adjustment	400. 70	4.00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00	5. 00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6.00	FTE count for allopathic 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)	0. 00	6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0. 00	6. 26
7. 00	the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(f)(f)(g)(f)	0.00	7. 01
7. 02	cost report straddles July 1, 2011 then see instructions.  Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0.00	7. 02
7.02	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)	0.00	7.02
8. 00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0.00	0.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0.00	8. 01
	report straddles 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)	0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	0.00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.	7. 11	11. 00
12.00	Current year allowable FTE (see instructions)	7. 11	
13. 00 14. 00	Total allowable FTE count for the prior year.	4. 43 1. 51	
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	1. 31	14.00
15. 00	Sum of lines 12 through 14 divided by 3.	4. 35	15. 00
16. 00	Adjustment for residents in initial years of the program (see instructions)		16. 00
17. 00	Adjustment for residents displaced by program or hospital closure		17. 00
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).	65. 97 0. 161304	18. 00 19. 00
20. 00	Prior year resident to bed ratio (see instructions)	0. 160698	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0. 160698	21. 00
22. 00	IME payment adjustment (see instructions)	7, 592, 427	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	5, 085, 176	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
24.00	(f)(1)(iv)(C).	0.00	24.00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	0. 00 0. 00	24. 00 25. 00
24 00	instructions)	0.000000	26. 00
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4)  IME payments adjustment factor. (see instructions)	0. 000000 0. 000000	26.00
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)	7, 592, 427	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	5, 085, 176	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2. 49	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	10. 47	31. 00
32. 00	Sum of lines 30 and 31	12. 96	32. 00
33. 00 34. 00	Allowable disproportionate share percentage (see instructions)	0.00	
34.00	Disproportionate share adjustment (see instructions)	<u> </u>	34. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0041	Peri od: From 01/01/2023	Worksheet E Part A	
			To 12/31/2023	Date/Time Prep 5/20/2024 2:3	pared 5 pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	University of Court December Additional		1. 00	2. 00	
5. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		0	0	35. (
5. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	
5. 02	Hospital UCP, including supplemental UCP (see instructions)		0. 00000000	0.000000000	35. (
5. 03	Pro rata share of the hospital UCP, including supplemental UCI	P (see instructions)	0	0	
6. 00					36.
	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throu	gh 46)		
0. 00	Total Medicare discharges (see instructions)		0		40.
1. 00	Total ESRD Medicare discharges (see instructions)		0		41.
1. 01	Total ESRD Medicare covered and paid discharges (see instruction		0		41.
2.00	Divide line 41 by line 40 (if less than 10%, you do not quality	ry for adjustment)	0.00		42. 43.
3. 00 4. 00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided I	by line 41 divided by 7	0. 000000		44.
4. 00	days)	by Title 41 divided by 7	0.000000		44.
5. 00	Average weekly cost for dialysis treatments (see instructions)	)	0.00		45.
5. 00	Total additional payment (line 45 times line 44 times line 41.		0		46.
7. 00	Subtotal (see instructions)		98, 966, 799		47.
3. 00	Hospital specific payments (to be completed by SCH and MDH, si	mall rural hospitals	0		48.
	only. (see instructions)				_
				Amount 1.00	
9. 00	Total payment for inpatient operating costs (see instructions)	)		104, 051, 975	49.
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and			7, 461, 995	
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.
2. 00	Direct graduate medical education payment (from Wkst. E-4, li			4, 158, 030	
3. 00	Nursing and Allied Health Managed Care payment	,		80, 314	53.
4. 00	Special add-on payments for new technologies			438, 297	54.
4. 01	Islet isolation add-on payment			0	54.
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55.
5. 01	Cellular therapy acquisition cost (see instructions)			0	55.
5. 00	Cost of physicians' services in a teaching hospital (see intru		heaven 2E)	0	56.
7. 00 3. 00	Routine service other pass through costs (from Wkst. D, Pt. I   Ancillary service other pass through costs from Wkst. D, Pt.		nrough 35).	47, 597	57. 58.
9. 00	Total (sum of amounts on lines 49 through 58)	1V, COI. 11 1111e 200)		116, 238, 208	
0.00	Primary payer payments			110, 230, 200	60.
1. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		116, 238, 208	
2. 00	Deductibles billed to program beneficiaries			9, 162, 852	
3. 00	Coinsurance billed to program beneficiaries			835, 916	63.
4. 00	Allowable bad debts (see instructions)			1, 537, 725	•
5. 00	Adjusted reimbursable bad debts (see instructions)			999, 521	65.
5. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		372, 159	66.
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	anni achia ta MC DDC- (-	oo imotmustis	107, 238, 961	67.
3. 00 9. 00	Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	68. 69.
). 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(101 3CH SEE THSTIUCTION	3)	0	69.   70.
). 50	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) adjustment (see	instructions)	0	70.
). 75	N95 respirator payment adjustment amount (see instructions)	. a.t. on, adjustment (366		0	70.
0. 87	Demonstration payment adjustment amount before sequestration			0	70.
0. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.
). 89	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)			70.
n on	HSD honus nayment HVRD adjustment amount (see instructions)			0	70

0 70. 91 0 70. 92 -152, 660 70. 93

-1, 205, 990 70. 94 0 70. 95

70.89 Proneer ACU demonstration payment adjustment amount (see instructions)
70.90 HSP bonus payment HVBP adjustment amount (see instructions)
70.91 HSP bonus payment HRR adjustment amount (see instructions)
70.92 Bundled Model 1 discount amount (see instructions)
70.93 HVBP payment adjustment amount (see instructions)
70.94 HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

Health Financial Systems COMMUNITY MEDIC	AL CENTER		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CO	CN: 31-0041	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/20/2024 2:3	
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96
0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)			0	0	70. 97
70. 98 Low Volume Payment-3			0	0	70. 98
70.99 HAC adjustment amount (see instructions)				0	70. 99
1		I			1

	the corresponding federal year for the period ending on or after 10/1)			
70. 98	Low Volume Payment-3	0	0	70. 98
70. 99	HAC adjustment amount (see instructions)		0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		105, 880, 311	71. 00
71. 01	Sequestration adjustment (see instructions)		2, 117, 606	71. 01
71.02	Demonstration payment adjustment amount after sequestration		39, 982	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs			71. 03
72.00	Interim payments		107, 108, 322	72. 00
72. 01	Interim payments-PARHM		, , , , , , , , , , , , , , , , , , , ,	72. 01
	Tentative settlement (for contractor use only)		0	
73. 01	Tentative settlement-PARHM (for contractor use only)		Ĭ	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		-3, 385, 599	ł
74.00	73)		3, 303, 377	74.00
74. 01	Balance due provider/program-PARHM (see instructions)			74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance with		2, 791, 837	
75.00	CMS Pub. 15-2, chapter 1, §115.2		2, 191, 031	/5.00
	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
90.00			0	90.00
01 00	plus 2.04 (see instructions)		0	01 00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		1	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	
	The rate used to calculate the time value of money (see instructions)		0.00	
	Time value of money for operating expenses (see instructions)		0	
96. 00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1. 00	2. 00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101. 00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			1
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions)	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
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Rei mbursement			
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
	Medi care di scharges (see instructions)			202.00
	Case-mix adjustment factor (see instructions)			203. 00
200.00	Computation of Demonstration Target Amount Limitation (N/A in first year of the current	5-vear demonst	tration	203.00
	period)	3-year demons	ti ati on	
204 00	Medicare target amount			204. 00
	Case-mix adjusted target amount (line 203 times line 204)			205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
206.00				J206. 00
207.00	Adjustment to Medicare Part A Inpatient Reimbursement		Γ	007 00
	Program reimbursement under the §410A Demonstration (see instructions)			207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
	Adjustment to Medicare IPPS payments (see instructions)			209. 00
	Reserved for future use			210. 00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211. 00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
	Low-volume adjustment (see instructions)			213. 00
	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
	(line 212 minus line 213) (see instructions)		l	l
	(True 212 minus True 213) (see thisti detrons)			

