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: 15-0074 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/24/2024 11:39 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/24/2024 Time: 11:39 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

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HEALTH NETWORK, INC. (15-0074) 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	Holly Millard			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	1, 194, 374	518, 835	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	1, 194, 374	518, 835	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 HEALTH NETWORK, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0074 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:39 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1500 NORTH RITTER AVENUE 1.00 PO Box: 1.00 City: INDIANAPOLIS State: IN 2.00 Zip Code: 46219 County: MARION 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 COMMUNITY HEALTH 150074 26900 07/01/1966 N 3.00 NETWORK, INC. 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 N 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.

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cost réporting period. Enter "1" for urban or "2" for rural. 7. 00 Enter your staindand geographic cales sil fcation (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic red assification in column 2. 8. 00 If this is a sole comman by hospital (SCH), enter the number of periods SCH status in enter in the cost reporting period. 8. 00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 9. 00 If this is a bedicare dependent hospital (MBH), enter the number of periods MBH status. 9. 01 Is this is a bedicare dependent hospital (MBH), enter the number of periods MBH status. 9. 02 Is in effect in the cost reporting period. 9. 02 Is in effect in the cost reporting period. 9. 02 Is in effect in the cost reporting period. 9. 03 Is in shospital a former MBH that is eligible for the MBH transitional payment in secondance with EV 2016 0PPS final rule? Fatter "Y" for yes or "N" for no. (see periods in excess of one and enter subsequent dates. 9. 00 Is this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(1), (ii), or (iii)? Enter in column 1.00 2.00 9. 00 Does this facility qualify for the inpatient hospital payment adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharg										1
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for unbane or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SOI), enter the number of periods SOI status in one of periods in excess of one and enter subsequent dates. 36.00 Enter applicable beginning and ending dates of SOI status. Subscript Line 36 for number of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MMH), enter the number of periods MOH status in its line of the cost reporting period. 37.01 If this is a Medicare dependent hospital (MMH), enter the number of periods MOH status. 38.00 If I line 37 is 1, enter the beginning and ending dates of MUH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. 39.00 Line line 37 is 1, enter the beginning and ending dates of MUH status. If line 37 is 1, enter the beginning and ending dates of MUH status. If line 37 is 1, enter the beginning and ending dates of MUH status. If line 37 is 1, enter the beginning and ending dates of MUH status. If line 37 is 1, enter the beginning and ending dates of MUH status. If line 37 is 1, enter the beginning and ending dates of MUH status. 39.00 bases this facility qualify for the inpatient hospital payment adjustment for low volume. No solidates in accordance with 42 CFR 412.101(b)(2)(2)(1), (1), or (1))? For the incolumn 2 TY? for yes or NY for no long or NY for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or NY for no long in column 2, for discharges on or after October 1. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or NY for no. N N N N N N N N N N N N N N N N N N N	26. 00			at the beg	ginning of	the	2			26. 00
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with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N A 47.0 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N N N N N N N N N N N N N N N N	45. 00		nt for disp	roporti onat	te share in	accordance	N	Υ	N	45. 00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N	46. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	•		,		N	N	N	46. 00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penul timate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e) (1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	47. 00		capital? F	nter "Y for	yes or "N'	' for no.	N	N	N	47. 00
Section 1. Solution 1. Solution 2. If column 2 is "Y", complete Wsksheet E-4. If column 2 is "N", complete Wskst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 is "N", complete Wskst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or column 2, if the response to column 1. If the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penul timate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wst. 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.		Is the facility electing full federal capital payment	•		-					48. 00
"Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	56. 00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter 'cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra	"Y" for yes r 27, 2020, olumn 1 is ams in the	or "N" for under 42 ("Y", or if prior year	no in colu CFR 413.78(b this hospit or penultin	umn 1. For b)(2), see tal was nate year,		Y		56. 00
		"Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to Decembers this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete Complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFW which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete.	er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i ete column	, if line 5 in approved If column ing period? E-4. If co. For cost (1)(1)(iv) ar f the respo	56, column 7 d GME progra 1 is "Y", c P Enter "Y' reporting p nd (v), rega onse to line blete Worksh	1, is yes, ams trained did ' for yes o 'N", oeriods ardless of e 56 is "Y" neet E-4.	r			57. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	58 00	If line 56 is yes, did this facility elect cost reim	bursement f	or physicia	ans' service	es as	N			58.00

