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: 15-0113 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/24/2024 11:54 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/24/2024 Time: 11:54 am use only] Manually prepared cost report 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 HOSPITAL ANDERSON (15-0113) 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	Hol	ly Millard	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	Holly Millard			2
3	Signatory Title	SVP FINANCE			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	325, 026	-47, 539	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	325, 026	-47, 539	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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.

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0113 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:54 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1515 NORTH MADISON AVE 1.00 PO Box: 1.00 State: IN 2.00 City: ANDERSON Zip Code: 46011 County: MADISON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal COMMUNITY HOSPITAL 150113 26900 01/01/1966 Ν 3.00 ANDERSON Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Υ 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

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

0.00 62.00

0.00 62.01

63.00

Enter the number of FTE residents that your hospital trained in this cost reporting period for which

Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital

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)

your hospital received HRSA PCRE funding (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

during in this cost reporting period of HRSA THC program. (see instructions)

62.00

62.01

Heal th	Financial Systems	COMMUNI T	Y HOSPITAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi der CC		eriod: fom 01/01/2023 o 12/31/2023		pared:
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Yea			This base year	is your cost r	reporting	
64. 00	period that begins on or after of 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 you of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00		0. 000000	64.00
		Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
				Si te	nospi tai	4/)	
		1. 00	2.00	3. 00	4. 00	5. 00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 Ratio (col. 1/	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
	la	V 575 D		1.00	2. 00	3. 00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	sEffective fo	r cost reporti	ng periods	
66. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0. 16	0. 000000	66. 00
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
				Si te	nospi tai	4))	
		1.00	2.00	3. 00	4. 00	5. 00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 000000	67. 00

Ν

0 00

Ν

0.00

96.00

97.00

applicable column.

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

96.00

Health Financial Systems COMMUNITY HOSPI			In Lie		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	rom 01/01/2023 o 12/31/2023	Worksheet S-2 Part Date/Time Pro	
				5/24/2024 11:	
			V 1. 00	XI X 2. 00	-
98.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 1			Y	N N	98. 00
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reC, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			Υ	Υ	98. 01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Y	Y	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a criticely reimbursed 101% of inpatient services cost? Enter "Y" for years.			N	N	98. 03
	O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, a				
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a		Y	Υ	98. 05	
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column		Y	Υ	98. 06	
column 2 for title XIX. Rural Providers					-
105.00 Does this hospital qualify as a CAH?			N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of payment	N		106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do	n 1. (see ins	tructions)	N		107. 00
approved medical education program in the CAH's excluded IF					
Enter "Y" for yes or "N" for no in column 2. (see instructi 107.01 If this facility is a REH (line 3, column 4, is "12"), is in reimbursement for L&R training programs? Enter "Y" for yes o	t eligible for				107. 01
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108. 00
	Physi cal	Occupati onal	Speech	Respi ratory	_
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2.00 N	3. 00 N	4. 00 N	109. 00
Tot yes or it for no for each therapy.					
110 00 Did this bessitely asset is the Donel Community Heavity	-		104	1.00	110.00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	'Y" for yes or	"N" for no. I	f yes,	1.00 N	110. 00
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Wor	'Y" for yes or	"N" for no. I	f yes, gh 215, as	N	110. 00
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	'Y" for yes or rksheet E-2, I	"N" for no. I ines 200 throu	f yes,		
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	'Y" for yes or ksheet E-2, I the Frontier Cost reporting olumn 1 is Y, ticipating in	"N" for no. I ines 200 throu ommunity period? Enter enter the column 2.	f yes, gh 215, as	N	110. 00
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this comparts of the FCHIP demonstration for the comparts of the FCHIP demonstration for the comparts of the FCHIP demonstration for the following program of the following progr	'Y" for yes or ksheet E-2, I the Frontier Cost reporting olumn 1 is Y, ticipating in	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as	N 2. 00	
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Word applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the Formula of the FCHIP demonstration for the compared by the FCHIP demonstration for the participate in the FCHIP demonstration for the participate in the FCHIP demonstration for the participate in the FCHIP demonstration for the FCHIP demonstration prompts and for the FCHIP demonstration for the FCHIP demonstr	'Y" for yes or ksheet E-2, I the Frontier Cost reporting olumn 1 is Y, ticipating indditional beds	"N" for no. I ines 200 throu ommunity period? Enter enter the column 2.	f yes, gh 215, as	N	111.00
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the property of the FCHIP demonstration for this compared by the property of the FCHIP demonstration for the participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If compared by the participate in the date the hospital participate in the date the hospital comparticipate in the date the hospital comparticipate in the date the hospital comparticipation in the demonstration, if applicable.	'Y" for yes or rksheet E-2, I the Frontier Cost reporting olumn 1 is Y, rticipating in dditional beds th Model eporting olumn 1 is soating in the	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as	N 2. 00	
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Word applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the project of the response to compare the project of the	the Frontier Cost reporting of Jumn 1 is Y, rticipating in dditional beds th Model eporting of Jumn 1 is pating in the ased "N" for no 3, or E only) p3" percent (includes	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as	2. 00 3. 00	111.00
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Word applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the propose of the FCHIP demonstration for this compared by the formulation prong of the FCHIP demonstration which this CAH is participated in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If compared by the period? Enter "Y" for yes or "N" for no in column 1. If compared by the period of the demonstration in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter in column 3 either "Gor short term hospital or "98" percent for long term care posychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.	the Frontier Cost reporting olumn 1 is Y, rticipating in dditional beds th Model eporting olumn 1 is youth for most reporting of the eporting	"N" for no. I i nes 200 throu ommunity period? Enter enter the column 2.; and/or "C"	f yes, gh 215, as	2. 00 3. 00	111.00
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared in the Health Integration Project (FCHIP) demonstration for this compared in the FCHIP demoin which this CAH is participated in the FCHIP demoin which this CAH is participated in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If compared in the hospital began participated demonstration. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "Groshort term hospital or "98" percent for long term care of psychiatric, rehabilitation and long term hospitals provider	the Frontier Cost reporting olumn 1 is Y, rticipating in dditional beds the Model eporting olumn 1 is pating in the ased "N" for no 3, or E only) 23" percent (includes rs) based on for yes or	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as	2. 00 3. 00	111.00

117. 00 118. 00

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

118.00 s the malpractice 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 HOSPITA				u of Form CM	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NITEICATION DATA	Provider CC	N: 15-0113	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part I Date/Time P 5/24/2024 1	repared:
			Premi ums	Losses	Insurance	1. 54 aiii
			1.00	0.00	2.00	
118.01 List amounts of malpractice premiums ar	d paid losses:		1. 00 1, 304, 6	2. 00 03	3. 00	0118.01
				1.00	2.00	
118.02 Are mal practice premiums and paid losse	s reported in a cost co	enter other t	han the	1. 00 N	2. 00	118. 02
Administrative and General? If yes, su and amounts contained therein. 119.00D0 NOT USE THIS LINE	bmit supporting schedul	e listing co	st centers			119. 00
120.00 Is this a SCH or EACH that qualifies for §3121 and applicable amendments? (see i	nstructions) Enter in o	column 1, "Y"	for yes or		N	120. 00
"N" for no. Is this a rural hospital wi Hold Harmless provision in ACA §3121 ar Enter in column 2, "Y" for yes or "N" f	d applicable amendments					
121.00 Did this facility incur and report cost patients? Enter "Y" for yes or "N" for		table devices	charged to	Y		121. 00
122.00 Does the cost report contain healthcare Act?Enter "Y" for yes or "N" for no in				122. 00		
the Worksheet A line number where these 123.00 Did the facility and/or its subprovider services, e.g., legal, accounting, tax	s (if applicable) purch			N		123. 00
management/consulting services, from ar for yes or "N" for no.						
If column 1 is "Y", were the majority of professional services expenses, for ser						
located in a CBSA outside of the main h						
"N" for no. Certified Transplant Center Information	1					
125.00 Does this facility operate a Medicare-c	ertified transplant cer		Y" for yes	N		125. 00
and "N" for no. If yes, enter certifica 126.00 If this is a Medicare-certified kidney	transplant program, en		fication dat	е		126. 00
in column 1 and termination date, if and 127.00 If this is a Medicare-certified heart t	ransplant program, ente	er the certif	ication date			127. 00
in column 1 and termination date, if ap 128.00 If this is a Medicare-certified liver t	ransplant program, ente	er the certif	ication date			128. 00
in column 1 and termination date, if ap 129.00 If this is a Medicare-certified lung tr	ansplant program, ente	the certifi	cation date			129. 00
in column 1 and termination date, if and 130.00 If this is a Medicare-certified pancrea	s transplant program, e		ti fi cati on			130. 00
date in column 1 and termination date, 131.00 If this is a Medicare-certified intesti	nal transplant program,	enter the c	erti fi cati on			131. 00
date in column 1 and termination date, 132.00 If this is a Medicare-certified islet t in column 1 and termination date, if an	ransplant program, ente		ication date			132. 00
133.00 Removed and reserved	pricable, ili corumni 2.					133. 00
134.00 f this is a hospital-based organ procuin column 1 and termination date, if ap		PO), enter th	e OPO number	•		134. 00
All Providers 140.00 Are there any related organization or h	ome office costs as det	fined in CMS	Pub. 15-1,	Y	HB0720	140. 00
chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home						
1.00 If this facility is part of a chain ord	2.00	nes 141 throu	 ah 143 the r	3.00	of the	
home office and enter the home office of	contractor name and con		er.			
141.00 Name: COMMUNITY HEALTH NETWORK 142.00 Street: 1500 NORTH RITTER AVE	Contractor's Name: WPS PO Box:		Contract	or's Number: 0810)1	141. 00 142. 00
143.00 Ci ty: INDIANAPOLIS	State: IN		Zi p Code	: 4621	19	143. 00
					1.00	-
144.00 Are provider based physicians' costs in	cluded in Worksheet A?				Y	144. 00
				1. 00	2.00	
145.00 If costs for renal services are claimed inpatient services only? Enter "Y" for no, does the dialysis facility include	yes or "N" for no in co Medicare utilization fo	olumn 1. If c	olumn 1 is	Y		145. 00
period? Enter "Y" for yes or "N" for r 146.00 Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu	nged from the previous			N		146. 00
yes, enter the approval date (mm/dd/yyy		-z, Giaptei 4	.u, 34020) IT			

Health Financial Systems	COMMUNI TY	HOSPI TA	AL ANDERSON			In Lie	eu of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Ą	Provi der CC	Provider CCN: 15-0113			epared:	
							1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for yes	s or "N" for	no.			N 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 meth	od? Ente					N	149. 00
			Part A	Part		Title V	Title XIX	_
Dana this facility and in a manife	-l +l+ : £: £		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '								
155. 00 Hospi tal			N	N		N	N	155. 00
156.00 Subprovi der - IPF			N	N		N	N	156. 00
57.00 Subprovi der - IRF			N	N		N	N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF			N	N		N	N	159. 00
50. 00 HOME HEALTH AGENCY			N	N		N	N	160. 00
161. 00 CMHC				N		N	N	161. 00
							1.00	_
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that h	as one o	or more campu	ses in di	fferer	nt CBSAs?	N	165. 00
, , , , , , , , , , , , , , , , , , , ,	Name		County	State	Zip (Code CBSA	FTE/Campus	
	0		1. 00	2. 00	3. 0	00 4.00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	0 166. 00
							1.00	_
Health Information Technology (HI	() incentive in the A	meri can	Recovery and	l Reinvest	tment	Act	1.00	
167.00 Is this provider a meaningful user							Υ	167. 00
168.00 If this provider is a CAH (line 10				167 is "	Υ"), ε	enter the		168. 00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r				qual i fy	for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)	'Enter "Y" for yes o	r "N" fo	or no. (see i	nstructio	ns)		1	
169.00 If this provider is a meaningful utransition factor. (see instruction) and is	s not a CAH (line 105	is "N"	'), enter the	9.9	9169. 00
transition factor. (See Thistractive	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					Begi nni ng	Endi ng	
						1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	eginning date and en	ding da	te for the re	porti ng				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 µmn 1. If column 1 is	, Pt. I,	, line 2, col	. 6? Ente		N N		0 171. 00

Heal th	Financial Systems COMMUNITY HOSPI	TAL ANDERSON		In Li€	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0113	Peri od:	Worksheet S-2	
				From 01/01/2023 To 12/31/2023		epared:
				Y/N	5/24/2024 11:	54 am
				1.00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ente	er 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			N		1.00
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	Y/N) Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare Program and the program and the medicare Program and the medicare Program and the progra		N			2. 00
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	n 3, V TOF				
3.00	Is the provider involved in business transactions, including	g management	N			3.00
	contracts, with individuals or entities (e.g., chain home or					
	or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members or					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)		\/ /N	T	D-+-	-
			1.00	2. 00	Date 3.00	
	Financial Data and Reports		1.00	2.00	0.00	
4.00	Column 1: Were the financial statements prepared by a Certi		Y	А	03/28/2024	4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date available.					
	column 3. (see instructions) If no, see instructions.	irable III				
5.00	Are the cost report total expenses and total revenues differ		N			5. 00
	those on the filed financial statements? If yes, submit reco	onciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for a nursing program? Column : the legal operator of the program?	2: If yes, is	the provide	r N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in:	structions.		N		7. 00
8.00	Were nursing programs and/or allied health programs approved		ved during th			8. 00
0.00	cost reporting period? If yes, see instructions.	araduata madia	al advoction	N		0.00
9. 00	Are costs claimed for Interns and Residents in an approved a program in the current cost report? If yes, see instructions	•	ar education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated on		he current	N		10.00
11 00	cost reporting period? If yes, see instructions.	⁰ Din on Ann	royad	N		11 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	α κ τιι απ Αρμ	or oved	IN		11. 00
					Y/N	
	D-4 Dalut-				1. 00	-
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Υ	12. 00
	If line 12 is yes, did the provider's bad debt collection po			ost reporting	N N	13. 00
	period? If yes, submit copy.					1
14. 00	If line 12 is yes, were patient deductibles and/or coinsural instructions.	nce amounts wa	nived? If yes	, see	N	14. 00
	Bed Complement					
15. 00	Did total beds available change from the prior cost reporting				Y	15. 00
		Y/N	t A Date	Y/N	rt B 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? If either column 1 or 3 is yes, enter the paid-through	N		N		16. 00
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	04/11/2024	Y	04/11/2024	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)		1			
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N	1	N		18. 00
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N	1	N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.		ı	I	I	I

	Financial Systems COMMUNITY HOSPI TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	N: 15-0113	Peri od:	u of Form C Worksheet	
				From 01/01/2023 To 12/31/2023	Part II Date/Time	Prepared:
		Descri	nti on	Y/N	5/24/2024 Y/N	11:54 am
		0		1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	-		N	N	20.0
	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. 0
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HO	SPI TALS)		1.00	
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 0
3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ing the cost	N	23. 0		
24. 00	Were new leases and/or amendments to existing leases entered of the second of the seco	eporting period?	N	24. 0		
25. 00	Have there been new capitalized leases entered into during	the cost report	ing period?	'If yes, see	N	25. 0
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	e cost reportir	ng period? I	f yes, see	N	26. 0
27. 00	instructions. Has the provider's capitalization policy changed during the	cost reporting	period? If	ves. submit	N	27. 0
	copy. Interest Expense		рэн ээн н	, , , , , , , , , , , , , , , , , , ,		
8. 00	Were new Loans, mortgage agreements or Letters of credit en	N	28. 0			
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or I	N	29. 0			
0. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		lebt? If yes	s, see	N	30.0
1. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is: instructions.</pre>	suance of new o	lebt? If yes	s, see	N	31. 0
	Purchased Services					
2. 00	Have changes or new agreements occurred in patient care servarrangements with suppliers of services? If yes, see instruc		I through co	ontractual	N	32. C
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.		j to competi	tive bidding? If	N	33. 0
	Provi der-Based Physi ci ans					
4. 00	Were services furnished at the provider facility under an all f yes, see instructions.	rrangement with	ı provider-b	pased physicians?	N	34.0
5. 00	If line 34 is yes, were there new agreements or amended exignly physicians during the cost reporting period? If yes, see in:		s with the	provi der-based	N	35. 0
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Y/N	Date	
	Home Offi on Conta			1.00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			N		36. 0
	If line 36 is yes, has a home office cost statement been pro	epared by the h	nome office?			37. C
8. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off			- N		38. 0
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			s, N		39. (
0. 00	see instructions. If line 36 is yes, did the provider render services to the I	home office? I	f yes, see	N		40. 0
	instructions.					
		1. 0	00	2.	00	
11 00	Cost Report Preparer Contact Information	CILI DI EV		DI CHOD		4.0
11. 00	held by the cost report preparer in columns 1, 2, and 3,	SHI RLEY		BI SHOP		41. C
12. 00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	COMMUNITY HEALT	H NETWORK			42.0
	nter the employer/company name of the cost report COMMUNITY HEALTH NETWORK reparer. nter the telephone number and email address of the cost 317-355-4135 SBISHOP@ECOMMUNI					II.

Heal th	Financial Systems COMMUNITY HOSP	PITAL ANDERSON	In Lieu of Form CMS-2552-1			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0113	Peri od:	Worksheet S-2		
			From 01/01/2023 To 12/31/2023			
		3. 00				
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	NETWORK DIRECTOR OF			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.					
42. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost	NETWORK DIRECTOR OF			42. 00	

Health Financial Systems COMMUNIT Period: Worksheet S-3 Provider CCN: 15-0113

					rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre 5/24/2024 11:	
						I/P Days / O/P	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Visits / Trips Title V	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA		2.00	0.00	1.00	0.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	100	37, 149	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		100	37, 149	0.00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00	17	6, 205	0.00	0	8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43. 00				0	13.00
14. 00	Total (see instructions)		117	43, 354	0.00	0	14.00
15. 00	CAH visits					0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		117				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
22 00	Labor & dolivery days (see instructions)		0	0	il .		22 00

30.00

32.00 32.01 33.00 33. 01

0 34.00

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
34.00 Temporary Expansion COVID-19 PHE Acute Care

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/24/2024	11:54 am

						5/24/2024 11:	54 am
		I/P Days	/ O/P Visits	/ Trips	Full Time E	qui val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 710	677	19, 164			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	0 425	4 (40				2 00
2. 00 3. 00	HMO and other (see instructions)	8, 425 0	4, 640 0				2.00
	HMO I PF Subprovi der	0	O O				
4. 00 5. 00	HMO I RF Subprovi der	0	0	C			4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	٩	O O	(1		6.00
7. 00	Total Adults and Peds. (exclude observation	4 710	677	19, 164	1		7.00
7.00	beds) (see instructions)	4, 710	077	19, 104	•		7.00
8. 00	INTENSIVE CARE UNIT	1, 168	320	4, 135			8. 00
9. 00	CORONARY CARE UNIT	1, 100	320	4, 130	,		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		727	921			13. 00
14. 00	Total (see instructions)	5, 878	1, 724	24, 220	I I	872. 69	
15. 00	CAH visits	3, 3, 5	1, 724	24, 220	0.10	072.07	15. 00
15. 10	REH hours and visits	0	o	Č			15. 10
16. 00	SUBPROVIDER - I PF	١	Ĭ	_			16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			54			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	O	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0. 16	872. 69	27. 00
28. 00	Observation Bed Days		382	2, 011			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			153	3		30.00
31.00	Employee discount days - IRF			C			31. 00
32.00	Labor & delivery days (see instructions)	0	24	260			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	C)		34.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems COMMUNIT Provider CCN: 15-0113

				To	12/31/2023	Date/Time Prep 5/24/2024 11:	
		Full Time		Di sch	arges	0/21/2021 11.	o r aiii
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
	PART I - STATISTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 325	203	6, 217	1. 00
1.00	8 exclude Swing Bed, Observation Bed and		0	1, 323	203	0, 217	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1, 759	1, 190		2. 00
3.00	HMO IPF Subprovider				o		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	1, 325	203	6, 217	14. 00
15. 00	CAH visits	0.00	O	1, 020	200	0, 217	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)						24. 00 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
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care						33. 01 34. 00
34.00	Tremporary Expansion Covid-19 Pric Acute Care			l l	l		34.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | To 12/31/20

					11	0 12/31/2023	Date/lime Pre 5/24/2024 11:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	A-6) 3. 00	3) 4.00	col . 4 5.00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3. 00	0.00	
1 00	SALARI ES	200. 00	71 020 0/2	275 045	71 445 040	1 015 107 00	20.24	1.00
1.00	Total salaries (see instructions)	200.00	71, 820, 063	-375, 015 0				
2.00	Non-physician anesthetist Part		0	0	0	0.00		
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00		3. 00
4. 00	Physician-Part A - Administrative		124, 189	0	124, 189	832. 00	149. 27	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 572, 609	0	572, 609	0. 00 9, 485. 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	21. 00	0	0	0	0.00	0.00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
8.00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9.00	SNF	44. 00	72/ /70	0	725 010	0. 00 19. 062. 00	l	
10. 00	Excluded area salaries (see instructions)		726, 679	-860	725, 819	19, 062. 00	38. 08	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient Care		2, 100, 925	0	2, 100, 925	16, 333. 00	128. 63	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		390, 438	0	390, 438	3, 221. 00	121. 22	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A		12, 569, 597 0 0	0 0 0	0	287, 132. 00 0. 00 0. 00	0.00	1
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 Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		18, 835, 729	0	18, 835, 729			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		199, 458	0	199, 458			19. 00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21. 00	Non-physician anesthetist Part B		0	0				21.00
22. 00	Physician Part A - Administrative		11, 100	0	11, 100			22. 00
22. 01 23. 00 24. 00 25. 00	Physician Part A - Teaching Physician Part B Wage-related costs (RHC/FOHC) Interns & residents (in an		0 114, 871 0 0	0 0 0 0	0 114, 871 0			22. 01 23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		3, 557, 537	_				25. 50
25. 50	(core) Related organization		0, 337, 337		, , , , , ,			25. 50
25. 52	wage-related (core) Home office: Physician Part A		0) 				25. 51
20. 02	- Administrative - wage-related (core)		O					25.52

					T	o 12/31/2023	Date/Time Pre	
							5/24/2024 11:	
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	50, 116		50, 116			26. 00
27. 00	Administrative & General	5. 00	7, 336, 474	-98, 120		·		
28. 00	Administrative & General under		2, 964, 144	0	2, 964, 144	21, 921. 00	135. 22	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	1, 886, 221	-6, 523	1, 879, 698	·		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	2, 199, 522	0	2, 199, 522	96, 066. 00	22. 90	32. 00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	1, 769, 683	-1, 211, 144	558, 539	24, 010. 00	23. 26	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	44, 574	1, 195, 801	1, 240, 375	53, 453. 00		36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37.00
38.00	Nursing Administration	13. 00	1, 719, 710	-119	1, 719, 591	51, 588. 00	33. 33	38. 00
39.00	Central Services and Supply	14. 00	446, 901	-1, 567	445, 334	17, 502. 00	25. 44	39. 00
40.00	Pharmacy	15. 00	2, 948, 188	-3, 692	2, 944, 496	59, 308. 00	49. 65	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41. 00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00
	•							

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

					'	0 12/31/2023	5/24/2024 11:	
		Worksheet A	Amount	Reclassi 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		74, 211, 598	-375, 015	73, 836, 583	1, 827, 633. 00	40. 40	1. 00
	instructions)							
2.00	Excluded area salaries (see		726, 679	-860	725, 819	19, 062. 00	38. 08	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		73, 484, 919	-374, 155	73, 110, 764	1, 808, 571. 00	40. 42	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		15, 060, 960	0	15, 060, 960	306, 686. 00	49. 11	4. 00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		22, 404, 366	0	22, 404, 366	0.00	30. 64	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		110, 950, 245					
7.00	Total overhead cost (see		21, 365, 533	-125, 364	21, 240, 169	566, 961. 00	37. 46	7. 00
	instructions)							

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0113	Peri od:	Worksheet S-3
		From 01/01/2023	
		T- 10/01/0000	D-+- /T! D

	To 12/31/2023	Date/Time Prep 5/24/2024 11:5	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	2, 893, 338	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	o	6. 00
7.00	Employee Managed Care Program Administration Fees	o	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	o	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	7, 860, 959	8. 02
8. 03	Health Insurance (Purchased)	0	1
9.00	Prescription Drug Plan	1, 949, 092	9. 00
10.00	Dental, Hearing and Vision Plan	66, 920	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	33, 114	11. 00
	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	875, 902	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		256, 993	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		1
	TAXES		1
17.00	FICA-Employers Portion Only	5, 274, 347	17. 00
18.00	Medicare Taxes - Employers Portion Only	O	18. 00
19. 00	Unemployment Insurance	-51, 508	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
22. 00	Day Care Cost and Allowances	o	22. 00
23.00	Tuition Reimbursement	2, 000	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	19, 161, 157	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
	•	'	

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		From 01/01/2023	Worksheet S-3 Part V Date/Time Prepared:

		0 12/31/2023	5/24/2024 11:	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2, 100, 925	19, 161, 157	1.00
2.00	Hospi tal	2, 100, 925	18, 961, 699	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6.00
7. 00	Swing Beds - NF	0	0	7. 00
8. 00	SKILLED NURSING FACILITY			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	0	0	17.00
18. 00	Other	0	199, 458	18.00

Heal th	Financial Systems	COMMUNITY HOSPITAL	ANDERSON		In Lie	eu of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der CC		Period: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II	0 pared:
						1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA	Λ				1. 00	
	Uncompensated and Indigent Care Cost-to-Ch						1
	Cost to charge ratio (see instructions)	ar ge natro				0, 204216	1.00
	Medicaid (see instructions for each line)					0.20.210	1 55
2.00	Net revenue from Medicaid					47, 766, 293	2.00
3.00	Did you receive DSH or supplemental paymen	ts from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all		ital payments	from Medica	i d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or sup	plemental payments f	rom Medicaio	ł		-3, 024, 697	5.00
6.00	Medicaid charges					188, 824, 918	6.00
	Medicaid cost (line 1 times line 6)					38, 561, 069	7. 00
	Difference between net revenue and costs f					0	8. 00
	Children's Health Insurance Program (CHIP)	(see instructions f	or each line	e)			
	Net revenue from stand-alone CHIP					0	
	Stand-alone CHIP charges						
	Stand-alone CHIP cost (line 1 times line 1		(!+·-			0	
	Difference between net revenue and costs f Other state or local government indigent control					0	12.00
	Net revenue from state or local indigent c				`	0	13.00
14. 00	Charges for patients covered under state o					0	
14.00	10)	r rocar rhargerr car	c program (iot Therauca	111 111103 0 01		14.00
15. 00	State or local indigent care program cost	(line 1 times line 1	4)			0	15. 00
	Difference between net revenue and costs f			program (see	instructions)	0	16.00
	Grants, donations and total unreimbursed coinstructions for each line)	ost for Medicaid, CH	IP and state	e/Local indig		ns (see	
	Private grants, donations, or endowment in					0	
	Government grants, appropriations or trans					21, 284	
19. 00	Total unreimbursed cost for Medicaid , CHI 8, 12 and 16)	P and state and loca	ıl indigent d		,	0	19. 00
				Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col . 2)	
		6 l' \		1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions		. 1	2 011 57	0 1 007 440	F (20 012	20.00
	Charity care charges and uninsured discoun Cost of patients approved for charity care			3, 811, 57 778, 38			
∠ 1. UU	instructions)	and unitiouted disco	uiits (See	118, 38	1, 539, 239	2,317,023	21.00
22. 00		s previously writter	off as		0 0	0	22. 00
23 00	Cost of charity care (see instructions)			778, 38	4 1, 539, 239	2, 317, 623	23 00
23.00	1005t or oriently care (300 mistractions)		I	770, 30	1, 007, 207	2, 317, 023	23.00

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit 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 | Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

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

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

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

1.00

24.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

0 25.00

360, 907

95, 129

146, 353

8, 959, 845

1, 880, 968

4, 198, 591

4, 198, 591 31. 00

9, 106, 198

25.00

25. 01

27.00

27.01

28.00

stay limit

	Financial Systems	COMMUNITY HOSPITAL			In Lie	u of Form CMS-2	2552-10
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der CO	CN: 15-0113	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Pre 5/24/2024 11:	pared:
						1. 00	
	PART II - HOSPITAL DATA						
	Uncompensated and Indigent Care Cost-to-Cha	arge Ratio					
. 00	Cost to charge ratio (see instructions)					0. 204216	1.00
	Medicaid (see instructions for each line)						
2. 00	Net revenue from Medicaid						2.00
3. 00	Did you receive DSH or supplemental payment						3.00
. 00	If line 3 is yes, does line 2 include all [ai d?		4.00
. 00	If line 4 is no, then enter DSH and/or supp	olemental payments fr	om Medicai	d			5.00
. 00	Medicaid charges						6.00
. 00	Medicaid cost (line 1 times line 6)						7.0
3. 00	Difference between net revenue and costs for						8.00
	Children's Health Insurance Program (CHIP)	(see instructions fo	<u>or each lin</u>	e)			
. 00	Net revenue from stand-alone CHIP						9.00
	Stand-alone CHIP charges						10.0
	Stand-alone CHIP cost (line 1 times line 10)						11.00
2. 00	Difference between net revenue and costs for stand-alone CHIP (see instructions)						12.00
0 00	Other state or local government indigent care program (see instructions for each line) Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)						40.00
3.00							13.00
4. 00	Charges for patients covered under state or 10)	r rocar indigent care	e program (Not included	in lines 6 or		14.00
E 00	State or local indigent care program cost ((line 1 times line 1/	1)				15. 00
	Difference between net revenue and costs for			program (so	instructions)		16. 0
0.00	Grants, donations and total unreimbursed co					ne (eno	10.00
	instructions for each line)	ost for medicard, cili	r anu stat	e/Tocal Thurg	jent care program	15 (566	
7 00	Private grants, donations, or endowment inc	come restricted to fi	ındi na char	ity care			17. 0
8. 00	Government grants, appropriations or transf		9	,			18.00
9. 00					s (sum of lines		19.0
	8, 12 and 16)		9	p9	(
				Uni nsured	Insured	Total (col. 1	
				pati ents	pati ents	+ col. 2)	
				1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions f						
	Charity care charges and uninsured discount	,		3, 811, 5			
1. 00		and uninsured discou	ınts (see	778, 38	1, 539, 239	2, 317, 623	21.00
	instructions)						
2. 00	Payments received from patients for amounts	s previously written	off as		0 0	0	22. 0
0 00	charity care			=====	4 500 5	0.017.17	00.5
3.00	Cost of charity care (see instructions)			778, 38	1, 539, 239	2, 317, 623	23.00
						1.00	
						1. 00	

24.00

25.01

26.00

27. 00

27.01

28.00

29.00

30.00

0 25.00

360, 907

95, 129

146, 353

8, 959, 845

1, 880, 968

4, 198, 591

4, 198, 591 31. 00

9, 106, 198

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit 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

25.00

25. 01

27.01

28.00

stay limit

Health Financial Systems	COMMUNITY HOSPITA	L ANDERSON		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN	N: 15-0113 P	eri od:	Worksheet A	
				rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/24/2024 11:	pared:
Cost Center Description	Sal ari es	Other -		Reclassi fi cati	Reclassi fied	34 4111
			+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
	1.00	0.00	2.00	4.00	col . 4)	
GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT		0	C	2, 919, 868	2, 919, 868	1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP		ō	C		6, 263, 909	1
3.00 00300 OTHER CAP REL COSTS		О	C	0	0	1
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	50, 116	30, 019	80, 135	-720	79, 415	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	7, 336, 474	74, 978, 166	82, 314, 640	-755, 950	81, 558, 690	5. 00
6.00 00600 MAINTENANCE & REPAIRS	0	0	C	0	0	
7.00 O0700 OPERATION OF PLANT	1, 886, 221	4, 889, 243	6, 775, 464		5, 513, 443	
8. 00 00800 LAUNDRY & LINEN SERVICE	0 100 533	553, 108	553, 108		0	
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	2, 199, 522	1, 145, 271	3, 344, 793		3, 421, 739 1, 077, 277	
11. 00 01100 CAFETERI A	1, 769, 683 44, 574	1, 879, 515 64, 467	3, 649, 198 109, 041		2, 440, 507	1
12. 00 01200 MAINTENANCE OF PERSONNEL	44, 374	04, 407	107, 041	l	2, 440, 307	1
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 719, 710	614, 876	2, 334, 586	-128, 914	2, 205, 672	
14. 00 01400 CENTRAL SERVICES & SUPPLY	446, 901	242, 638	689, 539		579, 886	1
15. 00 01500 PHARMACY	2, 948, 188	8, 494, 339	11, 442, 527	-7, 522, 658	3, 919, 869	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	20, 777	20, 777	0	20, 777	16. 00
17. 00 01700 SOCIAL SERVICE	0	0	C	0	0	
19. 00 O1900 NONPHYSI CI AN ANESTHETI STS	0	0	C	0	0	
20. 00 02000 NURSI NG PROGRAM	0	0	C	0	0	
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	Ü	0	0	
22. 00 02200 1 &R SERVI CES-OTHER PRGM. COSTS APPRVE	1	U O	0		0	
23. 00 02300 PARAMED ED PRGM-(EMS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	U		ol Ol	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	15, 643, 395	7, 189, 124	22, 832, 519	-3, 436, 156	19, 396, 363	30.00
31. 00 03100 I NTENSI VE CARE UNIT	4, 716, 495	1, 913, 154	6, 629, 649		6, 191, 440	1
43. 00 04300 NURSERY	0	0	0,02,,01,	l	1, 552, 121	1
ANCILLARY SERVICE COST CENTERS				, , , , , ,	, , , ,	
50. 00 05000 OPERATING ROOM	8, 092, 489	23, 891, 362	31, 983, 851	-14, 641, 970	17, 341, 881	50.00
51. 00 05100 RECOVERY ROOM	0	0	C	1	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	1, 423, 344	1, 423, 344	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 974, 857	1, 395, 757	3, 370, 614		2, 667, 168	
54. 01 05401 ULTRASOUND	602, 907	224, 646	827, 553		855, 762	1
56. 00 05600 RADI 01 SOTOPE	339, 123	462, 960	802, 083		539, 556	1
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	757, 208 622, 192	861, 905 1, 323, 311	1, 619, 113 1, 945, 503		1, 553, 354 1, 476, 571	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	808, 168	1, 819, 525	2, 627, 693		1, 476, 371	1
60. 00 06000 LABORATORY	2, 618, 636	5, 326, 445	7, 945, 081		7, 662, 500	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	218, 188	628, 354	846, 542		843, 595	1
64. 00 06400 I NTRAVENOUS THERAPY	0	0	C	0	0	1
65. 00 06500 RESPIRATORY THERAPY	2, 246, 486	877, 028	3, 123, 514	-175, 918	2, 947, 596	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 332, 999	1, 965, 430	5, 298, 429		3, 665, 961	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	000,,,0		
68. 00 06800 SPEECH PATHOLOGY	0	0	C	259, 353	259, 353	
69. 00 06900 ELECTROCARDI OLOGY	1, 203, 785	544, 224	1, 748, 009		1, 615, 979	
70. 00 07000 ELECTROENCEPHALOGRAPHY	587, 756	437, 269	1, 025, 025		999, 043	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	7, 375, 798 8, 734, 562	7, 375, 798 8, 734, 562	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	3, 017	3, 017		7, 588, 518	
74. 00 07400 RENAL DIALYSIS		434, 270	434, 270		426, 861	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	o	0	0.7276	0	0	1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	o	ő	C	ol ol	0	
OUTPATIENT SERVICE COST CENTERS]
90. 00 09000 CLI NI C	0	0	C	0	0	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	674, 178	1, 414, 271	2, 088, 449		1, 896, 066	1
90. 02 09002 CTR ADVANCED HEART CARE	374, 161	132, 061	506, 222		506, 299	
90. 03 09003 RADIATION ONCOLOGY	1, 945, 135	3, 067, 786	5, 012, 921		4, 100, 081	1
90. 04 09004 DI ABETI C PLUS CLI NI C	395, 909	99, 301	495, 210		493, 105	1
90. 05 09005 ANTI COAGULATI ON CLINI C	355, 317	110, 224	465, 541	I I	465, 541	1
90. 06 09006 MAB 3611 REED	0 F 102 (11	2, 086	2, 086		7 202 440	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 182, 611	2, 199, 958	7, 382, 569	-179, 120	7, 203, 449	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						1 /2.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 71, 093, 384	149, 235, 887	220, 329, 271	1, 240, 678	221, 569, 949	118. 00
NONREI MBURSABLE COST CENTERS						1
					0	190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	U	· ·	ا ا		1
190.00	617, 062	551, 791	1, 168, 853		788, 807	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 WELLNESS CENTERS 190.02 19002 MONTI CELLO HSE.	617, 062 0	51, 807	51, 807	-31, 875	788, 807 19, 932	190. 02
190.00	617, 062			-31, 875 -22, 874	788, 807 19, 932 151, 505	190. 02