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2023 | Part A Exhibit 4 | To 12/31/2023 | Date/Time Prepared: | 5/20/2024 2:35 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 31-0041

M/S E, Part A   Amounts (from   Period Prior   Period   Period   No.   Period   Period   No.	5. 00 0 0 66, 827, 832 76 23, 573, 276 0 0 0 897, 133	1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 2. 02
Iine	01 through 4) 5.00 0 66, 827, 832 0 23, 573, 276 0 0 0 0 897, 133	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01
0	5. 00 0 0 66, 827, 832 76 23, 573, 276 0 0 0 897, 133	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01
1.00 DRG amounts other than outlier payments  1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1  1.02 DRG amounts other than outlier payments for discharges occurring prior to October 1  1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1  1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1  1.04 DRG for Federal specific occurring prior to October 1  1.05 DRG for Federal specific occurring prior to October 1  1.06 DRG for Federal specific occurring prior to October 1  1.09 DRG for Federal specific occurring on or after October 1  1.00 DRG for Federal specific occurring on or after October 1  2.00 Outlier payments for occurring on or after October 1  2.00 Outlier payments for occurring or 0 October 1  2.00 Outlier payments for 0 October 1  2.00 October 1  2.00 October 1  3.00 October 1	0 0 0 66, 827, 832 76 23, 573, 276 0 0 0 0 0 0 0 897, 133	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01
payments DRG amounts other than outlier payments for discharges occurring prior to October 1  1.02 DRG amounts other than outlier payments for discharges occurring prior to October 1  1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1  1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1  2.00 Outlier payments for discharges (see instructions)  2.01 Outlier payments for discharges for Model 4 BPCI Outlier payments for discharges for Model 4 BPCI Outlier payments for discharges for Model 4 BPCI Outlier payments for discharges occurring prior to Outlier payments for discharges for Model 4 BPCI Outlier payments for discharges occurring prior to Outlier Dayments for discharges occurring Dayment for Outlier Dayments for Dayments for Outlier D	66, 827, 832 23, 573, 276 0 0 0 0 897, 133	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1  1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1  1.03 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to October 1  1.04 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1  2.00 Outlier payments for condischarges (see instructions)  2.01 Outlier payments for discharges for Model 4 BPCl Occurring prior to Outlier payments for discharges for Model 4 BPCl Occurring on or after October 1  2.02 Outlier payments for discharges for Model 4 BPCl Occurring prior to Outlier payments for discharges for Model 4 BPCl Outlier payments for discharges for Model 4 BPCl Outlier payments for discharges occurring prior to Outlier Dayments for discharges occurring Dayment Da	76 23, 573, 276 0 0 0 0 0 0 897, 133	1. 02 1. 03 1. 04 2. 00 2. 01
occurring prior to October 1  1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1  1.03 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to October 1  1.04 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1  2.00 Outlier payments for discharges (see instructions)  2.01 Outlier payments for discharges for Model 4 BPCl Outlier payments for Ou	0 0 0 0 0 897, 133	1. 03 1. 04 2. 00 2. 01
occurring on or after October  1  1.03  DRG for Federal specific operating payment for Model 4 BPCl occurring prior to October 1  1.04  DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1  2.00  Outlier payments for odischarges (see instructions)  2.01  Outlier payments for odischarges for Model 4 BPCl october 1  2.02  Outlier payments for odischarges for Model 4 BPCl october 1  2.03  Outlier payments for odischarges for Model 4 BPCl october 1  2.04  Outlier payments for odischarges for Model 4 BPCl october 1  2.05  Outlier payments for odischarges occurring prior to 0	0 0 897, 133	1. 04 2. 00 2. 01
operating payment for Model 4 BPCI occurring prior to October 1  1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1  2.00 Outlier payments for discharges (see instructions)  2.01 Outlier payments for discharges for Model 4 BPCI  2.02 Outlier payments for discharges for Model 4 BPCI  2.03 B97, 133 discharges occurring prior to	0 0 897, 133	1. 04 2. 00 2. 01
1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI 2.02 Outlier payments for 2.02 Outlier payments for 2.03 SP7, 133 Outlier payments for 3.03 SP7, 133 Outlier payments for 3.04 Outlier payments for 3.05 SP7, 133 Outlier payments for 3.05 SP7, 1	0 0 897, 133	2. 00
2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for 2.02 0 0 0 discharges for Model 4 BPCl 2.02 Outlier payments for 2.03 897,133 0 897,133 discharges occurring prior to	897, 133	2. 01
2.01 Outlier payments for 2.02 0 0 0 discharges for Model 4 BPCI 2.02 Outlier payments for 2.03 897,133 0 897,133 discharges occurring prior to	897, 133	
2.02 Outlier payments for 2.03 897,133 0 897,133 discharges occurring prior to		2. 02
october 1 (see that detroils)	76, 131	
2.03 Outlier payments for 2.04 76,131 0 76,1 discharges occurring on or after October 1 (see instructions)		2. 03
3.00 Operating outlier 2.01 0 0 0   reconciliation	0 0	3. 00
4.00 Managed care simulated 3.00 60,547,903 0 43,829,210 16,718,6	60, 547, 903	4. 00
Indirect Medical Education Adjustment		
5.00 Amount from Worksheet E, Part 21.00 0.160698 0.160698 0.160698 0.160698	/8	5. 00
A, line 21 (see instructions) 6.00   IME payment adjustment (see   22.00   7,592,427   0   5,612,602   1,979,8	7, 592, 427	6. 00
instructions) 6.01   IME payment adjustment for 22.01 5,085,176 0 3,681,040 1,404,1	5, 085, 176	6. 01
i nstructi ons)		
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
7.00   IME payment adjustment factor   27.00   0.000000   0.000000   0.000000   0.000000	)0	7. 00
(see instructions) 8.00 IME adjustment (see 28.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	8. 00
8.01   IME payment adjustment add on 28.01 0 0 0 for managed care (see	0 0	8. 01
instructions)   9.00   Total IME payment (sum of	7, 592, 427	9. 00
lines 6 and 8)   Total IME payment for managed   29.01   5,085,176   0   3,681,040   1,404,1     care (sum of lines 6.01 and	5, 085, 176	9. 01
8. 01)		
Di sproporti onate Share Adjustment		
10.00 Allowable disproportionate 33.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000	)0	10. 00
11.00 Disproportionate share 34.00 0 0 0 0 adjustment (see instructions)	0 0	11. 00
11.01 Uncompensated care payments 36.00 0 0 0  Additional payment for high percentage of ESRD beneficiary discharges	0 0	11. 01
12.00 Total ESRD additional payment 46.00 0 0 0	0 0	12.00
(see instructions)		
13.00 Subtotal (see instructions) 47.00 98,966,799 0 73,337,567 25,629,2  14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)		13. 00 14. 00
(see instructions) 15.00 Total payment for inpatient 49.00 104,051,975 0 77,018,607 27,033,3 operating costs (see instructions)	104, 051, 975	15. 00
16.00 Payment for inpatient program 50.00 7,461,995 0 5,480,275 1,981,7 capital (from Wkst. L, Pt. I, if applicable)	7, 461, 995	16. 00