	program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME					
	FTE unweighted count.					
61. 20	Of the FTEs in line 61.05, specify each expanded	FAMILY MEDICINE	1350	0. 00	0. 00	61. 20
	program specialty, if any, and the number of FTE					
	residents for each expanded program. (see					
	instructions) Enter in column 1, the program name.					
	Enter in column 2, the program code. Enter in column					
	3, the IME FTE unweighted count. Enter in column 4,					
	the direct GME FTE unweighted count.					
					1.00	
	ACA Provisions Affecting the Health Resources and Ser	rvices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting peri	od for which	0. 00	62. 00
	your hospital received HRSA PCRE funding (see instruc	ctions)				
62. 01	Enter the number of FTE residents that rotated from a	a Teaching Health Cent	er (THC) into	your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC prog	gram. (see instruction	ıs)			
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings				
63.00	Has your facility trained residents in nonprovider se	ettings during this co	ost reporting p	eriod? Enter	Υ	63.00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 6	57. (see instru	ctions)		

Heal th	Financial Systems	COMMUNI TY	HEALTH NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMP				eriod: com 01/01/2023	Worksheet S-2 Part I	pared:
				Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	
	C+:	FTF Daridanta in N		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year period that begins on or after .	luly 1, 2009 and befo	re June 30, 2010.	inis base year	is your cost r	eporting	
64. 00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted now tations occurring in number of unweighted our hospital. Enter in 1 + column 2)). (see	n-primary care all nonprovider d non-primary care n column 3 the ratio instructions)	0. 17	3. 25		64. 00
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1. 00	2.00	Si te 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)	FAMILY MEDICINE	1350	3. 92	25. 07	0. 135219	65. 00
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settina	1.00 sEffective fo	2.00 r cost reporti	3.00 ng periods	
	beginning on or after July 1, 20)10			•		
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 (col	ccurring in all nonpo unweighted non-prima al. Enter in column :	rovider settings. ry care resident 3 the ratio of	2. 00	14. 43		66.00
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1. 00	2.00	Si te 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)	FAMILY PRACTICE	1350	22. 78	12. 81	0. 640067	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