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 01/01/2023	D-+- /T: D	
				Го 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: <u>54 am</u>
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	2, 305, 889	2, 305, 889	-778, 340	1, 527, 549	192. 00
192.01 19201 MUNCIE MD OFFICES	0	37, 697	37, 69	-23, 828	13, 869	192. 01
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	6, 227	6, 22	-3, 715	2, 512	192. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	71, 820, 063	152, 254, 196	224, 074, 259	9 0	224, 074, 259	200. 00

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/24/2024 11:54 am

				5/24/2024 11:	54 am_
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT	0	2, 919, 868		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	4, 114, 065			2. 00
3. 00	00300 OTHER CAP REL COSTS	0			3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 615, 966	l		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-50, 962, 887	30, 595, 803		5. 00
6. 00	00600 MAINTENANCE & REPAIRS	00,702,007	0		6. 00
7. 00	00700 OPERATION OF PLANT	Ö	5, 513, 443		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0		8. 00
9. 00	00900 HOUSEKEEPI NG	0	3, 421, 739		9. 00
10. 00	01000 DI ETARY	0	1, 077, 277		10.00
11. 00	01100 CAFETERI A	-1, 115, 811	1, 324, 696		11. 00
	01200 MAINTENANCE OF PERSONNEL	0	0		12. 00
	01300 NURSING ADMINISTRATION	1, 516, 689	3, 722, 361		13. 00
	01400 CENTRAL SERVICES & SUPPLY	472, 494	1, 052, 380		14.00
	01500 PHARMACY	0	3, 919, 869		15. 00
	01600 MEDICAL RECORDS & LIBRARY	1, 068, 520	1		16. 00
	01700 SOCIAL SERVICE	0	l ol		17. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	l ol		19. 00
	02000 NURSI NG PROGRAM	0	l ol		20.00
	02100 I&R SERVICES-SALARY & FRINGES APPRVD	14, 234	14, 234		21.00
22.00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	33, 648	33, 648		22. 00
	02300 PARAMED ED PRGM-(EMS)	0	l		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>	'		
30.00	03000 ADULTS & PEDIATRICS	-668, 419	18, 727, 944		30.00
31.00	03100 INTENSIVE CARE UNIT	-761	6, 190, 679		31. 00
43.00	04300 NURSERY	0	1, 552, 121		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-3, 524, 739	13, 817, 142		50.00
51.00	05100 RECOVERY ROOM	0	l ol		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 423, 344		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	101, 959	2, 769, 127		54. 00
54.01	05401 ULTRASOUND	0	855, 762		54. 01
56.00	05600 RADI 0I S0T0PE	0	539, 556		56. 00
57.00	05700 CT SCAN	0	1, 553, 354		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 476, 571		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	1, 280, 232		59. 00
60.00	06000 LABORATORY	-1, 620	7, 660, 880		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	843, 595		62.00
64.00	06400 I NTRAVENOUS THERAPY	0	o		64. 00
65.00	06500 RESPI RATORY THERAPY	-3, 260	2, 944, 336		65. 00
66.00	06600 PHYSI CAL THERAPY	-61	3, 665, 900		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	506, 798		67. 00
68.00	06800 SPEECH PATHOLOGY	0	259, 353		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 615, 979		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	999, 043		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7, 375, 798		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8, 734, 562		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 588, 518		73. 00
74.00	07400 RENAL DIALYSIS	0	426, 861		74.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	0	0		90. 00
	09001 WOUND/OSTOMY CLINIC	0	1, 896, 066		90. 01
	09002 CTR ADVANCED HEART CARE	-311, 809	1		90. 02
	09003 RADIATION ONCOLOGY	-574, 624	3, 525, 457		90. 03
90. 04	09004 DIABETIC PLUS CLINIC	0	493, 105		90. 04
90. 05	09005 ANTI COAGULATI ON CLI NI C	0	465, 541		90. 05
90.06	09006 MAB 3611 REED	0	0		90. 06
91.00	09100 EMERGENCY	154, 445	7, 357, 894		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		102. 00
	SPECIAL PURPOSE COST CENTERS				
118. 00	, ,	-47, 071, 971	174, 497, 978		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19001 WELLNESS CENTERS	0			190. 01
190. 02	19002 MONTI CELLO HSE.	0	19, 932		190. 02
190. 03	19003 ROCK STEADY BOXING	0	151, 505		190. 03
	19004 DI ABETES MD	0	136		190. 04
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 527, 549		192. 00
192. 01	19201 MUNCIE MD OFFICES	0	13, 869		192. 01

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lieu	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	CN: 15-0113	Peri od: From 01/01/2023	Worksheet A	
					Date/Time Pre 5/24/2024 11:	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For Allocation				
	6.00	7.00				
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	2, 512				192. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	-47, 071, 971	177, 002, 288				200. 00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 11:54 am

		1			5/24/2024 11:	34 alli
		Increases		0.11		
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
	A - Chargeable Medical Suppli					
	ADMINISTRATIVE & GENERAL	5. 00	0			1. 00
2. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	7, 375, 798		2. 00
	PATI ENTS		_	_		
	HOUSEKEEPI NG	9.00	0			3. 00
	DI ETARY	10.00	0			4. 00
	NURSING ADMINISTRATION	13. 00	0	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	0		6. 00
7.00	PHARMACY	15. 00	0	0		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	0		8. 00
9.00	INTENSIVE CARE UNIT	31.00	0	0		9. 00
	OPERATING ROOM	50.00	0	0		10.00
	RADI OLOGY-DI AGNOSTI C	54.00	0	- 1		11. 00
	MAGNETIC RESONANCE I MAGING	58.00	0			12. 00
12.00	(MRI)	30.00	0	o o		12.00
13. 00	CARDIAC CATHETERIZATION	59.00	0	o		13. 00
	LABORATORY	60.00	0			14. 00
	RESPIRATORY THERAPY	65.00	0	- 1		15. 00
	1		0			
	PHYSI CAL THERAPY	66.00		- 1		16.00
	ELECTROCARDI OLOGY	69.00	0			17. 00
	ELECTROENCEPHALOGRAPHY	70.00	0	0		18. 00
	RADIATION ONCOLOGY	90. 03	0	0		19. 00
	EMERGENCY	91.00	0	0		20. 00
21. 00	WELLNESS CENTERS	190. 01	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24.00		0.00	0	0		24. 00
25. 00		0.00	0			25. 00
20.00	TOTALS — — — —	— — 	— — <u> </u>			1
	B - Implantable Device Reclas	L L		7,373,770		
1.00	IMPL. DEV. CHARGED TO	72.00	0	8, 734, 562		1.00
	PATIENTS	72.00	U	0, 734, 302		1.00
2.00	FATILITS	0.00	0	o		2. 00
		l I				1
3. 00	TOTAL C — — — —	0.00	0			3. 00
	TOTALS		0	8, 734, 562		ł
4 00	C - Drugs Charges to Pat	70.00		7 505 504		4 00
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0			1. 00
2.00		0.00	0			2. 00
3. 00		0.00	0			3. 00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	o		8. 00
9. 00		0.00	0	- 1		9. 00
10. 00		0.00	0	Ŏ		10.00
11. 00		0.00	0	0		11.00
12. 00		0.00	0	0		12.00
			0			
13.00		0.00		Ŭ		13.00
14.00		0.00	0			14.00
15. 00		0.00	0			15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21.00		0.00	0	0		21. 00
22.00		0.00	0	0		22. 00
	TOTALS — — — —		_ _ _ 0			1
	D - Depreciation Expense		-			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6, 770, 795		1. 00
2. 00		0.00	0			2. 00
3. 00		0.00	0			3. 00
		0.00	0			4. 00
4.00						
5.00		0.00	0			5. 00
6.00		0.00	0			6. 00
7.00		0.00	0	- 1		7. 00
8.00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0			14.00
					'	

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2023 To 12/31/2023 Provider CCN: 15-0113 Date/Time Prepared: 5/24/2024 11: 54 am

		·			5/24/2024 11	. 34 alli
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
45.00	2.00		4.00		,	15.00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
			0	1		1
18. 00		0.00	0			18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	i i		21. 00
			0	1		4
22.00		0.00	0	0		22. 00
23.00		0.00	0	0		23. 00
24.00		0.00	0	0		24. 00
		l I	0	1		4
25. 00		0.00				25. 00
26. 00		0.00	0	0		26. 00
27.00		0.00	0	0		27. 00
28.00		0.00	0	i		28. 00
			-	1		
29. 00		0.00	0	_		29. 00
30. 00		0.00	0	0		30. 00
31.00		0.00	0	ol ol		31.00
32.00		0.00	0	o		32. 00
			0			1
33. 00		0.00	Ü	y o		33. 00
34.00		0.00	0	0		34. 00
35.00		0.00	0	0		35. 00
	TOTALS — — — — —		— — — _ō	6, 770, 795		
			0	0,770,793		-
	F - Other Capital Rental					4
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 267, 192		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	l e		2. 00
3.00	SERVINGE SERVINGES & SOFTER	0.00				1
		l I	0			3. 00
4. 00		0.00	0	0		4. 00
5.00		0.00	0	ol ol		5. 00
6.00		0.00	0	o		6. 00
						1
7. 00		0.00	0	_		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	0			10.00
						1
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13. 00
			0	l .		1
14. 00		0.00	Ü	0		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0			17. 00
			0			
18. 00	<u> </u>		0	<u> </u>		18. 00
	TOTALS		0	2, 267, 259		
	G - STD BENEFIT RECLASS					
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	98, 120		1.00
						1
2.00	OPERATION OF PLANT	7.00	0			2. 00
3.00	OCCUPATI ONAL THERAPY	67. 00	0	21, 953		3. 00
4.00	SPEECH PATHOLOGY	68. 00	0	15, 343		4. 00
5. 00	NURSING ADMINISTRATION	13.00	0			5. 00
			0	117		
6.00	CENTRAL SERVICES & SUPPLY	14. 00	0	1, 567		6. 00
7. 00	PHARMACY	15. 00	0	3, 692		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	75, 508		8. 00
9. 00	INTENSIVE CARE UNIT	31.00	0	1		9. 00
			0	1		1
10. 00	OPERATING ROOM	50.00	0	62, 301		10. 00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	4, 069		11. 00
12.00	MAGNETIC RESONANCE IMAGING	58.00	0	1, 705		12. 00
	(MRI)	55.50	O	., . 33		-: 55
12 00		E0 00	^	101		12 00
13. 00	CARDI AC CATHETERI ZATI ON	59.00	0			13. 00
14. 00	LABORATORY	60.00	0	.,		14. 00
15.00	RESPIRATORY THERAPY	65.00	0	8, 288		15. 00
16. 00	PHYSI CAL THERAPY	66.00	0	24, 195		16. 00
			0			
17. 00	ELECTROCARDI OLOGY	69. 00	0	,		17. 00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	4, 181		18. 00
19.00	RADIATION ONCOLOGY	90. 03	0	1		19. 00
20. 00	EMERGENCY	91.00	0	1		20.00
			-			
21. 00	WELLNESS CENTERS	<u> </u>	0			21. 00
	TOTALS	<u> </u>	0	375, 015		
	H - Therapy Reclass					1
1 00		(7.00	272 427			1 1 00
1. 00	OCCUPATI ONAL THERAPY	67.00	373, 436			1.00
2.00	SPEECH PATHOLOGY	68. 00	187, 941	0		2. 00
3.00	OCCUPATIONAL THERAPY	67.00	0	111, 409		3. 00
4. 00	SPEECH PATHOLOGY	68.00	- -	56, 069		4. 00
4.00	TOTALS		<u></u> 561, 377			7.00
	LIVINES	ı I	301, 377	107,478		1

					10	12/31/2023	Date/lime Prepared: 5/24/2024 11:54 am
		Increases					37 2 17 202 1 11. 0 1 dill
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4. 00	5. 00			
	I - Labor and Delivery						
1.00	NURSERY	43.00	907, 295	0			1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	832, 018	0			2. 00
3.00	NURSERY	43.00	0	644, 826			3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	О	591, 326			4. 00
	TOTALS		1, 739, 313	1, 236, 152			
	J - Cafeteria						
1.00	CAFETERI A	11. 00	1, 195, 801	0			1.00
2.00	CAFETERI A	11. 00	o	1, 135, 665			2. 00
	TOTALS		1, 195, 801	1, 135, 665			
	K - Building Depreciation						
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	2, 774, 078			1. 00
	TOTALS			2, 774, 078			
	L - Capital Insurance Costs		·				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	145, 790			1.00
	TOTALS			145, 790			
	M - Radiology Support Staff						
1.00	ULTRASOUND	54. 01	34, 684	0			1.00
2.00	RADI OI SOTOPE	56.00	28, 122	0			2. 00
3.00	CT SCAN	57.00	174, 981	0			3. 00
4.00	MAGNETIC RESONANCE IMAGING	58. 00	49, 250	0			4. 00
	(MRI)						
5.00	ULTRASOUND	54. 01	0	10, 943			5. 00
6.00	RADI OI SOTOPE	56.00	0	8, 872			6. 00
7.00	CT SCAN	57. 00	0	55, 207			7. 00
8. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	15, 539			8. 00
	(MRI)						
	TOTALS		287, 037	90, 561			
	N - LINEN RECLASS						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 504			1.00
2.00	OPERATION OF PLANT	7. 00	0	8, 681			2. 00
3.00	HOUSEKEEPI NG	9. 00	0	89, 223			3. 00
4.00	DI ETARY	10. 00	0	1, 895			4. 00
5.00	CENTRAL SERVICES & SUPPLY	14. 00	0	2, 803			5. 00
6.00	ADULTS & PEDIATRICS	30. 00	0	141, 772			6. 00
7. 00	INTENSIVE CARE UNIT	31. 00	0	32, 658			7. 00
8.00	OPERATING ROOM	50. 00	0	143, 666			8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	55, 734			9. 00
10. 00	RADI OI SOTOPE	56. 00	0	1, 328			10.00
11. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	1, 476			11.00
12.00	PHYSI CAL THERAPY	66. 00	0	1, 721			12.00
13. 00	ELECTROCARDI OLOGY	69. 00	0	2, 951			13. 00
14.00	ELECTROENCEPHALOGRAPHY	70. 00	0	2, 656			14. 00
15. 00	WOUND/OSTOMY CLINIC	90. 01	0	3, 295			15. 00
16. 00	CTR ADVANCED HEART CARE	90. 02	0	1, 002			16.00
17. 00	EMERGENCY	91.00	•	60, 743			17. 00
E00.00	TOTALS		0	553, 108			F02 22
500.00	Grand Total: Increases		3, 783, 528	39, 211, 762			500. 00

In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 11:54 am

		Decreases				5/24/2024 11:	54 8111
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8. 00	9. 00	10.00		
	A - Chargeable Medical Suppli		0.00	7. 00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	0	0		1.00
2.00	OPERATION OF PLANT	7. 00	O	0	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	O	0	0		3. 00
4.00	CENTRAL SERVICES & SUPPLY	14. 00	O	46, 950	0		4. 00
5.00	PHARMACY	15. 00	0	31, 217	0		5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	461, 649	0		6. 00
7.00	INTENSIVE CARE UNIT	31.00	0	408, 628	0		7. 00
8.00	OPERATING ROOM	50.00	0	4, 745, 678			8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	26, 612	0		9. 00
10. 00	ULTRASOUND	54. 01	0	15, 091	0		10.00
11. 00	RADI OI SOTOPE	56.00	0	231	0		11. 00
12.00	CT SCAN	57.00	0	212, 595	0		12.00
13. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	11, 844	0		13. 00
14. 00	(MRI) CARDIAC CATHETERIZATION	59. 00	o	705 020	0		14. 00
15. 00	LABORATORY	60.00	0	795, 029 273	0		15. 00
16. 00	RESPIRATORY THERAPY	65.00	0	110, 545	0		16. 00
17. 00	PHYSICAL THERAPY	66.00	o	110, 343	0		17. 00
18. 00	ELECTROCARDI OLOGY	69.00	o	10, 129	0		18.00
19. 00	ELECTROENCEPHALOGRAPHY	70.00	ő	119	0		19.00
20. 00	RENAL DI ALYSI S	74.00	ol	7, 409	o		20.00
21. 00	WOUND/OSTOMY CLINIC	90. 01	o	175, 647	0		21. 00
22. 00	CTR ADVANCED HEART CARE	90. 02	O	237	0		22. 00
23.00	RADIATION ONCOLOGY	90. 03	o	110, 348	0		23. 00
24.00	EMERGENCY	91.00	О	179, 430	0		24. 00
25.00	WELLNESS CENTERS	190.01	o	25, 988	0		25. 00
	TOTALS		0	7, 375, 798			
	B - Implantable Device Reclas						
1. 00	OPERATING ROOM	50.00	0	8, 374, 104			1.00
2.00	CARDI AC CATHETERI ZATI ON	59.00	0	360, 004			2. 00
3. 00	WOUND/OSTOMY CLINIC	90.01	0	454	0		3. 00
	TOTALS		0	8, 734, 562			
1. 00	C - Drugs Charges to Pat PHARMACY	15. 00	0	7, 185, 403	0		1.00
2. 00	ADULTS & PEDIATRICS	30.00	o	6, 300	0		2. 00
3. 00	INTENSIVE CARE UNIT	31.00	o	4, 181	0		3. 00
4. 00	OPERATING ROOM	50.00	ő	4, 157	0		4. 00
5. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	6, 873	o		5. 00
6. 00	ULTRASOUND	54. 01	o	50	0		6. 00
7. 00	RADI OI SOTOPE	56.00	O	247, 017	0		7. 00
8.00	CT SCAN	57. 00	O	57, 410	0		8. 00
9.00	MAGNETIC RESONANCE IMAGING	58. 00	0	62, 300	0		9. 00
	(MRI)						
10. 00	CARDIAC CATHETERIZATION	59. 00	0	3, 430	0		10. 00
11. 00	LABORATORY	60.00	0	32	0		11. 00
12. 00	PHYSI CAL THERAPY	66.00	0	32	0		12. 00
13.00	ELECTROCARDI OLOGY	69.00	0	4, 668			13.00
	WOUND/OSTOMY CLINIC	90. 01	0	2, 062			14. 00
15. 00	CTR ADVANCED HEART CARE	90.02	0	323	0		15.00
16.00	RADIATION ONCOLOGY	90. 03	0	271 992	0		16.00
17. 00 18. 00	EMERGENCY RENAL DIALYSIS	91. 00 74. 00	0	992	0		17. 00 18. 00
19. 00	WOUND/OSTOMY CLINIC	90. 01	0	0	0		19. 00
20. 00	CTR ADVANCED HEART CARE	90.01	0	0	0		20.00
21. 00	RADI ATI ON ONCOLOGY	90.03	o	0	0		21.00
22. 00	EMERGENCY	91.00	ő	0	0		22. 00
22.00	TOTALS		— — ŏ	7, 585, 501	<u> </u>		22.00
	D - Depreciation Expense		<u> </u>	,			1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	720	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	O	610, 490	0		2. 00
3.00	OPERATION OF PLANT	7.00	O	1, 239, 128	0		3. 00
4.00	HOUSEKEEPI NG	9.00	0	1, 882	0		4. 00
5. 00	DI ETARY	10.00	0	223, 167	0		5. 00
6. 00	NURSING ADMINISTRATION	13. 00	0	708	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	65, 573	0		7. 00
8. 00	PHARMACY	15.00	0	5, 803	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	134, 514	1		9.00
10.00	INTENSIVE CARE UNIT	31.00	O	57, 862	0		10.00
11. 00	OPERATING ROOM	50.00	0	1, 333, 947	0		11.00
12. 00 13. 00	RADI OLOGY-DI AGNOSTI C ULTRASOUND	54. 00 54. 01	0	348, 097	0		12. 00 13. 00
14. 00	RADI OI SOTOPE	56.00	0	2, 277 53, 601	0		14. 00
15. 00	CT SCAN	57. 00	0	25, 942			15. 00
	1	37.50	<u> </u>	25, 772	9		

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/24/2024 11:54 am Provider CCN: 15-0113

						5/24/2024	11: 54 am
	0	Decreases	C-1	0+1	W+ 4 7 D-E		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
16, 00	MAGNETIC RESONANCE I MAGING	58.00	0.00	118, 577	10.00		16. 00
	(MRI)						
17. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	190, 474	0		17. 00
18.00	LABORATORY	60.00	0	231, 913	0		18.00
19. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	٥	2, 947	U		19. 00
20. 00	RESPIRATORY THERAPY	65.00	o	65, 373	0		20. 00
21.00	PHYSI CAL THERAPY	66.00	0	96, 321	0		21. 00
22. 00	ELECTROCARDI OLOGY	69. 00	0	120, 184	0		22. 00
23. 00	ELECTROENCEPHALOGRAPHY	70.00	0	27, 844	0		23. 00
24. 00	WOUND/OSTOMY CLINIC	90. 01 90. 02	0	17, 448	0		24. 00
25. 00 26. 00	CTR ADVANCED HEART CARE RADIATION ONCOLOGY	90.02	0	365 802, 221	0		25. 00 26. 00
27. 00	DIABETIC PLUS CLINIC	90. 04	ő	2, 105	Ö		27. 00
28. 00	MAB 3611 REED	90.06	O	2, 086	0		28. 00
29. 00	EMERGENCY	91.00	0	59, 245	0		29. 00
30.00	WELLNESS CENTERS	190. 01	0	148, 611	0		30.00
31. 00 32. 00	MONTICELLO HSE. ROCK STEADY BOXING	190. 02 190. 03	0	31, 875 3, 011	0		31. 00 32. 00
33. 00	PHYSICIANS' PRIVATE OFFICES	190.03	0	740, 441	0		33. 00
34. 00	MUNCIE MD OFFICES	192. 01	Ö	2, 328	Ö		34.00
35. 00	RESIDENTIAL PROPERTY (1430 N	192. 02	O	3, 715	0		35. 00
	MADI SON						
	TOTALS		0	6, 770, 795			
1. 00	F - Other Capital Rental ADMINISTRATIVE & GENERAL	5. 00	O	1, 174	10		1.00
2.00	OPERATION OF PLANT	7.00	0	31, 574	0		2.00
3. 00	HOUSEKEEPI NG	9. 00	o	10, 395	o		3. 00
4.00	DI ETARY	10.00	O	3, 840	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	128, 206	0		5. 00
6. 00	PHARMACY	15. 00	0	300, 235	0		6. 00
7.00	INTENSIVE CARE UNIT	31.00	0	196	0		7.00
8. 00 9. 00	OPERATING ROOM MAGNETIC RESONANCE IMAGING	50. 00 58. 00	0	327, 750 341, 000	0		8. 00 9. 00
7. 00	(MRI)	30.00	J	341,000	Ö		7.00
10.00	LABORATORY	60.00	0	50, 363	0		10.00
11. 00	PHYSI CAL THERAPY	66. 00	0	786, 879	0		11. 00
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	675	0		12.00
13. 00 14. 00	WOUND/OSTOMY CLINIC EMERGENCY	90. 01 91. 00	0	67 196	0		13. 00 14. 00
15. 00	WELLNESS CENTERS	190. 01	0	205, 447	0		15. 00
16. 00	ROCK STEADY BOXING	190. 03	ő	19, 863	Ö		16. 00
17. 00	PHYSICIANS' PRIVATE OFFICES	192.00	O	37, 899	0		17. 00
18.00	MUNCIE MD OFFICES	192.01	0_	2 <u>1, 5</u> 00	0		18. 00
	TOTALS		0	2, 267, 259			
1 00	G - STD BENEFIT RECLASS ADMINISTRATIVE & GENERAL	5.00	00 120	0	0		1 00
1. 00 2. 00	OPERATION OF PLANT	7.00	98, 120 6, 523	0			1.00
3. 00	PHYSI CAL THERAPY	66.00	21, 953	0	Ö		3. 00
4.00	DI ETARY	10.00	15, 343	0	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	119	0	0		5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	1, 567	0	0		6. 00
7.00	PHARMACY	15. 00	3, 692	0	0		7.00
8. 00 9. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	75, 508 20, 367	0	0		8. 00 9. 00
10. 00	OPERATING ROOM	50.00	62, 301	0	0		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	4, 069	0	0		11. 00
12.00	MAGNETIC RESONANCE IMAGING	58. 00	1, 705	0	0		12. 00
40.00	(MRI)			_1	_		40.00
13.00	CARDI AC CATHETERI ZATI ON LABORATORY	59.00	101 7 557	0	0		13.00
14. 00 15. 00	RESPI RATORY THERAPY	60. 00 65. 00	7, 557 8, 288	0	0		14. 00 15. 00
16. 00	PHYSICAL THERAPY	66.00	24, 195	0	0		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00	12, 899	0	0		17. 00
18. 00	ELECTROENCEPHALOGRAPHY	70. 00	4, 181	0	0		18. 00
19. 00	RADIATION ONCOLOGY	90. 03	3, 648	0	0		19. 00
20.00	EMERGENCY	91.00	2, 019	0	0		20.00
21. 00	WELLNESS CENTERS	190.01	860 375, 015		0		21. 00
	H - Therapy Reclass	<u> </u>	373, 015	U			
1.00	PHYSI CAL THERAPY	66.00	561, 377	0	0		1.00
2.00		0.00	0	0	0		2. 00
3.00	PHYSI CAL THERAPY	66.00	0	167, 478	0		3. 00
4. 00	1	0.00	0	0	0		4. 00

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/24/2024 11:54 am

						5/24/2024 11	1:54 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	TOTALS		561, 377	167, 478			
	I - Labor and Delivery	<u>'</u>			'		
1.00	ADULTS & PEDIATRICS	30.00	1, 739, 313	0	O		1.00
2.00	7.502.70 & 7.25777771 50	0.00	0	0			2. 00
3. 00	ADULTS & PEDIATRICS	30.00	Ö	1, 236, 152			3. 00
4. 00	ADDETS & LEDIATRICS	0.00	0	1, 230, 132			4.00
4.00	TOTALS — — — —		1, 739, 313				4.00
			1, 739, 313	1, 236, 152			
4 00	J - Cafeteria	10.00	4 405 004				4 00
1.00	DI ETARY	10.00	1, 195, 801				1.00
2.00	DI ETARY	1000	0	<u>1, 135, 6</u> 65	0		2. 00
	TOTALS		1, 195, 801	1, 135, 665			
	K - Building Depreciation						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 774, 078			1. 00
	TOTALS		0	2, 774, 078			
	L - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	145, 790	12		1.00
	TOTALS			145, 790			
	M - Radi ol ogy Support Staff		٥,	1 107 7 7 0			
1.00	RADI OLOGY-DI AGNOSTI C	54.00	287, 037	0	O		1.00
2. 00	INDIOLOGI DI AGNOSTI C	0.00	207, 037	0			2. 00
3. 00		0.00	0	0			3. 00
4. 00		0.00	0	0	0		4. 00
	DADLOLOGY DI AGNOCTI O		~ <u> </u>	ŭ	0		
5. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	90, 561			5. 00
6.00		0. 00	0	0	-		6. 00
7.00		0.00	0	0	0		7. 00
8.00			0_	0	0		8. 00
	TOTALS		287, 037	90, 561			
	N - LINEN RECLASS						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	553, 108	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	o	0	o		3.00
4.00		0.00	ol	0	0		4. 00
5.00		0.00	o	0	0		5. 00
6. 00		0.00	o	0	o o		6. 00
7. 00		0.00	o	0	0		7. 00
8. 00		0.00	o	0	0		8. 00
9. 00		0.00	0	0			9. 00
10. 00		0.00	0	0	0		10.00
			0	0	0		
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12. 00
13. 00		0.00	O	0	0		13. 00
14. 00		0. 00	0	0	0		14. 00
15. 00		0.00	0	0	0		15. 00
16.00		0.00	0	0	0		16. 00
17.00		0.00	0	0	o		17. 00
	TOTALS	- — T		553, 108			
500.00	Grand Total: Decreases		4, 158, 543	38, 836, 747			500.00
		'			'		•

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 01/01/2023 Part I Provider CCN: 15-0113

					From 01/01/2023 To 12/31/2023	Date/Time Pre	
						5/24/2024 11:	54 am
			5 .	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	0.00	0.00	4.00	Retirements	
	DADT I ANALYCIC OF CHANGES IN CARLTAL ACCE	1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		a				
1.00	Land	6, 268, 153	0	(0	0	1.00
2.00	Land Improvements	2, 023, 177	266, 000	(266, 000		2. 00
3.00	Buildings and Fixtures	82, 665, 381	5, 802, 621	(5, 802, 621	1, 987, 959	3. 00
4.00	Building Improvements	2, 763, 325	0	(0	0	4. 00
5.00	Fixed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	82, 518, 351	5, 128, 287		5, 128, 287	1, 021, 716	
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	176, 238, 387	11, 196, 908	(11, 196, 908	3, 009, 675	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	176, 238, 387	11, 196, 908		11, 196, 908	3, 009, 675	10.00
		Ending Balance	Fully				
		,	Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	6, 268, 153	0				1. 00
2.00	Land Improvements	2, 289, 177	0				2.00
3.00	Buildings and Fixtures	86, 480, 043	0				3. 00
4.00	Building Improvements	2, 763, 325	0				4. 00
5.00	Fi xed Equipment	O	0				5. 00
6.00	Movable Equipment	86, 624, 922	o				6.00
7. 00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	184, 425, 620	0				8.00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	184, 425, 620	0				10. 00

Heal th	Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der CC	CN: 15-0113	Peri od: From 01/01/2023 To 12/31/2023		
					10 12/31/2023	5/24/2024 11:	
			SU	JMMARY OF CAP	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		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	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
	I			I .		,	

0 0 0

0 0 0

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)

Health Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 01/01/2023 To 12/31/2023		nared·
				10 12/31/2023	5/24/2024 11:	
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
0 1 0 1 0 1 1	0 1	I o		D 11 (
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col. 1 - col	,		
			2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C			,			
1.00 CAP REL COSTS-BLDG & FLXT	97, 800, 699	l .	97, 800, 69		0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	86, 624, 922	l .	86, 624, 92		0	2. 00
3.00 Total (sum of lines 1-2)	184, 425, 621		184, 425, 62			3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		1	.1			4 00
1.00 CAP REL COSTS-BLDG & FIXT	0	_		2, 774, 078		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	_)	8, 110, 782		2.00
3.00 Total (sum of lines 1-2)	0		HAMADY OF OADI	10, 884, 860	2, 267, 192	3. 00
		SI	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
DART LLL DECONOLLIATION OF CATTER CONTRACTOR	11.00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		445 700			0.040.070	4 00
1.00 CAP REL COSTS-BLDG & FIXT	0		1	0	2, 919, 868	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	_	1	0		2.00
3.00 Total (sum of lines 1-2)	0	145, 790	ין	0	13, 297, 842	3. 00

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-0113

				To	o 12/31/2023	Date/Time Prep 5/24/2024 11:5	
				Expense Classification on		372472024 11.3	34 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		O				
4. 00	Trade, quantity, and time discounts (chapter 8)		0	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-12, 987	ADMINISTRATIVE & GENERAL	5. 00	О	5. 00
6.00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		O		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-182, 083			О	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-11, 099, 165			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service				0. 00	0	13. 00
14. 00	Cafeteria-employees and guests		-1, 101, 369	CAFETERI A	11. 00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	0	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		O		0.00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to				3. 33		22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
24 00	(chapter 21) Depreciation - CAP REL		0	CAD DEL COSTS BLDC • ELVI	1 00	0	26. 00
26. 00	COSTS-BLDG & FLXT			CAP REL COSTS-BLDG & FIXT	1. 00		
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist	А	0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest Misc Rev Sales	В	-375, 491	ADMINISTRATIVE & GENERAL	5. 00	О	33. 00
		·				<u>'</u>	

				To	12/31/2023	Date/Time Pre 5/24/2024 11:	
	·			Expense Classification on	Worksheet A	072172021 11.	o r diii
				To/From Which the Amount is			
				Toy I I om min on the yangant To	to bo haj aotoa		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33. 01	Investment Income	В	-1, 946, 969	ADMINISTRATIVE & GENERAL	5. 00	9	33. 01
33. 02	Space Rental Income	В	-68, 596	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	Space Rental Income	В	-568, 140	RADIATION ONCOLOGY	90. 03	0	33. 03
33.04	Loss on Assets	A	-833	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	Mi sc Revenue	В	-520	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 05
33.06	Mi sc Revenue	В	-1, 120, 800	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	Mi sc Revenue	В	-14, 442	CAFETERI A	11. 00	0	33. 07
33.08	Mi sc Revenue	В	-1, 050	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 08
33. 09	Mi sc Revenue	В	-1, 620	LABORATORY	60.00	0	33. 09
33. 10	Mi sc Revenue	В	0	LABORATORY	60.00	0	33. 10
34.00	HAF Tax Offset	A	-14, 667, 781	ADMINISTRATIVE & GENERAL	5. 00	0	
34. 01	Sponsorshi p	A	-481, 848	ADMINISTRATIVE & GENERAL	5. 00	0	34. 01
34. 02	Hospitalist Loss	A	-3, 088, 310	ADMINISTRATIVE & GENERAL	5. 00	0	34. 02
34. 03	Hospitalist Loss	A		ADULTS & PEDIATRICS	30.00	0	34. 03
34.04	Hospitalist Loss	A		OPERATING ROOM	50.00	0	34. 04
34. 05	APP	A		ADULTS & PEDIATRICS	30.00	0	34. 05
34.06	APP	A		INTENSIVE CARE UNIT	31.00	0	34. 06
34. 07	APP	A	· ·	RESPIRATORY THERAPY	65. 00	0	
34. 08	APP	A		PHYSI CAL THERAPY	66. 00	0	
34. 09	APP	A	· ·	CTR ADVANCED HEART CARE	90. 02		
34. 10	APP	A		RADIATION ONCOLOGY	90. 03		
35. 00	Bad Debt	A		ADMINISTRATIVE & GENERAL	5. 00		
36. 01	Non Allow Marketing	A		ADMINISTRATIVE & GENERAL	5. 00		
36. 02	EPIC Amortization	A		CAP REL COSTS-MVBLE EQUIP	2. 00		36. 02
36. 03	EPIC Amortization	A		ADMINISTRATIVE & GENERAL	5. 00	0	36. 03
50.00	TOTAL (sum of lines 1 thru 49)		-47, 071, 971				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0113

Worksheet A-8-1

Peri od: From 01/01/2023 OFFICE COSTS 12/31/2023 Date/Time Prepared: 5/24/2024 11:54 am