						Fo 12/31/2023	Date/Time Pre 5/20/2024 2:3	pared:
				Title	XVIII	Hospi tal	PPS	<u> </u>
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54. 00	438, 297	0	438, 297	7 0	438, 297	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	o	0	(	0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18. 00	Capital outlier reconciliation	93. 00	0	0	(	0	0	18. 00
	adjustment amount (see							
40.00	instructions)				00 007 47	00 045 000	444 050 047	40.00
19. 00	SUBTOTAL	W/S L. line	(Amounts from	0	82, 937, 179	29, 015, 088	111, 952, 267	19.00
		W/S L, TIME	(Alliounts Trolli					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1, 00	6, 852, 311	2.00	5, 027, 704		6, 852, 311	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0,002,011	0	0,027,70	0 1, 02 1, 007	0,002,011	
20.0.	than outlier		Ĭ		Ì			20.0.
21. 00	Capital DRG outlier payments	2. 00	28, 608	0	26, 222	2, 386	28, 608	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	o	0		0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0583	0. 0583	0. 0583	0. 0583		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	399, 490	0	293, 115	106, 375	399, 490	23. 00
04.00	adjustment (see instructions)	10.00	0.00/5	0.00/5	0.00/	0.00/5		04.00
24. 00	Allowable disproportionate	10. 00	0. 0265	0. 0265	0. 0265	0. 0265		24. 00
	share percentage (see instructions)							
25. 00	Di sproporti onate share	11. 00	181, 586	0	133, 234	48, 352	181, 586	25. 00
23.00	adjustment (see instructions)	11.00	101, 300	0	155, 25	40, 332	101, 300	25.00
26. 00	Total prospective capital	12. 00	7, 461, 995	0	5, 480, 275	1, 981, 720	7, 461, 995	26 00
20.00	payments (see instructions)	12.00	7, 101, 770		0, 100, 2, 1	1,701,720	7, 101, 7, 70	20.00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 000000	0. 000000		27. 00
28. 00	Low volume adjustment	70. 96			(		0	28. 00
	(transfer amount to Wkst. E,							
00.00	Pt. A, line)	70.07						00.00
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E, Pt. A, line)							
100 00	Pt. A, line)  Transfer Low volume		Y					100. 00
100.00	adjustments to Wkst. E, Pt. A.		'					100.00
	judy dot more to with the fit. A.	ı	ı I		ı	T.	Į.	ı

From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 12/31/2023 5/20/2024 2:35 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 66, 827, 832 66, 827, 832 66, 827, 832 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 23, 573, 276 23, 573, 276 1.02 23, 573, 276 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 897, 133 897, 133 897, 133 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 76, 131 76, 131 76, 131 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 60.547.903 43, 829, 210 16, 718, 693 60. 547. 903 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.160698 0.160698 0.160698 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 7, 592, 427 5, 612, 602 1, 979, 825 7, 592, 427 6.00 5, 085, 176 IME payment adjustment for managed care (see 6.01 22.01 5, 085, 176 3, 681, 040 1, 404, 136 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.000000 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 7, 592, 427 5, 612, 602 1, 979, 825 7, 592, 427 9.00 5, 085, 176 Total IME payment for managed care (sum of 5, 085, 176 9.01 29.01 3, 681, 040 1, 404, 136 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0000 0.0000 0.0000 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 0 0 11.00 0 instructions) 11.01 Uncompensated care payments 36 00 0 0 0 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 98, 966, 799 73, 337, 567 25, 629, 232 98, 966, 799 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 0 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 104, 051, 975 77, 018, 607 27, 033, 368 104, 051, 975 15.00 15.00 (see instructions) 16.00 50 00 7, 461, 995 5 480 275 1, 981, 720 7, 461, 995 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 438, 297 438, 297 438, 297 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 C 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 0 amount (see instructions) 19.00 SUBTOTAL 82, 937, 179 29, 015, 088 111, 952, 267

Heal th	Financial Systems	COMMUNITY MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO	CN: 31-0041	Period: From 01/01/2023 To 12/31/2023		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2. 00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	6, 852, 311	5, 027, 70	1, 824, 607	6, 852, 311	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	28, 608	26, 22	22 2, 386	28, 608	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0583	0. 058	0. 0583		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	399, 490	293, 1	106, 375	399, 490	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0265	0. 026	0. 0265		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	181, 586	133, 23	48, 352	181, 586	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	7, 461, 995	5, 480, 27	75 1, 981, 720	7, 461, 995	26. 00
	[TIISTI UCTI OIIS)						

			Wkst. L)				
		0	1.00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	6, 852, 311	5, 027, 704	1, 824, 607	6, 852, 311	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	C	0	20. 01
21.00	Capital DRG outlier payments	2.00	28, 608	26, 222	2, 386	28, 608	21. 00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	o	0	C	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0583	0. 0583	0. 0583		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	399, 490	293, 115	106, 375	399, 490	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0265	0. 0265	0. 0265		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	181, 586	133, 234	48, 352	181, 586	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	7, 461, 995	5, 480, 275	1, 981, 720	7, 461, 995	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	o	0		0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	o		C	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-152, 660	0	-152, 660	-152, 660	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	C	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-1, 205, 990	-753, 381	-452, 609	-1, 205, 990	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	C	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2. 00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		0	C	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041		Worksheet E Part B Date/Time Prepared: 5/20/2024 2:35 pm
	T1 11 10011		

		5/20/2024 2: 35	5 pm
	Title XVIII Hospital	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	22, 317	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	59, 300, 235	2.00
3.00	OPPS or REH payments	47, 566, 346	
4.00	Outlier payment (see instructions)	68, 038	4.00
4. 01	Outlier reconciliation amount (see instructions)	0	4.0
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)	0.00	8.00
9. 00	Ancillary service other pass through costs including REH direct graduate medical education costs fr	-	9.00
	Wkst. D, Pt. IV, col. 13, line 200		
10.00	Organ acqui si ti ons	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	22, 317	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges	24.440	
	Ancillary service charges	31, 168	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)	0 31, 168	13.00
14.00	Customary charges	31, 100	14.00
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
	Amounts that would have been realized from patients liable for payment for services on a chargebasi		16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
	Total customary charges (see instructions)	31, 168	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	8, 851	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	o	20.00
20. 00	instructions)	ا	20.00
21 00	Lesser of cost or charges (see instructions)	22, 317	21. 00
	Interns and residents (see instructions)	0	22. 00
	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 0
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	47, 764, 093	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	8, 369, 386	•
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	39, 417, 024	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)	2, 028, 788	28. 00
	REH facility payment amount (see instructions)	2, 020, 700	28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	41, 445, 812	30.00
	Primary payer payments	24, 630	
32.00	Subtotal (line 30 minus line 31)	41, 421, 182	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1	
	Composite rate ESRD (from Wkst. I-5, line 11)	0	
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	350, 936 228, 108	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	246, 261	
	Subtotal (see instructions)	41, 649, 290	
	MSP-LCC reconciliation amount from PS&R	-232	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 0
	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
	N95 respirator payment adjustment amount (see instructions)	0	39. 7
	Demonstration payment adjustment amount before sequestration	0	
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 9
	Subtotal (see instructions) Sequestration adjustment (see instructions)	41, 649, 522	
	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration	832, 990	
40. 02	Sequestration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs	3, 812	40. 0
	Interim payments	38, 455, 000	
	Interim payments-PARHM	22, 30, 550	41. 0
	Tentative settlement (for contractors use only)	0	42. 0
42. 01	Tentative settlement-PARHM (for contractor use only)		42. 0°
43.00	Balance due provider/program (see instructions)	2, 357, 720	
43. 01	Balance due provider/program-PARHM (see instructions)		43.0
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 0
00		1	
00	§115. 2	•	
	TO BE COMPLETED BY CONTRACTOR		90 0
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0	
90. 00 91. 00	TO BE COMPLETED BY CONTRACTOR	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	91.0

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	Peri od:	Worksheet E	
		From 01/01/2023		
		To 12/31/2023	Date/Time Pre	
			5/20/2024 2: 3	5 pm
	Title XVIII	Hospi tal	PPS	
			1. 00	
94.00 Total (sum of lines 91 and 93)			0	94.00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041		Worksheet E
		From 01/01/2023	Part B
	Component CCN: 31-5490	To 12/31/2023	Date/Time Prepared:
			5/20/2024 2: 35 pm
	Title XVIII	Skilled Nursing	PPS
		Facility	