98.00 Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f			Y	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 re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			Y	Y	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 of	alculation of (observati on	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 crit reimbursed 101% of inpatient services cost? Enter "Y" for ye	tical access h	ospital (CAH)	N	N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in	reimbursed 10	1% of	N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c	ack the RCE di	sallowance on	Y	Y	98. 05
oclumn 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	reimbursed fo	r Wkst. D,	Y	Y	98. 06
column 2 for title XIX. Rural Providers		v, and in			
105.00 Does this hospital qualify as a CAH? 106.00 olf this facility qualifies as a CAH, has it elected the all-	-inclusive met	hod of payment	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for co		. 3	N		107. 00
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 approved medical education program in the CAH's excluded IF	n 1. (see ins you train I&R	tructions) s in an	IV		107.00
Enter "Y" for yes or "N" for no in column 2. (see instructi 107.01 of this facility is a REH (line 3, column 4, is "12"), is it reimbursement for L&R training programs? Enter "Y" for yes of the column 4.	t eligible for				107. 01
instructions) 108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respirator 4.00	У
109.00 of this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00
therapy services provided by outside supplier? Enter "Y"					
				1,00	
therapy services provided by outside supplier? Enter "Y"	al Demonstratio	"N" for no. If	yes,	1. 00 N	110. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 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 Wor	al Demonstratio	"N" for no. If	yes,		110. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 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 Wor	al Demonstration "Y" for yes or rksheet E-2, I the Frontier Co ost reporting of olumn 1 is Y, rticipating in	"N" for no. If ines 200 throug ommunity period? Enter the column 2.	yes, h 215, as	N	110. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 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. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this comparting the response to continuous prong of the FCHIP demoning which this CAH is participate all that apply: "A" for Ambulance services; "B" for accompanies of the services of the response to accompanies of the FCHIP demoning the services of the services of the response to accompanies of the FCHIP demoning the services of the services of the response to accompanies of the FCHIP demoning the services of the serv	al Demonstration "Y" for yes or rksheet E-2, I the Frontier Co ost reporting of olumn 1 is Y, rticipating in	"N" for no. If ines 200 throug ommunity period? Enter the column 2.	yes, h 215, as	N	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 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. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compart of the FCHIP demonstration for this compart of the FCHIP demonstration for the participate in the response to compare the formula of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the formula of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the formula of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the formula of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the formula of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the formula of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the formula of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the formula of the current cost reports of the formula of the current cost reports of the formula of the current cost reports of the formula of th	al Demonstration "Y" for yes or rksheet E-2, I the Frontier Co ost reporting of the second of the s	"N" for no. If ines 200 througon ty period? Enter enter the column 2.; and/or "C"	1.00 N	N 2. 00	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 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. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this complete "Y" for yes or "N" for no in column 1. If the response to complete integration prong of the FCHIP demoin which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for act for tele-health services. 112.00 Did this hospital 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 complete the hospital began participate demonstration. In column 3, enter the date the hospital cean participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or 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 "S for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	al Demonstration "Y" for yes or rksheet E-2, I the Frontier Co ost reporting of our 1 is y, or rticipating in diditional beds Ith Model eporting of our 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes	ommunity period? Enter enter the column 2. ; and/or "C"	1.00 N	N 2. 00	111.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 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. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this conviction of the response to conviction of the FCHIP demonstration for this capacities and that apply: "A" for Ambulance services; "B" for action tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost respective of the period? Enter "Y" for yes or "N" for no in column 1. If convicting demonstration. In column 2, the date the hospital began participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "Gentle of the definition in CMS Pub. 15-1, chapter 22, \$2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	al Demonstration "Y" for yes or rksheet E-2, I the Frontier Co ost reporting of the second of the s	ommunity period? Enter enter the column 2. ; and/or "C"	1.00 N	N 2. 00	111.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 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. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this come "Y" for yes or "N" for no in column 1. If the response to come integration prong of the FCHIP demo in which this CAH is 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 come "Y", enter in column 2, the date the hospital began participate demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or 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 "S for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility legally-required to carry malpractice insur	al Demonstration "Y" for yes or rksheet E-2, I the Frontier Co ost reporting of the content of	ommunity period? Enter enter the column 2. ; and/or "C"	1.00 N	N 2. 00	111.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 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. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this complete integration prong of the FCHIP demoin which this CAH is participate in the response to complete integration prong of the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for action for tele-health services. 112.00 Did this hospital 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 comperiod? Enter "Y" for yes or "N" for no in column 1. If comparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "Gor short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	al Demonstration "Y" for yes or rksheet E-2, I the Frontier Co ost reporting of the content of	"N" for no. If ines 200 throug ommunity period? Enter enter the column 2. ; and/or "C" 1.00 N	1.00 N	N 2. 00	111.00

Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If

yes, enter the approval date (mm/dd/yyyy) in column 2.