					3/24/2024 11.	J4 aiii
	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	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	21. 00	I&R SERVICES-SALARY & FRINGE	RESI DENTS	14, 234	0	1. 00
2.00	22. 00	I&R SERVICES-OTHER PRGM. COS	RESI DENTS	33, 648	0	2. 00
3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1, 290, 741	0	3. 00
3.01	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2, 616, 486	0	3. 01
3.02	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	21, 353, 121	40, 151, 038	3. 02
3.03	13. 00	NURSING ADMINISTRATION	HOME OFFICE	1, 516, 689	0	3. 03
3.04	14. 00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	472, 494	0	3. 04
3.05	16. 00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1, 069, 570	0	3. 05
3.06	30.00	ADULTS & PEDIATRICS	HOME OFFICE	388, 646	0	3. 06
3.07	54. 00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	119, 517	o	3. 07
3.08	5. 00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	22, 282	o	3. 08
3.09	91. 00	EMERGENCY	CPN CALL	154, 445	o	3. 09
4.00	0.00			0	o	4. 00
5.00	TOTALS (sum of lines 1-4).			29, 051, 873	40, 151, 038	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

6. 00	A	IN PROHEALTH	100.00	0. 00	6. 00
7.00	В	CHNW	100.00	0. 00	7. 00
8.00			0.00	0. 00	8. 00
9.00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

					5/24/2024 11:	54 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED O	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					
1.00	14, 234	0				1.00
2.00	33, 648	0				2. 00
3.00	1, 290, 741	9				3. 00
3.01	2, 616, 486	0				3. 01
3.02	-18, 797, 917	0				3. 02
3.03	1, 516, 689	0				3. 03
3.04	472, 494	0				3. 04
3.05	1, 069, 570	0				3. 05
3.06	388, 646	0				3. 06
3.07	119, 517	0				3. 07
3.08	22, 282	0				3. 08
3.09	154, 445					3. 09
4.00	0	0				4.00
5.00	-11, 099, 165					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.

 	cordinate i diagraf 2, the discourt difference of cordinate of the cordinate in cordinate in the partition	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	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 Committee	
6. 00		6. 00
7.00		7.00
8.00		8.00
9. 00		9.00
10.00		10.00
100.00		100.00

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

Provider CCN: 15-0113

| Peri od: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					٦	To 12/31/2023	B Date/Time Pre 5/24/2024 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	164, 525					
2.00		RADI OLOGY-DI AGNOSTI C	17, 558			C	1	
3.00	0. 00		0		_	C	0	
4.00	0.00		0	l ~		C	0	
5.00	0. 00		0	0	0	C	0	
6.00	0.00		0	0	0	C	0	6. 00
7. 00	0. 00		0	0	0	C	0	7. 00
8.00	0.00		0	0	0	C	0	8. 00
9.00	0. 00		0	0	0	C	0	9. 00
10.00	0.00		0	0	0	C	0	
200.00			182, 083				0	
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00		ADMINISTRATIVE & GENERAL	0.00					1. 00
2. 00		RADI OLOGY-DI AGNOSTI C						
3.00	0.00	NADI OLOGI -DI AGNOSTI C		0			0	1
4. 00	0.00			0				
5.00	0.00				0		0	1
6. 00	0.00				0	,	Ö	
7. 00	0.00				0	l c		1
8. 00	0.00		0		0	Ĭ		
9. 00	0.00		0		0	Ĭ		1
10. 00	0.00		0		0	l c	1	
200.00	0.00		0		0	Ĭ		
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	164, 525		1. 00
2.00		RADI OLOGY-DI AGNOSTI C	0	0	0	17, 558	3	2. 00
3.00	0.00		0	0	0	C		3. 00
4.00	0.00		0	0	0	C		4. 00
5.00	0.00		0	0	0	C		5. 00
6.00	0.00		0	0	0	C		6. 00
7.00	0.00		0	0	0	C		7. 00
8.00	0.00		0	0	0	[C)	8. 00
9.00	0.00		0	0	0	[C)	9. 00
10. 00	0.00		0	0	0	C	1	10. 00
200.00			0	0	0	182, 083		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:54 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 2, 919, 868 00100 CAP REL COSTS-BLDG & FLXT 2, 919, 868 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 10, 377, 974 10, 377, 974 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 695, 381 30, 400 2, 726, 502 721 4.00 00500 ADMINISTRATIVE & GENERAL 4, 283, 690 35, 328, 763 5 00 30, 595, 803 172, 844 276, 426 5 00 6.00 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 5, 513, 443 561, 251 478, 090 71, 784 6, 624, 568 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 0 3, 549, 129 00900 HOUSEKEEPI NG 83, 998 9 00 3, 421, 739 31, 091 12, 301 9 00 10.00 01000 DI ETARY 1,077,277 34, 628 37, 718 21, 330 1, 170, 953 10.00 01100 CAFETERI A 11.00 1, 324, 696 83, 160 57, 049 47, 369 1, 512, 274 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 3, 949, 669 32, 473 13.00 3, 722, 361 129, 166 65, 669 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 1,052,380 77, 133 51, 967 17,007 1, 198, 487 14.00 01500 PHARMACY 15.00 3, 919, 869 35, 228 306, 203 112, 447 4, 373, 747 15.00 01600 MEDICAL RECORDS & LIBRARY 1,089,297 1, 127, 472 16,00 38, 175 0 0 16,00 17 00 01700 SOCIAL SERVICE 0 0 0 Ω 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 20.00 02000 NURSING PROGRAM 0 0 0 0 O 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 14, 234 0 14, 234 0 21.00 0 22.00 02200 & SERVICES-OTHER PRGM. COSTS APPRVD 33, 648 r 0 33, 648 22.00 02300 PARAMED ED PRGM-(EMS) 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 18, 727, 944 109, 781 19, 710, 702 30.00 344.876 528, 101 31.00 03100 INTENSIVE CARE UNIT 6, 190, 679 135, 096 56, 819 179, 340 6, 561, 934 31.00 04300 NURSERY 43.00 1, 552, 121 99, 615 13, 038 34, 649 1, 699, 423 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13, 817, 142 404, 608 1, 503, 479 306, 665 16, 031, 894 50.00 05100 RECOVERY ROOM 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 423, 344 47, 353 11, 956 31, 774 1, 514, 427 52.00 05400 RADI OLOGY-DI AGNOSTI C 3, 156, 981 54 00 2, 769, 127 32, 443 291.110 64, 301 54 00 54.01 05401 ULTRASOUND 855, 762 11,770 2,720 24, 349 894, 601 54.01 05600 RADI OI SOTOPE 56, 00 539, 556 15, 276 54,061 14,025 622, 918 56.00 05700 CT SCAN 1, 553, 354 35, 599 1, 675, 451 57.00 26, 857 57.00 59, 641 05800 MAGNETIC RESONANCE I MAGING (MRI) 25, 577 461, 097 1, 963, 245 58.00 1, 476, 571 58.00 59.00 05900 CARDIAC CATHETERIZATION 1, 280, 232 66, 257 166, 350 30, 859 1, 543, 698 59.00 60.00 06000 LABORATORY 7, 660, 880 79, 013 268, 333 99, 714 8, 107, 940 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 843, 595 8, 680 2, 953 863, 560 62 00 8 332 62 00 64.00 06400 I NTRAVENOUS THERAPY C Ω 64.00 65.00 06500 RESPIRATORY THERAPY 2, 944, 336 2, 541 62, 750 85, 475 3, 095, 102 65.00 66.00 06600 PHYSI CAL THERAPY 3, 665, 900 65, 515 879, 984 104, 083 4, 715, 482 66.00 06700 OCCUPATIONAL THERAPY 506, 798 2 981 67 00 12,064 14, 261 536, 104 67 00 68.00 06800 SPEECH PATHOLOGY 259, 353 6,068 1,500 7, 177 274, 098 68.00 06900 ELECTROCARDI OLOGY 1, 615, 979 148, 014 120, 419 45, 479 1, 929, 891 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 999,043 35.095 28, 575 22, 286 1,084,999 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7, 375, 798 7, 375, 798 71.00 C 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 734, 562 C 0 0 8, 734, 562 72.00 07300 DRUGS CHARGED TO PATIENTS 0 7, 588, 518 73.00 7, 588, 518 0 73.00 0 07400 RENAL DIALYSIS 0 74.00 426, 861 0 426, 861 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77 00 0 C 0 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 0 90.01 09001 WOUND/OSTOMY CLINIC 1, 896, 066 55, 270 8,006 25, 746 1, 985, 088 90.01 09002 CTR ADVANCED HEART CARE 14, 289 209, 145 90.02 194, 490 366 90.02 09003 RADIATION ONCOLOGY 10, 957 4, 061, 142 90.03 3, 525, 457 450, 585 74.143 90.03 09004 DIABETIC PLUS CLINIC 90.04 493, 105 2.109 15, 119 510, 333 90 04 13, 569 90.05 09005 ANTICOAGULATION CLINIC 465, 541 479, 110 90.05 C 90 06 09006 MAB 3611 REED Ω 90.06 09100 EMERGENCY 7, 357, 894 197, 842 91.00 91.00 126, 315 44, 258 7, 726, 309 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 Ω 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 174, 497, 978 2, 862, 850 9, 926, 992 2, 698, 784 173, 962, 260 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 190. 01 19001 WELLNESS CENTERS 1, 175, 240 190. 01 788, 807 354, 750 8, 151 23, 532 190. 02 19002 MONTI CELLO HSE. 19,932 19, 932 190. 02

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	eu 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		pared: 54 am
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		Subtotal	
	for Cost			BENEFI TS		
	Allocation (from Wkst A			DEPARTMENT		
	col. 7)					
	0	1. 00	2.00	4. 00	4A	
190. 03 19003 ROCK STEADY BOXING	151, 505	0	22, 91	8 4, 186	178, 609	190. 03
190. 04 19004 DIABETES MD	136	0		0	136	190. 04
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 527, 549	48, 867	51, 77	2 0	1, 628, 188	192. 00
192.01 19201 MUNCIE MD OFFICES	13, 869	0	21, 54	2 0	35, 411	192. 01
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON	2, 512	0		0		192. 02
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)	177, 002, 288	2, 919, 868	10, 377, 97	4 2, 726, 502	177, 002, 288	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

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

5/24/2024 11:54 am 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 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 35, 328, 763 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 1, 651, 949 8, 276, 517 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 885, 036 00900 HOUSEKEEPI NG 119, 387 4, 553, 552 9.00 9 00 10.00 01000 DI ETARY 291, 997 132, 969 74, 227 10.00 11.00 01100 CAFETERI A 377, 111 319, 329 0 178, 259 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 0 13.00 01300 NURSING ADMINISTRATION 984.917 124, 695 69,609 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 298, 863 296, 185 0 165, 339 14.00 01500 PHARMACY 1, 090, 668 15.00 135, 272 75. 513 15.00 01600 MEDICAL RECORDS & LIBRARY 81, 831 16.00 281, 154 146, 590 16.00 17.00 01700 SOCIAL SERVICE 0 C 0 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 0 0 19.00 02000 NURSI NG PROGRAM 20.00 0 0 20.00 0 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 3.549 0 0 21.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 8, 391 0 0 22.00 23.00 02300 PARAMED ED PRGM-(EMS) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 915, 262 0 1, 324, 305 0 739, 266 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 636, 330 0 518, 763 0 289, 589 31.00 04300 NURSERY 423, 780 0 382, 515 0 213, 531 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 997, 825 0 1, 553, 675 0 867, 308 50.00 05100 RECOVERY ROOM 51.00 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 377.648 0 181.832 0 101, 504 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 787, 247 0 124, 578 69, 543 54.00 54.01 05401 ULTRASOUND 223, 084 45, 195 25, 229 54.01 05600 RADI OI SOTOPE 56.00 155, 335 0 58, 659 0 32, 745 56.00 57 00 05700 CT SCAN 417 802 Ω 229, 018 127, 844 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 489, 569 0 58.00 0 05900 CARDIAC CATHETERIZATION 384, 947 0 254, 425 142, 028 59.00 59.00 0 60.00 06000 LABORATORY 2,021,853 0 303, 405 169, 370 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 215, 343 0 33, 330 18, 606 62.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 771, 816 9, 757 0 5, 447 65.00 66 00 06600 PHYSI CAL THERAPY 1, 175, 886 Ω 251, 576 140, 437 66 00 06700 OCCUPATIONAL THERAPY 67.00 133, 687 C 46, 326 25, 861 67.00 0 06800 SPEECH PATHOLOGY 23, 300 13, 007 68.00 68.351 68.00 69.00 06900 ELECTROCARDI OLOGY 481, 251 0 568, 368 0 317, 280 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 270 563 75, 229 70 00 134, 764 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,839,281 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 178, 112 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 892, 326 0 73.00 0 0 73.00 0 07400 RENAL DIALYSIS O 0 74.00 106, 445 0 74 00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0 90 00 90.01 09001 WOUND/OSTOMY CLINIC 495, 015 212, 235 118, 476 90.01 90 02 09002 CTR ADVANCED HEART CARE 52, 154 0 90.02 0 09003 RADIATION ONCOLOGY 1, 012, 715 90.03 0 42,072 23, 486 90.03 90.04 09004 DIABETIC PLUS CLINIC 127, 260 Ω 0 0 Λ 90.04 09005 ANTICOAGULATION CLINIC 0 90.05 90.05 119, 474 0 0 o 90.06 09006 MAB 3611 REED 90.06 Ω 1, 926, 686 91.00 09100 EMERGENCY C 485, 043 0 270, 765 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 8, 057, 568 4, 431, 329 118. 00 34, 570, 682 0 0 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 190. 01 19001 WELLNESS CENTERS 293, 066 C 31, 301 0 17, 473 190. 01 190. 02 19002 MONTI CELLO HSE. 0 0 190. 02 4,970 0 C 190. 03 19003 ROCK STEADY BOXING o 44, 539 0 0 0 190. 03 190, 04 19004 DIABETES MD 0 0 190 04 34 0 Ω 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 406,016 0 187, 648 0 104, 750 192. 00 192. 01 19201 MUNCIE MD OFFICES 0 0 192. 01 8,830 192. 02 19202 RESIDENTIAL PROPERTY (1430 N MADISON 0 0 192. 02 626

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10	O
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0113	Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/24/2024 11:54 am	

						5/24/2024 11:	54 am
	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	
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	C	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	35, 328, 763	0	8, 276, 517	0	4, 553, 552	202.00

Provider CCN: 15-0113

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 54 am

							5/24/2024 11:	54 am
		Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
					PERSONNEL	ADMI NI STRATI ON	SERVICES & SUPPLY	
			10.00	11. 00	12.00	13.00	14. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT					l	1. 00
2.00		CAP REL COSTS-MVBLE EQUIP					I	2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
5.00		ADMINISTRATIVE & GENERAL					l	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT					I	6. 00 7. 00
8.00	1	LAUNDRY & LINEN SERVICE					l	8. 00
9. 00	1	HOUSEKEEPI NG					l	9. 00
10. 00		DI ETARY	1, 670, 146				l	10.00
11.00		CAFETERI A	o	2, 386, 973			l	11. 00
12.00		MAINTENANCE OF PERSONNEL	0	0	C		l	12. 00
13. 00		NURSING ADMINISTRATION	0	89, 736		5, 218, 626		13. 00
14.00		CENTRAL SERVICES & SUPPLY	0	28, 715		0	1, 987, 589	1
15.00	1	PHARMACY	0	104, 094		0	8, 125	1
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	0	1		0	1
19. 00		NONPHYSICIAN ANESTHETISTS	0	0			0	
20. 00		NURSI NG PROGRAM		0			0	1
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD	ol	0	ĺ	ol ol	0	
22. 00		I&R SERVICES-OTHER PRGM. COSTS APPRVD	O	0	C	o	0	22. 00
23. 00		PARAMED ED PRGM-(EMS)	0	0	C	0	0	23. 00
		IENT ROUTINE SERVICE COST CENTERS			,			
30.00		ADULTS & PEDI ATRI CS	1, 349, 135	588, 669			81, 225	1
31.00		INTENSIVE CARE UNIT	305, 496	168, 703			22, 088	
43. 00		NURSERY LARY SERVICE COST CENTERS	0	32, 305	<u> </u>	151, 390	5, 115	43. 00
50. 00		OPERATING ROOM	813	333, 817		1, 546, 990	174, 934	50. 00
51. 00		RECOVERY ROOM	0	0			0	1
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	28, 715			4, 691	1
54.00		RADI OLOGY-DI AGNOSTI C	o	68, 199		o	3, 700	1
54. 01	05401	ULTRASOUND	0	17, 947	C	0	3, 326	54. 01
56. 00	1	RADI OI SOTOPE	0	10, 768			523	1
57. 00	1	CT SCAN	0	35, 894			3, 185	1
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	21, 537			1, 324	1
59.00		CARDI AC CATHETERI ZATI ON	0	28, 715			10, 476	1
60. 00 62. 00		LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	147, 167			223, 967	1
64. 00		INTRAVENOUS THERAPY	0	10, 768 0			42, 453 0	1
65. 00		RESPI RATORY THERAPY	0	75, 378			9, 547	1
66. 00	1	PHYSI CAL THERAPY	o	139, 988			2, 873	1
67.00	1	OCCUPATIONAL THERAPY	o	7, 179		o	266	1
68. 00	06800	SPEECH PATHOLOGY	0	3, 589	C	0	134	68. 00
69. 00		ELECTROCARDI OLOGY	0	53, 841	C	0	2, 293	1
70. 00		ELECTROENCEPHALOGRAPHY	0	25, 126	1		2, 222	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			598, 089	
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	708, 279	72. 00 73. 00
74.00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0			450	74.00
77. 00	1	ALLOGENEIC HSCT ACQUISITION	o o	0		_	0	1
78. 00		CAR T-CELL IMMUNOTHERAPY	o	0			0	
	OUTPA	TIENT SERVICE COST CENTERS						
90.00		CLINIC	0	0			0	
90. 01	1	WOUND/OSTOMY CLINIC	이	25, 126		0	10, 588	1
90. 02		CTR ADVANCED HEART CARE	0	14, 358			813	1
90. 03 90. 04	1	RADIATION ONCOLOGY DIABETIC PLUS CLINIC	0	75, 378 17, 947			10, 196 896	1
90.04	1	ANTI COAGULATION CLINIC	0	14, 358			1, 336	1
90.06	1	MAB 3611 REED	0	14, 550	1		1, 330	1
91. 00		EMERGENCY	14, 702	211, 777	· -	ol ol	51, 269	1
		OBSERVATION BEDS (NON-DISTINCT PART)	,	,	_		1	92.00
		REIMBURSABLE COST CENTERS						1
102.00		OPIOID TREATMENT PROGRAM	0	0	C	0	0	102. 00
		AL PURPOSE COST CENTERS			T			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1, 670, 146	2, 379, 794	C	5, 218, 626	1, 984, 393	1118. 00
100.00		IMBURSABLE COST CENTERS				1 1	^	100 00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN WELLNESS CENTERS		0				190. 00 190. 01
		MONTI CELLO HSE.		0				190. 01
		ROCK STEADY BOXING		7, 179				190. 02
		DI ABETES MD		0		ol ol	0	190. 04
		PHYSICIANS' PRIVATE OFFICES	0	0				192. 00
192. 01	19201	MUNCIE MD OFFICES	0	0	C	0	. 0	192. 01
								

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
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:
					5/24/2024 11:	54 am
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE (OF NURSI NG	CENTRAL	
			PERSONNEL	ADMINISTRATION	SERVICES &	

						5/24/2024 11:	54 am
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		10.00	11. 00	12.00	13.00	14.00	
192. 02 19202	RESIDENTIAL PROPERTY (1430 N MADISON	0	0	C	0	0	192. 02
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	o	0) c	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 670, 146	2, 386, 973	c c	5, 218, 626	1, 987, 589	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

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

5/24/2024 11:54 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSI NG RECORDS & **ANESTHETISTS PROGRAM** LI BRARY 15. 00 17.00 19. 00 20.00 16,00 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 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10 00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 5, 787, 419 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1,637,047 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 0 0 02000 NURSING PROGRAM 0 20 00 C Λ 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 C 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 22.00 22.00 02300 PARAMED ED PRGM-(EMS) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 123, 020 0 0 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 39, 211 0 0 0 31.00 43 00 04300 NURSERY 0 9 187 0 0 0 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 353, 997 0 0 50.00 0 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 8, 424 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 31, 168 0 0 54.00 0 54.01 05401 ULTRASOUND 00000000 22, 013 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 54.01 56 00 05600 RADI OI SOTOPE 18 023 0 0 56 00 0 57.00 05700 CT SCAN 112, 043 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 41, 143 0 0 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 62, 856 0 0 59.00 06000 LABORATORY 127, 499 0 60 00 60 00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 5, 804 0 62.00 06400 INTRAVENOUS THERAPY 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 00000 36, 563 0 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 22. 534 0 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 3, 933 0 67.00 68.00 06800 SPEECH PATHOLOGY 1, 979 0 0 68.00 06900 ELECTROCARDI OLOGY 32, 912 0 69.00 69.00 0 0 13, 397 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 44, 063 0 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 49, 724 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 787, 419 0 115, 801 73.00 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 2, 971 0 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 90.01 09001 WOUND/OSTOMY CLINIC 0 15, 693 0 0 0 90.01 0 0 09002 CTR ADVANCED HEART CARE 0 90.02 90.02 1.557 0 0 90.03 09003 RADIATION ONCOLOGY 114, 924 0 90.03 09004 DIABETIC PLUS CLINIC 0 595 0 90.04 90.04 0 0 0 90.05 09005 ANTICOAGULATION CLINIC 2, 467 0 90.05 0 90.06 09006 MAB 3611 REED 0 0 90.06 91.00 09100 EMERGENCY 223, 546 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS | SUBTOTALS (SUM OF LINES 1 through 117) | NONREI MBURSABLE COST CENTERS 118.00 5, 787, 419 1, 637, 047 0 0 0 118. 00 n 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 01 19001 WELLNESS CENTERS 0 0 0 0 190. 01 C 0 0 190. 02 19002 MONTI CELLO HSE. 0 0 0 190. 02 190. 03 19003 ROCK STEADY BOXING Ω 0 0 190. 03 0 0 0 190. 04 19004 DI ABETES MD 0 0 190.04 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 192. 01 19201 MUNCIE MD OFFICES 0 0 192. 01

Health Financial S	Systems	COMMUNITY HOSPITAL ANDERSON			In Lie	u of Form CMS-	2552-10
COST ALLOCATION -	GENERAL SERVICE COSTS		Provi der	CCN: 15-0113	From 01/01/2023	Worksheet B Part I Date/Time Pre 5/24/2024 11:	
Cost	Contor Doscription	DHVDWVCA	MEDICAL	SUCTAL SED	DVI CE NONDUVSI CI ANI	MIDSING	

						5/24/2024 11:	54 am
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	
			RECORDS &		ANESTHETI STS	PROGRAM	
			LI BRARY				
		15. 00	16.00	17. 00	19. 00	20.00	
192. 02 19202	RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	192. 02
200.00	Cross Foot Adjustments				0	0	200. 00
201.00	Negative Cost Centers	o	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	5, 787, 419	1, 637, 047	0	0	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113

					To 12/31/2023	B Date/Time Pre 5/24/2024 11:	
		INTERNS &	RESI DENTS			372472024 11.	54 aiii
	Cook Cooks Decoristics	CEDVILOEC CALAD	CEDVI CEC OTUED	DADAMED ED	C	1 + 0	
	Cost Center Description	SERVICES-SALAR Y & FRINGES	PRGM. COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost	
				(=)		& Post	
						Stepdown	
		21.00	22. 00	23. 00	24.00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS						19. 00
20. 00	02000 NURSI NG PROGRAM						20.00
21. 00 22. 00	02100 1 & R SERVI CES-SALARY & FRINGES APPRVD 02200 1 & R SERVI CES-OTHER PRGM. COSTS APPRVD	17, 783	42, 039				21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)		42, 037		o		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	11 0	26 0		31, 564, 160 10, 329, 82	•	30. 00 31. 00
43. 00	04300 NURSERY	0	0		2, 917, 246		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	17, 772	42, 013		24, 921, 038	1	50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 217, 24 ²	-	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		4, 241, 416	1	54.00
54. 01	05401 ULTRASOUND	0	0	•	1, 231, 395		54. 01
56. 00 57. 00	05600	0	0	ł	898, 97 ² 2, 601, 23 ³	1	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	1	2, 516, 818	1	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	•	2, 427, 145	1	59. 00
60. 00 62. 00	O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	•	0 11, 101, 20° 0 1, 189, 864		60. 00 62. 00
64. 00	06400 I NTRAVENOUS THERAPY		0	l	0 1, 169, 602		64.00
65.00	06500 RESPI RATORY THERAPY	0	0		4, 003, 610	1	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 6, 448, 776	1	66. 00 67. 00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	0		753, 356 384, 458	1	68. 00
	06900 ELECTROCARDI OLOGY	0	0		3, 385, 836		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	1, 606, 300		70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		9, 857, 23° 11, 670, 67°		71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		15, 384, 065		73. 00
74.00	07400 RENAL DIALYSIS	0	0		536, 736	1	74.00
77. 00 78. 00	O7700 ALLOGENEIC HSCT ACQUISITION O7800 CAR T-CELL IMMUNOTHERAPY	0	0			0 0	77. 00 78. 00
70.00	OUTPATIENT SERVICE COST CENTERS		0		<u> </u>	·	70.00
90.00	09000 CLI NI C	0	0) (90.00
90. 01 90. 02	09001 WOUND/OSTOMY CLINIC 09002 CTR ADVANCED HEART CARE	0	0		2, 862, 22° 278, 02°	1	90. 01 90. 02
90. 03	09003 RADI ATI ON ONCOLOGY	0	0		5, 339, 913		90. 03
90. 04	09004 DIABETIC PLUS CLINIC	0	0		0 657, 031	0	90. 04
90. 05 90. 06	09005 ANTI COAGULATION CLINIC 09006 MAB 3611 REED	0	0		0 616, 745	0 0	90. 05 90. 06
91.00	09100 EMERGENCY		0	•	0 10, 910, 09		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_		,	0	92. 00
100.00	OTHER REIMBURSABLE COST CENTERS						100.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0	0	102. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	17, 783	42, 039		172, 852, 632	-59, 822	118. 00
400 -	NONREI MBURSABLE COST CENTERS	1			I		100 0-
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1900 WELLNESS CENTERS	0	0		0 0 1, 517, 513		190. 00 190. 01
	19001 WELLNESS CENTERS	0	0		24, 902	1	190. 01
			· '	-	•		

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0113			Peri od: Worksheet B			
				From 01/01/2023 To 12/31/2023		nared:	
				10 12/31/2023	5/24/2024 11:	54 am_	
	INTERNS &	RESI DENTS					
	CEDVILOEC CALAB	CEDVI OEC OTUED	DADAMED ED				
Cost Center Description	SERVI CES-SALAR			Subtotal	Intern &		
	Y & FRINGES	PRGM. COSTS	PRGM-(EMS)		Residents Cost		
					& Post		
					Stepdown		
					Adjustments		
	21. 00	22. 00	23. 00	24. 00	25. 00		
190. 03 19003 ROCK STEADY BOXING	0	0		0 230, 730	0	190. 03	
190. 04 19004 DI ABETES MD	0	0		0 170	0	190. 04	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 2, 328, 962	0	192. 00	
192.01 19201 MUNCIE MD OFFICES	0	0		0 44, 241	0	192. 01	
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0		0 3, 138	0	192. 02	
200.00 Cross Foot Adjustments	0	0		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)	17, 783	42, 039		0 177, 002, 288	-59, 822	202. 00	

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/24/2024	11:54 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113

				10 12/31/2023 Date/11me Pre 5/24/2024 11:	
		Cost Center Description	Total		
	CENED	AL SERVICE COST CENTERS	26. 00		
1. 00		CAP REL COSTS-BLDG & FIXT			1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	1	ADMINISTRATIVE & GENERAL			5. 00
6. 00 7. 00	1	MAINTENANCE & REPAIRS OPERATION OF PLANT			6. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE			8.00
9. 00	1	HOUSEKEEPI NG			9. 00
10.00	1	DI ETARY			10.00
11. 00	1	CAFETERI A			11. 00
12.00	1	MAINTENANCE OF PERSONNEL			12.00
13. 00 14. 00	1	NURSI NG ADMI NI STRATI ON			13. 00 14. 00
15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY			15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY			16. 00
17. 00	1	SOCIAL SERVICE			17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS			19. 00
20.00	1	NURSI NG PROGRAM			20.00
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM. COSTS APPRVD			21. 00 22. 00
23. 00		PARAMED ED PRGM-(EMS)			23. 00
20.00		IENT ROUTINE SERVICE COST CENTERS			20.00
30.00	03000	ADULTS & PEDI ATRI CS	31, 564, 123		30. 00
31. 00	1	INTENSIVE CARE UNIT	10, 329, 821		31. 00
43. 00		NURSERY	2, 917, 246		43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	24, 861, 253		50.00
51.00		RECOVERY ROOM	24, 601, 253		51.00
52. 00	1	DELIVERY ROOM & LABOR ROOM	2, 217, 241		52. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	4, 241, 416		54.00
54. 01	1	ULTRASOUND	1, 231, 395		54. 01
56. 00	1	RADI OI SOTOPE	898, 971		56.00
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	2, 601, 237 2, 516, 818		57. 00 58. 00
59. 00		CARDI AC CATHETERI ZATI ON	2, 427, 145		59. 00
60.00	1	LABORATORY	11, 101, 201		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 189, 864		62. 00
64. 00	1	INTRAVENOUS THERAPY	0		64. 00
65. 00	1	RESPI RATORY THERAPY	4, 003, 610		65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	6, 448, 776 753, 356		66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY	384, 458		68. 00
69. 00	1	ELECTROCARDI OLOGY	3, 385, 836		69.00
70. 00	1	ELECTROENCEPHALOGRAPHY	1, 606, 300		70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 857, 231		71.00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	11, 670, 677		72.00
	1	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	15, 384, 065 536, 736		73. 00 74. 00
		ALLOGENEIC HSCT ACQUISITION	0		77. 00
78. 00	1	CAR T-CELL IMMUNOTHERAPY	Ö		78. 00
		TIENT SERVICE COST CENTERS			
90.00		CLINIC	0		90.00
90. 01 90. 02	1	WOUND/OSTOMY CLINIC CTR ADVANCED HEART CARE	2, 862, 221		90. 01 90. 02
90. 02	1	RADIATION ONCOLOGY	278, 027 5, 339, 913		90.02
90. 04	1	DI ABETI C PLUS CLI NI C	657, 031		90. 04
90. 05		ANTICOAGULATION CLINIC	616, 745		90. 05
90.06		MAB 3611 REED	0		90. 06
91.00		EMERGENCY	10, 910, 097		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS			92.00
102 00		OPIOID TREATMENT PROGRAM	0		102. 00
102.00		AL PURPOSE COST CENTERS	<u> </u>		102.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	172, 792, 810		118. 00
		IMBURSABLE COST CENTERS			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
		WELLNESS CENTERS MONTI CELLO HSE.	1, 517, 513 24, 902		190. 01 190. 02
		ROCK STEADY BOXING	24, 902		190. 02
	1	DI ABETES MD	170		190. 03
		PHYSICIANS' PRIVATE OFFICES	2, 328, 962		192. 00
	1	MUNCIE MD OFFICES	44, 241		192. 01
		RESIDENTIAL PROPERTY (1430 N MADISON	3, 138		192. 02
200.00	וי	Cross Foot Adjustments	0		200. 00

Health Fina	ancial Systems	COMMUNITY HOSPITA	AL ANDERSON	In Lieu of Form CMS-2552-10			
COST ALLOCA	ATION - GENERAL SERVICE COSTS		Provider CCN: 15-0113	Peri od: From 01/01/2023	Worksheet B Part I		
				To 12/31/2023	Date/Time Prep 5/24/2024 11:5		
	Cost Center Description	Total					
		26. 00					
201.00	Negative Cost Centers	0			2	201. 00	
202. 00	TOTAL (sum lines 118 through 201)	176, 942, 466			2	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: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

					То	12/31/2023	Date/Time Pre 5/24/2024 11:	
				CAPI TAL REI	LATED COSTS			
		Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New				BENEFITS	
			Capi tal Rel ated Costs				DEPARTMENT	
			0	1. 00	2.00	2A	4. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-BLDG & FIXT						2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	30, 400		31, 121	31, 121	4. 00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	0	172, 844 0		4, 456, 534 0	3, 156 0	5. 00 6. 00
7. 00		OPERATION OF PLANT	0	561, 251	-	1, 039, 341	820	7. 00
8.00	1	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	31, 091 34, 628		43, 392 72, 346	959 244	9. 00 10. 00
11. 00		CAFETERI A	o o	83, 160		140, 209	541	11. 00
12.00	1	MAINTENANCE OF PERSONNEL	0	0 470		0	0	12.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	32, 473 77, 133		161, 639 129, 100	750 194	13. 00 14. 00
15. 00		PHARMACY	o o	35, 228		341, 431	1, 284	15. 00
16.00	1	MEDICAL RECORDS & LIBRARY	0	38, 175	1	38, 175	0	16.00
17. 00 19. 00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0		O O	0	17. 00 19. 00
20. 00		NURSI NG PROGRAM	o	0	Ö	Ö	0	20. 00
21. 00		I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	21. 00
22. 00 23. 00		I &R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM-(EMS)	0	0	-	ol Ol	0	22. 00 23. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS	-	-	- 1	-1		
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	344, 876		454, 657	6, 021	30. 00 31. 00
43. 00		NURSERY	0	135, 096 99, 615		191, 915 112, 653	2, 048 396	43.00
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	0	404, 608 0		1, 908, 087 0	3, 501 0	50. 00 51. 00
51.00		DELIVERY ROOM & LABOR ROOM	0	47, 353	-	59, 309	363	
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	32, 443	291, 110	323, 553	734	54.00
54. 01 56. 00	1	ULTRASOUND RADI OI SOTOPE	0	11, 770 15, 276		14, 490 69, 337	278 160	
57. 00		CT SCAN	0	59, 641		86, 498	406	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	0		461, 097	292	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0	66, 257 79, 013		232, 607 347, 346	352 1, 138	59. 00 60. 00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	8, 680		11, 633	95	62. 00
64. 00	1	INTRAVENOUS THERAPY	0	0	-	0	0	64. 00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	2, 541 65, 515		65, 291 945, 499	976 1, 188	65. 00 66. 00
67. 00		OCCUPATI ONAL THERAPY	0	12, 064		15, 045	163	
68. 00		SPEECH PATHOLOGY	0	6, 068		7, 568	82	
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	148, 014 35, 095		268, 433 63, 670	519 254	69. 00 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	0		00, 070	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	O	0	72.00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0	0	0	0	73. 00 74. 00
77. 00	07700	ALLOGENEIC HSCT ACQUISITION	O	0	Ö	Ö	0	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
90. 00		CLINIC	0	0	O	ol	0	90. 00
90. 01	09001	WOUND/OSTOMY CLINIC	0	55, 270	8, 006	63, 276	294	90. 01
90. 02 90. 03		CTR ADVANCED HEART CARE RADIATION ONCOLOGY	0	0 10, 957	366 450, 585	366 461, 542	163 846	
90. 03		DIABETIC PLUS CLINIC	0	10, 437	2, 109	2, 109	173	
90. 05	1	ANTICOAGULATION CLINIC	0	0	0	O	155	
90. 06 91. 00		MAB 3611 REED EMERGENCY	0	0 126, 315	0	170 573	0 2, 259	90. 06 91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART)		120, 313	44, 258	170, 573 0	2, 239	91.00
	OTHER	REIMBURSABLE COST CENTERS						
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 862, 850	9, 926, 992	12, 789, 842	30, 804	118. 00
466 -	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN WELLNESS CENTERS	0	0 8, 151	-	0 362, 901		190. 00 190. 01
190. 02	19002	MONTI CELLO HSE.		0, 131	0	0	0	190. 02
190. 03	19003	ROCK STEADY BOXING	<u> </u>	0	22, 918	22, 918	48	190. 03