	Facility	113	_
		1. 00	+
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
00	Medical and other services (see instructions)	2, 231	
00	Medical and other services reimbursed under OPPS (see instructions)	0	
0	OPPS or REH payments		
)0 )1	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)		
00	Enter the hospital specific payment to cost ratio (see instructions)		
00	Line 2 times line 5	0	
00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	
00	Transitional corridor payment (see instructions)	0	
00	Ancillary service other pass through costs including REH direct graduate medical education costs from	0	
00	Wkst. D, Pt. IV, col. 13, line 200	0	
00	Organ acquisitions Total cost (sum of Lines 1 and 10) (see instructions)	0 2, 231	
UU	Total cost (sum of lines 1 and 10) (see instructions)  COMPUTATION OF LESSER OF COST OR CHARGES	2, 231	┨ '
	Reasonable charges		1
00	Ancillary service charges	3, 116	1
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
	Total reasonable charges (sum of lines 12 and 13)	3, 116	1
	Customary charges		
00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	1
00	had such payment been made in accordance with 42 CFR §413.13(e)	0.00000	, 1
	Ratio of line 15 to line 16 (not to exceed 1.000000)  Total customary charges (see instructions)	0. 000000 3, 116	
00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	885	
00	instructions)	000	Ι.
00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	) 2
	instructions)		
	Lesser of cost or charges (see instructions)	2, 231	
	Interns and residents (see instructions)	0	
	Cost of physicians' services in a teaching hospital (see instructions)	0	
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)  COMPUTATION OF REIMBURSEMENT SETTLEMENT	U	2
00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	2
00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	G	2
00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	2, 231	
	instructions)		
	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	
	REH facility payment amount (see instructions)		2
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	–
00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments	2, 231	3
00	Subtotal (line 30 minus line 31)	2, 231	
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	2, 251	1 ~
00	Composite rate ESRD (from Wkst. I-5, line 11)	0	3
	Allowable bad debts (see instructions)	0	
00	Adjusted reimbursable bad debts (see instructions)	0	) 3
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	
	Subtotal (see instructions)	2, 231	
00	MSP-LCC reconciliation amount from PS&R		3
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	1
50 75	Pioneer ACO demonstration payment adjustment (see instructions)  N95 respirator payment adjustment amount (see instructions)	0	3
	Demonstration payment adjustment amount (see Instructions)	0	
98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
99	RECOVERY OF ACCELERATED DEPRECIATION	0	
	Subtotal (see instructions)	2, 231	
01	Sequestration adjustment (see instructions)	45	
02	Demonstration payment adjustment amount after sequestration	0	4
03	Sequestration adjustment-PARHM pass-throughs		4
	Interim payments	3, 054	
	Interim payments-PARHM		4
	Tentative settlement (for contractors use only)  Tentative settlement DADUM (for contractor use only)	0	
01	Tentative settlement-PARHM (for contractor use only)  Ralance due provider/program (see instructions)	040	4
00 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	-868	4
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	
00	§115. 2	U	-
	TO BE COMPLETED BY CONTRACTOR		1
00	Original outlier amount (see instructions)		9
			9
00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money		9

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0041	Peri od:	Worksheet E	
		From 01/01/2023		
	Component CCN: 31-5490	To 12/31/2023	Date/lime Pre	pared:
	T1.11 \0.011.1		5/20/2024 2: 3	5 pm
	Title XVIII	Skilled Nursing	PPS	
		Facility		
			1. 00	
93.00 Time Value of Money (see instructions)				93. 00
94.00 Total (sum of lines 91 and 93)				94.00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				200. 00

Health Financial Systems COMMANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 31-0041

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.						5/20/2024 2: 35	5 pm
Total interim payments paid to provider   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   38,455,000   1.00   2.00   3.00   4.00   38,455,000   1.00   2.00   3.00   4.00   38,455,000   1.00   2.00   3.0			Title	XVIII	Hospi tal	PPS	
1.00   7.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   4.00   3.00   3.00   4.00   3.00   3.00   4.00   3.00   3.00   4.00   3.00			Inpatien	t Part A	Par	t B	
Total interim payments paid to provider   1.00   2.00   3.00   4.00   1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero.				2.00	3. 00	4. 00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1.00			103, 164, 228	3	38, 455, 000	1. 00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero.	2.00			(	)	0	2.00
Write NoNE" or enter a zero   Section   Sect							
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)							
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Program to Provider							
3. 01							
3.02   3.03   3.04   3.05   3.06   3.06   3.06   3.06   3.07	3 01		07/20/2023	3 767 110		0	3. 01
3.04 3.04 3.05 Provider to Program  3.50 3.51 3.52 3.53 3.53 3.59 3.59 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50		ADSOSTMENTS TO TROVIDER					3. 02
3.04   0   0   0   3.			0772072020			- 1	3. 03
3.05   Provider to Program						- 1	3. 04
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   0   3   3   5   5   5   5   5   5   5   5							3. 05
3. 50   ADJUSTMENTS TO PROGRAM	0.00	Provider to Program			1	0	0.00
3.52   3.53   3.54   3.59   3.50   3.60	3.50			(	)	0	3. 50
3.53   Subtotal (sum of lines 3.01-3.49 minus sum of lines   3,944,094   0   3   3,50-3.98	3.51					0	3. 51
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   107, 108, 322   38, 455, 000   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	3.52			(		0	3. 52
3. 99   Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 5.01-3. 98)   3. 50-3. 98)   107, 108, 322   38, 455, 000   4. 00   Total interim payments (sum of lines 1, 2, and 3. 99)   107, 108, 322   38, 455, 000   4. 00   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108, 322   38, 455, 000   107, 108,	3.53			(		0	3. 53
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)	3.54			(	)	0	3. 54
107, 108, 322   38, 455, 000   4.	3. 99			3, 944, 094	ļ.	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR		1 2 2 2 2 2 2					
appropriate   TO BE COMPLETED BY CONTRACTOR	4.00			107, 108, 322	2	38, 455, 000	4. 00
TO BE COMPLÉTED 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		appropri ate)					
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	5 00	List soperately each tentative settlement nayment after					5. 00
Write "NONE" or enter a zero. (1)   Program to Provider   S. 01   TENTATIVE TO PROVIDER   O	5.00						5.00
Program to Provider							
TENTATI VE TO PROVI DER		Program to Provider		ı	II.		
Description	5.01			(	)	0	5. 01
Provider to Program	5.02			(		0	5. 02
TENTATI VE TO PROGRAM	5.03			(	)	0	5. 03
5.51   0							
5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1. 00 2. 00		TENTATI VE TO PROGRAM				- 1	5. 50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 3, 385, 599 0 6.00 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr) 0 1.00 2.00							5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00						- 1	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	5. 99	· ·		(	)	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 2, 357, 720 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.							/ 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6.00	` '					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  3,385,599 103,722,723 40,812,720 7.0  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01					2 357 720	6. 01
7.00 Total Medicare program liability (see instructions) 103,722,723 40,812,720 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1	1		6. 02
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00						- 1	
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Total medicale program trabitity (see this tructions)		103, 122, 12			7.00
0 1.00 2.00						1 1 1	
			(	)			
0.00   1.00.00   0.00.00   0.00	8. 00	Name of Contractor					8. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 01/01/2023 | Part I | Date/Time Prepared: | 5/20/2024 2:35 pm | Skilled Nursing | PPS | Provider CCN: 31-0041 Component CCN: 31-5490 Title XVIII Skilled Nursing

		litie	XVIII S	Killed Nursing Facility	PPS	
		Innatien	t Part A		rt B	
		i inpati cii	rui e n	i di		
		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, 537, 676		3, 054	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					
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					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54	Subtatal (sum of lines 2 01 2 40 minus sum of lines		0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		U	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 537, 676		3, 054	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2, 337, 070		3,034	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		'			
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			ı	_	
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Dragnam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	TENTATIVE TO PROGRAW		0			5. 50
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
0. , ,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		1, 045		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		868	6. 02
7.00	Total Medicare program liability (see instructions)		2, 538, 721		2, 186	7. 00
				Contractor	NPR Date	
		,	2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(	)	1. 00	2. 00	8. 00
6.00	INAMIC OF COTTLEACTOR	I		I	ı l	0.00