146, 00

Ν

Health Financial Systems	COMMUNITY H	IEALTH NI	ETWORK, INC.			In Lie	u of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			Provi der CC	N: 15-0074		iod: m 01/01/2023 12/31/2023	Worksheet S	-2 repared:
							1, 00	_
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for ves	s or "N" for	no			N N	147. 00
148.00 Was there a change in the order of							N N	148. 00
149.00 Was there a change to the simplifi					or no.		N	149. 00
			Part A	Part E	3	Title V	Title XIX	
			1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov 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
157.00 Subprovi der - IRF			N	N		N	N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF			N	N		N	N	159. 00 160. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC			N	N N		N N	N N	161. 00
161. OU CWINC				IN		IV	IV	161.00
							1.00	
Multicampus 165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that h	as one o	or more campu	ıses in dif	ferent	t CBSAs?	N	165. 00
Enter 1 for yes of N for no.	Name		County	State	Zip Co	ode CBSA	FTE/Campus	
	0		1. 00	2.00	3.00		5. 00	
166.00 If line 165 is yes, for each								00 166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in column 5 (see instructions)								
							1.00	
Health Information Technology (HI	Γ) incentive in the A	meri can	Recovery and	d Reinvestr	ment A	ct		
167.00 Is this provider a meaningful user							Y	167. 00
168.00 If this provider is a CAH (line 10				: 167 is "Y	/"), er	nter the		168. 00
reasonable cost incurred for the I				and the		a a radobi n		168. 01
exception under §413.70(a)(6)(ii)						iai usni p		108.01
169.00 If this provider is a meaningful utransition factor. (see instruction	user (line 167 is "Y") and is	s not a CAH (line 105 i	s "N")), enter the	0.	00169.00
Transition ractor. (See matruction	лю,					Begi nni ng	Endi ng	
						1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	peginning date and en	ding da	te for the re	porting				170. 00
						1. 00	2.00	
171.00 If line 167 is "Y", does this prov	/i der have any davs f	or indiv	vi dual s enrol	led in		N N	2.00	0171.00
section 1876 Medicare cost plans i "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (:	reported on Wkst. S-3 umn 1. If column 1 is	, Pt. I,	, line 2, col	. 6? Enter		··		

Heal th	Financial Systems COMMUNITY HEALTH	NETWORK INC.		In lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Peri od:	Worksheet S-2	
				From 01/01/2023 To 12/31/2023		enared.
					5/24/2024 11:	39 am
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	EMENT OUESTLONN	IΔI RF	1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N			all dates in	the	1
	mm/dd/yyyy format.		<u>'</u>			
	COMPLETED BY ALL HOSPITALS					-
1.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e heainning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in a					1.00
			Y/N	Date	V/I	
2.00	lua tha anni dan tami natad nanti si nati an i n tha Madi anni 1	D	1. 00 N	2. 00	3. 00	2.00
2. 00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colum		IN IN			2. 00
	voluntary or "I" for involuntary.	0,				
3.00	Is the provider involved in business transactions, including		Y			3. 00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions))/ /N		D 1	
			1. 00	7ype 2. 00	3.00	
	Financial Data and Reports		1.00	2.00	3.00	
4.00	Column 1: Were the financial statements prepared by a Cer		Y	А	03/28/2024	4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C"					
	or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	arrabre in				
5. 00	Are the cost report total expenses and total revenues diffe	erent from	Y			5. 00
	those on the filed financial statements? If yes, submit red	conciliation.				
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provider	N		6.00
	the legal operator of the program?					
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		od during the	Y N		7. 00 8. 00
8.00	cost reporting period? If yes, see instructions.	eu anuzor renew	rea dui riig tile	IN IN		8.00
9. 00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	Υ		9. 00
40.00	program in the current cost report? If yes, see instruction					10.00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	ne current	Y		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	I & R in an App	roved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.					
					1. 00	
	Bad Debts				1.00	
12.00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	i ons.		Υ	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection p	policy change d	luring this cos	st reporting	N	13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura	anco amounte wa	ivod2 Lf voc	500	N	14. 00
14.00	instructions.	ance amounts wa	ii veu? II yes,	See	IN	14.00
	Bed Complement					
15. 00	Did total beds available change from the prior cost reporti				Y	15. 00
		Y/N	t A Date	Y/N	t 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?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	04/11/2024	Υ	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)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	I	I		I	1