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-0113	Peri od:	Worksheet B		
				From 01/01/2023 To 12/31/2023		narodi	
				10 12/31/2023	Date/Time Pre 5/24/2024 11:		
		CAPI TAL REL	ATED COSTS				
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE		
	Assigned New				BENEFITS		
	Capi tal				DEPARTMENT		
	Related Costs						
	0	1. 00	2.00	2A	4. 00		
190. 04 19004 DI ABETES MD	0	0		0	0	190. 04	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	48, 867	51, 77	100, 639	0	192. 00	
192.01 19201 MUNCIE MD OFFICES	0	0	21, 54	21, 542	0	192. 01	
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0		0	0	192. 02	
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)	o	2, 919, 868	10, 377, 97	13, 297, 842	31, 121	202. 00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

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

5/24/2024 11:54 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 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 00 4, 459, 690 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 208, 535 1, 248, 696 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 174, 086 9.00 111, 723 18, 012 9 00 10.00 01000 DI ETARY 36,860 20, 061 2,838 10.00 11.00 01100 CAFETERI A 47,605 48, 178 0 6,815 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 C 0 13.00 01300 NURSING ADMINISTRATION 124, 332 18, 813 2,661 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 37, 727 44,686 0 6, 321 14.00 01500 PHARMACY 15.00 137.681 20.409 2.887 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 35, 492 22, 116 3, 128 16.00 17.00 01700 SOCIAL SERVICE 0 C 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 0 0 19.00 02000 NURSI NG PROGRAM 20.00 0 0 20.00 0 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 448 0 0 21 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 0 22.00 1,059 0 0 22.00 23.00 02300 PARAMED ED PRGM-(EMS) 0 ol 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 620, 421 0 199, 801 0 28, 263 30.00 31.00 03100 INTENSIVE CARE UNIT 206, 563 0 78. 267 0 11,071 31.00 04300 NURSERY 0 57, 711 0 43.00 53, 496 8, 163 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 504,668 0 234, 408 0 33, 157 50.00 05100 RECOVERY ROOM 51.00 0 51.00 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 47.673 0 27. 433 3.881 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 99, 379 0 54.00 18, 795 2,659 54.00 54.01 05401 ULTRASOUND 28, 161 0 6,819 965 54.01 05600 RADI OI SOTOPE 56.00 19,609 0 8,850 0 1, 252 56.00 57 00 05700 CT SCAN 52 742 Ω 4.888 57 00 34, 552 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 61,801 0 Ω 58.00 05900 CARDIAC CATHETERIZATION 48, 594 0 38, 386 0 5, 430 59.00 59.00 0 60.00 06000 LABORATORY 255, 230 45.775 6, 475 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 27, 184 0 5,029 711 62.00 0 64.00 06400 INTRAVENOUS THERAPY 0 Ω 64.00 06500 RESPIRATORY THERAPY 65.00 97, 431 1, 472 0 208 65.00 66 00 06600 PHYSI CAL THERAPY 148 439 Ω 37, 956 5, 369 66 00 06700 OCCUPATIONAL THERAPY 67.00 16,876 C 6, 989 989 67.00 0 06800 SPEECH PATHOLOGY 3, 515 497 68.00 8.628 68.00 06900 ELECTROCARDI OLOGY 60, 751 0 85, 751 0 12, 130 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 Ω 20, 332 70 00 34 155 2,876 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 232, 183 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 274, 955 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 238, 879 0 73.00 0 0 73.00 0 07400 RENAL DIALYSIS 0 0 74.00 13, 437 0 74 00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0 0 90 00 90.01 09001 WOUND/OSTOMY CLINIC 62, 489 32, 020 0 4, 529 90.01 90 02 09002 CTR ADVANCED HEART CARE 6,584 0 90.02 0 09003 RADIATION ONCOLOGY 6, 348 90.03 127.841 0 898 90.03 90.04 09004 DIABETIC PLUS CLINIC 16,065 Ω C Λ 90.04 09005 ANTICOAGULATION CLINIC 0 90.05 90.05 15,082 0 0 0 o 90.06 09006 MAB 3611 REED 90.06 09100 EMERGENCY 91.00 243, 216 C 73, 179 0 10, 352 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 0 SPECIAL PURPOSE COST CENTERS 4, 363, 994 SUBTOTALS (SUM OF LINES 1 through 117) 1, 215, 663 169, 413 118. 00 0 0 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 190. 01 19001 WELLNESS CENTERS 36, 995 C 4, 722 0 668 190. 01 190. 02 19002 MONTI CELLO HSE. 0 190. 02 627 0 C 0 190. 03 19003 ROCK STEADY BOXING o 0 0 0 190. 03 5.622 190, 04 19004 DIABETES MD 0 0 190 04 0 \cap 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 51, 254 0 28, 311 0 4, 005 192. 00 192. 01 19201 MUNCIE MD OFFICES 0 0 192. 01 1, 115 192. 02 19202 RESIDENTIAL PROPERTY (1430 N MADISON 0 0 192. 02 79

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0113	From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/24/2024 11:54 am

						5/24/2024 11:	<u>54 am</u>
	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	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	C	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 459, 690	0	1, 248, 696	0	174, 086	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

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

5/24/2024 11:54 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL SUPPLY** 10.00 11.00 12.00 13.00 14.00 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 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 132, 349 10 00 01100 CAFETERI A 11.00 243, 348 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 9, 148 317, 343 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 2, 927 220, 955 14.00 01500 PHARMACY 0 15.00 10,612 0 903 15.00 0 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 0 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 0 19.00 19.00 0 02000 NURSING PROGRAM 20 00 C Λ 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 0 22.00 0 22.00 02300 PARAMED ED PRGM-(EMS) 23.00 0 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 106, 911 60, 013 0 166, 165 9,029 30.00 03100 INTENSIVE CARE UNIT 31.00 24, 209 17, 199 0 47, 900 2, 455 31.00 569 43.00 04300 NURSERY 3. 293 0 9, 206 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 34, 032 94, 072 19, 446 50.00 0 51.00 05100 RECOVERY ROOM 0 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 2, 927 0 52.00 0 521 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 953 0 0 411 54.00 0 54.01 05401 ULTRASOUND 0 0 1,830 0 370 54.01 56 00 05600 RADI OI SOTOPE 1 098 0 56 00 58 0 57.00 05700 CT SCAN 3, 659 354 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0000 2, 196 0 0 147 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 2, 927 0 0 1, 165 59.00 06000 LABORATORY 15, 003 0 60 00 24, 897 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 1,098 4, 719 62.00 06400 INTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0000000000 7, 685 0 0 1.061 65.00 06600 PHYSI CAL THERAPY 0 66.00 14, 272 319 66.00 67.00 06700 OCCUPATIONAL THERAPY 732 30 67.00 68.00 06800 SPEECH PATHOLOGY 366 0 0 15 68.00 06900 ELECTROCARDI OLOGY 69.00 5. 489 0 255 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 2.562 247 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 66, 485 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 78, 746 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 C 51 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 1, 177 90.01 09001 WOUND/OSTOMY CLINIC 0 2, 562 0 0 90.01 09002 CTR ADVANCED HEART CARE 0 0 0 90.02 1.464 90 90.02 0 90.03 09003 RADIATION ONCOLOGY 7, 685 1, 133 90.03 09004 DIABETIC PLUS CLINIC 0 0 0 90.04 90.04 1,830 100 0 0 90.05 09005 ANTICOAGULATION CLINIC 0 90.05 148 1.464 90.06 09006 MAB 3611 REED 0 0 90.06 91.00 09100 EMERGENCY 1, 165 21, 590 0 0 5, 699 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 132, 349 242, 616 0 317, 343 220, 600 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 0 190. 01 19001 WELLNESS CENTERS 0 0 0 48 190. 01 C 0 190. 02 19002 MONTI CELLO HSE. 0 0 0 190. 02 190. 03 19003 ROCK STEADY BOXING 0 0 45 190. 03 732 0 0 190. 04 19004 DI ABETES MD C 0 0 190.04 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 262 192.00 0 192. 01 19201 MUNCIE MD OFFICES 0 0 0 192. 01

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/24/2024 11:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE (PERSONNEL	F NURSING ADMINISTRATION	CENTRAL SERVI CES &	

						5/24/2024 11:	54 alli
Cost Cente	r Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
192. 02 19202 RESI DENTI A	L PROPERTY (1430 N MADISON	0	0	C	0	0	192. 02
200.00 Cross Foot	Adjustments						200. 00
201.00 Negative C	ost Centers	0	0	C	o	0	201. 00
202.00 TOTAL (sum	lines 118 through 201)	132, 349	243, 348	C	317, 343	220, 955	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

Period: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/24/2024 11:54 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSI NG RECORDS & **ANESTHETISTS PROGRAM** LI BRARY 15. 00 17.00 19. 00 20.00 16,00 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 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10 00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 515, 207 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 98, 911 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 02000 NURSING PROGRAM Ω 20 00 C 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 C 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 22.00 22.00 02300 PARAMED ED PRGM-(EMS) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 7, 438 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 2, 371 0 31.00 43.00 04300 NURSERY 0 555 0 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 21, 329 50.00 0 0 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 509 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,885 54.00 000000000000000 0 54.01 05401 ULTRASOUND 1, 331 54.01 56 00 05600 RADI OI SOTOPE 1 090 0 56 00 0 57.00 05700 CT SCAN 6, 775 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 488 0 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 801 0 59.00 06000 LABORATORY 7, 709 0 60 00 60 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 351 62.00 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 2, 211 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 1, 363 66 00 67.00 06700 OCCUPATIONAL THERAPY 238 67.00 68.00 06800 SPEECH PATHOLOGY 120 0 68.00 06900 ELECTROCARDI OLOGY 1, 990 0 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 810 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2, 664 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 3,007 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 7,002 73.00 515, 207 73.00 0 07400 RENAL DIALYSIS 74.00 0 180 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 90.01 09001 WOUND/OSTOMY CLINIC 0 949 0 90.01 0 0 09002 CTR ADVANCED HEART CARE 90.02 90.02 94 90.03 09003 RADIATION ONCOLOGY 6, 949 90.03 09004 DIABETIC PLUS CLINIC 0 90.04 90.04 0 36 90.05 09005 ANTICOAGULATION CLINIC 149 0 90.05 90.06 09006 MAB 3611 REED 0 90.06 91.00 09100 EMERGENCY 0 13, 517 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 98, 911 118.00 515, 207 0 0 0 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 190. 01 19001 WELLNESS CENTERS 0 0 190. 01 C 190. 02 19002 MONTI CELLO HSE. 0 0 0 0 190.02 190. 03 19003 ROCK STEADY BOXING Ω 0 190 03 0 190. 04 19004 DI ABETES MD 0 190.04 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 192. 01 19201 MUNCIE MD OFFICES 0 192.01

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2023	Part II	
			-	To 12/31/2023	Date/Time Pre	pared:
					5/24/2024 11:	54 am_
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVIC	E NONPHYSICIAN	NURSI NG	
		RECORDS &		ANESTHETI STS	PROGRAM	
		LIDDADY				

						5/24/2024 11	:54 am_
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	
			RECORDS &		ANESTHETI STS	PROGRAM	
			LI BRARY				
		15. 00	16. 00	17. 00	19. 00	20.00	
192. 02 1920	2 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0			192. 02
200. 00	Cross Foot Adjustments				0	(0 200. 00
201.00	Negative Cost Centers	0	0	0	0	(0 201. 00
202. 00	TOTAL (sum lines 118 through 201)	515, 207	98, 911	0	0		0 202. 00

| In Lieu of Form CMS-2552-10 | Worksheet B | Part II | B1/2023 | Date/Time Prepared: | 5/24/2024 | 11: 54 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113 Peri od: From 01/01/2023 To 12/31/2023 INTERNS & RESIDENTS SERVICES-SALAR SERVICES-OTHER PARAMED ED Cost Center Description Subtotal Intern &

	Cost Center Description	Y & FRINGES	PRGM. COSTS	PRGM-(EMS)	Subtotal	Residents Cost & Post	
						Stepdown	
		21.00	22.00	22.00	24.00	Adjustments	
	GENERAL SERVICE COST CENTERS	21. 00	22. 00	23. 00	24. 00	25. 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						4. 00 5. 00
6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
19. 00							19. 00
20. 00	02000 NURSI NG PROGRAM						20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	448	l e				21.00
22. 00 23. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)		1, 059	0			22. 00 23. 00
20.00	I NPATIENT ROUTINE SERVICE COST CENTERS	I .					20.00
30.00	03000 ADULTS & PEDIATRICS				1, 658, 719		30. 00
31.00					583, 998		31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				246, 042	0	43. 00
50. 00	05000 OPERATING ROOM				2, 852, 764	0	50.00
51. 00	05100 RECOVERY ROOM				0	1	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM				142, 616		52. 00
54. 00 54. 01	05400 RADI OLOGY - DI AGNOSTI C				454, 369		54. 00 54. 01
56. 00	05401 ULTRASOUND 05600 RADI OI SOTOPE				54, 244 101, 454		56.00
57. 00	05700 CT SCAN				189, 874		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)				528, 021	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON				333, 262		59. 00
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				703, 573 50, 820		60. 00 62. 00
64. 00	06400 I NTRAVENOUS THERAPY				0 30, 620	0	64. 00
65. 00	06500 RESPI RATORY THERAPY				176, 335	0	65. 00
66.00	06600 PHYSI CAL THERAPY				1, 154, 405		66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY				41, 062 20, 791		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY				435, 318		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY				124, 906		70. 00
71. 00					301, 332		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				356, 708 761, 088		
	07400 RENAL DIALYSIS				13, 668		ı
	07700 ALLOGENEIC HSCT ACQUISITION				0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY				0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC				0	1 0	00.00
90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC				0 167, 296	_	90. 00 90. 01
90. 02					8, 761	Ö	90. 02
	09003 RADI ATI ON ONCOLOGY				613, 242		90. 03
90. 04					20, 313		90. 04
90. 05 90. 06					16, 998 0	0	90. 05 90. 06
91.00		1			541, 550		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
405 :	OTHER REIMBURSABLE COST CENTERS	1					100 0-
102.00	D 10200 OPLOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS				0] 0	102. 00
118. 00		0	0	0	12, 653, 529	n	118. 00
	NONREI MBURSABLE COST CENTERS				.2,000,027		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0		190. 00
	1 19001 WELLNESS CENTERS 2 19002 MONTI CELLO HSE.				405, 603 627		190. 01 190. 02
170.02	I TOOZ MONTH OLLEGI HOL.	1	I	I	027	1 0	1170.02

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-0113	Peri od:	Worksheet B	
				From 01/01/2023 To 12/31/2023		pared: 54 am
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
	Y & FRINGES	PRGM. COSTS	PRGM-(EMS)		Residents Cost	
					& Post	
					Stepdown	
					Adjustments	
	21. 00	22. 00	23. 00	24. 00	25. 00	
190. 03 19003 ROCK STEADY BOXING				29, 365	-	190. 03
190. 04 19004 DI ABETES MD				4	0	190. 04
192.00 19200 PHYSICIANS' PRIVATE OFFICES				184, 471	0	192. 00
192.01 19201 MUNCIE MD OFFICES				22, 657	0	192. 01
192.02 19202 RESIDENTIAL PROPERTY (1430 N MADISON				79	0	192. 02
200.00 Cross Foot Adjustments	448	1, 059		0 1, 507	0	200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	448	1, 059		0 13, 297, 842	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

			5/24/2024 11	
	Cost Center Description	Total	0,2,,202	
		26. 00		
-	GENERAL SERVICE COST CENTERS			
	00100 CAP REL COSTS-BLDG & FIXT			1.00
	00200 CAP REL COSTS-MVBLE EQUIP			2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
	00500 ADMI NI STRATI VE & GENERAL			5. 00
	00600 MAINTENANCE & REPAIRS			6.00
	00700 OPERATION OF PLANT			7.00
	00800 LAUNDRY & LINEN SERVICE			8. 00
	00900 HOUSEKEEPI NG			9. 00
	01000 DI ETARY			10.00
	01100 CAFETERI A			11.00
	01200 MAI NTENANCE OF PERSONNEL			12.00
	01300 NURSI NG ADMI NI STRATI ON			13.00
	01400 CENTRAL SERVICES & SUPPLY			14.00
	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16.00
	01700 SOCIAL SERVICE			17. 00
	01900 NONPHYSI CI AN ANESTHETI STS			19. 00
	02000 NURSING PROGRAM			20.00
	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD			21. 00
	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD			22. 00
	02300 PARAMED ED PRGM-(EMS)			23. 00
-	INPATIENT ROUTINE SERVICE COST CENTERS	1 450 710		20.00
	03000 ADULTS & PEDIATRICS	1, 658, 719		30. 00 31. 00
	03100 NTENSIVE CARE UNIT	583, 998		
	04300 NURSERY	246, 042		43. 00
	ANCILLARY SERVICE COST CENTERS	2.052.744		F0.00
	05000 OPERATING ROOM	2, 852, 764		50.00
	05100 RECOVERY ROOM	142 (14		51.00
	05200 DELIVERY ROOM & LABOR ROOM	142, 616		52.00
	05400 RADI OLOGY-DI AGNOSTI C	454, 369		54.00
	05401 ULTRASOUND	54, 244		54. 01
	05600 RADI OI SOTOPE	101, 454		56.00
	05700 CT SCAN	189, 874		57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	528, 021		58. 00
	05900 CARDI AC CATHETERI ZATI ON	333, 262		59.00
	06000 LABORATORY	703, 573		60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	50, 820 0		62.00
	06400 I NTRAVENOUS THERAPY	-		64.00
	06500 RESPIRATORY THERAPY	176, 335		65. 00
	06600 PHYSI CAL THERAPY	1, 154, 405		66.00
	06700 OCCUPATIONAL THERAPY	41, 062		67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	20, 791 435, 318		68. 00 69. 00
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	124, 906		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	301, 332		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	356, 708		71.00
	07300 DRUGS CHARGED TO PATIENTS	761, 088		73.00
	07400 RENAL DIALYSIS	13, 668		74.00
	07700 ALLOGENEIC HSCT ACQUISITION	13,000		77. 00
	07/00 ALLOGENETE HISET ACCOUNTION 07800 CAR T-CELL IMMUNOTHERAPY	0		78.00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		78.00
	09000 CLINIC	ol		90.00
	09001 WOUND/OSTOMY CLINIC	167, 296		90.00
	09002 CTR ADVANCED HEART CARE	8, 761		90.01
	09003 RADIATION ONCOLOGY	613, 242		90. 02
	09004 DIABETIC PLUS CLINIC	20, 313		90.03
	09005 ANTI COAGULATI ON CLI NI C	16, 998		90.04
	09006 MAB 3611 REED	10, 770		90.06
	09100 EMERGENCY	541, 550		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	341, 330		92. 00
	OTHER REIMBURSABLE COST CENTERS			72.00
	10200 OPI OI D TREATMENT PROGRAM	0		102. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>		1.02.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	12, 653, 529		118. 00
-	NONREI MBURSABLE COST CENTERS	12,000,029		-1.10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O		190. 00
	19001 WELLNESS CENTERS	405, 603		190.00
	19002 MONTI CELLO HSE.	627		190. 01
	19003 ROCK STEADY BOXING	29, 365		190. 02
	19004 DI ABETES MD	27, 303		190. 03
	19200 PHYSICIANS' PRIVATE OFFICES	184, 471		192. 00
	19200 MUNCIE MD OFFICES	22, 657		192. 00
	19202 RESIDENTIAL PROPERTY (1430 N MADISON	79		192. 01
200.00	Cross Foot Adjustments	1, 507		200. 00
200.00	101 000 1 001 Auj ustilletits	1, 307		1200.00

Health Financial Systems	COMMUNITY HOSPITA	AL ANDERSON	In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0113	From 01/01/2023			
			To 12/31/2023	Date/Time Pre 5/24/2024 11:		
Cost Center Description	Total					
	26. 00					
201.00 Negative Cost Centers	0				201. 00	
202.00 TOTAL (sum lines 118 through 201)	13, 297, 842				202. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113

					Т	o 12/31/2023	Date/Time Pre 5/24/2024 11:	
			CAPITAL REI	LATED COSTS			0,21,2021111	9 , 4
		Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		·	(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
					DEPARTMENT (GROSS		(ACCUM. COST)	
					SALARI ES)			
	CENED	AL CEDVICE COCT CENTERS	1.00	2. 00	4. 00	5A	5. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	287, 283					1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP		10, 357, 757				2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	2, 991	720			141 (72 525	4. 00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	17, 006 0	4, 275, 345 0		-35, 328, 763 0	141, 673, 525 0	5. 00 6. 00
7.00	00700	OPERATION OF PLANT	55, 221	477, 159	1, 879, 698	0	6, 624, 568	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	3, 059	0 12, 277	1	0	0 3, 549, 129	8. 00 9. 00
10. 00		DIETARY	3, 407	37, 645			1, 170, 953	
11. 00		CAFETERI A	8, 182		1		1, 512, 274	•
12. 00 13. 00		MAI NTENANCE OF PERSONNEL NURSI NG ADMI NI STRATI ON	0 3, 195	0 128, 914	1		0 3, 949, 669	12. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	7, 589				1, 198, 487	14. 00
15. 00	1	PHARMACY	3, 466		1		4, 373, 747	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	3, 756	0		0	1, 127, 472 0	1
19. 00		NONPHYSICIAN ANESTHETISTS	0	Ö	Ö	0	0	19. 00
20.00		NURSI NG PROGRAM	0	0	0	0	0	20. 00
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	14, 234 33, 648	•
23. 00		PARAMED ED PRGM-(EMS)	0	Ö			0	
00.00		I ENT ROUTI NE SERVI CE COST CENTERS	00.000	100 5/7	10.000 574		40 740 700	
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	33, 932 13, 292				19, 710, 702 6, 561, 934	30. 00 31. 00
43. 00		NURSERY	9, 801	13, 013			1, 699, 423	
50.00		LARY SERVICE COST CENTERS		4 500 550			4/ 004 004	
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	39, 809	1, 500, 550 0			16, 031, 894 0	50. 00 51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	4, 659	1	1	_	1, 514, 427	52. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	3, 192				3, 156, 981	54.00
54. 01 56. 00	1	ULTRASOUND RADI OI SOTOPE	1, 158 1, 503			0	894, 601 622, 918	54. 01 56. 00
57. 00	1	CT SCAN	5, 868				1, 675, 451	•
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	,			1, 963, 245	•
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	6, 519 7, 774	166, 026 267, 810			1, 543, 698 8, 107, 940	
62. 00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	854				863, 560	
64.00	1	I NTRAVENOUS THERAPY	0	0		0	0	64. 00 65. 00
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	250 6, 446				3, 095, 102 4, 715, 482	
67.00	06700	OCCUPATI ONAL THERAPY	1, 187	2, 975	373, 436		536, 104	67. 00
		SPEECH PATHOLOGY ELECTROCARDI OLOGY	597	1, 497 120, 184		0	274, 098 1, 929, 891	•
69. 00 70. 00	1	ELECTROCARDIOLOGY	14, 563 3, 453	28, 519			1, 929, 891	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7, 375, 798	•
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	8, 734, 562 7, 588, 518	
74. 00		RENAL DIALYSIS	0	Ö	Ö	0	426, 861	
77. 00	1	ALLOGENEIC HSCT ACQUISITION	0	0			0	
78. 00		CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
90. 00		CLINIC	0	0	0	0	0	90. 00
90. 01		WOUND/OSTOMY CLINIC	5, 438				1, 985, 088	•
90. 02 90. 03		CTR ADVANCED HEART CARE RADIATION ONCOLOGY	1, 078	365 449, 707			209, 145 4, 061, 142	90. 02 90. 03
90. 04		DIABETIC PLUS CLINIC	0	2, 105			510, 333	•
90. 05		ANTI COAGULATI ON CLINIC	0	0		0	479, 110	
90. 06 91. 00		MAB 3611 REED EMERGENCY	12, 428	0 44, 172	· -	0	0 7, 726, 309	90. 06 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	12, 420	77, 172	3, 100, 372	0	7,720,307	92. 00
		REIMBURSABLE COST CENTERS	_	_	_	_		
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	281, 673	9, 907, 654	70, 669, 113	-35, 328, 763	138, 633, 497	118. 00
100.00		IMBURSABLE COST CENTERS						100 00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN WELLNESS CENTERS	0 802				0 1, 175, 240	190. 00 190. 01
		MONTI CELLO HSE.	0		1		19, 932	190. 02

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of	Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0113	Peri od: Worl From 01/01/2023	ksheet B-1

						o 12/31/2023		
			CAPITAL REI	LATED COSTS				
		Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Poconciliation	ADMI NI STRATI VE	
		cost center bescription		(DOLLAR VALUE)		Reconciliation	& GENERAL	
			(040/1112 / 221)	(50227111 171202)	DEPARTMENT		(ACCUM. COST)	
					(GROSS		,	
					SALARI ES)			
			1. 00	2. 00	4. 00	5A	5. 00	
		3 ROCK STEADY BOXING	0	22, 873	109, 617	0	178, 609	1
	-	4 DIABETES MD	0	0	0	0		190. 04
		O PHYSICIANS' PRIVATE OFFICES	4, 808		0	0	1, 628, 188	1
		1 MUNCIE MD OFFICES	0	21, 500	0	0	35, 411	1
	1	2 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0		192. 02
	200. 00	Cross Foot Adjustments						200. 00
	1							
2	202. 00	SI .	2, 919, 868	10, 377, 974	2, 726, 502		35, 328, 763	202. 00
_		1						
			10. 163734	1. 001952				1
2	204. 00	••			31, 121		4, 459, 690	204. 00
,	205 00	,			0.000407		0.004.470	005 00
2	205.00				0.000436		0.031479	205.00
,	206 00	1 /						206 00
	200.00							200.00
-	207 00		1					207 00
	207.00							207.00
2 2 2 2	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)	2, 919, 868 10. 163734				35, 328, 763 0. 249367 4, 459, 690 0. 031479	203. 00 204. 00

| Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0113

				' T	o 12/31/2023	Date/Time Pre 5/24/2024 11:	
	Cost Center Description	MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	54 aiii
		REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(PATIENT DAYS DIETARY)	
		,	· ·	LAUNDRY)		ŕ	
	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 MAI NTENANCE & REPAI RS	0					6. 00
7.00	00700 OPERATION OF PLANT	0	212, 065	i			7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	0 3, 059	1	209, 006		8. 00 9. 00
10. 00	01000 DI ETARY	Ö	3, 407	1	· ·	22, 606	10. 00
11.00	01100 CAFETERI A	0	8, 182	1			11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0 3, 195	_	0 3, 195	0	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	Ö	7, 589		,		14. 00
15. 00	01500 PHARMACY	0	3, 466	I	3, 466		15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	3, 756	1	3, 756 0	0	16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	Ö	Ö			Ö	19. 00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20. 00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRINGES APPRVD 02200 &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)	0	0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	00,702	1			30. 00 31. 00
43. 00	04300 NURSERY	0				4, 133	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	39, 809	1	,	11	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		4, 659			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 192	1	3, 192	0	54. 00
54. 01	05401 ULTRASOUND	0	1, 158	1	,		54. 01
56. 00 57. 00	05600	0	1, 503 5, 868	1			56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	i		Ö	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	6, 519	i			59. 00
60. 00 62. 00	O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7, 774 854	1	7, 774 854	0	60. 00 62. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	1	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	250	0	250	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	6, 446	1			66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	1, 187 597			0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	14, 563	l .		Ö	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	3, 453				70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö	Ö	0	Ö	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0		0	77. 00 78. 00
76.00	OUTPATIENT SERVICE COST CENTERS	0		<u> </u>	0	0	76.00
90. 00	09000 CLI NI C	0	0			_	90. 00
90. 01 90. 02	O9001 WOUND/OSTOMY CLINIC O9002 CTR ADVANCED HEART CARE	0	5, 438	0	5, 438	0	90. 01 90. 02
90. 02	09003 RADI ATI ON ONCOLOGY		1, 078	1	1, 078		90. 02
90. 04	09004 DI ABETI C PLUS CLINI C	0	0	Ō	0	0	90. 04
90. 05	1	0	0	0	0	0	90. 05
90. 06 91. 00	09006 MAB 3611 REED 09100 EMERGENCY	0	12, 428	0		0 199	90. 06 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		12, 420		12, 420	177	92. 00
	OTHER REIMBURSABLE COST CENTERS	1	I	I			
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118.00		0	206, 455	0	203, 396	22, 606	118. 00
400 -	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 WELLNESS CENTERS	0	0 802				190. 00 190. 01
	19001 WELLNESS CENTERS 19002 MONTI CELLO HSE.		0		0		190. 01
190. 03	19003 ROCK STEADY BOXING	0	0	O	0	0	190. 03
	19004 DIABETES MD 19200 PHYSICIANS' PRIVATE OFFICES	0	0 4, 808	0	0		190. 04 192. 00
172.00	1/17200/FIII31CIANS PRIVATE UFFICES	1 0	1 4, 808	<u>'I</u>	4, 808	ı U	1172. UU

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0113	Peri od:	Worksheet B-1	

				T	o 12/31/2023	Date/Time Pre 5/24/2024 11:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		DI ETARY)	
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
192. 01 1	9201 MUNCIE MD OFFICES	0	0	0	0	0	192. 01
192. 02 1	9202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	192. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	0	8, 276, 517	0	4, 553, 552	1, 670, 146	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	39. 028208	0.000000	21. 786705	73. 880651	203. 00
204.00	Cost to be allocated (per Wkst. B,	0	1, 248, 696	0	174, 086	132, 349	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	5. 888270	0.000000	0. 832923	5. 854596	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)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 11:54 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL ADMI NI STRATI ON (ONSITE FTES) SERVICES & (COSTED (NUMBER **SUPPLY** REQUIS.) (DIRECT NURS HOUSED) (COSTED REQUIS.) HRS.) 11.00 12.00 13.00 14.00 15.00 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 01100 CAFETERI A 11.00 665 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 25 650, 855 13.00 01400 CENTRAL SERVICES & SUPPLY 8 24, 511, 367 14 00 14 00 C 15.00 01500 PHARMACY 29 0 100, 201 7, 638, 097 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 16.00 0 01700 SOCIAL SERVICE 17 00 0 0 17 00 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 02000 NURSING PROGRAM 0 0 0 20.00 20.00 0 02100 | &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 0 22 00 22 00 C 0 02300 PARAMED ED PRGM-(EMS) 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 164 0 340, 796 1,001,693 0 30.00 03100 INTENSIVE CARE UNIT 47 Ω 272.392 31 00 98 241 0 31 00 43.00 04300 NURSERY 0 18,881 63,085 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 93 50.00 192, 937 2, 157, 332 0 50.00 05100 RECOVERY ROOM Ω 51.00 0 C 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 8 0 0 57, 851 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 19 0 0 45, 624 54.00 5 54.01 05401 ULTRASOUND 0 0 41, 015 0 54.01 05600 RADI OI SOTOPE 0 56.00 0 6, 447 0 56.00 05700 CT SCAN 10 39, 280 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 6 0 0 16, 334 58.00 05900 CARDIAC CATHETERIZATION 8 0 59.00 0 129, 191 59.00 0 0 60.00 06000 LABORATORY 41 0 2, 762, 025 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3 523, 538 62.00 06400 INTRAVENOUS THERAPY 0 64.00 64.00 06500 RESPIRATORY THERAPY 21 0 65.00 117, 734 Λ 65.00 66.00 06600 PHYSI CAL THERAPY 39 35, 436 66.00 67.00 06700 OCCUPATIONAL THERAPY 2 3, 286 67.00 06800 SPEECH PATHOLOGY 1 0 1, 654 68.00 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 15 C 28, 278 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 7 27, 406 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 7, 375, 798 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72 00 C 8, 734, 561 Λ 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 7, 638, 097 73.00 17 07400 RENAL DIALYSIS 0 0 74.00 0 5, 658 0 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 7 90 01 09001 WOUND/OSTOMY CLINIC Ω 0 130 577 90 01 0 0 90.02 09002 CTR ADVANCED HEART CARE 0 10,024 0 90.02 09003 RADIATION ONCOLOGY 21 125, 743 90.03 90.03 90.04 09004 DIABETIC PLUS CLINIC 0 0 11,047 90.04 5 0 90.05 09005 ANTI COAGULATION CLINIC 4 0 90 05 Ω 16, 473 0 0 90.06 09006 MAB 3611 REED 0 0 0 90.06 09100 EMERGENCY 0 632, 259 91.00 91.00 59 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 650, 855 24, 471, 959 7, 638, 097 118. 00 118.00 663 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 190. 01 19001 WELLNESS CENTERS 0 0 5, 339 0 190. 01 0 01190.02 190. 02 19002 MONTI CELLO HSE 0 190. 03 19003 ROCK STEADY BOXING 2 0 0 4, 969 0 190. 03 190. 04 19004 DI ABETES MD 0 0 190, 04

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0113	Peri od: Worksheet B-1		
		From 01/01/2023 To 12/31/2023 Date/Time Prepared:		

				To	12/31/2023	Date/Time Pre 5/24/2024 11:	
	Cost Center Description		MAINTENANCE OF		CENTRAL	PHARMACY	
		(ONSITE FTES)		ADMI NI STRATI ON	SERVICES &	(COSTED	
			(NUMBER	(DI DECT NUDC	SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT NURS.	(COSTED		
		11.00	10.00	HRS.)	REQUIS.)	45.00	
100 00 1000	DUNGLOLANOL BRUVATE OFFLORO	11.00	12.00	13. 00	14.00	15. 00	100.00
	PHYSICIANS' PRIVATE OFFICES	0	0	0	29, 100		192. 00
	MUNCIE MD OFFICES	0	0	0	O		192. 01
	RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	192. 02
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	2, 386, 973	0	5, 218, 626	1, 987, 589	5, 787, 419	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	3, 589. 433083	0. 000000	8. 018108	0. 081088	0. 757704	203. 00
204. 00	Cost to be allocated (per Wkst. B,	243, 348	0	317, 343	220, 955	515, 207	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	365. 936842	0. 000000	0. 487579	0. 009014	0.067452	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)						
'	•		•			'	•

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 11:54 am INTERNS & **RESI DENTS** MEDI CAL SOCIAL SERVICE NONPHYSI CI AN NURSI NG SERVI CES-SALAR Cost Center Description Y & FRINGES RECORDS & **ANESTHETI STS PROGRAM** (ASSI GNED (ASSI GNED LI BRARY (TIME SPENT) (ASSI GNED (GROSS TIME) TIME) TIME) CHARGES) 17. 00 19.00 20.00 21.00 16, 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 846, 129, 277 16,00 16,00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 20.00 02000 NURSING PROGRAM 0 0 02100 I &R SERVICES-SALARY & FRINGES APPRVD 1, 601 21.00 0 0 21.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 0 Ω 02300 PARAMED ED PRGM-(EMS) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 63, 576, 477 0 0 0 0 0 31.00 03100 INTENSIVE CARE UNIT 20, 264, 275 C 0 04300 NURSERY 0 0 43.00 4.747.590 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 183, 054, 348 0 0 1,600 50.00 05100 RECOVERY ROOM 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 4, 353, 685 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 16, 107, 325 0 54 00 0 54 00 54.01 05401 ULTRASOUND 11, 376, 053 0 0 54.01 05600 RADI OI SOTOPE 9, 314, 412 0 56, 00 0 0 05700 CT SCAN 57, 903, 138 0 0 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 21, 262, 700 0 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 32, 483, 880 0 0 0 60.00 06000 LABORATORY 65, 891, 138 0 2, 999, 456 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62 00 0 62 00 0 06400 INTRAVENOUS THERAPY 0 64.00 0 65.00 06500 RESPIRATORY THERAPY 18, 895, 822 0 06600 PHYSI CAL THERAPY 66.00 11, 645, 523 0 0 06700 OCCUPATIONAL THERAPY 2 032 424 0 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 1,022,920 0 68.00 06900 ELECTROCARDI OLOGY 17, 008, 533 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 6, 923, 673 0 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71 00 22, 771, 440 Ω 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 25, 697, 053 0 0 0 59, 845, 486 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 07400 RENAL DIALYSIS 1,535,261 0 0 74.00 0 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77 00 77 00 0 0 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0 0 0 0 90.01 09001 WOUND/OSTOMY CLINIC 8, 110, 133 0 0 0 90.01 804, 837 09002 CTR ADVANCED HEART CARE 0 90.02 90.02 0 59, 392, 100 09003 RADIATION ONCOLOGY 90.03 90.03 0 0 0 0 90.04 09004 DIABETIC PLUS CLINIC 90.04 307, 237 0 0 90.05 09005 ANTICOAGULATION CLINIC 1, 274, 812 0 0 0 90.05 0 0 90.06 09006 MAB 3611 REED 0 09100 EMERGENCY 115, 527, 546 C 0 0 91.00 91.00 0