Heal th	Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0041	Peri od:	Worksheet E-3	
		0 1 001 04 5400	From 01/01/2023		
		Component CCN: 31-5490	To 12/31/2023	Date/Time Pre 5/20/2024 2:3	
		Title XVIII	Skilled Nursing		o piii
			Facility		
				1. 00	
		TLEMEMENT - ALL OTHER HEALTH SERVICES FOR T	TITLE XVIII PART A	A PPS SNF	
	SERVI CES				
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIO	NS)			
1. 00	Resource Utilization Group Payment (RUGS)			2, 622, 465	1. 00
2.00	Routine service other pass through costs			0	2. 00
3.00	Ancillary service other pass through costs			1, 045	
4.00	Subtotal (sum of lines 1 through 3)			2, 623, 510	4. 00
	COMPUTATION OF NET COST OF COVERED SERVICE				
5.00		s line as vaccine costs are included in lin	ie 1 of W/S E,		5. 00
	Part B. This line is now shaded.)				,
6.00	Deducti bl e			0	6. 00
7.00	Coinsurance			33, 000	1
8.00	Allowable bad debts (see instructions)			0	8. 00
9.00	Reimbursable bad debts for dual eligible b			0	9. 00
10.00	Adjusted reimbursable bad debts (see instr	ructions)		0	10.00
	Utilization review	17 1 1 10 141)	,	0 500 510	11.00
		and 7, plus lines 10 and 11)(see instruction	ins)	2, 590, 510	
13.00	Inpatient primary payer payments	U.F.V.)		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPEC	IFY)		0	14.00

14.50 Pioneer ACO demonstration payment adjustment (see instructions)

Demonstration payment adjustment amount after sequestration

Sequestration for non-claims based amounts (see instructions)

Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)

19.00 Protested amounts (nonal owable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,

14.99 Demonstration payment adjustment amount before sequestration

Recovery of accelerated depreciation.

Sequestration adjustment (see instructions)

17.00 Tentative settlement (for contractor use only)

Subtotal (see instructions

2, 590, 510

2, 537, 676

51, 789

1,045

14. 50

14. 98

14. 99

15.00

15.01

15.02

15. 75

16.00

17.00 Ω

18.00

19.00

14. 98

15.00

15.01

15. 02

15. 75

18.00

16.00 Interim payments

§115. 2

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0041	From 01/01/2023	Worksheet E-3 Part VII Date/Time Prepared:

			10 12/31/2023	5/20/2024 2:3	
		Title XIX	Hospi tal	TEFRA	
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		261, 064		1.00
2.00	Medical and other services			692, 665	2. 00
3.00	Organ acquisition (certified transplant programs only)		o		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		261, 064	692, 665	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		261, 064	692, 665	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		9, 885, 154		8. 00
9.00	Ancillary service charges		6, 094, 576	5, 407, 255	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		15, 979, 730	5, 407, 255	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
45.00	a charge basis had such payment been made in accordance with	12 CFR §413.13(e)			4- 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)	1611 44	15, 979, 730	5, 407, 255	
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	15, 718, 666	4, 714, 590	17. 00
10.00	line 4) (see instructions)	! &   ! == 4		0	10.00
18. 00	Excess of reasonable cost over customary charges (complete onl	y IT Time 4 exceeds Time	0	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19. 00
		suctions)		0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		261, 064	692, 665	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			092,003	21.00
22. 00	Other than outlier payments	Completed for FF3 provide	0	0	22. 00
	Outlier payments			0	
24. 00	Program capital payments			O	24.00
	Capital exception payments (see instructions)		o o		25. 00
	Routine and Ancillary service other pass through costs		o o	0	
	Subtotal (sum of lines 22 through 26)			0	
28. 00	Customary charges (title V or XIX PPS covered services only)		Ö	0	
29. 00	, , , , , , , , , , , , , , , , , , , ,		261, 064	692, 665	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		20.700.1	0,2,000	27.00
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)	)	261, 064	692, 665	
32. 00	Deducti bl es		0	0	
33. 00			o	0	
34.00	Allowable bad debts (see instructions)		o	0	34.00
35.00	Utilization review		o		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	261, 064	692, 665	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•	O	0	37.00
	Subtotal (line 36 ± line 37)		261, 064	692, 665	
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		261, 064	692, 665	
41.00	Interim payments		2, 428, 074	732, 960	
42.00	Balance due provider/program (line 40 minus line 41)		-2, 167, 010	-40, 295	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	
	chapter 1, §115.2				
			•		•

Health Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0041	Peri od: From 01/01/2023	Worksheet E-3
	Component CCN: 31-5490		
	Title XIX	Skilled Nursing	Cost

		II tie xix	Facility	COST	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	S FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	TOK TITLES V OK XIT	COLITYTOLO		
1.00	Inpati ent hospi tal /SNF/NF servi ces		0		1.00
2. 00	Medical and other services			0	1
3. 00	Organ acquisition (certified transplant programs only)		o	Ü	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		o	0	4. 00
5. 00	Inpatient primary payer payments			Ü	5. 00
6.00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		o	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		٥,		/ / / /
	Reasonable Charges				
8.00	Routi ne servi ce charges		0		8. 00
9. 00	Ancillary service charges		o	0	1
10.00	Organ acquisition charges, net of revenue		o	ŭ	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		o	0	•
	CUSTOMARY CHARGES		-1		
13. 00	Amount actually collected from patients liable for payment for serv	vices on a charge	0	0	13. 00
	basis				
14.00	Amounts that would have been realized from patients liable for payr	ment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFF	₹ §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		O	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instruction	ons)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	eted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0	_	25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				00.00
30.00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	1
	Allowable bad debts (see instructions)		0	0	34.00
35. 00 36. 00	Utilization review		0	0	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	, , , ,			0	38.00
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		0	Ü	38.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)			0	
	Interim payments			0	
41.00	Balance due provider/program (line 40 minus line 41)			0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub 15_2		0	42.00
73.00	chapter 1, §115.2	11 OND 1 UD 10-2,		U	75.00
			1		1