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

						5/24/2024 11:	<u>54 am</u>
						INTERNS &	
						RESI DENTS	
(Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	SERVI CES-SALAR	
		RECORDS &		ANESTHETI STS	PROGRAM	Y & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		(GROSS		TIME)	TIME)	TIME)	
		CHARGES)					
		16. 00	17. 00	19. 00	20. 00	21. 00	
190. 03 19003 F	ROCK STEADY BOXING	0	0	0	0	0	190. 03
190. 04 19004 [DIABETES MD	0	0	0	0	0	190. 04
192. 00 19200 F	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 19201 N	MUNCIE MD OFFICES	0	0	0	0	0	192. 01
192. 02 19202 F	RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0	0	0	192. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 637, 047	0	0	0	17, 783	202. 00
F	Part I)						
203. 00 l	Unit cost multiplier (Wkst. B, Part I)	0. 001935	0. 000000	0.000000	0.000000	11. 107433	203. 00
204.00	Cost to be allocated (per Wkst. B,	98, 911	0	0	0	448	204. 00
	Part II)						
205. 00 l	Unit cost multiplier (Wkst. B, Part	0. 000117	0. 000000	0.000000	0.000000	0. 279825	205. 00
	II)						
206.00	NAHE adjustment amount to be allocated				0		206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,				0.000000		207. 00
	Parts III and IV)						

COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113

DOUGLOST Center Description					10 12/31/202	3 Date/lime Prepared: 5/24/2024 11:54 am
PRIOR COSTS PRIOR COST CENTERS 1.00			RESI DENTS			
CAST CREED (ASS) CREED (Cost Center Description				
1.00 1.00			(ASSI GNED	(ASSI GNED		
1.00 00100 COM PILL COSTS-HULE & FIRM 2.00						
2.00 00.000 CAP REL DOSTS-MINEL EQUIP	1 00					1.00
4.00		1 1				
6.00 00000 MATEMANICE & REPAIRS						•
7.00 00000 00000 00000 00000 00000 00000 000000	5.00	00500 ADMINISTRATIVE & GENERAL				5. 00
8.00						
0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00						
10.00 01000 DETARY						
12.00 0.1200 MAINTENANCE OF PERSONNEL 13.00 0.300 MISESIN ACM MISTART NON 13.00 0.300 MISESIN ACM MISTART NON 14.00 15.00 0.30				•		
13.00 1300 MURSING ADMINISTRATION 13.00 15	11. 00	01100 CAFETERI A				11. 00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 HEDICAL RECORDS & LIBRARY 15.00 01500 HEDICAL RECORDS & LIBRARY 15.00 17.00 1700 07100 0		1				•
15.00 10500 PHASHMACY 15.00 10700 SCILAL SERVICE 17.00		1				•
16. 00 10400 MEDI CAL RECORDS & LIBRARY 10. 00 170. 00		1 1				•
19.00 1900 MOMPHYSICI AM AMESTHETISTS 20.00 2020 LARS SERVICES-SALARY & FRINGES APPRVD 2.1.00 22.00 2020 LARS SERVICES-SALARY & FRINGES APPRVD 1,601 22.00 2020 188 SERVICES-SALARY & FRINGES APPRVD 1,601 22.00 2020 PARAMER DE D'ROUL (EMS) 22.00 187 SERVICES SERVICE COSTS APPRVD 1,601 30.00 30.000 ADULTS & PEDIATRICS 0 0 33.00 31.00 310 01.00 10 10 10 10 10 10		1 1				
20.00 2000 MURSI NO, PROCRAM 22.00 2		1 1				· ·
21.00 2020 IAR SERVI CES-SALARY & FEINRES APPRIVD		1 1				· ·
22.00 02200 RAS SERVICES-OTHER PROM. COSTS APPRVD 1,601 0 22.00 02300 RAS SERVICES-OTHER PROM. COSTS APPRVD 0 0 23.00 02300 02100 PARAMED ED PROM. (EMS) 0 0 0 0 0 0 0 0 0						· ·
INPATT ENT ROUTINE SERVICE COST CENTERS 1		1	1, 601			· ·
30.00 30000 ADULTS & PEDIATRICS 1 0 31.0	23. 00			0		23. 00
31.00	20.00		1			20.00
43. 00 04300 NURSERY 0 0 0 50.00				•		•
50.00 GS0000 OPERATI NG ROOM 1,600 51.00 51.00 52.00 5			1	•		•
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0						
52.00 05200 DELLYERY ROOM & LABOR ROOM 0 0 54.00 55.00 55.00 55.00 55.00 55.00 57.00			1, 600	•		•
54.00 0.6400 0.			0			•
54. 01 05401 ULTRASOUND		1				•
57, 00 05700 CT SCAN 57, 00 58, 00 58, 00 59, 00 5	54. 01	1	O	0		54. 01
58. 00 OSBOO MAGNETIC RESONANCE INAGING (MRI) 0 0 59. 00			0			
59, 00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 0 0 0 0 0			0			
60. 00 06.000 LABORATORY 0 0 0 0 62.00 06.200		1 1				•
64. 00 06400 NTRAVERIOUS THERAPY 0 0 0 0 0 0 0 0 0			o			
65. 00 06500 06500 RESPIRATORY THERAPY 0 0 0 0 066. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 068. 00 06800 SPEECH PATHOLOGY 0 0 0 0 068. 00 069. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 069. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 071.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72.00 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73. 00 74.00		1	0			
66. 00 06600 PIYSI CAL THERAPY		1 1	0	- 1		
67. 00 66700 OCCUPATIONAL THERAPY 0 0 0 68. 00 6800 SPEECH PATHOLOGY 0 0 0 68. 00 6800 SPEECH PATHOLOGY 0 0 0 68. 00 6900 ELECTROCARDI OLOGY 0 0 0 69. 00 70. 00 0710. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71. 00 772. 00 772. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73. 00 7300 DRUGS CHARGED TO PATIENTS 0 0 0 74. 00 74. 00 74.00 RMAL DIALYSIS 0 0 0 0 74. 00 77. 00 77.00 ALLOGENEIC HSCT ACQUISITION 0 0 0 77. 00 78. 00 07600 [AR T-CELL IMMUNOTHERAPY 0 0 0 77. 00 78. 00 07600 [AR T-CELL IMMUNOTHERAPY 0 0 0 0 77. 00 78. 00 07900 [CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
69. 00 06900 ELECTROCARDI OLOGY		+ I	o	O		
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 77. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72. 00 072. 00 072. 00 072. 00 073. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	0			· ·
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 073. 00 073.00 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		+ I	0	0		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73. 00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 74. 00 74. 00 74. 00 77. 00 7				0		
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 77. 00 0 0 0 0 0 0 0 0 0			Ö	o		· ·
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0			0	0		
78. 00			0	0		
OUTPATI ENT SERVICE COST CENTERS		1				l l
90. 01		OUTPATIENT SERVICE COST CENTERS				7 5. 00
90. 02			0			ı
90. 03			0	0		ı
90. 04		1		0		ı
90. 06	90. 04	09004 DIABETIC PLUS CLINIC	0	ō		90. 04
91. 00			0	0		•
92. 00 07200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS 102. 00 10200 0PI 0I D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1,601 0 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 01 190. 01 19001 WELLNESS CENTERS 0 0 0 190. 01 190. 02 19002 MONTI CELLO HSE. 0 0 0 190. 02			0	0		
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O				U		
102. 00	, 2. 00					72.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 601 0 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 01 190. 01 19001 WELLNESS CENTERS 0 0 0 190. 01 190. 02 19002 MONTI CELLO HSE. 0 0 0 190. 02	102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 01 190. 01 19001 WELLNESS CENTERS 0 0 0 190. 01 190. 02 19002 MONTI CELLO HSE. 0 0 0 190. 02	110 00		4 (64	ما		440.00
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 190. 01 19001 WELLNESS CENTERS 0 0 190. 01 190. 02 19002 MONTI CELLO HSE. 0 0 190. 02	118.00		1, 601	U		118.00
190. 01 19001 WELLNESS CENTERS 0 0 190. 01 190. 02 19002 MONTI CELLO HSE. 0 0 0 190. 02	190. 00		O	0		190. 00
	190. 01	19001 WELLNESS CENTERS	0			
190. 03 1900 1 1 0 0 0 1 1900 03			0			
	190.03	PINANOPLYNCK STEANT BOYING	ı o	υĮ		1190. 03

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113
Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

				'	12/31/2023	5/24/2024 11:	
		INTERNS &	·				
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	PARAMED ED				
		PRGM. COSTS	PRGM-(EMS)				
		(ASSI GNED	(ASSI GNED				
		TIME)	TIME)				
		22. 00	23. 00				
	19004 DI ABETES MD	0	0				190. 04
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192. 00
	19201 MUNCIE MD OFFICES	0	0				192. 01
192. 02	19202 RESIDENTIAL PROPERTY (1430 N MADISON	0	0				192. 02
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	42, 039	0				202. 00
	Part I)						
203.00		26. 257964	0. 000000				203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 059	0				204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 661462	0. 000000				205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated		0				206. 00
	(per Wkst. B-2)						
207.00			0. 000000				207. 00
	Parts III and IV)						

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0113	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared:

			Т	o 12/31/2023	Date/Time Prep 5/24/2024 11:	pared: 54 am
		Title	XVIII	Hospi tal	PPS	<u> </u>
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
· ·	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST	CENTERS	•				
30. 00 03000 ADULTS & PEDIATRICS	31, 564, 123	3	31, 564, 123	0	31, 564, 123	30. 00
31.00 03100 INTENSIVE CARE UNIT	10, 329, 821		10, 329, 821	o	10, 329, 821	31. 00
43. 00 04300 NURSERY	2, 917, 246		2, 917, 246	o	2, 917, 246	
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATING ROOM	24, 861, 253	3	24, 861, 253	0	24, 861, 253	50. 00
51.00 05100 RECOVERY ROOM			0	ol	0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOF	M 2, 217, 241		2, 217, 241	ol	2, 217, 241	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 241, 416		4, 241, 416	0	4, 241, 416	
54. 01 05401 ULTRASOUND	1, 231, 395		1, 231, 395	ol	1, 231, 395	54. 01
56. 00 05600 RADI 0I SOTOPE	898, 971		898, 971	0	898, 971	
57. 00 05700 CT SCAN	2, 601, 237	l e	2, 601, 237	o	2, 601, 237	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGI NO			2, 516, 818	o	2, 516, 818	
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 427, 145		2, 427, 145	l ől	2, 427, 145	59. 00
60. 00 06000 LABORATORY	11, 101, 201		11, 101, 201		11, 101, 201	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED I			1, 189, 864		1, 189, 864	
64. 00 06400 NTRAVENOUS THERAPY	1, 184, 80 ²	1	1, 107, 004		1, 109, 804	64. 00
65. 00 06500 RESPIRATORY THERAPY	4, 003, 610	1	U		- 1	
66. 00 06600 PHYSI CAL THERAPY		1	4, 003, 610	0	4, 003, 610	
	6, 448, 776	l l	6, 448, 776	0	6, 448, 776	
67. 00 06700 OCCUPATI ONAL THERAPY	753, 356		753, 356	0	753, 356	
68. 00 06800 SPEECH PATHOLOGY	384, 458		384, 458	0	384, 458	
69. 00 06900 ELECTROCARDI OLOGY	3, 385, 836	1	3, 385, 836	0	3, 385, 836	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 606, 300		1, 606, 300	0	1, 606, 300	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED			9, 857, 231	0	9, 857, 231	
72.00 07200 IMPL. DEV. CHARGED TO PAT			11, 670, 677	0	11, 670, 677	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	15, 384, 065	l l	15, 384, 065	0	15, 384, 065	
74. 00 07400 RENAL DIALYSIS	536, 736	I .	536, 736	0	536, 736	
77.00 07700 ALLOGENEIC HSCT ACQUISITION		l l	0	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	()	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS			_	_1	_	
90. 00 09000 CLINIC	()	1	0	0	0	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	2, 862, 221	l l	2, 862, 221	0	2, 862, 221	
90. 02 09002 CTR ADVANCED HEART CARE	278, 027	l control of the cont	278, 027	0	278, 027	90. 02
90. 03 09003 RADI ATI ON ONCOLOGY	5, 339, 913	l e	5, 339, 913	0	5, 339, 913	
90. 04 09004 DIABETIC PLUS CLINIC	657, 031	l l	657, 031	0	657, 031	90. 04
90. 05 09005 ANTI COAGULATI ON CLINI C	616, 745	5	616, 745	0	616, 745	
90.06 09006 MAB 3611 REED)	0	0	0	90. 06
91. 00 09100 EMERGENCY	10, 910, 097		10, 910, 097	0	10, 910, 097	91. 00
92.00 09200 OBSERVATION BEDS (NON-DIS			2, 997, 657		2, 997, 657	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM		1	0			102. 00
200.00 Subtotal (see instructions			175, 790, 467	0	175, 790, 467	
201.00 Less Observation Beds	2, 997, 657	1	2, 997, 657		2, 997, 657	
202.00 Total (see instructions)	172, 792, 810	0	172, 792, 810	0	172, 792, 810	202. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0113	Period: W	Vorksheet C
		From 01/01/2023 F	
			\+_ /T! D

				To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: 54 am
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
INDATIONE DOUTING CODY OF COST CONTEDC	6. 00	7. 00	8. 00	9. 00	10. 00	
30.00 O3000 ADULTS & PEDIATRICS	59, 713, 329		59, 713, 32			30.00
31. 00 03000 ADULTS & PEDIATRICS						30.00
43. 00 04300 NURSERY	20, 264, 275 4, 747, 590		20, 264, 27 4, 747, 59			43.00
ANCI LLARY SERVI CE COST CENTERS	4, 747, 390		4, 141, 39	U _I		43.00
50. 00 05000 OPERATING ROOM	44, 267, 911	138, 786, 437	183, 054, 34	8 0. 135814	0. 000000	50. 00
51. 00 05100 RECOVERY ROOM	44, 207, 711	130, 700, 437		0. 000000	0. 000000	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	4, 353, 685	0	4, 353, 68		0. 000000	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 189, 585	12, 917, 740			0. 000000	54.00
54. 01 05401 ULTRASOUND	1, 477, 084	9, 898, 969			0. 000000	54. 01
56. 00 05600 RADI OI SOTOPE	574, 763	8, 739, 649			0. 000000	56. 00
57. 00 05700 CT SCAN	12, 426, 764	45, 476, 374			0.000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 407, 998	18, 854, 702			0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	11, 147, 630	21, 336, 250	32, 483, 88	0. 074718	0.000000	59. 00
60. 00 06000 LABORATORY	13, 325, 231	52, 565, 907	65, 891, 13	8 0. 168478	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 115, 702	883, 754	2, 999, 45	6 0. 396693	0.000000	62. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0. 000000	0.000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	15, 422, 423	3, 473, 399	18, 895, 82	2 0. 211878	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 298, 104	10, 347, 419			0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	907, 471	1, 124, 953			0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	644, 275	378, 645	1, 022, 92		0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 519, 655	12, 488, 878			0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 544, 047	5, 379, 626			0. 000000	70. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	7, 746, 277	15, 025, 163			0. 000000	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 602, 520	17, 094, 533			0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	21, 154, 388	38, 691, 098			0.000000	73.00
74. 00 07400 RENAL DIALYSIS	1, 535, 261	0	1, 535, 26		0.000000	74.00
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0		0.000000	0.000000	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	l O	0		0. 000000	0. 000000	78. 00
90. 00 09000 CLI NI C	0	0		0. 000000	0. 000000	90. 00
90. 01 09001 WOUND/OSTOMY CLINIC	235, 705	7, 874, 428			0.000000	90. 01
90. 02 09002 CTR ADVANCED HEART CARE	6, 713	7, 874, 428	804, 83		0. 000000	90. 02
90. 03 09003 RADI ATI ON ONCOLOGY	455, 329	58, 936, 771	59, 392, 10		0. 000000	90. 03
90. 04 09004 DI ABETI C PLUS CLI NI C	484	306, 753			0. 000000	90. 04
90. 05 09005 ANTI COAGULATI ON CLI NI C	3, 233	1, 271, 579			0. 000000	90. 05
90. 06 09006 MAB 3611 REED	0,200	0		0. 000000	0. 000000	90.06
91. 00 09100 EMERGENCY	25, 698, 561	89, 828, 985	115, 527, 54		0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	489, 327	3, 373, 821	3, 863, 14	8 0. 775962	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		0		102. 00
200.00 Subtotal (see instructions)	270, 275, 320	575, 853, 957	846, 129, 27	7		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	270, 275, 320	575, 853, 957	846, 129, 27	7		202. 00

Heal th Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0113 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 11: 54 am

Cost Center Description	ent Hospital PPS	
Ratio 11.00 11.00	ent	
11.00 1.00		
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00		
31. 00		
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 135	30	0. 00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 135		1. 00
50. 00 05000 OPERATING ROOM 0. 135	43	3. 00
		0. 00
51. 00 05100 RECOVERY ROOM 0. 000		1. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 509		2. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 263		4. 00
54. 01 05401 ULTRASOUND 0. 108		4. 01
56. 00 05600 RADI 0I SOTOPE 0. 096		6. 00
57. 00 05700 CT SCAN 0. 044		7. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0. 118		8. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 074		9. 00
60. 00 06000 LABORATORY		0. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 396	6693 62	2. 00
64. 00 06400 I NTRAVENOUS THERAPY 0. 000	0000	4. 00
65. 00 06500 RESPI RATORY THERAPY 0. 211	1878 65	5. 00
66. 00 06600 PHYSI CAL THERAPY 0. 553		6. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 370	0669 67	7. 00
68. 00 06800 SPEECH PATHOLOGY 0. 375	5844 68	8. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 199		9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 232		0. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 432		1. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 454		2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 257		3. 00
74. 00 07400 RENAL DI ALYSI S 0. 349		4. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0. 000		7. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000	0000 78	8. 00
OUTPATIENT SERVICE COST CENTERS		
90. 00 09000 CLI NI C		0. 00
90. 01 09001 WOUND/OSTOMY CLINIC		0. 01
90. 02 09002 CTR ADVANCED HEART CARE 0. 345		0. 02
90. 03 09003 RADI ATI ON ONCOLOGY 0. 089		0. 03
90. 04 09004 DI ABETI C PLUS CLI NI C 2. 138		0. 04
90. 05 09005 ANTI COAGULATI ON CLINI C		0. 05
90. 06 09006 MAB 3611 REED 0. 000		0. 06
91. 00 09100 EMERGENCY		1. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 775	5962 92	2. 00
OTHER REIMBURSABLE COST CENTERS		
102.00 10200 OPI OI D TREATMENT PROGRAM		2. 00
200.00 Subtotal (see instructions)		0. 00
201.00 Less Observation Beds		1. 00
202.00 Total (see instructions)	202	2. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0113	Period: Worksheet C From 01/01/2023 Part I		

					o 12/31/2023	Date/Time Pre 5/24/2024 11:	pared:
-			Ti +I	e XIX	Hospi tal	972472024 TT. PPS	34 alli
			11 61	C ALK	Costs	113	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	occi contor bocorrptron	(from Wkst. B,	Adj.	1014. 00010	Di sal I owance	.014. 00010	
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
I NP	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 030	000 ADULTS & PEDIATRICS	31, 564, 160		31, 564, 160	0	31, 564, 160	30.00
31. 00 031	100 INTENSIVE CARE UNIT	10, 329, 821		10, 329, 821	0	10, 329, 821	31. 00
43.00 043	NURSERY	2, 917, 246		2, 917, 246	0	2, 917, 246	43.00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	24, 921, 038		24, 921, 038		24, 921, 038	
	100 RECOVERY ROOM	0		0	, , , , , , , , , , , , , , , , , , ,	0	51.00
	200 DELIVERY ROOM & LABOR ROOM	2, 217, 241		2, 217, 241		2, 217, 241	
	100 RADI OLOGY-DI AGNOSTI C	4, 241, 416		4, 241, 416		4, 241, 416	
	401 ULTRASOUND	1, 231, 395		1, 231, 395		1, 231, 395	
	600 RADI OI SOTOPE	898, 971		898, 971		898, 971	
	700 CT SCAN	2, 601, 237		2, 601, 237		2, 601, 237	1
	BOO MAGNETIC RESONANCE IMAGING (MRI)	2, 516, 818		2, 516, 818		2, 516, 818	
	900 CARDI AC CATHETERI ZATI ON	2, 427, 145		2, 427, 145		2, 427, 145	
	DOO LABORATORY	11, 101, 201		11, 101, 201		11, 101, 201	
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 189, 864		1, 189, 864		1, 189, 864	1
	100 I NTRAVENOUS THERAPY	4 000 (40	•	4 000 (40	0	0	64.00
	500 RESPI RATORY THERAPY	4, 003, 610	0			4, 003, 610	
	500 PHYSI CAL THERAPY	6, 448, 776	0	-,		6, 448, 776	
	700 OCCUPATIONAL THERAPY	753, 356	0	753, 356		753, 356	
	BOO SPEECH PATHOLOGY POO ELECTROCARDI OLOGY	384, 458	0			384, 458	
	DOO ELECTROCARD OLOGY	3, 385, 836 1, 606, 300		3, 385, 836 1, 606, 300		3, 385, 836 1, 606, 300	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 857, 231		9, 857, 231		9, 857, 231	1
	200 IMPL. DEV. CHARGED TO PATIENTS	11, 670, 677		11, 670, 677	-	11, 670, 677	
	BOO DRUGS CHARGED TO PATIENTS	15, 384, 065		15, 384, 065		15, 384, 065	1
	100 RENAL DIALYSIS	536, 736		536, 736		536, 736	
	700 ALLOGENEIC HSCT ACQUISITION	330, 730		330, 730		0 0	1
	BOO CAR T-CELL IMMUNOTHERAPY	0				0	1
	PATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		70.00
	DOO CLINIC	0		C	0	0	90.00
	001 WOUND/OSTOMY CLINIC	2, 862, 221		2, 862, 221		2, 862, 221	
	002 CTR ADVANCED HEART CARE	278, 027		278, 027		278, 027	1
	DO3 RADI ATI ON ONCOLOGY	5, 339, 913		5, 339, 913		5, 339, 913	1
	004 DIABETIC PLUS CLINIC	657, 031		657, 031		657, 031	
	005 ANTICOAGULATION CLINIC	616, 745		616, 745		616, 745	
90.06 090	006 MAB 3611 REED	0		l c	0	0	90. 06
91.00 091	100 EMERGENCY	10, 910, 097		10, 910, 097	0	10, 910, 097	91.00
92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 997, 657		2, 997, 657		2, 997, 657	92. 00
	HER REIMBURSABLE COST CENTERS]
	200 OPIOID TREATMENT PROGRAM	0		C		0	102. 00
200. 00	Subtotal (see instructions)	175, 850, 289	0	175, 850, 289	0	175, 850, 289	200. 00
201. 00	Less Observation Beds	2, 997, 657		2, 997, 657		2, 997, 657	
202.00	Total (see instructions)	172, 852, 632	0	172, 852, 632	0	172, 852, 632	202. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-255		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0113	Peri od:	Worksheet C	
		From 01/01/2023		

					To 12/31/2023	Date/Time Pre 5/24/2024 11:	
-			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS				•		
30.00	03000 ADULTS & PEDIATRICS	59, 713, 329		59, 713, 329)		30. 00
31.00	03100 INTENSIVE CARE UNIT	20, 264, 275		20, 264, 275	5		31.00
	04300 NURSERY	4, 747, 590		4, 747, 590			43.00
A	ANCILLARY SERVICE COST CENTERS				<u> </u>		
50.00	05000 OPERATING ROOM	44, 267, 911	138, 786, 437	183, 054, 348	0. 136140	0.000000	50. 00
51.00	D5100 RECOVERY ROOM	0	0	(0. 000000	0.000000	51.00
52.00 0	D5200 DELIVERY ROOM & LABOR ROOM	4, 353, 685	0	4, 353, 685	0. 509279	0.000000	52.00
54.00 0	D5400 RADI OLOGY-DI AGNOSTI C	3, 189, 585	12, 917, 740	16, 107, 325	0. 263322	0.000000	54.00
54. 01 0	D5401 ULTRASOUND	1, 477, 084	9, 898, 969	11, 376, 053	0. 108244	0.000000	54. 01
56.00 0	D5600 RADI OI SOTOPE	574, 763	8, 739, 649	9, 314, 412	0. 096514	0.000000	56.00
57.00	D5700 CT SCAN	12, 426, 764	45, 476, 374	57, 903, 138	0. 044924	0.000000	57.00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	2, 407, 998	18, 854, 702	21, 262, 700	0. 118368	0.000000	58. 00
59.00	D5900 CARDI AC CATHETERI ZATI ON	11, 147, 630	21, 336, 250	32, 483, 880	0. 074718	0.000000	59. 00
60.00	06000 LABORATORY	13, 325, 231	52, 565, 907	65, 891, 138	0. 168478	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 115, 702	883, 754	2, 999, 456	0. 396693	0.000000	62. 00
64.00	06400 INTRAVENOUS THERAPY	0	0	(0. 000000	0.000000	64. 00
65.00	06500 RESPIRATORY THERAPY	15, 422, 423	3, 473, 399	18, 895, 822	0. 211878	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 298, 104	10, 347, 419	11, 645, 523	0. 553756	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	907, 471	1, 124, 953	2, 032, 424	0. 370669	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	644, 275	378, 645	1, 022, 920	0. 375844	0.000000	68. 00
	06900 ELECTROCARDI OLOGY	4, 519, 655	12, 488, 878	17, 008, 533	0. 199067	0.000000	69. 00
	07000 ELECTROENCEPHALOGRAPHY	1, 544, 047	5, 379, 626	6, 923, 673		0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 746, 277	15, 025, 163	22, 771, 440	0. 432877	0.000000	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 602, 520	17, 094, 533	25, 697, 053	0. 454164	0.000000	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	21, 154, 388	38, 691, 098	59, 845, 486	0. 257063	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	1, 535, 261	0	1, 535, 261	0. 349606	0.000000	74. 00
77. 00 C	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0. 000000	0.000000	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0.000000	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	(0.00000	0. 000000	
	09001 WOUND/OSTOMY CLINIC	235, 705	7, 874, 428			0. 000000	1
	09002 CTR ADVANCED HEART CARE	6, 713	798, 124	804, 837		0. 000000	90. 02
	09003 RADI ATI ON ONCOLOGY	455, 329	58, 936, 771	59, 392, 100		0. 000000	1
	09004 DIABETIC PLUS CLINIC	484	306, 753	307, 237		0. 000000	
	09005 ANTICOAGULATION CLINIC	3, 233	1, 271, 579	1, 274, 812		0. 000000	1
	09006 MAB 3611 REED	0	0	(0.000000	0. 000000	
	09100 EMERGENCY	25, 698, 561	89, 828, 985	115, 527, 546		0. 000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	489, 327	3, 373, 821	3, 863, 148	0. 775962	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS				1		
	10200 OPIOID TREATMENT PROGRAM	0	0	(1		102. 00
200.00	Subtotal (see instructions)	270, 275, 320	575, 853, 957	846, 129, 277	7		200. 00
201.00	Less Observation Beds						201. 00
202. 00	Total (see instructions)	270, 275, 320	575, 853, 957	846, 129, 277	/		202. 00

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

Provider CCN: 15-0113 | Period: From 01/01/2023 | Part I To 12/31/2023 | Part I To 12/31/2023 | Part I To 12/31/2023 | Propagate Computation of From CMS-2552-10 | Provider CCN: 15-0113 | Period: From 01/01/2023 | Part I To 12/31/2023 | Part I T

				10 12/31/2023	5/24/2024 11:54 am
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · · ·	
	·	Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
50. 00	05000 OPERATING ROOM	0. 136140			50.00
51. 00	05100 RECOVERY ROOM	0. 000000			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 509279			52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 263322			54.00
54. 01	05401 ULTRASOUND	0. 108244			54. 01
56. 00	05600 RADI OI SOTOPE	0. 096514			56. 00
57. 00	05700 CT SCAN	0. 044924			57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 118368			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 074718			59. 00
60.00	06000 LABORATORY	0. 168478			60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 396693			62.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00	06500 RESPI RATORY THERAPY	0. 211878			65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 553756			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 370669			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 375844			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 199067			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 232001			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 432877			71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 454164			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 257063			73. 00
74.00	07400 RENAL DI ALYSI S	0. 349606			74.00
77. 00	07700 ALLOGENEIC HSCT 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. 000000			90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0. 352919			90. 01
90. 02	09002 CTR ADVANCED HEART CARE	0. 345445			90. 02
90. 03	09003 RADI ATI ON ONCOLOGY	0. 089909			90. 03
90. 04	09004 DI ABETI C PLUS CLINI C	2. 138515			90. 04
90. 05	09005 ANTI COAGULATI ON CLINI C	0. 483793			90. 05
90. 06	09006 MAB 3611 REED	0. 000000			90.06
91.00	09100 EMERGENCY	0. 094437			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 775962			92. 00
100.00	OTHER REIMBURSABLE COST CENTERS				100.00
	10200 OPI OI D TREATMENT PROGRAM				102.00
200.00					200. 00 201. 00
201. 00 202. 00					201.00
202.00	Total (see instructions)				J202. 00

Cost Center Description	KEDOOTI ONO TO	(MEDI ON D ONE)			То	12/31/2023	Date/Time Pre 5/24/2024 11:	
WALLELARY SERVICE COST CENTERS				Ti tl	e XIX	Hospi tal		01 4111
ANCILLARY SERVICE COST CENTERS	Co	ost Center Description				Capi tal		
NACILLARY SERVICE COST CENTERS						Reduction		
ANCILLARY SERVICE COST CENTERS			I, col. 26)	II col. 26)	` .		Amount	
ANCILLARY SERVICE COST CENTERS			1.00	2.00		4.00	F 00	
SOLIC DESCRIPTION ROOM COLOR C	ANCLLLA	DV SEDVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
S1. 00			24 921 038	2 852 764	22 068 274	0	0	50 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 217, 241 142, 616 2, 074, 625 0 0 52, 00 64.00 63400 RADIOLOGY-DIAGNOSTIC 4, 241, 416 454, 369 3, 787, 647 0 0 54.01 65.00 05600 RADIOLOGY-DIAGNOSTIC 1, 231, 395 54, 244 1, 177, 151 0 0 54.01 65.00 05600 RADIOLOGY-DIAGNOSTIC 1, 231, 395 54, 244 1, 177, 151 0 0 56.00 057, 00 05700 CT SCAN 2, 601, 237 189, 874 2, 411, 363 0 0, 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 516, 818 528, 021 1, 998, 797 0 0, 58.00 05900 CARDIAC CATHETERI ZATION 2, 427, 145 333, 262 2, 093, 883 0 0, 59.00 60.00 06000 LABORATORY 11, 101, 201 703, 573 10, 397, 628 0 0, 60.00 06000 LABORATORY 11, 101, 201 703, 573 10, 397, 628 0 0, 60.00 06000 CARDIAC ROTAGE IMAGING (MRI) 1, 189, 844 50, 820 1, 139, 044 0 0, 62.00 060, 00 0 0 0 0 0 0 0 0			24, 721, 030	2,032,704	22,000,274	0	-	
54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 241, 416 454, 369 3, 787, 047 0 0 54, 00 54, 00 54, 00 54, 00 54, 00 54, 00 54, 00 54, 00 54, 00 54, 00 54, 00 56, 00 56, 00 57, 00 05700 CT SCAN 2, 601, 237 190, 874 2, 411, 363 0 0, 57, 00 059, 00 05900 CARDITI C RESONANCE I MAGING (MRI) 2, 516, 818 528, 021 1, 998, 977 0 0, 58, 00 05900 CARDITI C RESONANCE I MAGING (MRI) 2, 2516, 818 528, 021 1, 998, 979 0 0, 58, 00 05900 CARDITI C RESONANCE I MAGING (MRI) 2, 427, 145 333, 262 2, 093, 893 0 0, 59, 00 0,			2, 217, 241	142, 616	2, 074, 625	0		
54.01 05401 UTRASQUIND	1 1					0	0	
57. 00 05700 CT SCAN 2, 601, 237 189, 874 2, 411, 363 0 0 57, 00						0	0	•
58. 00 05800 MARNETIC RESONANCE IMAGING (MRI) 2, 516, 818 528, 021 1, 988, 797 0 0 58. 00	56. 00 05600 RA	ADI OI SOTOPE	898, 971	101, 454	797, 517	0	0	56.00
59,00 05900 CARDI AC CATHETER IZATION 2, 427, 145 333, 262 2, 093, 883 0 0 59,00	57. 00 05700 C	T SCAN	2, 601, 237	189, 874	2, 411, 363	0	0	57.00
60.00 06000 LABORATORY 11, 101, 201 703, 573 10, 397, 628 0 0 60.00	58. 00 05800 M	AGNETIC RESONANCE IMAGING (MRI)	2, 516, 818	528, 021	1, 988, 797	0	0	58. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 189, 864 50, 820 1, 139, 044 0 0 62. 00 64. 00 06400 O6400 INTRAVENOUS THERAPY 4, 003, 610 176, 335 3, 827, 275 0 0 65. 00 65. 00 06600 PHYSI CAL THERAPY 4, 003, 610 176, 335 3, 827, 275 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 753, 356 41, 062 712, 294 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 384, 458 20, 791 363, 667 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 3, 385, 836 435, 318 2, 950, 518 0 0 69. 00 69. 00 06900 ELECTROCARDI OLOGY 3, 385, 836 435, 318 2, 950, 518 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 9, 857, 231 301, 332 9, 555, 899 0 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 15, 384, 065 761, 088 14, 622, 977 0 73. 00 73. 00 07300 RESPICATION OF PATI ENTS 15, 384, 065 761, 088 14, 622, 977 0 73. 00 74. 00 07400 RENAL DI ALYSI S 536, 736 13, 668 523, 068 0 0 74. 00 75. 00 0700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 76. 00 0700 CINIC 0 0 0 0 0 77. 00 0700 CINIC 0 0 0 0 0 78. 00 0700 CINIC 0 0 0 0 0 79. 00 09000 CINIC 0 0 0 0 0 79. 01 09001 MUNIDO/OSTOMY CLINIC 2, 862, 221 167, 296 2, 694, 925 0 90. 01 79. 02 09002 CITR ADVANCED HEART CARE 278, 027 8, 761 269, 266 0 90. 03 79. 04 09004 DI ABETI C PLUS CLINIC 657, 031 20, 313 636, 718 0 90. 04 79. 05 09005 AND ARTION MOLOOGY 5, 339, 913 613, 242 4, 726, 671 0 90. 05 79. 00 09006 MB 3611 REED 0 0 0 0 0 0 0 79. 00 09000 DI DI TREATMENT PROGRAM 0 0 0 0 0 79. 00 09000 DI DI TREATMENT PROGRAM 0 0 0 0 0 70. 00 00 00 00 00 00 00 0	59. 00 05900 C	ARDIAC CATHETERIZATION	2, 427, 145	333, 262	2, 093, 883	0	0	59. 00
64.00 06400 INTRAVENOUS THERAPY						0	-	
65. 00 06500 RESPI RATORY THERAPY 4,003,610 176,335 3,827,275 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 6,448,776 1,154,405 5,294,371 0 0 66. 00 67. 00 06700 06CUPATI ONAL THERAPY 753,356 41,062 712,294 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 3,84,458 20,791 363,667 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 3,385,836 435,318 2,950,518 0 0 0 0 70. 00 07000 ELECTROCARDIOLOGY 1,606,300 124,906 1,481,394 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 9,857,231 301,332 9,555,899 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 11,670,677 356,708 11,313,969 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 15,384,065 761,088 14,622,977 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 536,736 13,668 523,068 0 0 74. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 79. 01 09000 CLINIC 0 0 0 0 0 0 79. 02 09000 CLINIC 0 0 0 0 0 79. 03 09000 CURA DVANCED HEART CARE 278,027 8,761 269,266 0 0 0 79. 04 09004 DIATION ONCOLOGY 5,339,913 613,242 4,726,671 0 0 90.02 79. 04 09004 DIABETIC PLUS CLINIC 657,031 20,313 636,718 0 90.05 79. 05 09005 MITICOAGULATION CLINIC 616,745 16,998 599,747 0 90.05 79. 06 09006 MERGRENCY 10,910,097 541,550 10,388,547 0 91.00 70 09000 DEBERGANCY 10,910,097 541,550 10,388,547 0 91.00 70 09000 DEBERGANCY 10,910,097 541,550 10,388,547 0 92.00 70 00000 DEBERGENCY 10,910,097 541,550 10,388,547 0 92.00 70 00000 00000 00000 00000 000000			1, 189, 864	50, 820	1, 139, 044	0		
66.00 06600 PHYSICAL THERAPY 6, 448, 776 1, 154, 405 5, 294, 371 0 0 66.00 67.00 06700 06COLPATIONAL THERAPY 753, 356 41, 062 712, 294 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 3, 384, 488 20, 791 363, 667 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 3, 385, 836 435, 318 2, 950, 518 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 606, 300 124, 906 1, 481, 394 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 857, 231 301, 332 9, 555, 899 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11, 670, 677 356, 708 11, 313, 969 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 15, 384, 065 761, 088 14, 622, 977 0 0 73.00 74.00 07400 RENAL DI ALYSIS 536, 736 13, 668 523, 068 0 0 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 79.01 09001 WOUND/OSTOMY CLINIC 2, 862, 221 167, 296 2, 694, 925 0 0 0 0 79.02 09002 CIR TEAT EARY ICE COST CENTERS 79.03 09003 RADIATION ONCOLOGY 5, 339, 913 613, 242 4, 726, 671 0 0 90.03 79.04 09004 DI ABETIC PLUS CLINIC 657, 031 20, 313 636, 718 0 0 0 0 79.05 09005 AMB 3611 REED 0 0 0 0 0 0 79.06 09006 MAB 3611 REED 0 0 0 0 0 79.07 09007 CHER REIMBURSABLE COST CENTERS 79.00 09008 DEMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 70 00 00 DEMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 70 00 00 00 00 00			0	0	0	0	· · · · · · · · · · · · · · · · · · ·	
67.00 06700 OCCUPATIONAL THERAPY 753, 356 41, 062 712, 294 0 0 67.00 68.00 06800 SPECEH PATHOLOGY 384, 458 20, 791 363, 667 0 0 69.00 70.00 06900 ELECTROCARDIOLOGY 3, 385, 836 435, 318 2, 950, 518 0 0 69.00 70.00 07000 ELECTROCARDIOLOGY 1, 606, 300 124, 906 1, 481, 394 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 9, 857, 231 301, 332 9, 555, 899 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 11, 670, 677 356, 708 11, 313, 969 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 15, 384, 065 761, 088 14, 622, 977 0 0 73.00 74.00 07400 RENAL DIALYSIS 536, 736 13, 668 523, 068 0 0 74.00 78.00 07700 ALLOGENEIC HSCT 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 79.01 090001 WOUND/OSTOMY CLINIC 2, 862, 221 167, 296 2, 694, 925 0 0 90.01 79.02 09002 CTR ADVANCED HEART CARE 278, 027 8, 761 269, 266 0 90.02 79.03 09003 RADIATION ONCOLOGY 5, 339, 913 613, 242 4, 726, 671 0 90.03 79.04 09004 DIABETIC PLUS CLINIC 657, 031 20, 313 636, 718 0 0 0 79.05 09005 ANTICOAGULATION CLINIC 667, 031 20, 313 636, 718 0 0 0 79.06 09006 MAB 3611 REED 0 0 0 0 0 79.07 09100 EMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 90.05 79.08 09006 DIBERTIC PLUS CLINIC 616, 745 16, 998 599, 747 0 0 90.05 79.09 09200 OSSERVATION BEDS (NON-DISTINCT PART) 2, 997, 657 157, 530 2, 840, 127 0 0 70.00 09100 EMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 70.00 09100 DSERVATION BEDS (NON-DISTINCT PART) 2, 997, 657 157, 530 2, 840, 127 0 0 70.00 09100 Less Observation Beds 2, 997, 657 157, 530 2, 840, 127 0 0 70.01 09100 09100 09100 09100 09100 09100 09100 09100						0	-	
68. 00 06800 SPEECH PATHOLOGY 384, 458 20, 791 363, 667 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 3, 385, 836 435, 318 2, 950, 518 0 0 69. 00 70. 00 07000 ELECTROCARDI PALLOGRAPHY 1, 606, 300 124, 906 1, 481, 394 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 9, 857, 231 301, 332 9, 555, 899 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 11, 670, 677 356, 708 11, 313, 969 0 0 72. 00 73. 00 07300 DRIGS CHARGED TO PATI ENTS 15, 384, 065 761, 088 14, 622, 977 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 536, 736 13, 668 523, 068 0 0 74. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 79. 01 09000 CLI NI C 0 0 0 0 0 0 79. 01 09000 CLI NI C 0 0 0 0 0 79. 02 09000 CLI NI C 0 0 0 0 0 79. 03 09003 RADI ATI ON ONCOLOGY 5, 339, 913 613, 242 4, 726, 671 0 0 90. 03 79. 04 09004 DI ABETI C PLUS CLI NI C 657, 031 20, 313 636, 718 0 0 0 79. 05 09005 ANTI COAGULATION CLINI C 657, 031 20, 313 636, 718 0 0 0 79. 00 09000 EMERGENCY 10, 910, 997 541, 550 10, 368, 547 0 0 90. 06 79. 00 09000 EMERGENCY 10, 910, 997 541, 550 10, 368, 547 0 0 91. 00 79. 00 07000 EMERGENCY 10, 910, 997 541, 550 10, 368, 547 0 0 92. 00 70 00 00 00 00 00 00			1 1			0	-	
69.00 06900 ELECTROCARDI OLOGY 3, 385, 836 435, 318 2, 950, 518 0 0 69.00 70.00 07000 ELECTROCARDI OLOGY 1, 606, 300 124, 906 1, 481, 394 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 9, 857, 231 301, 332 9, 555, 899 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11, 670, 677 356, 708 11, 313, 969 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 15, 384, 065 761, 088 14, 622, 977 0 0 73.00 74.00 07400 RENAL DI ALYSI S 536, 736 13, 668 523, 068 0 0 0 0 75.00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 76.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 77.00 09000 CLINI C 0 0 0 0 0 0 78.00 09000 CLINI C 0 0 0 0 0 0 79.01 09001 WOUND/OSTOMY CLINI C 2, 862, 221 167, 296 2, 694, 925 0 0 90.01 79.02 09002 CTR ADVANCED HEART CARE 278, 027 8, 761 269, 266 0 0 0 0 79.04 09004 DIABETI C PLUS CLINI C 657, 031 20, 313 636, 718 0 0 90.03 79.05 09005 ANTI COAGULATI ON CLINI C 6657, 031 20, 313 636, 718 0 0 90.05 79.00 09000 MAB 3611 REED 0 0 0 0 0 0 0 70.00 09000 MAB 3611 REED 0 0 0 0 0 70.00 09000 DEMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 91.00 70.00 09000 DEMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 91.00 70.00 0000 ODD DEMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 91.00 70.00 0000 ODD DEMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 91.00 70.00 0000 ODD DEMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 91.00 70.00 0000 ODD DEMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 91.00 70.00 0000 ODD DEMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 91.00 70.00 0000 ODD DEMERGENCY 00, 910, 910, 910, 910, 910, 910, 910,						0	-	
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OUTPATIENT SERVICE COST CENTERS OUTP	1 1		o	0	ō	0		
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90. 03	90. 01 09001 W	OUND/OSTOMY CLINIC	2, 862, 221	167, 296	2, 694, 925	0	0	90. 01
90. 04 09004 DI ABETI C PLUS CLINI C 657, 031 20, 313 636, 718 0 0 90. 04 90. 05 09005 ANTI COAGULATI ON CLINI C 616, 745 16, 998 599, 747 0 0 90. 05 90. 06 09006 MAB 3611 REED 0 0 0 0 0 0 0 90. 06 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 2, 997, 657 157, 530 2, 840, 127 0 0 0 0 0 0 0 0 0						0	-	1
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91. 00 09100 EMERGENCY 10, 910, 097 541, 550 10, 368, 547 0 0 91. 00 92. 00 085ERVATI ON BEDS (NON-DISTINCT PART) 2, 997, 657 157, 530 2, 840, 127 0 0 92. 00 0 0 0 0 0 0 0 0 0			616, 745	16, 998	599, 747	0	-	1
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 2,997,657 157,530 2,840,127 0 0 92. 00			0	0	0	0		
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 102. 00 200. 00 Subtotal (sum of lines 50 thru 199) 131, 039, 062 10, 322, 300 120, 716, 762 0 0 200. 00 201. 00 Less Observation Beds 2, 997, 657 157, 530 2, 840, 127 0 0 201. 00						0	-	
102. 00 10200 OPLOID TREATMENT PROGRAM 0 0 0 0 102. 00 200. 00 Subtotal (sum of lines 50 thru 199) 131, 039, 062 10, 322, 300 120, 716, 762 0 0 200. 00 201. 00 Less Observation Beds 2, 997, 657 157, 530 2, 840, 127 0 0 201. 00			2, 997, 657	157, 530	2, 840, 127	0	0	92.00
200.00 Subtotal (sum of lines 50 thru 199) 131,039,062 10,322,300 120,716,762 0 0 200.00 201.00 Less Observation Beds 2,997,657 157,530 2,840,127 0 0 201.00				0	0	0	0	102 00
201.00 Less Observation Beds 2, 997, 657 157, 530 2, 840, 127 0 0 201.00				10 322 300		0		
		,	1 1			0		
	1 1		1 1			0		

			10	12/31/2023	5/24/2024 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to Charge			
	Operating Cost	Part I, column	Ratio (col. 6			
	Reduction	8)	/ col. 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	24, 921, 038	183, 054, 348	0. 136140			50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 217, 241	4, 353, 685	0. 509279			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 241, 416	16, 107, 325	0. 263322			54.00
54. 01 05401 ULTRASOUND	1, 231, 395	11, 376, 053	0. 108244			54. 01
56. 00 05600 RADI 0I SOTOPE	898, 971	9, 314, 412	0. 096514			56.00
57. 00 05700 CT SCAN	2, 601, 237		1			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 516, 818					58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 427, 145		1			59.00
60. 00 06000 LABORATORY	11, 101, 201					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 189, 864					62.00
64. 00 06400 I NTRAVENOUS THERAPY	0					64.00
65. 00 06500 RESPIRATORY THERAPY	4, 003, 610	_				65. 00
66. 00 06600 PHYSI CAL THERAPY	6, 448, 776					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	753, 356					67.00
68. 00 06800 SPEECH PATHOLOGY	384, 458					68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 385, 836					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 606, 300					70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 857, 231					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 670, 677					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	15, 384, 065					73.00
74. 00 07400 RENAL DI ALYSI S	536, 736					74.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	030,730					77. 00
78. 00 07700 ALLOGENETE HISET ACCOUNTING 78. 00 07800 CAR T-CELL IMMUNOTHERAPY						78.00
OUTPATIENT SERVICE COST CENTERS		0	0.000000			78.00
90. 00 09000 CLINIC	1 0	0	0.000000			90.00
90. 01 09001 WOUND/OSTOMY CLINIC	2, 862, 221	ļ				90.00
90. 02 09002 CTR ADVANCED HEART CARE	278, 027					90.01
90. 03 09003 RADIATION ONCOLOGY	5, 339, 913					90.02
90. 04 09004 DIABETIC PLUS CLINIC	657, 031		1			90.03
90. 04 09004 DEABETTC PLOS CLENTC 90. 05 09005 ANTI COAGULATI ON CLINI C	616, 745					90.04
	010, 745					90.05
	_	_				
91. 00 09100 EMERGENCY	10, 910, 097					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	2, 997, 657	3, 863, 148	0. 775962			92. 00
OTHER REIMBURSABLE COST CENTERS			0.000000			100 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	121 020 072		0.000000			102. 00
200.00 Subtotal (sum of lines 50 thru 199)	131, 039, 062					200.00
201. 00 Less Observation Beds	2, 997, 657					201.00
202.00 Total (line 200 minus line 201)	128, 041, 405	761, 404, 083	1			202. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narad.
				To 12/31/2023	Date/Time Pre 5/24/2024 11:	
		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost		·	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 658, 719	0	1, 658, 71	9 21, 175	78. 33	30. 00
31.00 INTENSIVE CARE UNIT	583, 998		583, 99	8 4, 135	141. 23	31.00
43. 00 NURSERY	246, 042		246, 04	2 921	267. 15	43.00
200.00 Total (lines 30 through 199)	2, 488, 759		2, 488, 75	9 26, 231		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	4, 710	368, 934				30. 00
31.00 INTENSIVE CARE UNIT	1, 168	164, 957				31. 00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	5, 878	533, 891				200. 00

Health Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/24/2024 11:	pared: 54 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			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	T	1		T		
50.00 05000 OPERATING ROOM	2, 852, 764				162, 299	
51.00 05100 RECOVERY ROOM	0	1	0.00000		0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	142, 616		•		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	454, 369		•		24, 825	
54. 01 05401 ULTRASOUND	54, 244				1, 722	54. 01
56. 00 05600 RADI OI SOTOPE	101, 454				-	
57. 00 05700 CT SCAN	189, 874				11, 017	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	528, 021				16, 091	
59. 00 05900 CARDI AC CATHETERI ZATI ON	333, 262				25, 568	
60. 00 06000 LABORATORY	703, 573				37, 658	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	50, 820	2, 999, 456			9, 209	
64. 00 06400 I NTRAVENOUS THERAPY	0		0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	176, 335		II.		36, 442	
66. 00 06600 PHYSI CAL THERAPY	1, 154, 405	11, 645, 523			41, 294	
67. 00 06700 OCCUPATI ONAL THERAPY	41, 062				5, 786	
68. 00 06800 SPEECH PATHOLOGY	20, 791				4, 241	
69. 00 06900 ELECTROCARDI OLOGY	435, 318	17, 008, 533	0. 02559	4 1, 242, 638	31, 804	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	124, 906	6, 923, 673	0. 01804	0 278, 877	5, 031	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	301, 332	22, 771, 440	0. 01323	3 1, 925, 299	25, 477	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	356, 708	25, 697, 053	0. 01388	1 2, 337, 037	32, 440	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	761, 088	59, 845, 486	0. 01271	8 6, 045, 447	76, 886	73. 00
74.00 07400 RENAL DIALYSIS	13, 668			3 414, 197	3, 688	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	l c	0.00000	0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	(0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C			_	
OO OA OOOOA WOUND (OCTON), OLINIO	4/7 00/	0 440 400		0 50 744	4 040	00 04

167, 296

613, 242

20, 313

16, 998

541, 550

157, 530 10, 322, 300

8, 761

0. 020628

0.010885

0.010325

0.066115

0.013334

0.000000

0.004688

0.040778

58, 746

206, 246

6, 822, 989

46, 741, 923

208, 597

8, 110, 133

59, 392, 100 307, 237

1, 274, 812

115, 527, 546 3, 863, 148 761, 404, 083

804, 837

90.01

90.02

90.03

90.04

90.05

90.06

91.00

1, 212

2, 129

31, 986

0

0

0

8, 506 92. 00 597, 044 200. 00

09001 WOUND/OSTOMY CLINIC

09004 DIABETIC PLUS CLINIC

09005 ANTI COAGULATION CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

90. 03 | 09003 | RADI ATI ON ONCOLOGY

90. 06 09006 MAB 3611 REED

91. 00 09100 EMERGENCY

09002 CTR ADVANCED HEART CARE

90. 01

90.02

90.04

90.05

200.00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	S Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/24/2024 11:	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	· ·	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	•		
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	,-		· · · - g j -	
		minus col. 4)				
	4.00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00 03000 ADULTS & PEDIATRICS	0	0	21, 17	5 0.00	4, 710	30.00
31.00 03100 INTENSIVE CARE UNIT		0	4, 13			
43. 00 04300 NURSERY		0	92			1
200.00 Total (lines 30 through 199)		0				200. 00
Cost Center Description	Inpatient	-		-		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9, 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31. 00
43. 00 04300 NURSERY						43. 00
200.00 Total (lines 30 through 199)	o o					200.00
255.55 10tal (11165 55 through 177)	١					_55.55

Health Financial Systems	COMMUNITY HOSPITA	L ANDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0113	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

THROUG	H COSTS				To 12/31/2023		pared: 54 am
			Ti tl e	XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			Adjustments				
	ANOLULARY OFRICAS COOT OFFITTERS	1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1	1				
50.00	05000 OPERATI NG ROOM	0	_	1	0	0	
51. 00	05100 RECOVERY ROOM	0	0)	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54. 00
54. 01	05401 ULTRASOUND	0	0)	0	0	54. 01
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 MAGNETIC RESONANCE I MAGING (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
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0)	0	0	62. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0)	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0)	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		2	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0)	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		2	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		2	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		2	0	0	70.00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS			(0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		<u>'</u>	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		(0	0	73.00
74. 00 77. 00	07400 RENAL DI ALYSI S				0	0	74.00
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	1	0 0	0	1
76.00	OUTPATIENT SERVICE COST CENTERS			1	0 0	0	76.00
90. 00	09000 CLINIC	1 0	0	1	0 0	0	90.00
90. 01	09001 WOUND/OSTOMY CLINIC			1		0	90. 01
	09002 CTR ADVANCED HEART CARE					n	90. 02
90. 03	09003 RADI ATI ON ONCOLOGY					0	90. 03
90. 04	09004 DI ABETI C PLUS CLINI C					,	90. 04
90. 05	09005 ANTI COAGULATI ON CLI NI C					ň	90. 05
90. 06	09006 MAB 3611 REED					, O	90.06
91. 00	09100 EMERGENCY				o o	Ö	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				ol	ő	1
200.00		0	o		o o	Ő	200. 00
		•	•	•	•	•	•

Health Financial Systems	COMM	MUNITY HOSPITA	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE	OTHER PASS	Provider CCN: 15-0113	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

THROUGH COSTS			Γο 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: 54 am	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	/ 00	7.00	instructions)	
ANCI LLARY SERVI CE COST CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
50. 00 05000 OPERATING ROOM		0	(183, 054, 348	0. 000000	50.00
51. 00 05100 RECOVERY ROOM		0		0		
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0		4, 353, 685		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0		16, 107, 325		1
54. 01 05401 ULTRASOUND		0		11, 376, 053		1
56. 00 05600 RADI OI SOTOPE		0		9, 314, 412		
57. 00 05700 CT SCAN	0	0		57, 903, 138		1
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0		21, 262, 700		
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		32, 483, 880		1
60. 00 06000 LABORATORY		0		65, 891, 138		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	l ol	0		2, 999, 456		
64. 00 06400 I NTRAVENOUS THERAPY	l ol	0		0 0		
65. 00 06500 RESPIRATORY THERAPY	O	0		18, 895, 822		1
66. 00 06600 PHYSI CAL THERAPY	o	0		11, 645, 523	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0		2, 032, 424		67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	(1, 022, 920	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0	(17, 008, 533	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0	(6, 923, 673	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	(22, 771, 440		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(25, 697, 053	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(59, 845, 486	0.000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	(1, 535, 261	0.000000	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0		
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				
90. 01 09001 WOUND/OSTOMY CLINIC	0	0		8, 110, 133		
90. 02 09002 CTR ADVANCED HEART CARE	0	0		804, 837		
90. 03 09003 RADI ATI ON ONCOLOGY	0	0		59, 392, 100		
90. 04 09004 DI ABETI C PLUS CLINI C	0	0		307, 237		1
90. 05 09005 ANTI COAGULATI ON CLINI C	0	0		1, 274, 812		
90. 06 09006 MAB 3611 REED	0	0		0	0.00000	
91. 00 09100 EMERGENCY	0	0	(1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		3, 863, 148		1
200.00 Total (lines 50 through 199)	l O	0	l (761, 404, 083		200. 00

Health Financial Systems	COMMUNITY HOSPIT		In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL THROUGH COSTS	ANCILLARY SERVICE OTHER PASS			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/24/2024 11:	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8		Outpatient Program Pass-Through Costs (col. 9	

			litle	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
P	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	10, 414, 470	0	22, 253, 965	0	50.00
51.00	D5100 RECOVERY ROOM	0. 000000	0	0	0	0	51. 00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0. 000000	880, 054	0	1, 932, 245	0	54. 00
54. 01	D5401 ULTRASOUND	0. 000000	361, 061	0	1, 621, 335	0	54. 01
56.00	D5600 RADI OI SOTOPE	0. 000000	159, 149	0	2, 017, 336	0	56. 00
57. 00	D5700 CT SCAN	0. 000000	3, 359, 981	0	9, 298, 963	0	57. 00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	647, 963	0	3, 847, 904	0	58. 00
59.00	D5900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 492, 281	0	5, 232, 425	0	59. 00
	06000 LABORATORY	0. 000000	3, 526, 703		3, 226, 550		60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	543, 526		241, 308		62. 00
64.00	06400 INTRAVENOUS THERAPY	0. 000000	. 0	o	. 0	0	64. 00
	06500 RESPIRATORY THERAPY	0. 000000	3, 905, 063	0	526, 514	0	65. 00
	06600 PHYSI CAL THERAPY	0. 000000	416, 568		23, 238	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0. 000000	286, 387		9, 088		67. 00
	06800 SPEECH PATHOLOGY	0. 000000	208, 644		4, 183		68. 00
	06900 ELECTROCARDI OLOGY	0. 000000	1, 242, 638		2, 878, 586		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	278, 877		606, 750		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 925, 299		2, 586, 514		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 337, 037		2, 689, 800		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 045, 447		10, 545, 683		73. 00
	07400 RENAL DIALYSIS	0. 000000	414, 197		10, 010, 000	0	74. 00
	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0.11, 177	1	0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	0. 000000		0	0	0	70.00
	09000 CLINIC	0. 000000	0	0	0	0	90. 00
	D9001 WOUND/OSTOMY CLINIC	0. 000000	58, 746		2, 312, 232		90. 01
	09002 CTR ADVANCED HEART CARE	0. 000000	30, 740		208, 547		90. 02
	09003 RADIATION ONCOLOGY	0. 000000	206, 246	- 1	13, 072, 785		90. 02
	D9004 DI ABETI C PLUS CLI NI C	0. 000000	200, 240		13, 072, 703	0	90.03
	D9005 ANTI COAGULATI ON CLI NI C	0. 000000	0	0	350, 358		90.04
	09006 MAB 3611 REED	0. 000000	0	0	330, 336 A	0	90.05
	D9100 EMERGENCY	0. 000000	6, 822, 989		12, 095, 193	- 1	91.00
	D9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	6, 822, 989 208, 597		12, 095, 193 280, 532		91.00
200.00		0.000000			·		92. 00 200. 00
200.00	Total (lines 50 through 199)	1	46, 741, 923	ı Y	97, 862, 034	l O	∠UU. UU

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0113 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/24/2024 11:54 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 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. 135814 22, 253, 965 3, 022, 400 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.509279 52 00 0 |05400| RADI OLOGY-DI AGNOSTI C 0 0 54.00 0.263322 1, 932, 245 508, 803 54.00 54.01 05401 ULTRASOUND 0. 108244 1, 621, 335 0 175, 500 54.01 2, 017, 336 56.00 05600 RADI OI SOTOPE 0.096514 0 0 194, 701 56 00 0 57.00 05700 CT SCAN 0.0449249, 298, 963 417, 747 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.118368 3, 847, 904 0 455, 469 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.074718 5, 232, 425 0 0 390, 956 59.00 06000 LABORATORY 60 00 0 168478 3, 226, 550 15, 180 543, 603 60 00 |06200|WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.396693 241, 308 0 95, 725 62.00 06400 INTRAVENOUS THERAPY 0.000000 0 0 64.00 0 64.00 0 06500 RESPIRATORY THERAPY 526, 514 0. 211878 0 111, 557 65.00 65.00 06600 PHYSI CAL THERAPY 0. 553756 O 66.00 23, 238 12,868 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.370669 9, 088 0 0 3, 369 67.00 06800 SPEECH PATHOLOGY 0.375844 68.00 4, 183 0 1, 572 68.00 06900 ELECTROCARDI OLOGY 0. 199067 2, 878, 586 0 0 573, 031 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 0.232001 606, 750 0 140, 767 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.432877 2, 586, 514 2, 489 0 1, 119, 642 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0.454164 2, 689, 800 0 1, 221, 610 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 257063 10, 545, 683 0 8,864 2, 710, 905 73.00 07400 RENAL DIALYSIS 0 74.00 0.349606 Ω 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 0 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 0 0 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 Λ 90.00 09001 WOUND/OSTOMY CLINIC 0.352919 2, 312, 232 0 816, 031 90.01 90.01 0 90.02 09002 CTR ADVANCED HEART CARE 0. 345445 208, 547 0 72,042 90.02 09003 RADIATION ONCOLOGY 0.089909 0 90.03 13, 072, 785 1, 175, 361 90.03 0 90.04 09004 DIABETIC PLUS CLINIC 2. 138515 90.04 09005 ANTI COAGULATION CLINIC 0 90. 05 0.483793 350, 358 0 169, 501 90.05 Ol 09006 MAB 3611 REED 90.06 0.000000 0 90.06 0 91.00 09100 EMERGENCY 0.094437 12, 095, 193 0 0 1, 142, 234 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.775962 280, 532 217, 682 92.00 8,864 15, 293, 076 200. 00 200.00 Subtotal (see instructions) 97.862.034 17, 669

97, 862, 034

17, 669

8, 864

201.00

15, 293, 076 202. 00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

 Heal th Financial
 Systems
 COMMUNITY
 HOSPIT

 APPORTIONMENT OF MEDICAL,
 OTHER HEALTH SERVICES AND VACCINE COST
 In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113

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

					10 12/31/2023	5/24/2024 11:	
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost	1			
	, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	1			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	1			50.00
51.00	05100 RECOVERY ROOM	0	0)			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)			54.00
54. 01	05401 ULTRASOUND	0	0				54. 01
56.00	05600 RADI OI SOTOPE	0	0	,			56. 00
57. 00	05700 CT SCAN	0	0	,			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	,			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	,			59. 00
60.00	06000 LABORATORY	2, 557	0	,			60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	,			62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	,			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 077	0				71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,0,7	0	1			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 279	,			73. 00
74. 00	07400 RENAL DI ALYSI S	0	2,2,7	1			74. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	Ö	1			77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	-	1			78. 00
70.00	OUTPATIENT SERVICE COST CENTERS						70.00
90.00	09000 CLI NI C	0	0				90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0	Ö				90. 01
90. 02	09002 CTR ADVANCED HEART CARE	0	Ö	1			90. 02
90. 03	09003 RADI ATI ON ONCOLOGY	0	0				90. 03
90. 04	09004 DI ABETI C PLUS CLINI C	0					90. 04
90. 05	09005 ANTI COAGULATI ON CLI NI C	0					90. 05
90. 06	09006 MAB 3611 REED	0					90.06
91. 00	09100 EMERGENCY		0				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
200.00		3, 634	2, 279				200.00
200.00		3,034	2,217				201.00
201.00	Only Charges						201.00
202.00		3, 634	2, 279	,			202. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		-//	1			,

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023	Part Date/Time Pre	narodi
				10 12/31/2023	5/24/2024 11:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	•	Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 658, 719	0	1, 658, 71	9 21, 175	78. 33	30. 00
31.00 INTENSIVE CARE UNIT	583, 998		583, 99	8 4, 135	141. 23	31.00
43. 00 NURSERY	246, 042		246, 04	2 921	267. 15	43.00
200.00 Total (lines 30 through 199)	2, 488, 759		2, 488, 75	9 26, 231		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	677	53, 029				30. 00
31.00 INTENSIVE CARE UNIT	320	45, 194				31. 00
43. 00 NURSERY	727	194, 218				43. 00
200.00 Total (lines 30 through 199)	1, 724	292, 441				200. 00

Health Financial Systems	COMMUNITY HOSPI	TAL	ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	ſ	Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/24/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Capital Related Cost (from Wkst. B, Part II, col.	(fro	m Wkst. C,		Program	Capital Costs (column 3 x column 4)	

			e vi v	nospi tai	FF3	
Cost Center Description	Capi tal		Ratio of Cost	I npati ent	Capital Costs	
		(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		T	,			
50.00 05000 OPERATING ROOM	2, 852, 764	183, 054, 348		1, 073, 946	16, 736	
51.00 05100 RECOVERY ROOM	0	0	0. 000000	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	142, 616			199, 831	6, 546	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	454, 369			102, 180		
54. 01 05401 ULTRASOUND	54, 244			107, 005	510	
56. 00 05600 RADI 0I SOTOPE	101, 454	9, 314, 412		7, 005	76	56.00
57. 00 05700 CT SCAN	189, 874	57, 903, 138	0. 003279	382, 328	1, 254	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	528, 021	21, 262, 700	0. 024833	84, 485	2, 098	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	333, 262	32, 483, 880	0. 010259	63, 949	656	59.00
60. 00 06000 LABORATORY	703, 573	65, 891, 138	0. 010678	544, 013	5, 809	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	50, 820	2, 999, 456	0. 016943	91, 604	1, 552	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	176, 335	18, 895, 822	0.009332	709, 637	6, 622	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 154, 405	11, 645, 523	0. 099129	37, 099	3, 678	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	41, 062	2, 032, 424	0. 020203	29, 570	597	67. 00
68. 00 06800 SPEECH PATHOLOGY	20, 791	1, 022, 920	0. 020325	24, 457	497	68. 00
69. 00 06900 ELECTROCARDI OLOGY	435, 318			116, 268	2, 976	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	124, 906	6, 923, 673	0. 018040	38, 485	694	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	301, 332			302, 623	4, 005	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	356, 708			142, 923	1, 984	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	761, 088			1, 021, 063	12, 986	
74.00 07400 RENAL DIALYSIS	13, 668			67, 749	603	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 000000	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	i o	0. 000000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS				-	-	
90. 00 09000 CLI NI C	0	О	0.000000	0	0	90. 00
90. 01 09001 WOUND/OSTOMY CLINIC	167, 296	8, 110, 133		10, 324	213	90. 01
90. 02 09002 CTR ADVANCED HEART CARE	8, 761	804, 837		269	3	90. 02
90. 03 09003 RADI ATI ON ONCOLOGY	613, 242			899	9	90. 03
90. 04 09004 DI ABETI C PLUS CLINI C	20, 313			0	0	90. 04
90. 05 09005 ANTI COAGULATI ON CLINIC	16, 998			0	0	90. 05
90. 06 09006 MAB 3611 REED	0	1	0. 000000	0	0	90. 06
91. 00 09100 EMERGENCY	541, 550	115, 527, 546		885, 882	4, 153	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	157, 530			2, 930	· ·	92. 00
200.00 Total (lines 50 through 199)	10, 322, 300			6, 046, 524		
, ,	1		1			

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider CO		Period: From 01/01/2023 Fo 12/31/2023	Worksheet D Part III Date/Time Pre 5/24/2024 11:	pared: 54 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDLATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	0 0	0 0 0 0	(0 0 0	0 0 0 0	30. 00 31. 00 43. 00 200. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6. 00	7. 00	8. 00	
30.00 03000 ADULTS & PEDLATRICS 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0 0 0	21, 17! 4, 13! 92. 26, 23	0. 00 0. 00	677 320 727 1 724	30. 00 31. 00 43. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	J			1,72	
30. 00 03000 ADULTS & PEDLATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0 0 0 0					30. 00 31. 00 43. 00 200. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0113	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2023 Part IV

THROUG	H COSTS				To 12/31/2023	Date/Time Pre 5/24/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician	Nursi ng	Nursi ng Program	Allied Health Post-Stepdown	Allied Health	
		Anesthetist Cost	Program Post-Stepdown	Program	Adjustments		
		COST	Adjustments		Auj us tillerits		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	271	2.00	- Ort	0.00	
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
51.00	05100 RECOVERY ROOM	0	0)	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
54. 01	05401 ULTRASOUND	0	0		0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0	0		0	0	56.00
57.00	05700 CT SCAN	0	0		0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0)	0	0	62.00
64.00	06400 I NTRAVENOUS THERAPY	0	0)	0	0	64. 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
	06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0)	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0)	0	0	73. 00
	07400 RENAL DIALYSIS	0	0)	0	0	74. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	-		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0) (0 0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS		1 0			0	00.00
90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0	•	1	0 0	0	90.00
	09002 CTR ADVANCED HEART CARE	0	0		0	0	90. 01
	09003 RADI ATI ON ONCOLOGY	0	0			0	90. 02 90. 03
	09004 DI ABETI C PLUS CLINI C	0	0			0	90.03
	09005 ANTI COAGULATI ON CLINI C					0	90.04
90. 06	09006 MAB 3611 REED					0	90.06
91. 00	09100 EMERGENCY					0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		١			0	1
200.00		0	0		o o	_	200. 00
200.00	1 1.0 ca. (111103 00 cili ough 177)	1		1	-1	. 0	1200.00

Health Financial Systems	COMMUNITY HOSPITA	L ANDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0113	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

THROUGH COSTS				Γο 12/31/2023		pared: 54 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
				7.00	instructions)	
ANOLLI ADV. CEDIU OF COCT. CENTEDO	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	0		183, 054, 348	0.000000	FO 00
51. 00 05000 0PERATTING ROOM 51. 00 05100 RECOVERY ROOM	0	0	•		l .	1
52. 00 05100 RECOVERY ROOM	0	0		0 4, 353, 685	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		16, 107, 325		
54. 00 05400 RADI OLOGI - DI AGNOSTI C	0	0		11, 376, 053		
56. 00 05600 RADI 01 SOTOPE	0	0		9, 314, 412		1
57. 00 05700 CT SCAN	0	0		57, 903, 138		1
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0		21, 262, 700	l .	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		32, 483, 880		
60. 00 06000 LABORATORY	0	0	l	65, 891, 138		1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		2, 999, 456		1
64. 00 06400 I NTRAVENOUS THERAPY	0	0		2, 999, 430	0.00000	
65. 00 06500 RESPI RATORY THERAPY	0	0		18, 895, 822		1
66. 00 06600 PHYSI CAL THERAPY	0	0		11, 645, 523		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	2, 032, 424		
68. 00 06800 SPEECH PATHOLOGY	0	0		1, 022, 920		
69. 00 06900 ELECTROCARDI OLOGY	0	0		17, 008, 533		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		6, 923, 673	l .	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		22, 771, 440		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		25, 697, 053		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		59, 845, 486		1
74. 00 07400 RENAL DIALYSIS	0	0		1, 535, 261		
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0		
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		o o		
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0.000000	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	0	0		8, 110, 133	0.000000	90. 01
90.02 09002 CTR ADVANCED HEART CARE	0	0		804, 837	0.000000	90. 02
90. 03 09003 RADI ATI ON ONCOLOGY	0	0		59, 392, 100	0.000000	90. 03
90. 04 09004 DIABETIC PLUS CLINIC	O	0		307, 237	0.000000	90. 04
90. 05 09005 ANTICOAGULATION CLINIC	0	0		1, 274, 812	0.000000	90. 05
90. 06 09006 MAB 3611 REED	o	0		0	0.000000	90. 06
91. 00 09100 EMERGENCY	o	0		115, 527, 546	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(3, 863, 148	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	(761, 404, 083		200. 00