DI RECT	Financial Systems COMMUNITY MEDICA FGRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CC	CN: 31-0041	Peri od:	u of Form CMS-2 Worksheet E-4	
MEDI CA	AL EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/20/2024 2:3!	
		Title	XVIII	Hospi tal	PPS	. piii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.		cost reporti	ng periods	0. 00	
1. 01 2. 00	FTE cap adjustment under §131 of the CAA 2021 (see instruction Unweighted FTE resident cap add-on for new programs per 42 CFF		1) (saa instr	ructions)	0. 00 0. 00	
2. 26	Rural track program FTE cap limitation adjustment after the cathe CAA 2021 (see instructions)				0.00	2. 26
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of MM/ Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0. 00 0. 00	3. 00 3. 01
	instructions for cost reporting periods straddling 7/1/2011)				0.00	
3. 02	Adjustment (increase or decrease) to the hospital's rural track programs with a rural track Medicare GME affiliation agreement 49075 (August 10, 2022) (see instructions)				0.00	3. 02
1. 00	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. 00
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instristraddling 7/1/2011)		cost reporti	ng periods	0. 00	4. 01
. 02	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
. 21	The amount of increase if the hospital was awarded FTE cap sld instructions)				0.00	4. 21
. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line 3.01, plus or minus line 3.02, plus or minus line 4, plus line	es 4.01 thro	ugh 4. 27		0. 00	5.00
. 00	Unweighted resident FTE count for allopathic and osteopathic precords (see instructions)	programs for	the current	year from your	0.00	6.0
7. 00	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 osteopa program for the current year.		0. 0		0.00	
	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount.  6. For cost reporting periods beginning on or after October 1,	ise unt on line	0. (			
. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount from line 8.	ise unt on line , 2022, or			0.00	9. 00
0. 00 0. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the current.	ise unt on line , 2022, or ent year	0. (	7. 11 7. 11	0.00	9. 00 10. 00 10. 0
0. 00 0. 00 0. 01 1. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amou 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count	ise unt on line , 2022, or ent year rrent year	0. (	7. 11 7. 11 7. 11 7. 11	0.00	9. 00 10. 00 10. 0 11. 0
0. 00 0. 00 0. 01 1. 00 2. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amou 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)	ise unt on line , 2022, or ent year rrent year g year (see	0.0	7. 11 7. 11 7. 11 7. 11 7. 11 7. 11 4. 43	0.00	9. 00 10. 00 10. 0 11. 00 12. 00
0.00 0.00 0.01 1.00 2.00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curred Unweighted dental and podiatric resident FTE count for the curred unweighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reporting instructions)	ise unt on line , 2022, or ent year rrent year g year (see	0. C 0. C 0. C	7. 11 7. 11 7. 11 7. 11 7. 11 4. 43	0.00	9. 00 10. 00 11. 00 12. 00
0. 00 0. 01 1. 00 2. 00 3. 00 4. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amou 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost repear (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided)	ise unt on line , 2022, or ent year rrent year g year (see	0. 0 0. 0 0. 0	7. 11 7. 11 7. 11 7. 11 90 4. 43 90 4. 35	0.00	9. 00 10. 00 11. 00 12. 00 13. 00
0. 00 0. 01 1. 00 2. 00 3. 00 4. 00 5. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curred Unweighted dental and podiatric resident FTE count for the curred unweighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost regular (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	ise unt on line , 2022, or ent year rrent year g year (see porting by 3).	0. ( 0. ( 0. ( 28. 7	7. 11 7. 11 7. 11 7. 11 90 7. 11 4. 43 90 1. 51 90 4. 35 73 32. 90	0.00	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
0. 00 0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amou 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the curroul weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reparance (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs	ise unt on line , 2022, or ent year rrent year g year (see porting by 3). rograms	0. 0 0. 0 0. 0	7. 11 7. 11 7. 11 7. 11 90 4. 43 90 1. 51 90 4. 35 93 32. 90 93 32. 90	0.00	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 0
0. 00 0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimul tiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curred unweighted dental and podiatric resident FTE count for the curred unweighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reporting instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new productions Unweighted adjustment for residents displaced by program or hospital closure	ise unt on line , 2022, or ent year rrent year g year (see porting by 3). rograms sure	0.0 0.0 0.0 0.0 28.1 28.1 0.0	7. 11 7. 11 7. 11 7. 11 90 90 1. 51 1. 51 1. 51 32. 90 13 32. 90 90 90 90 90 90 90	0.00	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 0
0. 00 0. 01 1. 00 2. 00 3. 00 4. 00 5. 01 6. 00 6. 01 7. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimul tiply line 8 times the result of line 5 divided by the amou 6. For cost reporting periods beginning on after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost repear (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs  Unweighted adjustment for residents in initial years of new produst closs of the program of the closure Adjusted rolling average FTE count	ise unt on line , 2022, or ent year rrent year g year (see porting by 3). rograms sure	0. 0 0. 0 0. 0 28. 7 28. 1 0. 0	7. 11 7. 11 7. 11 7. 11 90 7. 11 4. 43 90 1. 51 90 4. 35 93 32. 90 90 0. 00 90 0. 00	0.00	9. 00 10. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
. 00 0. 00 0. 01 1. 00 2. 00 3. 00 4. 00 5. 01 6. 00 6. 01 7. 00 8. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost represer (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital closure  Adjusted rolling average FTE count  Per resident amount	ise unt on line , 2022, or ent year rrent year g year (see porting by 3). rograms sure	0. 0 0. 0 0. 0 28. 7 0. 0 28. 7 0. 0	7. 11 7. 11 7. 11 7. 11 90 7. 11 90 4. 43 90 1. 51 90 4. 35 93 32. 90 90 0. 00 90 0. 00	0.00	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00
0. 00 0. 01 1. 00 2. 00 3. 00 4. 00 5. 01 6. 00 6. 01 7. 00 8. 00 8. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimul tiply line 8 times the result of line 5 divided by the amou 6. For cost reporting periods beginning on after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost repear (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs  Unweighted adjustment for residents in initial years of new produst closs of the program of the closure Adjusted rolling average FTE count	ise unt on line , 2022, or ent year rrent year g year (see porting by 3). rograms sure	0. 0 0. 0 0. 0 28. 7 28. 1 0. 0	7. 11 7. 11 7. 11 7. 11 90 4. 43 90 1. 51 90 4. 35 93 32. 90 90 0. 00 90 0. 00 91 33, 058. 09	0.00	9. 00 10. 00 10. 07 11. 00 12. 00 13. 00 14. 00 15. 07 16. 00 16. 07 17. 00 18. 00 18. 00
0.00 0.00 0.01 1.00 2.00 3.00 4.00 5.00 6.01 7.00 8.00 8.01 9.00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the curroutal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reparate (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital closure  Adjusted rolling average FTE count  Per resident amount  Per resident amount under §131 of the CAA 2021	ise unt on line , 2022, or ent year rrent year g year (see porting by 3). rograms sure pospital	0. 0 0. 0 0. 0 28. 1 28. 2 0. 0 130, 058. 0 3, 736, 56	7. 11 7. 11 7. 11 7. 11 7. 11 90 90 10. 4. 35 32. 90 90 90 90 90 90 90 90 90 90 90 90 90 9	0. 00 0. 00 8, 581, 233	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
0.00 0.00 0.01 1.00 2.00 3.00 4.00 5.01 6.00 6.01 7.00 8.01 9.00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost regulated to penultimate cost regulated penultimate cost r	ise unt on line , 2022, or ent year rrent year g year (see porting by 3). rograms sure pospital	0. 0 0. 0 0. 0 28. 1 28. 2 0. 0 130, 058. 0 3, 736, 56	7. 11 7. 11 7. 11 7. 11 7. 11 90 90 10. 4. 35 32. 90 90 90 90 90 90 90 90 90 90 90 90 90 9	0. 00 0. 00 8, 581, 233 1. 00 0. 00	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00 20. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Unweighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost region year (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital closure  Adjusted rolling average FTE count  Per resident amount  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instructions)	ise unt on line , 2022, or ent year rrent year g year (see porting by 3). rograms sure pospital	0. 0 0. 0 0. 0 28. 1 28. 2 0. 0 130, 058. 0 3, 736, 56	7. 11 7. 11 7. 11 7. 11 7. 11 90 90 10. 4. 35 32. 90 90 90 90 90 90 90 90 90 90 90 90 90 9	8, 581, 233 1. 00 0. 00	9. 00 10. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the prior cost reporting instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital closure  Adjusted rolling average FTE count  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instructional lines) and in the count over cap (see instructional lines) additional direct GME FTE Resident Count (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count over cap (see instructional lines) and in the count of the count	ise unt on line, 2022, or ent year rrent year g year (see porting by 3). rograms sure pospital  TE resident of ctions)	0.0 0.0 0.0 28.7 0.0 0.0 28.7 0.0 130,058.0 3,736,56	7. 11 7. 11 7. 11 7. 11 7. 11 90 90 10. 4. 35 32. 90 90 90 90 90 90 90 90 90 90 90 90 90 9	8, 581, 233 1. 00 0. 00 0. 00 0. 00	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00
16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Unweighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the prior cost reporting instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital closure  Adjusted rolling average FTE count  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instructional long and in the count over cap (see instructional long and instructional direct GME FTE Resident Count (see instructional long and instructional direct GME FTE Resident Count (see instructional long and instructional long direct GME FTE Resident Count (see instructional long and long long long and long long and long long long and long long long and long long long and long long long long long long long long	ise unt on line, 2022, or ent year rrent year g year (see porting by 3). rograms sure pospital  TE resident of ctions)	0.0 0.0 0.0 28.7 0.0 0.0 28.7 0.0 130,058.0 3,736,56	7. 11 7. 11 7. 11 7. 11 7. 11 90 90 10. 4. 35 32. 90 90 90 90 90 90 90 90 90 90 90 90 90 9	8, 581, 233 1. 00 0. 00 0. 00 0. 00	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00