Health Financial Systems	COMMUNITY HOSPIT	AL ANDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0113	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

THROUGH COSTS			Ţ	0 12/31/2023	Date/Time Pre 5/24/2024 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
·	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	Ü	Costs (col. 8	Ŭ	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	1, 073, 946	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	199, 831	0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	102, 180	0	0	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	107, 005	0	0	0	54. 01
56. 00 05600 RADI OI SOTOPE	0. 000000	7, 005	0	0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	382, 328	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	84, 485		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	63, 949	0	0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	544, 013		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	91, 604	l o	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	709, 637	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	37, 099	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	29, 570		0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	24, 457		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	116, 268		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	38, 485		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	302, 623		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	142, 923		0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 021, 063			0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	67, 749		0	0	74. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0,,,,,		0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	0.000000			J		70.00
90. 00 09000 CLINIC	0. 000000	0	0	0	0	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	0. 000000	10, 324			0	90. 01
90. 02 09002 CTR ADVANCED HEART CARE	0. 000000	269		_	0	90. 02
90. 03 09003 RADIATION ONCOLOGY	0. 000000	899		-	0	90. 03
90. 04 09004 DI ABETI C PLUS CLI NI C	0. 000000	0,,		_	0	90. 04
90. 05 09005 ANTI COAGULATI ON CLI NI C	0. 000000	0		_	0	90.05
90. 06 09006 MAB 3611 REED	0. 000000	0		0	0	90.06
91. 00 09100 EMERGENCY	0. 000000	885, 882		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 930		_	0	92. 00
200.00 Total (lines 50 through 199)	0.000000	6, 046, 524		_		200. 00
255.55 ₁ 15tal (11165 55 till 64gli 177)	1	0,010,024	١ ٠	١		1-30.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0113 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/24/2024 11:54 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. 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. 136140 1, 888, 925 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.509279 52 00 0 52 00 0 0 |05400| RADI OLOGY-DI AGNOSTI C 54.00 0. 263322 0 276, 598 0 54.00 54.01 05401 ULTRASOUND 0.108244 233, 346 0 54.01 56.00 05600 RADI OI SOTOPE 0.096514 0 66, 243 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 56.00 0 1, 007, 919 05700 CT SCAN 0.044924 57.00 0 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.118368 279, 426 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.074718 0 105, 408 0 59.00 06000 LABORATORY 0 168478 0 60 00 60 00 956 462 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.396693 0 19, 486 0 62.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 64.00 06500 RESPIRATORY THERAPY 0. 211878 29, 134 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 0.553756 126, 742 0 67.00 06700 OCCUPATIONAL THERAPY 0.370669 0 13, 486 0 67.00 06800 SPEECH PATHOLOGY 0.375844 5, 734 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 199067 0 127, 671 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0.232001 0 70.00 70 00 134, 087 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.432877 441, 412 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 230, 145 72.00 0.454164 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.257063 275, 193 0 73.00 07400 RENAL DIALYSIS 0 74.00 0.349606 0 0 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0.000000 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0.000000 O 0 90.00 90. 01 09001 WOUND/OSTOMY CLINIC 0.352919 309, 358 0 90.01 0 0 0 0 0 0 0 0 0 90.02 09002 CTR ADVANCED HEART CARE 0. 345445 0 12, 665 0 90.02 09003 RADIATION ONCOLOGY 0.089909 0 1.741.599 90.03 90.03 0 90.04 09004 DIABETIC PLUS CLINIC 2. 138515 4, 418 0 90.04 09005 ANTI COAGULATION CLINIC 90. 05 0.483793 8, 914 0 90.05 09006 MAB 3611 REED 90.06 90.06 0.000000 C 0 09100 EMERGENCY 91.00 0.094437 0 3, 434, 533 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.775962 44, 258 0 92.00 200.00 Subtotal (see instructions) 11, 773, 162 200.00 0 Less PBP Clinic Lab. Services-Program 201. 00 201.00 Ω

11, 773, 162

0 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

 Heal th Financial
 Systems
 COMMUNITY
 HOSPIT

 APPORTIONMENT OF MEDICAL,
 OTHER HEALTH SERVICES AND VACCINE COST
 In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113

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

					10 12/31/2023	5/24/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	
		Cos					
	Cost Center Description	Cost	Cost	1			
	, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	1			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	257, 158	0)			50.00
	05100 RECOVERY ROOM	0	0	,			51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05400 RADI OLOGY-DI AGNOSTI C	72, 834	0				54.00
54. 01	05401 ULTRASOUND	25, 258	0				54. 01
56. 00	05600 RADI OI SOTOPE	6, 393	0				56.00
57. 00	05700 CT SCAN	45, 280	0	1			57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	33, 075	0	1			58.00
59. 00	05900 CARDIAC CATHETERIZATION	1	0				59.00
	06000 LABORATORY	7, 876	0				
60.00		161, 143	0				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 730	_	1			62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00	06500 RESPI RATORY THERAPY	6, 173	0	1			65. 00
66. 00	06600 PHYSI CAL THERAPY	70, 184	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	4, 999	0	1			67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 155	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	25, 415	0				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	31, 108	0				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	191, 077	0				71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	104, 524	0	1			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	70, 742	0)			73. 00
	07400 RENAL DIALYSIS	0	0)			74. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0)			77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0				90. 00
90. 01	09001 WOUND/OSTOMY CLINIC	109, 178	0)			90. 01
90. 02	09002 CTR ADVANCED HEART CARE	4, 375	0				90. 02
90. 03	09003 RADI ATI ON ONCOLOGY	156, 585	0				90. 03
90.04	09004 DIABETIC PLUS CLINIC	9, 448	0				90. 04
90. 05	09005 ANTI COAGULATI ON CLINIC	4, 313	0				90. 05
90.06	09006 MAB 3611 REED	0	0				90. 06
91.00	09100 EMERGENCY	324, 347	0	1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	34, 343	0)			92.00
200.00		1, 765, 713	0	,			200. 00
201.00	1 ,	0					201. 00
	Only Charges						
202.00		1, 765, 713	0				202. 00
				'			•

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0113	Peri od: From 01/01/2023	Worksheet D-1
			Date/Time Prepared: 5/24/2024 11:54 am
	Title XVIII	Hospi tal	PPS

Cost Centre Description No. PART All PROVIDER COMPONEYS			Title XVIII	Hospi tal	5/24/2024 11: PPS	54 am_
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description	THE AVITE	nospi tai	'	
Impatriant parks (including private room days and swing-bed days, excluding neaborn) 21,175 1.00 Inpatriant days (including private room days, excluding swing-bed and meaborn days) 21,175 2.00 Inpatriant days (including private room days, excluding swing-bed and meaborn days) 17,00 1.		DADT I ALL DROW DED COMPONENTS			1. 00	
Inpatient days (Including private room days and saing-bed days, excluding newborn)						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 19,164 4.00	1.00		s, excluding newborn)			
do not complete this line. 4. 00 Semi-private room days (excluding swing-bed and observation bed days) 10. 10. 10. 10. 10. 10. 10. 10. 10. 10.						
5.00 Somi-privatic room days (excluding swing-bed and observation bed days) 19,104 4.00	3.00		ys). If you have only pri	vate room days,	0	3.00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost of Potal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 8.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 8.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 8.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and nezborn days) (see instructions) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 10.00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost	4.00		ed days)		19, 164	4. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of the cost propriod (if cal endar year, enter 0 on this iline) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this iline) Total inpatient days including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this iline) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Swing-bed NF type inpatient days applicable to title XVII only (including private room days) after through December 31 of the cost reporting period (see instructions) Swing-bed NF type inpatient days applicable to title XVII only (including private room days) Swing-bed NF type inpatient days applicable to title XVII only (including private room days) Swing-bed NF type inpatient days applicable to title XVII only (including private room days) Swing-bed NF type inpatient days applicable to title XVII only (including private room days) Wed call by necessary private room days applicable to the Program (excluding swing-bed days) Medically necessary private room days applicable to the Program (excluding swing-bed days) Medically necessary private room days applicable to the Program (excluding swing-bed days) Medically necessary private room days applicable to the Program (excluding swing-bed days) Medically necessary private room days applicable to the Program (excluding swing-bed days) Medically necessary private room days applicable to the Program (excluding swing-bed days) Medically necessary private room days applicable to services through Dec	5.00		om days) through Decembe	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing bead by type inpatitent days (including private room days) through December 31 of the cost 7. 00 Total swing bead by type inpatitent days (including private room days) after December 31 of the cost 9. 00 Total inpatitent days including private room days) after December 31 of the cost 10 Swing-bed SNF type inpatitent days applicable to the Program (excluding swing-bed and 11 newtorn days) (see instructions) 11 00 Swing-bed SNF type inpatitent days applicable to title XVIII only (including private room days) after 12 December 31 of the cost reporting period (see instructions) 13 December 31 of the cost reporting period (see instructions) 14 December 31 of the cost reporting period (including private room days) 15 December 31 of the cost reporting period (including private room days) 16 December 31 of the cost reporting period (including private room days) 17 December 31 of the cost reporting period (including private room days) 18 December 31 of the cost reporting period (including private room days) 19 December 31 of the cost reporting period (including private room days) 19 December 31 of the cost reporting period (including private room days) 10 December 31 of the cost reporting period (including private room days) 10 December 31 of the cost reporting period (including private room days) 11 December 31 of the cost reporting period (including private room days) 12 December 31 of the cost reporting period (including private room days) 13 December 31 of the cost reporting period (including private room days) 14 December 31 of the cost (including private room days) 15 December 31 of the cost (including private room days) 16 December 31 of the cost (including private room days) 17 December 31 of the cost (including private room days) 18 December 31 of the cost (including private room days) 19 December 31 of the cost (including private room days) 19 December 31 of the cost (including private room days) 10 December 31 of the cost (including p						,
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00 Intervining period (if cal endar year, enter 0 on this line) 7.00 Sing-bed SNF type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (in only (including private room days) after December 31 of the cost reporting period (see instructions) 7.00 Sing-bed SNF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (see instructions) 7.00 Sing-bed NF type inpatient days applicable to title XV or XX only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00 Sing-bed NF type inpatient days applicable to title X or XX only (including private room days) and through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00 Sing-bed NF type inpatient days applicable to title X or XX only (including private room days) 7.00 Sing-bed NF type inpatient days applicable to title X or XX only (including private room days) 7.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 7.00 Noversery days (title V or XIX only) 7.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 8.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 8.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 8.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room	6.00		om days) after December .	31 OF the COST	0	6.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line)	7.00		n days) through December	31 of the cost	0	7. 00
reporting period (if cal endar year, enter 0 on this line) 9.00						
10.00 Normal impatient days including private name days applicable to the Program (excluding swing-bed and newborn days) 0.00 0	8.00		n days) after December 3	of the cost	0	8.00
newborn days) (see Instructions) 10.00 Sing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see Instructions) 10.00 Sing-bed SNT type inpatient days applicable to 11tie XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Sing-bed NT type inpatient days applicable to 11ties V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Sing-bed NT type inpatient days applicable to 11ties V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Sing-December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 All to December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 NE Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 NE NF type services after December 31 of the cost reporting period (line 6 NF Type services after December 31 of the cost reporting period (line 6 NF Type services after December 31 of the co	9. 00		the Program (excluding	swing-bed and	4, 710	9. 00
through December 31 of the cost reporting period (see instructions) 1.00 Sung-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.20 Out of through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Sung-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Sung-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Sung-bed NF type (itle V or XIX only) 1.00 Sung-bed NF type (itle V or XIX only) 1.00 Sung-bed NF type (itle V or XIX only) 1.00 Sung-bed NF type services applicable to services after December 31 of the cost or porting period (including private room days applicable to services after December 31 of the cost or porting period (including private room days) 1.00 Medicair are for swing-bed NF services applicable to services after December 31 of the cost or porting period (including private room days) 1.00 Medicair are for swing-bed NF services applicable to services after December 31 of the cost or porting period (including private room days applicable to services after December 31 of the cost or porting period (including private room days applicable to services after December 31 of the cost reporting period (line or porting period (including private room days applicable to NF type services after December 31 of the cost reporting period (line or porting period (including private room days applicable to NF type services after December 31 of the cost reporting period (line or porting period (including private promaticable to NF type services after December 31 of the cost re		newborn days) (see instructions)				
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7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 29 ÷ line 4) 30.00 Average per diem private room charge differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 31, 564, 123) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 31, 564, 123) 38.00 Application (line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Medically necessary private room cost dipplicable to the Program (line 14 x line 35) 0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	20.00		or or the cost reporting	g perrou (Trite o	Ü	20.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERENTI AL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 29 + line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 31,564,123) 32.00 Adjusted general inpatient routine service cost per diem (see instructions) 33.00 Adjusted general inpatient routine service cost (line 9 x line 38) 34.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 35.00 Aoo Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		31 of the cost reporti	ng period (line	0	24. 00
x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per diem private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Average linpatient routine service cost net of swing-bed cost and private room cost differential (line 31, 564, 123) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Averag	25 00		R1 of the cost reporting	neriod (line 8	0	25 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 28. 00 29. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 31. 00 30. 00 31. 00 30. 00	20.00		or the cost reporting	perred (Trie 6	Ü	20.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room charge differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 31, 564, 123) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 7,020,867 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 30.00 30.00 30.00					-	•
28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) Semi-private room per diem charges Semi-private room per diem charge (line 27 ÷ line 28) Semi-private room per diem charge (line 30 ÷ line 4) Semi-private room per diem charge (line 30 ÷ line 4) Semi-private room per diem charge (line 30 ÷ line 4) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line 32 minus line 33)(see instructions) Semi-private room cost differential (line	27. 00		(line 21 minus line 26)		31, 564, 123	27.00
29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 32. 00 Average semi-private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 31, 564, 123) 37. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29. 00 0 30. 00 0 0 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00		d and observation bed cha	arges)	0	28. 00
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32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 31, 564, 123) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 37.00 Program general inpatient routine service cost (line 9 x line 38) 37.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 36.00 0						1
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34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 31, 564, 123) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 7,020,867 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 31, 564, 123 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 31, 564, 123 37.00 31,			nus line 33)(see instruc	tions)		1
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 21, 564, 123) 37. 00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 490. 63 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 7, 020, 867 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00		, ,	ne 31)			1
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , ,	and private room cost dis	ferential (line		•
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 7,020,867 9.00 40.00	37.00		and private room cost dr	recentral (TITIE	31, 304, 123	37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,490.63 38.00 Program general inpatient routine service cost (line 9 x line 38) 7,020,867 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 7,020,867 39.00 40.00	00.00				4 100 :=	00.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			•			1
			•			1
	41. 00		,		7, 020, 867	41. 00

COMPLIT	Financial Systems ATION OF INPATIENT OPERATING COST	COMMONITY 1103FT	TAL ANDERSON Provider CO	CN: 15-0113	Peri od:	u of Form CMS-2 Worksheet D-1	
20mi 01					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared:
	Cost Center Description	Total Inpatient Cost	Total	XVIII Average Per Diem (col. 1 col. 2)		PPS Program Cost (col. 3 x col. 4)	
42.00	NUDSERV (+i+Lo V & VIV only)	1.00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	<u> </u>	0	0.	00 0	0	42.00
43. 00 44. 00 45. 00 46. 00 47. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	10, 329, 821	4, 135	2, 498.	1, 168	2, 917, 828	43. 00 44. 00 45. 00 46. 00 47. 00
						1.00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)	8, 918, 137 0	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				Corumn 1)	18, 856, 832	
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, su	m of Parts I and	533, 891	50.00
51. 00	Pass through costs applicable to Program inp and IV)		y services (fr	om Wkst. D,	sum of Parts II	597, 044	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	ding capital re	lated, non-phy	sician anest	netist, and	1, 130, 935 17, 725, 897	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	, 9						54.00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge						55. 00 55. 01
55. 02	Adjustment amount per discharge (contractor					0.00	55. 02
56.00	Target amount (line 54 x sum of lines 55, 55			! !	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (i	THE 50 III HUS	11 ne 53)	0	1
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	rting period	endi ng 1996,		59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year c	ost report,	updated by the	0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (iflin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	hich operati	ng costs (line	0	61.00
62. 00 63. 00	enter zero. (see instructions) Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				62. 00 63. 00
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +b	21 -E +b-			0	
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos						64.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi			•			66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	•	•	, ,	3,		67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	•				0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service c	ost (line 37)		70. 00
71.00	Adjusted general inpatient routine service c	,	ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	ice costs (line	72 + line 73)		Part II, column		74. 00 75. 00
76 00	26, line 45)	no 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces	, ,			1: 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ust iimitation	(iine /8 mii	ius iine 79)		80.00
	Inpatient routine service cost per drem from)				82. 00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in		ne)				84. 00 85. 00
86. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00	Total observation bed days (see instructions					2, 011 1, 490. 63	
88. 00	Adjusted general inpatient routine cost per	ruam (lina 27 ±	11na 21				

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		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		
		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	1, 658, 719	31, 564, 123	0. 05255	1 2, 997, 657	157, 530	90. 00
91.00 Nursing Program cost	0	31, 564, 123	0.00000	2, 997, 657	0	91.00
92.00 Allied health cost	0	31, 564, 123	0.00000	2, 997, 657	0	92. 00
93.00 All other Medical Education	0	31, 564, 123	0.00000	2, 997, 657	0	93.00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0113	Peri od: From 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/24/2024 11:	
	Title XIX	Hospi tal	PPS	
Cost Contor Description				

		Title XIX	Hospi tal	5/24/2024 11: PPS	54 am_
	Cost Center Description	THE XIX	nospi tai		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.	ed and newborn days)	ivate room days,	21, 175 21, 175 0	1. 00 2. 00 3. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period		r 31 of the cost	19, 164 0	4. 00 5. 00
6.00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)			677	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	i ons)		0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er China bed NF type inpatient days applicable to title XVIII or December 31 of the cost reporting	nter O on this line)	,	0	11.00
12. 00 13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX			0	12. 00 13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this lin	e)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	iii (exer darrig sirrig bed	adys)	921 727	15. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	<u> </u>		0. 00	
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services				19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions			31, 564, 160	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	·		0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December \mathbf{x} line 18)	•		0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	·		0	24. 00
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 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0 31, 564, 160	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	I and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		· ,	0	29. 00
	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 =	· line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 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 lin	ne 31)		0. 00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 31, 564, 160	36. 00 37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
20 00	Adjusted general inpatient routine service cost per diem (see			1 400 42	38. 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see	•		1, 490. 63 1, 009, 157	
40. 00	Medically necessary private room cost applicable to the Progra	-		1,009,157	40.00
	Total Program general inpatient routine service cost (line 39	•		1, 009, 157	
11.00	1.53 Sgram general ripatront routine service cost (Tille 37		'	1, 507, 157	1 11.00

Heal th	Financial Systems (OMMUNITY HOSPIT	TAL ANDERSON			u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC	CN: 15-0113	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	pared:
-			Titl	e XIX	Hospi tal	5/24/2024 11: PPS	54 am_
	Cost Center Description	Total npatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	2, 917, 246	921	3, 167. 4	8 727	2, 302, 758	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	10, 329, 821	4, 135	2, 498. 1	4 320	799, 405	43. 00
44. 00	CORONARY CARE UNIT	10, 027, 021	1, 100	2, 170. 1		, , , , , ,	44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
40.00	Program inpatient ancillary service cost (Wks	+ D 2 and 2	Line 200)			1. 00 1, 242, 040	48. 00
48. 00 48. 01	Program inpatient cellular therapy acquisition			III, line 10,	column 1)	1, 242, 040	1
49. 00	Total Program inpatient costs (sum of lines 4	,				5, 353, 360	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tient routine s	ervices (from	Wket D sum	of Parts I and	292, 441	50.00
30.00		trent routine s	ervices (IIOIII	WKST. D, Suii	or raits railu	272, 441	30.00
51. 00	Pass through costs applicable to Program inpa	tient ancillary	services (fr	om Wkst. D, s	um of Parts II	77, 258	51.00
52. 00	and IV) Total Program excludable cost (sum of lines 5	0 and 51)				369, 699	52.00
53. 00	Total Program inpatient operating cost exclud	ing capital rel	ated, non-phy	sician anesth	etist, and	4, 983, 661	1
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	2)					
54. 00	Program di scharges					0	54.00
55. 00	Target amount per discharge						55. 00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor u	so only)					55. 01 55. 02
56. 00	Target amount (line 54 x sum of lines 55, 55.					0.00	1
57. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, o	r line 55 from	the cost reno	rting period	endina 1996	0 00	58. 00 59. 00
37.00	updated and compounded by the market basket)	1 11116 33 11 0111	the cost repo	rting perrou	charing 1770,	0.00	37.00
60. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior year c	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 53) are less than expected costs (lines 54 x	er of 50% of th	e amount by w	hich operatin	g costs (İine	0	61. 00
(2.00	enter zero. (see instructions)						(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	nt (see instruc	tions)				62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
64. 00	Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	s through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	s 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 routin</pre>	e costs (line 6	4 plus line 6	5)(title XVII	l only): for	0	66. 00
	CAH, see instructions		•		•		
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through	December 31 o	f the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine	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 r	outine costs (L	ine 67 + line	68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY,	AND ICF/IID	ONLY			07.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70. 00 71. 00
71.00	Program routine service cost (line 9 x line 7		ne /o - ime :	2)			72.00
73. 00	Medically necessary private room cost applica		•	ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r		,	orksheet B F	art II column		74. 00 75. 00
70.00	26, line 45)	outine service	00313 (110111 11	or Rancet B, T	are rr, coramir		70.00
76. 00	Per diem capital related costs (line 75 ÷ lin						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	costs (from pr					79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		st limitation	(line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem rimit						82.00
83.00			5)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation (ıs)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST				2.011	07.00
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per d	iem (line 27 ÷	line 2)			2, 011 1, 490. 63	1
89. 00	Observation bed cost (line 87 x line 88) (see					2, 997, 657	

Health Financial Systems	COMMUNITY HOSP	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2023	Worksheet D-1	
				To 12/31/2023		
		Ti tl	e XIX	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	1, 658, 719	31, 564, 160	0. 05255	1 2, 997, 657	157, 530	90.00
91.00 Nursing Program cost	0	31, 564, 160	0.00000	2, 997, 657	0	91.00
92.00 Allied health cost	0	31, 564, 160	0.00000	2, 997, 657	0	92.00
93.00 All other Medical Education	0	31, 564, 160	0.00000	2, 997, 657	0	93.00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	COMMUNITY HOSPITAL ANDERSON Provider CC		In Lie Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/24/2024 11:	pared:
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			11, 577, 366 5, 115, 588		30. 00 31. 00 43. 00
		0. 13581	10 414 470	1 414 421	FO 00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM		0. 13581		1, 414, 431 0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 50927		0	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 26332			
54. 01 05401 ULTRASOUND		0. 20332		39, 083	
56. 00 05600 RADI OI SOTOPE		0. 09651			
57. 00 05700 CT SCAN		0. 04492		150, 944	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 11836			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 07471		186, 218	
60. 00 06000 LABORATORY		0. 16847			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 39669	3 543, 526	215, 613	62.00
64.00 06400 INTRAVENOUS THERAPY		0. 00000	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY		0. 21187	8 3, 905, 063	827, 397	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 55375	6 416, 568	230, 677	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37066	9 286, 387	106, 155	
68. 00 06800 SPEECH PATHOLOGY		0. 37584	4 208, 644	78, 418	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 19906			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 23200	1 278, 877	64, 700	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 43287			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 45416			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 25706		1, 554, 061	
74. 00 07400 RENAL DI ALYSI S		0. 34960		144, 806	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000		0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	0 الا	0	78. 00
OUTPATIENT SERVICE COST CENTERS		0.00000		_	00.00
90. 00 09000 CLI NI C 90. 01 09001 WOUND/OSTOMY CLI NI C		0.00000		0 20, 733	
90. 01 09001 WOUND/USTOMY CLINIC		0. 35291		20, 733	

206, 246

6, 822, 989

46, 741, 923

46, 741, 923

208, 597

0.345445

0.089909

2. 138515

0. 483793

0.000000

0.094437

0.775962

18, 543

0

0

644, 343 91. 00 161, 863 92. 00 8, 918, 137 200. 00

90.02

90. 04

90.05

90.06

201. 00

202. 00

09002 CTR ADVANCED HEART CARE

09004 DIABETIC PLUS CLINIC 09005 ANTICOAGULATION CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

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

09003 RADIATION ONCOLOGY

09006 MAB 3611 REED

09100 EMERGENCY

90.02

90.03

90.04

90.05

90.06

91.00

200.00

201.00

202.00

lealth Financial Systems	COMMUNITY HOSPITAL	L ANDERSON		In Lie	u of Form CMS-2	2552-10
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre	
					5/24/2024 11:	54 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	•	Inpatient	
			To Charges		Program Costs (col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00		3.00	
RO OO OROOO ADUUTS & PEDLATRICS				1 916 911		1 30

Cost Center Description	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		1, 916, 911		30. 00
31.00 03100 INTENSIVE CARE UNIT		1, 521, 770		31. 00
43. 00 04300 NURSERY		617, 278		43.00
ANCILLARY SERVICE COST CENTERS			1	
50. 00 05000 OPERATI NG ROOM	0. 136140	1, 073, 946	l	50. 00
51. 00 05100 RECOVERY ROOM	0. 000000	0	0	51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 509279	199, 831	101, 770	52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 263322	102, 180		54.00
54. 01 05401 ULTRASOUND	0. 108244	107, 005		54. 01
56. 00 05600 RADI 0I SOTOPE	0. 096514	7, 005	l e	56. 00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 044924 0. 118368	382, 328		57. 00 58. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	1	84, 485		59.00
60. 00 06000 LABORATORY	0. 074718 0. 168478	63, 949 544, 013		60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 166478	91, 604	1	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	91,004	0 30, 339	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 211878	709, 637	150, 356	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 553756	37, 099		66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	0. 333730	29, 570		
68. 00 06800 SPEECH PATHOLOGY	0. 375844	24, 457	9, 192	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 199067	116, 268		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 232001	38, 485		70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 432877	302, 623	1	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 454164	142, 923		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 257063	1, 021, 063		73. 00
74. 00 07400 RENAL DIALYSIS	0. 349606	67, 749		74. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	77. 00
78. OO O780O CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	'			
90. 00 09000 CLI NI C	0.000000	0	0	90. 00
90.01 09001 WOUND/OSTOMY CLINIC	0. 352919	10, 324	3, 644	90. 01
90.02 09002 CTR ADVANCED HEART CARE	0. 345445	269	93	90. 02
90. 03 09003 RADIATION ONCOLOGY	0. 089909	899	81	90. 03
90. 04 09004 DI ABETI C PLUS CLINI C	2. 138515	0	0	90. 04
90.05 09005 ANTICOAGULATION CLINIC	0. 483793	0	0	90. 05
90. 06 09006 MAB 3611 REED	0.000000	0	0	90. 06
91. 00 09100 EMERGENCY	0. 094437	885, 882		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 775962	2, 930		92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		6, 046, 524	1, 242, 040	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		6, 046, 524		202. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	From 01/01/2023	Worksheet E Part A Date/Time Prepared: 5/24/2024 11:54 am
	Ti tla YVIII	Hospi tal	DDS

PART A - IMPAILED HOSPITAL SEMPLES MINERAL PROPERTY 1.00 DRC Amounts other than Outline Payments for discharges occurring prior to October 1 (see 9,884,447 1.01 1.00		Title XVIII Hospital	5/24/2024 11: PPS	54 am
BART A. INPATITY HOSPITAL SPRINGS INDIFE IPPS				
1.00 306 Amounts other than Outlier Payments for discharges occurring prior to October 1 (see 9,884,447 1.01 1.02 1.		PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00	
1.02 10K amounts other than outline payment for Model 4 IRCL for discharges occurring prior to October 1 (see 1.02 1.02 1.02 1.02 1.03 1.03 1.03 1.03 1.03 1.03 1.04 1.03 1.04 1.03 1.04 1.03 1.04 1.03 1.04 1.04 1.03 1.04 1.03 1.04 1.03 1.04 1.03 1.04 1.03		DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see		1. 00 1. 01
1.03 1.03	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	3, 110, 229	1. 02
1.04 ORC for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0.1.04	1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octob	per 0	1. 03
2.01 Outlier rescond liation anount 0 2.02	1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
2.03 Outlier payments for discharges occurring prior to October 1 (see Instructions) 26,377 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 26,377 2.04 Control of Standard Payments 26,377 2.04 Control of Standard Payments 27,559,809 3.00 3.	2.01	Outlier reconciliation amount		
2.0 0utiler payments for discharges occurring on or after October 1 (see Instructions) 26.377 2.04 2.04 2.00 0utiler payments (see Instructions) 17.59, 809 3.00 0utiler (see Instructions) 17.59, 809 3.00 0.0		, , ,		
3.00 Managed Care Simulated Payments 17,559,809 3.00				
Indirect Medical Education Adjustment	3.00			
FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see instructions) 0.00 5.00	4.00		113. 12	4.00
FIE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions)	5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending	on 0.00	5. 00
6.26 Rural track program FTE cap Limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(1) 0.00 7.01 ACA 5 \$5030 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the 0.00 7.01 ACA 5 \$5030 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the 0.00 7.01 ACA 5 \$5030 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the 0.00 7.01 ACA 5 \$5030 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the 0.00 7.01 ACA 5 \$5030 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the 0.00 7.01 ACA 5 \$40.00 ACA 5 \$		FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap 1	l .	5. 01 6. 00
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(fY)(1)(8)(8)(1) (10)(8)(1) 0.00 7.01 7.01 ACS \$503 reduction amount to the IME cap as specified under 42 CFR \$412.105(fY)(1)(8)(2) (1) (the cost report straddles July 1, 2011 then see instructions. 0.00 7.01 7.02 Aljustment (increase or decrease) to the hospital's rural track programs FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022). 0.00 0.00 7.02 8.00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (Mey 12, 1999), and 67 FR 50069 (August 1, 2002). 0.00 8.00 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions. 0.00 8.01 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions) and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or Sufficient (august 1) and 5.01, plus line 6.20 (plus lines 6.20	6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	of 0.00	6. 26
7. Q2 Adjustment (increase or decrease) to the hospital's rural track programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8. 00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002) 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$5500 of ACA. (see instructions) 8. 02 The amount of increase if the hospital was awarded FTE cap slots under \$5500 of ACA. (see instructions) 8. 03 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions) 8. 04 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions) 8. 05 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 9. 00 FTE count for allopathic and osteopathic programs in the current year from your records 10. 00 Current year allowable FTE (see instructions) 11. 00 Current year allowable FTE (see instructions) 11. 01. 01 Total allowable FTE count for the prior year: 15. 00 Sum of lines 12 through 14 divided by 3. 16. 00 Adjustment for residents in initial years of the program (see instructions) 17. 00 Adjustment for residents of layleads by program or hospital closure 18. 00 Adjustment for residents of layleads by program or hospital closure 19. 00 Current year resident to bed ratio (see instructions) 19. 00 Enter the lesser of lines 19 or 20 (see instructions) 19. 00 Current year resident to bed ratio (see instructions) 19. 00 Current year resident in bed ratio (see instructions) 19. 00 Current year resident to bed ratio (see instructions) 19. 00 Current year resident to bed ratio (see instructions) 19. 00 Current year resident to bed ratio (see instructions) 19. 00 Current year resident to bed ratio (se		MMA Section 422 reduction amount to the IME cap as specified under 42 CFR $\S412.105(f)(1)(iv)(B)(1)$ ACA \S 5503 reduction amount to the IME cap as specified under 42 CFR $\S412.105(f)(1)(iv)(B)(2)$ If the specified under 42 CFR $\S412.105(f)(1)(iv)(B)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)$		
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	32. 00	Sum of lines 30 and 31	30. 22	32. 00
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34.00 Disproportionate share adjustment (see instructions) 449,074 34.00	34.00	prisproportionate share adjustiment (see instructions)	1 449, 0/4	J 34. UU

Health Financial Systems COMMUNITY CALCULATION OF REIMBURSEMENT SETTLEMENT		OSPITAL ANDERSON Provider CCN: 15-0113	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2023 To 12/31/2023	Part A Date/Time Pre 5/24/2024 11:	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	On/After 10/1	
	Uncompensated Care Payment Adjustment		1.00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		6, 874, 403, 459	5, 938, 006, 757	35. 00
35. 01	Factor 3 (see instructions)	_	0. 000124273	0. 000126319	1
35. 02	Hospital UCP, including supplemental UCP (see instruction	•	854, 301	750, 082	1
35. 03 36. 00		,	638, 970 827, 515		35. 03 36. 00
30.00	Additional payment for high percentage of ESRD beneficia				30.00
40.00	Total Medicare discharges (see instructions)	<u>, , , , , , , , , , , , , , , , , , , </u>	0		40.00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see in		0		41.01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not Total Medicare ESRD inpatient days (see instructions)	quality for adjustment)	0.00		42.00
44. 00	Ratio of average length of stay to one week (line 43 di	vided by line 41 divided by 7	0. 000000		44.00
00	days)	read by removed an evaluation by r	0.00000		00
45.00	Average weekly cost for dialysis treatments (see instru		0.00		45. 00
46.00	1 3 1	ine 41.01)	0		46.00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and	MDH small rural bosnitals	14, 623, 954 0		47. 00 48. 00
46.00	only. (see instructions)	mbii, siilari rurai nospitars	0		40.00
				Amount	
10.00				1.00	40.00
49. 00 50. 00	Total payment for inpatient operating costs (see instru- Payment for inpatient program capital (from Wkst. L, Pt	•		14, 636, 615 1, 034, 695	1
51.00	Exception payment for inpatient program capital (Wkst.			1, 034, 073	1
52. 00	Direct graduate medical education payment (from Wkst. E	•		6, 838	1
53.00	Nursing and Allied Health Managed Care payment			0	
54.00	Special add-on payments for new technologies			49, 787	1
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,	lino 60)		0	
55. 01	Cellular therapy acquisition cost (see instructions)	111le 09)		0	
56. 00	Cost of physicians' services in a teaching hospital (se	e intructions)		0	1
57.00	Routine service other pass through costs (from Wkst. D,	Pt. III, column 9, lines 30 t	hrough 35).	0	
58. 00	Ancillary service other pass through costs from Wkst. D	, Pt. IV, col. 11 line 200)		0	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58)			15, 727, 935	1
61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59)	minus line 60)		0 15, 727, 935	
62. 00	Deductibles billed to program beneficiaries			1, 535, 252	
63.00	Coinsurance billed to program beneficiaries			1, 600	1
64.00				40, 477	
65.00	Adjusted reimbursable bad debts (see instructions)	- !+		26, 310	
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (se Subtotal (line 61 plus line 65 minus lines 62 and 63)	e instructions)		16, 479 14, 217, 393	
	Credits received from manufacturers for replaced device	s for applicable to MS-DRGs (s	ee instructions)	14, 217, 373	1
69.00	·			0	
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
70. 50	Rural Community Hospital Demonstration Project (§410A D		instructions)	0	1
70. 75 70. 87	N95 respirator payment adjustment amount (see instruction Demonstration payment adjustment amount before sequestrials).			0	1
70. 87	SCH or MDH volume decrease adjustment (contractor use o			0	
70. 89	Pioneer ACO demonstration payment adjustment amount (se				70. 89
70. 90	, ,			0	
70. 91	HSP bonus payment HRR adjustment amount (see instruction	ns)		0	
70. 92	,			0	1
70. 93	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-30, 473 -57, 032	1
	print aujustilierit alliourit (see Histructions)				70. 94

Health Financial Systems COMMUNITY	HOSPITAL ANDERSON		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der (CCN: 15-0113	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/24/2024 11:	
	Ti tl	e XVIII	Hospi tal	PPS	
		FFY	['] (уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (the corresponding federal year for the period prior to			0	0	70. 96
			_		l

					5/24/2024 11:	54 am_
		Titl∈	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	1. 00	70. 96
70. 70	the corresponding federal year for the period prior to 10/1)	COI UIIII O		0	U	70. 90
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 97
	the corresponding federal year for the period ending on or after					
70. 98	Low Volume Payment-3			0	0	70. 98
70. 99	HAC adjustment amount (see instructions)				36, 392	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	9 & 70)			14, 093, 496	•
71. 01	Sequestration adjustment (see instructions)				281, 870	
71. 02 71. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs				0	71. 02 71. 03
71.03	Interim payments				13, 486, 600	72.00
72. 00	Interim payments-PARHM				13, 400, 000	72. 00
73. 00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)				_	73. 01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02,	72, and			325, 026	74.00
	73)					
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance	ce with			305, 012	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
90. 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	F 2 03			0	90.00
90.00	plus 2.04 (see instructions)	1 2.03			U	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92. 00	Operating outlier reconciliation adjustment amount (see instruc	ctions)			0	92. 00
93.00	Capital outlier reconciliation adjustment amount (see instructi				0	93.00
94.00	The rate used to calculate the time value of money (see instruc	ctions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)				0	95. 00
96. 00	Time value of money for capital related expenses (see instructi	ons)			0	96. 00
				Prior to 10/1		
	LICD D. D. L. A. L.			1. 00	2. 00	
	HSP Bonus Payment Amount					
100 00	HSD bonus amount (see instructions)			0	Λ	1100 00
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
101. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions))		0. 0000000000	0. 0000000000	101. 00
101. 00	HVBP Adjustment for HSP Bonus Payment)			0. 0000000000	
101. 00 102. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions))			0. 0000000000	101. 00 102. 00
101. 00 102. 00 103. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment)		0.0000000000	0. 0000000000 0	101. 00 102. 00
101. 00 102. 00 103. 00 104. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adju		0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrations) Is this the first year of the current 5-year demonstration peri	ation) Adju		0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrations) Is this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no.	ation) Adju		0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration to this the first year of the current 5-year demonstration perion Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ation) Adju iod under t		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration because this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	ation) Adju iod under t		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	ation) Adju iod under t		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration to the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	ation) Adju dod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	ation) Adju dod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration to the first year of the current 5-year demonstration perion Contury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in feperiod) Medicare target amount	ation) Adju dod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 o	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Proje	ation) Adju dod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 o	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration to the current 5-year demonstration perion to the current 5-year demonstration perion to the current Service cost (from Wkst. D-1, Pt. II, line Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ation) Adju dod under t	he 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 o	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration to the current 5-year demonstration perion to the current 5-year demonstration perion to the current Service cost (from Wkst. D-1, Pt. II, line Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ation) Adju iod under t 49) First year	he 21st	0. 0000000000 0 0. 0000 0	0.000000000000000000000000000000000000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration (§410	ation) Adju iod under t 49) First year uctions)	he 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration perions) Is this the first year of the current 5-year demonstration perions Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine perion) Medicare target amount Case-mix adjustment factor (see instructions) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	ation) Adju iod under t 49) First year uctions)	he 21st	0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration (§410A Demonstration (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (§410A Demons	ation) Adju iod under t 49) First year uctions)	he 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration that the first year of the current 5-year demonstration perion Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use	ation) Adju iod under t 49) First year uctions)	he 21st	0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
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101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration perion Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 205)	ation) Adju dod under t 49) First year uctions)	he 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 213. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration perion Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ation) Adjudication and adjudication and adjudications and adjudic	of the curren	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
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Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	Peri od: Worksheet E From 01/01/2023 Part B To 12/31/2023 Date/Time Prepared: 5/24/2024 11:54 am

Medical and other services (see instructions)			Title XVIII	Hospi tal	5/24/2024 11: PPS	54 am
					1. 00	
1.00 OVER payment (see Instructions) 0.00 0			ons)			
0.000			0113)			
Enter the hospit tall specific purjeont to cost ratio (see instructions) 0.000 5.00		, , ,				
Line 2 times line 5		1	i ana)		-	
2.00 Sum of Fines 3 4, and 4.01, divided by line 6 0.00 7.00 7.00 8.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00		, , , , , , , , , , , , , , , , , , , ,	ions)			
Ancil lary service other pass through costs including REH direct graduate medical education costs from Wists. 0.000 0.00					-	
West		1 , 3 ,			-	
10.00 Organ acquist froms 1.00 Total coat (sum of lines 1 and 10) (see instructions) 5,913 11.00	9. 00		graduate medical educa	ation costs from	0	9. 00
1.00 Total cost (sum of lines 1 and 10) (see Instructions) 5.913 11.00	10. 00				0	10.00
Reasonable charges 26,533 12.00 Ancil Tary service charges 26,533 12.00 Ancil Tary service charges 26,533 12.00 26,533 14.00 Total Iransenable charges (sum of lines 12 and 13) 26,533 14.00 13.00 26,533 14.00 15.00 26,533 14.00 15.00 26,533 14.00 15.00 26,533 14.00 26,533 26,533 26,533 26,533 26,533 26,533 26,533					5, 913	
2.00 Ancil lary service charges 26,533 12.00 Total reasonable charges (from Wist. D-4, Pt. III, col. 4, line 69) 26,533 12.00 Total reasonable charges (sum of lines 12 and 13) 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533 14.00 26,533						
13.00 Organ acquisition charges (from Wikst. D-4, Pt. III., col. 4, line 69) 0 13.00	12 00				26 522	12 00
14.00 Total reasonable chargés (sum of lines 12 and 13) 26,533 14,00		1	e 69)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00	14.00				26, 533	14. 00
16.00 Amounts that would have been real ized from patients Liable for payment for services on a chargebasis 0 10.00	15 00				0	15 00
had such payment been made in accordance with 42 CFR \$413.13(e)					-	
18.00 Total customary charges (see instructions) 20.633 18.00	10.00		payment for services of	r a chargebasis	G	10.00
19. 00 Excess of customary Charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 20. 00						
instructions			if line 10 exceeds lin	no 11) (soo		
Instructions	19.00		II IIIle 10 exceeds III	ie 11) (See	20, 020	19.00
21.00 Lesser of cost or charges (see instructions) 5,913 21.00	20. 00		if line 11 exceeds lir	ne 18) (see	0	20. 00
22.00 Interns and residents (see instructions) 0.22.00 23.00	21 00	1			E 012	21 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 13,442,776 24.00 COMPUTATION OF RELIMBURSEMENT SETTLEMENT 13,442,776 24.00 COMPUTATION OF RELIMBURSEMENT SETTLEMENT 24.00 COMPUTATION OF RELIMBURSEMENT SETTLEMENT 25.00 Deductible sand coinsurance amounts (for CAH, see instructions) 2,555,100 26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2,525,100 26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2,525,100 26.00 Instructions) 2,525,100 26.00 Instructions) 2,525,100 26.00 Instructions) 2,525,100 26.00 Instructions) 2,546 28.00 Instructions) 2,546 28.00 Instructions) 2,546 28.00 28.50		,				
COMPUTATION OF RELIMBURSEMENT SETTLEMENT 498 25. 00			ctions)		0	
25.00 Deductible is and coin surance amounts (For CAH, see instructions) 2,525,106 26.00 20.00 Subtotal [(I ines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 2,525,106 26.00 27.00 Subtotal [(I ines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 2.525,106 26.00 27.00 28.50 29.00 29.	24. 00				13, 442, 176	24. 00
20.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 525, 106 26. 00	25 00				408	25 00
Instructions			24 (for CAH, see instru	ıctions)		
28.50 Direct graduate medical education payments (from Wkst. E-4, line 50) 5,546 28.00 28.50 28.50 28.50 28.50 28.50 28.50 28.50 28.50 28.50 28.50 29.00 28.50 28.50 29.00 28.50 29.00 28.50 29.00	27. 00		us the sum of lines 22	and 23] (see	10, 922, 485	27. 00
28. 50 REH Facility payment amount (see instructions) 28. 50 REND direct medical education costs (from Wkst. E-4, line 36) 29. 00 29. 00 30. 00 Subtotal (sum of lines 27, 28, 28. 50 and 29) 10, 928, 031 30. 00 70 70 70 70 70 70 70	28 00		a 50)		5 5/6	28 00
29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29. 00 30. 0			e 30)		3, 340	
31.00 Primary payer payments 2,761 31.00 32.00 Subtotal (line 30 minus line 31) 10,925,270 32.00 20.		, , , , , , , , , , , , , , , , , , , ,			0	
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 105,876 34.00 35.00 Allowable bad debts (see instructions) 98,073 36.00 Allowable bad debts (see instructions) 98,073 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 98,073 36.00 37.00 Subtotal (see instructions) 98,073 36.00 39.00 39.50 3						
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 33. 00 33. 00 33. 00 34. 00 34. 00 34. 00 34. 00 34. 00 34. 00 35. 00 35. 00 35. 00 36. 00 34. 00 35. 0						
34.00 Allowable bad debts (see instructions) 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 68,819 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 98,073 36.00 37.00 Subtotal (see instructions) 10,994,089 37.00 38.00 MSP-LCC reconciliation amount from PS&R -71 38.00 MSP-LCC reconciliation amount from PS&R -71 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 99.	02.00		S)		10, 720, 270	02.00
35.00 Adjusted reimbursable bad debts (see instructions) 68,819 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 98,073 36.00 37.00 Subtotal (see instructions) 10,994,098 37.00 38.00 MSP-LCC reconciliation amount from PS&R -71 38.00 39.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.75 39.50 39.75 39.77 39.97					-	
36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 99,073 36. 00 37. 00 Subtotal (see instructions) 10,994,089 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R -71 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 50 39. 75 N95 respirator payment adjustment amount before sequestration 0 39. 75 39. 97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 10, 994, 160 40. 00 40. 01 Sequestration adjustment (see instructions) 219, 883 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 219, 883 40. 01 40. 03 Sequestration adjustment (see instructions) 219, 883 40. 01 40. 03 Interim payments 10, 821, 816 41. 00 41. 00 Interim payments 10, 821, 816 41. 00						
37. 00 Subtotal (see instructions) 10,994,089 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R -17 38. 00 39. 00			ctions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.50 39.50 39.50 39.75 39.75 39.75 39.75 39.75 Demonstration payment adjustment amount (see instructions) 0 39.75 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Sequestration adjustment (see instructions) 10,994,160 40.00 40.01 Sequestration adjustment (see instructions) 219,883 40.01 40.02 Demonstration payment adjustment amount after sequestration 219,883 40.01 40.02 40.03 Sequestration adjustment amount after sequestration 219,883 40.01 41.01 Interim payments 41.01 Interim payments 41.01 Interim payments 41.01 Interim payments 41.01 42.00 Tentative settlement (for contractors use only) 42.00 42.01 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program (see instructions) 43.01			,			
9.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.75 ny 75 respirator payment adjustment amount (see instructions) 39.75 Demonstration payment adjustment amount before sequestration 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 39.99 Sequestration adjustment (see instructions) 39.99 Sequestration adjustment (see instructions) 39.99 10,994,160 40.00 40.01 Sequestration adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 41.01 Interim payments-PARHM 42.01 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 50 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 60 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 61 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 62 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 63 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 64 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 65 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 66 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 67 Protested amounts (nonallowable cost report items) in ac						
39.75 39.97 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9 RECOVERY OF ACCELERATED DEPRECIATION 10,994,160 40.00 Subtotal (see instructions) 10,994,160 40.01 Sequestration adjustment (see instructions) 10,994,160 40.02 Demonstration payment adjustment amount after sequestration 10,821,816 41.00 41.01 Interim payments 10,821,816 41.00 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (see instructions) 8al ance due provi der/program (see instructions) 90.00 Original outlier amount (see instructions)					0	
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50 Sequestration adjustment (see instructions) 40. 01 Demonstration payment adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment amount after sequestration 40. 03 Sequestration adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 10, 821, 816 41. 00 42. 01 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Sequestration payments 44. 00 Original outlier amount (see instructions) 90. 00 Original outlier amount (see instructions) 0 39. 98 39. 98 39. 99 30. 90 39. 98 30. 90 39. 98 30. 90 39. 98 30. 90 39. 98 30. 90 39. 98 30. 90 39. 98 30. 90 39. 90 39. 90 39. 90 39. 90 39. 90 39. 90 39. 90 39. 90 39. 90 39. 90 39. 90 39. 90 39. 90 39. 90 30 30. 90 30. 90 30. 90 30. 90 30 30. 90 30. 90 30. 90 30. 90 30. 9		, , , , , , , , , , , , , , , , , , , ,			0	
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 00 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Frotested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 70 BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 0 39. 99 40. 00 30 39. 99 40. 00 30 39. 99 40. 00 30 39. 99 40. 00 30 39. 99 40. 00 30 39. 99 40. 00 30 39. 90 40. 00 30 39. 00 40. 00 30 39. 00 40. 00 30 39. 00 40. 00 30 39. 00 40. 00 30 39. 00 40. 00 30 39. 00 40. 00 30 39. 00 40. 00 30 39. 00 40.		Demonstration payment adjustment amount before sequestration			0	39. 97
40. 00 Subtotal (see instructions) 10, 994, 160 40. 00 40. 01 Sequestration adjustment (see instructions) 219, 883 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 10, 821, 816 41. 00 41. 00 Interim payments 10, 821, 816 41. 00 42. 00 Tentative settlement (for contractors use only) 41. 01 42. 00 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) -47, 539 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 0 44. 00 10 BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 0 90. 00		•	d devices (see instruct	i ons)	-	
40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments-PARHM 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Bal ance due provider/program (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 70 BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 0 40. 02 40. 03 41. 00 41. 00 41. 00 42. 00 42. 01 43. 00 44. 00 45. 01 46. 02 47. 539 48. 00 49. 01 49. 02 49. 02 49. 03 49. 03 40. 03 41. 00 41. 00 42. 00 42. 01 43. 00 44. 00 45. 01 46. 02 47. 539 47. 539 48. 00 49. 00 49. 00 40. 02 40. 03 41. 00 41. 00 42. 00 42. 00 43. 01 44. 00 44. 00 45. 01 46. 02 47. 539 48. 00 49. 02 49. 03 49. 03 40. 03 41. 00 41. 00 42. 00 42. 01 43. 01 44. 00 45. 01 46. 02 47. 539 47. 539 48. 00 49. 01 49. 02 49. 02 40. 03 41. 00 41. 00 42. 00 42. 01 43. 01 44. 00 45. 01 46. 02 47. 539 48. 00 49. 02 49. 03 49. 03 49. 03 41. 00 41. 00 42. 00 42. 01 43. 01 44. 00 45. 01 46. 02 47. 539 48. 01 49. 02 49. 03 49. 03 41. 00 41. 00 42. 01 42. 01 43. 00 44. 00 45. 01 46. 02 47. 539 48. 01 49. 02 49. 03 49. 03 49. 03 41. 00 41. 00 42. 01 43. 01 44. 00 45. 01 46. 02 47. 539 48. 01 49. 02 49. 03 49. 03 41. 00 41. 00 42. 00 42. 01 43. 01 44. 00 45. 01 46. 02 47. 539 47. 01 48. 02 49. 03 49. 03 49. 03 41. 00 41. 00 42. 01 43. 01 44. 00 45. 01 46. 02 47. 539 48. 02 49. 03 49. 03 49. 03 41. 00 41. 00 42. 00 42. 01 43. 00 44. 00 45. 01 46. 02 47. 539 48. 02 49. 03 49. 03 49. 03 49. 03 41. 00 41. 00 42. 00 42. 01 43. 00 44. 00 45. 01 46. 02 47. 539 48. 02 49. 02 49. 03 49. 03 49. 03 49. 03 49. 03 49. 03 49. 03 49. 03 49. 03 49. 03 49. 03 49. 03 49. 01 49. 02 49. 03 49. 03 49. 03 49. 03 49. 03 49. 03 49. 01 49. 02 49. 03 49. 03 49. 03 49. 03 49. 03 49. 03 49.					-	
40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 0 40. 02 40. 03 10, 821, 816 41. 00 42. 00 42. 01 42. 01 42. 01 43. 00 43. 01 44. 00 90. 00 Original outlier amount (see instructions)						1
41.00		, , , , , , , , , , , , , , , , , , , ,			0	
41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00		, ,			10 021 017	
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00		1			1∪, 0∠1, 816	
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 8115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00		1			0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90.00 Original outlier amount (see instructions) 43.01 44.00 44.00 90.00		,			.=	
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\fr		, , , , , , , , , , , , , , , , , , , ,			-47, 539	1
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00			e with CMS Pub. 15-2. c	chapter 1.	0	
90.00 Original outlier amount (see instructions) 0 90.00	55	§115. 2				
	00.00					00.00
91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00					0	90.00
92.00 The rate used to calculate the Time Value of Money 0.00 92.00		1			0. 00	92. 00
93.00 Time Value of Money (see instructions) 0 93.00	93. 00	Time Value of Money (see instructions)			0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL	L ANDERSON	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0113	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023		pared:
				5/24/2024 11:	54 am
		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 COMMU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: Provider CCN: 15-0113

					5/24/2024 11:	54 am
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		13, 486, 60	0	10, 821, 816	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			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				0	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		13, 486, 60	0	10, 821, 816	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
	Provi der to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52	C. ht-t-1 (6 i 5 01 5 40 minus 6 i			0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	l 0	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		325, 02	6	0	6. 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	47, 539	6. 02
				~		7. 00
7. 00	Total Medicare program liability (see instructions)		13, 811, 62	Contractor	10, 774, 277 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 00	1.0.00			1	1 1	0.00

Heal th	Financial Systems COMMUNITY HOS	PITAL ANDERSON	In Lie	u of Form CMS-	2552-10
CALCUL				Worksheet E-	1
					epared:
				5/24/2024 11:	
	<u> </u>	Title XVIII	Hospi tal	PPS	
	TO DE COMPLETED DV CONTRACTOR FOR MONOTANDARD COOT DEPORT			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from WI		. 14		1.00
1. 00 2. 00	Medicare days (see instructions)	(St. 5-3, Pt. 1 COL. 15 TIME	14		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200)			5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col.				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of		Wkst. S-2, Pt. I		7. 00
	line 168	33	·		
8.00	Calculation of the HIT incentive payment (see instructions	5)			8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestrati	on (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)		,		31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 an	nd line 31) (see instruction	ıs)		32. 00

	Financial Systems COMMUNITY HOSPITA				eu of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CO	CN: 15-0113	Peri od: From 01/01/2023	Worksheet E-4	
	E 2000 111 011 000 10			To 12/31/2023	5/24/2024 11:	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
1.00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	na periods	0.00	1.00
	ending on or before December 31, 1996.	. 0		ng paratas		
1. 01 2. 00	FTE cap adjustment under §131 of the CAA 2021 (see instructio Unweighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	ructions)	0. 00 0. 00	
2. 26	Rural track program FTE cap limitation adjustment after the c				0.00	
3. 00	the CAA 2021 (see instructions) Amount of reduction to Direct GME cap under section 422 of MM.	٨			0.00	3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0.00	
2 02	instructions for cost reporting periods straddling 7/1/2011)	ak ETE limi+	ation(s) for	rural track	0.00	3. 02
3. 02	Adjustment (increase or decrease) to the hospital's rural tra- programs with a rural track Medicare GME affiliation agreemen				0.00	3.02
4 00	49075 (August 10, 2022) (see instructions)				0.00	4 00
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0.00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng peri ods	0.00	4. 01
4. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0.00	4. 02
1. 02	periods straddling 7/1/2011)	3 (300 11131	ractions for	cost reporting	0.00	1.02
4. 21	The amount of increase if the hospital was awarded FTE cap slinstructions)	ots under §1	26 of the CAA	2021 (see	0.00	4. 21
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line	es 2.26 thro	ugh 2.49, mir	nus lines 3 and	0.00	5. 00
	3.01, plus or minus line 3.02, plus or minus line 4, plus lin		J		0.00	
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0.00	6. 00
7. 00	Enter the lesser of line 5 or line 6				0.00	7. 00
			Primary Care	0ther 2.00	Total 3.00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	0.0			8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	i se	0. (0.00	0.00	9. 00
7. 00	multiply line 8 times the result of line 5 divided by the amo		0. 0	0.00	0.00	7.00
	6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.	, 2022, or				
10. 00	Weighted dental and podiatric resident FTE count for the curry	ent year		0. 16		10. 00
10. 01	Unweighted dental and podiatric resident FTE count for the cu	rrent year		0. 16		10. 01
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	n vear (see	0. (0. (11. 00 12. 00
12.00	instructions)	g year (see	0. 0	0.10		12.00
13. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	0.0	0. 25		13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0.0	0. 19		14. 00
15. 00	Adjustment for residents in initial years of new programs		0.0			15. 00
15. 01			0. (15. 01
16. 00 16. 01	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h		0. (0. (16. 00 16. 01
	closure	оор: ta.				
17. 00 18. 00	Adjusted rolling average FTE count Per resident amount		0. (0. (17. 00 18. 00
18. 01	Per resident amount under §131 of the CAA 2021		109, 467.			18. 01
	Approved amount for resident costs		,	0 20, 799	20, 799	
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	cei ved under 42	0.00	20. 00
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru-	ctions)			0.00	21. 00
21.00	Allowable additional direct GME FTE Resident Count (see instru	,			0.00	
23. 00	Enter the locality adjustment national average per resident a		nstructions)		0.00	23. 00
	Multiply line 22 time line 23				0 20, 799	
25.00	Total direct GME amount (sum of lines 19 and 24)				20, 799	25.00

Heal th	Financial Systems COMMUNITY HOSPITA	L ANDERSON		In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	_	CN: 15-0113	Peri od:	Worksheet E-4	
MEDI CA	AL EDUCATION COSTS			From 01/01/2023	D-+- /T: D	
				To 12/31/2023	Date/Time Prep 5/24/2024 11:	
		Title	XVIII	Hospi tal	PPS	<u> </u>
			Inpatient Par	t Managed Care	Total	
			Α			
	COMPUTATION OF PROCESS PATIENT LOAD		1.00	2. 00	3. 00	
26. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I.	Y line	5, 8	78 8, 425		26. 00
20.00	3. 02, column 2)	X, TITIE	3, 0	0, 423		20.00
27. 00			23. 55	23, 559		27. 00
28. 00	, , , , , , , , , , , , , , , , , , , ,		0. 24950	•		28. 00
29. 00	Program direct GME amount		5, 18	7, 438	12, 627	29. 00
29. 01				3. 27		29. 01
	Reduction for direct GME payments for Medicare Advantage			243	243	30. 00
31.00	Net Program direct GME amount				12, 384	31. 00
					4 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE	E VVIII ONLY	((NUIDCL NC DD)	CDAM AND DADAMER	1. 00	
	EDUCATION COSTS)	E XVIII UNLY	(NURSING PRO	GRAM AND PARAMEL	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		L. col. 8. s	sum of lines 7	'4 and 94)	1, 535, 261	33. 00
34. 00				,	0. 000000	
35.00	9 ,		•		0	35. 00
36.00	Medicare outpatient ESRD direct medical education costs (line	34 x line 3	35)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
37. 00		`			18, 856, 832	
38. 00	3				0	
39. 00 40. 00		ructions)			0	39. 00 40. 00
	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)			18, 856, 832	
41.00	Part B Reasonable Cost	3 11116 40)			10, 030, 032	41.00
42. 00					15, 298, 989	42. 00
43. 00	,				2, 761	
44. 00					15, 296, 228	
45.00					34, 153, 060	45. 00
	Ratio of Part A reasonable cost to total reasonable cost (lin				0. 552127	46. 00
47. 00	Ratio of Part B reasonable cost to total reasonable cost (lin		45)		0. 447873	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART A	RT B				
	Total program GME payment (line 31)				12, 384	
49. 00	7.				6, 838	
50. 00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see mstru	icti OHS)		5, 546	50.00

Heal th	Financial Systems COMMUNITY HOSPITA	AL ANDERSON	In Lie	u of Form CMS-2	552-10
		Worksheet E-5			
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 11:5	oared: 54 am
		Title XVIII		PPS	
				1. 00	
TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see 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 instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	tions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00	Time value of money for operating expenses (see instructions)			0	6.00
7.00	Time value of money for capital related expenses (see instruc	tions)		0	7.00

Health Financial Systems

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

Provider CCN: 15-0113 | Period: From 01/01

oni y)					5/24/2024 11:	54 am
		General Fund	Specific	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	176, 093	1	0	0	
2.00	Temporary investments Notes receivable	0		-	0	
4. 00	Accounts receivable	86, 158, 077	1		0	
5. 00	Other receivable	-63, 549, 865		o o	Ö	
6.00	Allowances for uncollectible notes and accounts receivable	1, 022, 301		0	0	6. 00
7.00	Inventory	3, 695, 214	1	0	0	
8.00	Prepai d expenses	83, 915	1	0	0	
9.00	Other current assets	311, 387	1	1	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	27, 897, 122		-	0	
11.00	FIXED ASSETS	21,091,122		<u> </u>	0	11.00
12.00	Land	6, 268, 153	(0	0	12. 00
13.00	Land improvements	2, 289, 177	1	0	0	
14. 00	Accumulated depreciation	0	(0		
15. 00	Bui I di ngs	86, 480, 043	1	-	0	
16.00	Accumulated depreciation	0 7/2 225		-	0	
17. 00 18. 00	Leasehold improvements Accumulated depreciation	2, 763, 325		0	0	
19. 00	Fi xed equi pment	85, 748, 195			0	
20. 00	Accumul ated depreciation	00,710,170		o o	Ö	
21.00	Automobiles and trucks	876, 727		0	0	
22. 00	Accumul ated depreciation	0	(0	0	22. 00
23. 00	Major movable equipment	0	(0	0	
24. 00	Accumulated depreciation	-127, 822, 634	(0	0	
25. 00	Mi nor equipment depreciable	0		0	0	
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0			0	
28. 00	Accumulated depreciation	0			0	
29. 00	Mi nor equi pment-nondepreci abl e	Ö		o o	Ö	
30.00	Total fixed assets (sum of lines 12-29)	56, 602, 986		0	0	30.00
	OTHER ASSETS					
31. 00	Investments	1, 015, 216		-		
32. 00	Deposits on leases	0		1	0	
33. 00 34. 00	Due from owners/officers Other assets	310, 597, 429	1	,	0	1
35. 00	Total other assets (sum of lines 31-34)	311, 612, 645	1	1	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	396, 112, 753	1	o o	l	
	CURRENT LIABILITIES					
37. 00	Accounts payable	992, 746	1	-		
38. 00	Sal ari es, wages, and fees payable	0	(-	l ~	
39. 00	Payroll taxes payable (chart tarm)	0		0	0	
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	0				
42. 00	Accel erated payments	0			0	42.00
43. 00	Due to other funds	0		0	0	
44.00	Other current liabilities	8, 872, 207		0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9, 864, 953	(0	0	45. 00
	LONG TERM LIABILITIES	I .	1		_	
46.00	Mortgage payable	0		1	0	
47. 00 48. 00	Notes payable Unsecured Loans	0		-	l .	
49. 00	Other long term liabilities	2, 714, 513		-	Ö	
50.00	Total long term liabilities (sum of lines 46 thru 49)	2, 714, 513	1	o o	l	
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	12, 579, 466		0	0	51.00
52. 00	General fund balance	383, 533, 287				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	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				l "	30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	383, 533, 287		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	396, 112, 753	1	0	0	
	[59]		[

Provider CCN: 15-0113

					10 12/31/2023	5/24/2024 11:	
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		359, 338, 284		C		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		24, 195, 003				2.00
3.00	Total (sum of line 1 and line 2)		383, 533, 287		C		3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8. 00 9. 00					0	0	8. 00 9. 00
10.00	Total additions (sum of line 4-9)		0				10.00
11. 00	Subtotal (line 3 plus line 10)		383, 533, 287				11. 00
12. 00	Deductions (debit adjustments) (specify)	0	303, 333, 207		0	ĺ	12.00
13. 00	Sound training (appearing)				0	0	13. 00
14.00		0			0	0	14.00
15.00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		C		18. 00
19. 00	Fund balance at end of period per balance		383, 533, 287		C)	19. 00
	sheet (line 11 minus line 18)	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 5. 00	Additions (credit adjustments) (specify)		0				4. 00 5. 00
6. 00			0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9. 00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13. 00			0				13. 00
14.00			0				14. 00
15.00			0				15.00
16. 00 17. 00			0				16. 00 17. 00
18.00	Total deductions (sum of lines 12-17)		U		0		17. 00
19. 00	Fund balance at end of period per balance				Ö		19. 00
	sheet (line 11 minus line 18)						
		•					

Health Financial Systems CC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0113

			10	5 12/31/2023	Date/IIme Prep 5/24/2024 11:5				
	Cost Center Description	Inpatie	nt	Outpati ent	Total				
	'	1.00		2. 00	3. 00				
	PART I - PATIENT REVENUES	<u> </u>							
	General Inpatient Routine Services								
1.00	Hospi tal	56, 77	3, 731		56, 773, 731	1.00			
2.00	SUBPROVI DER - I PF					2.00			
3.00	SUBPROVI DER - I RF					3.00			
4.00	SUBPROVI DER					4. 00			
5.00	Swing bed - SNF		0		0	5. 00			
6.00	Swing bed - NF		0		0	6. 00			
7. 00	SKILLED NURSING FACILITY		_		-	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)	56, 77	3 731		56, 773, 731				
10.00	Intensive Care Type Inpatient Hospital Services	00,77	3, 701		00, 110, 101	10.00			
11. 00	INTENSIVE CARE UNIT	20, 29	5 487		20, 296, 487	11. 00			
12. 00	CORONARY CARE UNIT	20,27	3, .0,		20,2,0,10,	12. 00			
13. 00	BURN INTENSIVE CARE UNIT					13. 00			
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00			
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00			
16. 00	Total intensive care type inpatient hospital services (sum of I	nes 20, 29	6 487		20, 296, 487	16. 00			
10.00	11-15)	20, 27	3, 407		20, 270, 407	10.00			
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	77, 07	າ 218		77, 070, 218	17. 00			
18. 00	Ancillary services	182, 29		604, 585, 078	786, 879, 902	18. 00			
19. 00	Outpatient services	102, 29	+, 024 N	004, 363, 076	780, 874, 402	19. 00			
20. 00	RURAL HEALTH CLINIC		0	0	0	20. 00			
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00			
21.00			U	٩	U	22. 00			
23. 00	HOME HEALTH AGENCY AMBULANCE SERVICES					23. 00			
24. 00	CMHC					24. 00			
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00			
26. 00	HOSPI CE		0		0	26. 00			
27. 00	OTHER (SPECIFY)	- 1111	- 040	(04 505 070	0	27. 00			
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to 2 diagrams)	o Wkst. 259, 36	5, 042	604, 585, 078	863, 950, 120	28. 00			
	G-3, line 1) PART II - OPERATING EXPENSES								
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			224, 074, 259		29. 00			
30.00	ADD (SPECIFY)		0	224, 074, 239		30.00			
31. 00	ADD (SPECIFI)		0			31. 00			
32. 00			0			32. 00			
32.00			0			32.00			
			0						
34. 00			0			34. 00 35. 00			
35. 00	T-+-1		U	0					
36.00	Total additions (sum of lines 30-35)		0	U		36.00			
37. 00	DEDUCT (SPECIFY)		0			37. 00			
38. 00			0			38. 00			
39. 00			0			39. 00			
40.00			0			40.00			
41. 00	T-t-1 deductions (com of lines 27 41)		U			41. 00			
42. 00	Total deductions (sum of lines 37-41)	(transfer		0		42.00			
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transter		224, 074, 259		43. 00			
	to Wkst. G-3, line 4)								

Heal th	Financial Systems	COMMUNITY HOSPITAL ANDERSON	In lie	eu of Form CMS-2	2552-10
				Worksheet G-3	
			From 01/01/2023		
To 12/31/2023					pared:
				5/24/2024 11:	54 alli
				1.00	
1.00	1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				
2.00	Less contractual allowances and discounts of			863, 950, 120 633, 659, 677	1. 00 2. 00
3.00				230, 290, 443	3.00
4.00	Less total operating expenses (from Wkst. G	-2. Part II. line 43)		224, 074, 259	1
5. 00	Net income from service to patients (line 3			6, 216, 184	•
	OTHER I NCOME			5/=:5/:5:	
6.00	Contributions, donations, beguests, etc			249, 456	6.00
7.00	Income from investments			1, 946, 969	7. 00
8.00	Revenues from telephone and other miscellan	eous communication services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and gu	ests		1, 101, 369	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical s	upplies to other than patients		0	16. 00
17.00	Revenue from sale of drugs to other than pa	tients		0	17. 00
18.00	Revenue from sale of medical records and ab	stracts		0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen		0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			2, 414, 891	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MISC: ALL OTHER REVENUE			12, 267, 729	24. 00
24. 50	COVI D-19 PHE Funding			0	24. 50
25. 00	Total other income (sum of lines 6-24)			17, 980, 414	25. 00
26 00	Total (line 5 plus line 25)			2/ 106 500	1 26 00

24, 196, 598 26. 00

-5

1, 600 27. 02 1, 595 28. 00 24, 195, 003 29. 00

27.00

26.00 Total (line 5 plus line 25)

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

27. 00 ROUNDING

From 01/01/2023 Parts I - To 12/31/2023 Date/Tim 5/24/202	t L	332-10						
Title XVIII Hospital	Worksheet L Parts I-III							
	PPS							
1.00								
	PART I - FULLY PROSPECTIVE METHOD							
	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier 962,690							
1.00 Capital DRG other than outlier 1.01 Model 4 BPCI Capital DRG other than outlier	2, 690	1. 00 1. 01						
), 489	2. 00						
2.01 Model 4 BPCI Capital DRG outlier payments	0	2. 00						
	54. 96	3. 00						
4.00 Number of interns & residents (see instructions)	0. 19	4. 00						
5.00 Indirect medical education percentage (see instructions)	0.08	5. 00						
6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and	770	6. 00						
1.01) (see instructions)								
7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line	4. 29	7. 00						
30) (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions)	25. 93	8. 00						
	30. 22	9. 00						
10.00 Allowable disproportionate share percentage (see instructions)	6. 31	10. 00						
	0. 746	11. 00						
		12. 00						
72. 66 Total prospective capital payments (see this tractions)	1, 070	12.00						
1.00								
PART II - PAYMENT UNDER REASONABLE COST								
1.00 Program inpatient routine capital cost (see instructions)	0	1.00						
2.00 Program inpatient ancillary capital cost (see instructions)	0	2.00						
3.00 Total inpatient program capital cost (line 1 plus line 2)	0	3. 00						
4.00 Capital cost payment factor (see instructions)	0	4. 00						
5.00 Total inpatient program capital cost (line 3 x line 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 circumstances (see instructions)	0	2. 00						
3.00 Net program inpatient capital costs (line 1 minus line 2)	0	3.00						
4.00 Applicable exception percentage (see instructions)	0.00	4. 00						
5.00 Capital cost for comparison to payments (line 3 x line 4)	0	5.00						
6.00 Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6. 00						
7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7)	0	7. 00 8. 00						
9.00 Current year capital payments (from Part I, line 12, as applicable)	0	9. 00						
10.00 Current year capital payments (from Part 1, fille 12, as appricable)	0	10. 00						
11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year	0	11. 00						
Worksheet L, Part III, line 14)	°	11.00						
12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00						
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00						
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period	0	14.00						
(if line 12 is negative, enter the amount on this line)								
	0	15. 00						
15.00 Current year allowable operating and capital payment (see instructions)		16.00						
15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 17.00 Current year exception offset amount (see instructions)	0	17. 00						