	Financial Systems COMMUNITY MEDICA GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	AL CENTER Provider C	CN: 21 00//1	Period:	u of Form CMS-2 Worksheet E-4	2552-10
	L EDUCATION COSTS	Provider C	CN: 31-0041	From 01/01/2023	Worksneet E-4	
WILDICA	E EDUCATION COSTS			To 12/31/2023	Date/Time Prep 5/20/2024 2:39	
		Titl∈	XVIII	Hospi tal	PPS	
			Inpatient Pa	rt Managed Care	Total	
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I) 3.02, column 2)	X, line	51, 1:	21 35, 524		26. 00
27. 00	Total Inpatient Days (see instructions)		118, 50	57 118, 567		27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 4311!	0. 299611		28. 00
29.00	Program direct GME amount		3, 699, 8!	59 2, 571, 032	6, 270, 891	29. 00
29. 01	Percent reduction for MA DGME			3. 27		29. 01
30.00				84, 073	84, 073	30. 00
31. 00	Net Program direct GME amount				6, 186, 818	31.00
					1.00	
	DIDECT MEDICAL EDUCATION COSTS FOR ESDD COMPOSITE DATE. TITLE	- VVIII ONIV	/ (NUIDCLNC DD)	CDAM AND DADAME	1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)		`		JI CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32. 00	
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I			74 and 94)	0	33. 00
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line	33)		0.000000	34.00
35. 00	Medicare outpatient ESRD charges (see instructions)				0	
36. 00	Medicare outpatient ESRD direct medical education costs (line		15)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
07.00	Part A Reasonable Cost				404 000 5/4	07.00
37. 00	Reasonable cost (see instructions) Organ acquisition and HSCT acquisition costs (see instructions	-)			121, 802, 561	
38. 00 39. 00	Cost of physicians' services in a teaching hospital (see instructions				0	
40. 00	Primary payer payments (see instructions)	uctions)			0	40.00
	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)			121, 802, 561	
41.00	Part B Reasonable Cost	3 11110 40)			121,002,301	71.00
42. 00	Reasonable cost (see instructions)				59, 454, 492	42.00
43. 00	Primary payer payments (see instructions)				24, 630	
44. 00					59, 429, 862	
45.00	Total reasonable cost (sum of lines 41 and 44)				181, 232, 423	45. 00
	Ratio of Part A reasonable cost to total reasonable cost (line				0. 672079	46. 00
47. 00	Ratio of Part B reasonable cost to total reasonable cost (line		45)		0. 327921	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B				
	Total program GME payment (line 31)				6, 186, 818	
49. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				4, 158, 030	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instru	ıctı ons)		2, 028, 788	50.00

Heal th	Financial Systems COMMUNITY MEDI	CAL CENTER	In Lie	u of Form CMS-2	552-10
				Worksheet E-5	·
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/20/2024 2:35	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sun	n of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see inst	ructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instru	ıcti ons)		0	4.00
5.00	The rate used to calculate the time value of money (see inst	ructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions	s)		0	6.00
7.00	Time value of money for capital related expenses (see instru	ıcti ons)		0	7.00

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

Provider CCN: 31-0041 Period: From 01

oni y)					5/20/2024 2: 3	5 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4.00	
	CURRENT ASSETS		.1		_	
1.00	Cash on hand in banks	10, 025		0	0	
2.00	Temporary investments Notes receivable	0			0	
4. 00	Accounts receivable	61, 053, 558	1		0	
5. 00	Other recei vabl e	01,000,000		o o	Ö	
6.00	Allowances for uncollectible notes and accounts receivable	-11, 780, 343		0	0	
7.00	Inventory	9, 616, 197	' (	0	0	7. 00
8.00	Prepai d expenses	4, 256, 749		0	0	
9.00	Other current assets	16, 529, 004		1	0	
10.00	Due from other funds	258, 353, 813	l	0	0	1
11. 00	Total current assets (sum of lines 1-10)	338, 039, 003		0	0	11. 00
12. 00	FIXED ASSETS Land	198, 713		0	0	12. 00
13. 00	Land improvements	3, 070, 534			1	
14. 00	Accumulated depreciation	-2, 355, 661	1	o o		
15. 00	Bui I di ngs	318, 099, 740	1	o o	Ō	
16.00	Accumulated depreciation	-146, 974, 676		0	0	16. 00
17.00	Leasehold improvements	17, 860, 652	2	0	0	17. 00
18.00	Accumulated depreciation	-5, 606, 180	1	0	0	1
19. 00	Fi xed equipment	78, 755, 860	1	0	0	
20.00	Accumulated depreciation	-73, 561, 110	1	0	0	
21. 00 22. 00	Automobiles and trucks	0	1	0	0	
23. 00	Accumulated depreciation Major movable equipment	208, 109, 528	1		0	
24. 00	Accumulated depreciation	-122, 593, 221	1		0	
25. 00	Mi nor equi pment depreci abl e	0 122, 070, 221			Ö	
26.00	Accumul ated depreciation	O		0	0	1
27.00	HIT designated Assets	0	) (	0	0	27. 00
28. 00	Accumulated depreciation	0	) (	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0	1	0	0	
30. 00	Total fixed assets (sum of lines 12-29)	275, 004, 179	)  (	0	0	30.00
31. 00	OTHER ASSETS Investments	500		0	0	31.00
32. 00	Deposits on Leases	300			· -	
33. 00	Due from owners/officers	0	1		0	
34. 00	Other assets	36, 094, 761		o o	0	1
35.00	Total other assets (sum of lines 31-34)	36, 095, 261		0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	649, 138, 443	(	0	0	36.00
	CURRENT LIABILITIES			1	1	
37. 00	Accounts payable	19, 963, 553	1	0		1
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	18, 554, 000	1	0	0	
40. 00	Notes and Loans payable (short term)	976, 826			0	
41. 00	Deferred income	5, 307, 636			0	
42. 00	Accel erated payments	0,007,000			Ĭ	42. 00
43.00	Due to other funds	o		0	0	
44.00	Other current liabilities	26, 179, 753	(	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	70, 981, 768	3	0	0	45.00
	LONG TERM LIABILITIES	Г			T	
46. 00	Mortgage payable	0		٦	0	
47. 00 48. 00	Notes payable	0	1	0 0		1
49. 00	Unsecured Loans Other Long term Liabilities	170, 187, 773				
50.00	Total long term liabilities (sum of lines 46 thru 49)	170, 187, 773		-		1
51. 00	Total liabilities (sum of lines 45 and 50)	241, 169, 541		o o		
	CAPITAL ACCOUNTS		•			1
52.00	General fund balance	407, 968, 902	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	
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	407, 968, 902		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	649, 138, 443		o o	0	
	59)		1			

Provider CCN: 31-0041

					10 12/31/2023	5/20/2024 2:3	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		365, 156, 459		(	D	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2, 686, 124				2. 00
3.00	Total (sum of line 1 and line 2)		362, 470, 335		(		3. 00
4.00	OTHER CHANGES IN NET ASSETS	48, 835, 862			0	0	4. 00
5.00		0			0	0	
6.00		0			0	0	
7.00		0			0	0	
8. 00 9. 00					0	0	
10.00	Total additions (sum of line 4-9)	٩	48, 835, 862		9		10.00
11. 00	Subtotal (line 3 plus line 10)		411, 306, 197				11.00
12. 00	NON-OPERATING REVENUE	3, 337, 295	411, 300, 197		0	0	
13. 00	NOW OF EIGHT NO REVENUE	0, 337, 273			0	0	
14. 00					0	l ő	
15. 00		o			0	0	
16.00		o			0	0	16. 00
17. 00		o			0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		3, 337, 295		(		18. 00
19. 00	Fund balance at end of period per balance		407, 968, 902		(		19. 00
	sheet (line 11 minus line 18)	Fredering to Fred	DI	E d			
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8.00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	OTHER CHANGES IN NET ASSETS		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8. 00 9. 00			0				8. 00 9. 00
10.00	Total additions (sum of line 4-9)		U		0		10.00
11. 00	Subtotal (line 3 plus line 10)				0		11.00
12. 00	NON-OPERATING REVENUE	١	0				12.00
13. 00	NOW OF EIGHT NO REVENUE		0				13.00
14. 00			0				14. 00
15. 00			0				15. 00
16.00			0				16. 00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	o			0		18. 00
19. 00	Fund balance at end of period per balance	o			0		19. 00
	sheet (line 11 minus line 18)						

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

			0 12/31/2023	5/20/2024 2:3	
	Cost Center Description	Inpatient	Outpati ent	Total	J piii
	,	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	532, 184, 060	)	532, 184, 060	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		)	0	5. 00
6.00	Swing bed - NF		)	0	6. 00
7.00	SKILLED NURSING FACILITY	18, 119, 997	7	18, 119, 997	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	550, 304, 057	'	550, 304, 057	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	I NTENSI VE CARE UNIT	471, 365, 736		471, 365, 736	11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T	43, 935, 96		43, 935, 961	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)	545 004 (0		F45 004 (07	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	515, 301, 697	′	515, 301, 697	16. 00
17.00	11-15)	1 0/5 /05 75		1 0/5 /05 754	17 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	1, 065, 605, 754		1, 065, 605, 754	17. 00
18. 00 19. 00	Ancillary services	549, 733, 673		1, 159, 917, 228	18. 00 19. 00
	Outpatient services	162, 650, 022	289, 995, 498	452, 645, 520 0	
20.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER		-	· ·	20. 00 21. 00
21.00	HOME HEALTH AGENCY		)	0	22.00
23. 00	AMBULANCE SERVICES	,	0	0	23. 00
24. 00	CMHC	,	,	0	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, 777, 989, 449	900 179 053	2, 678, 168, 502	
20.00	G-3, line 1)		700/177/000	2,0,0,100,002	20.00
	PART II - OPERATING EXPENSES			l.	
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		524, 006, 180		29. 00
30.00	ADD (SPECIFY)				30. 00
31.00					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)		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)(trans	fer	524, 006, 180		43. 00
	to Wkst. G-3, line 4)	I			

Heal th	Financial Systems	COMMUNITY MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
	MENT OF REVENUES AND EXPENSES	Provider CCN: 31-0041	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/20/2024 2:3	
1.00	T. I. I. I. O. O. D. I.	1 0 11 00)		1.00	4.00
1.00	Total patient revenues (from Wkst. G-2, Part I			2, 678, 168, 502	1.00
2.00	Less contractual allowances and discounts on p	attents accounts		2, 165, 365, 615	1
3.00	Net patient revenues (line 1 minus line 2)	D+ 11 1: 42)		512, 802, 887	1
4. 00 5. 00	Less total operating expenses (from Wkst. G-2,			524, 006, 180	ł
5.00	Net income from service to patients (line 3 mi OTHER INCOME	nus irrie 4)		-11, 203, 293	5.00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8. 00	Revenues from telephone and other miscellaneou	s communication services		0	
9. 00	Revenue from television and radio service	is comman carron sor vices		0	ı
10. 00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and quest	S		0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supp	lies to other than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patie	ents		0	17. 00
18. 00	Revenue from sale of medical records and abstr	racts		0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, et	c.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and	canteen		0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
	OTHER OPERATING REVENUE			7, 166, 640	24. 00
24. 01	FEMA C-19			-222, 824	24. 01
24. 02	ER RETENTION TAX CREDIT			1, 573, 353	
	COVI D-19 PHE Funding			0	
25 00	T-+-1 -+b ! (£   ! ( 24)			0 517 1/0	25 00

8, 517, 169

-2, 686, 124 26. 00 0 27. 00

-2, 686, 124 29. 00

25.00

0 28.00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

	Financial Systems COMMU LATION OF CAPITAL PAYMENT	NITY MEDICAL CENTER Provider CCN: 31-0041	Peri od:	u of Form CMS-2 Worksheet L	2552-10
CALCUI	ATION OF CAPITAL PAYMENT	Provider CCN: 31-0041	From 01/01/2023 To 12/31/2023	Parts I-III Date/Time Pre 5/20/2024 2:3	
		Title XVIII	Hospi tal	PPS	э рііі
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			6, 852, 311	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			28, 608	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in t	the cost reporting period (see ins	tructi ons)	328. 19	3.00
4. 00	Number of interns & residents (see instructions)			65. 97	4.00
5.00	Indirect medical education percentage (see instruct	•		5. 83	5.00
6. 00	Indirect medical education adjustment (multiply lir 1.01) (see instructions)	,		399, 490	6. 00
7. 00	Percentage of SSI recipient patient days to Medicar 30) (see instructions)		E, part A line	2. 49	7.00
8. 00	Percentage of Medicaid patient days to total days (	(see instructions)		10. 47	8.00
9.00	Sum of lines 7 and 8			12. 96	9.00
10. 00 11. 00				2. 65 181, 586	
12. 00	Total prospective capital payments (see instruction			7, 461, 995	
12.00	Total prospective capital payments (see Tristi detroi	13)		7, 401, 773	12.00
				1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST	ati ana)		0	1 00
1. 00 2. 00	Program inpatient routine capital cost (see instruction of the cost (see instruction) Program inpatient ancillary capital cost (see instruction)			0	1. 00 2. 00
3.00	Total inpatient program capital cost (see First)	,		0	3.00
4. 00				0	4.00
5. 00	Total inpatient program capital cost (line 3 x line	2 4)		0	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 of			0	2.00
3.00	Net program inpatient capital costs (line 1 minus l	ine 2)		0	3.00
4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x l	ino (1)		0. 00 0	4. 00 5. 00
5. 00 6. 00	Percentage adjustment for extraordinary circumstance	,		0.00	6.00
7. 00	Adjustment to capital minimum payment level for ext	,	x line 6)	0.00	7.00
3. 00	Capital minimum payment level (line 5 plus line 7)	ruorarnary erroumstances (rrne 2	x Title 0)	0	8.00
9. 00	Current year capital payments (from Part I, line 12	2, as applicable)		0	9. 00
10. 00	Current year comparison of capital minimum payment	level to capital payments (line 8	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment le Worksheet L, Part III, line 14)	evel over capital payment (from pr	ior year	0	11. 00
12. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	12.00
13. 00	Current year exception payment (if line 12 is posit	·	,	0	13.00
14. 00	Carryover of accumulated capital minimum payment le		following period	0	14.00
	(if line 12 is negative, enter the amount on this I Current year allowable operating and capital paymer			0	15. 00
15 00				ı U	10.00
15. 00 16. 00				0	16. 00