Heal th	Financial Systems COMMUNITY HEALTH	I NETWORK, INC.		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0074	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time P 5/24/2024 1	repared:
			i pti on	Y/N	Y/N	
20.00	If line 1/ or 17 is use were adjustments made to DCOD		0	1. 00 N	3. 00 N	20. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	IN	20.00
	,,	Y/N	Date	Y/N	Date	
	In	1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
			1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE					
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais made dur	ring the cost		23. 00
24. 00	Were new leases and/or amendments to existing leases entere	ed into durina	this cost re	eportina period?		24. 00
	If yes, see instructions	3		3 1 1 1 1 1 1 1 1 1		
25. 00	Have there been new capitalized leases entered into during	the cost repor	rting period?	Plf yes, see		25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost renorti	na neriod2 l	f ves see		26. 00
20.00	instructions.	ic cost reporti	ing perrou: i	1 yes, see		20.00
27. 00	Has the provider's capitalization policy changed during the	e cost reporti	ng period? If	yes, submit		27. 00
	Copy.					
28. 00	Unterest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into du	ring the cost	reporting		28. 00
20.00	period? If yes, see instructions.		g : 333.	. Topo: triig		20.00
29. 00	Did the provider have a funded depreciation account and/or		ebt Service F	Reserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see instr		dob+2 Lf voc			30.00
30.00	Has existing debt been replaced prior to its scheduled maturinstructions.	in ty with new	debt? IT yes	s, see		30.00
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see		31. 00
	instructions.					
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvi cas furni sh	ed through co	ntractual		32. 00
32.00	arrangements with suppliers of services? If yes, see instru	uctions.	sa tili oagii ee	niti actual		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app	olied pertaini	ng to competi	tive bidding? If		33. 00
	no, see instructions. Provider-Based Physicians					
34. 00	Were services furnished at the provider facility under an a	arrangement wi	th provider-b	pased physicians?		34.00
01.00	If yes, see instructions.	arrangement wi	in provider i	basea priysi erans.		01.00
35. 00	If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs					
36. 00	Were home office costs claimed on the cost report?					36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?	'		37. 00
38. 00	IIT yes, see instructions. Iffline 36 is yes , was the fiscal year end of the home off	ice different	from that of	=		38. 00
55. 55	the provider? If yes, enter in column 2 the fiscal year end					55. 55
39. 00	, , ,	er chain compon	nents? If yes	5,		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If was soo			40. 00
40.00	instructions.			40.00		
	Coat Deport Dropovov Control Informati	1.	2.	00		
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	SHI RLEY	BI SHOP		41. 00	
- 1.00	held by the cost report preparer in columns 1, 2, and 3,					-1.00
	respecti vel y.					
42. 00		COMMUNITY HEAL	_TH NETWORK			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	317-355-4135		SBI SHOP@ECOMMU	NLTY, COM	43. 00
	report preparer in columns 1 and 2, respectively.	355 1165		35. 331 °E30/////01		.5. 55

Heal th	Financial Systems	I NETWORK, INC.	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT OF	UESTI ONNAI RE	Provider CCN: 15-007	ri od: om 01/01/2023 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/24/2024 11:	epared:
			3.00		37 247 2024 11.	J7 alli
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the titheld by the cost report preparer in columns respectively.		NETWORK DIRECTOR OF REIMBURSEMENT			41. 00
42.00	Enter the employer/company name of the cost	t report				42. 00
43. 00	preparer. Enter the telephone number and email addres report preparer in columns 1 and 2, respect					43. 00

Heal th Fi nancialSystemsCOMMUNITYHOSPITALANDHOSPITAL HEALTH CARE COMPLEXSTATISTICAL DATA Provider CCN: 15-0074

					1	To 12/31/2023		
							5/24/2024 11: I/P Days / 0/P	39 am
							Visits / Trips	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA					<u> </u>		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		300	109, 500	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 I PF Subprovi der							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0 0	5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			300	100 500	0.00		6. 00 7. 00
7.00	beds) (see instructions)			300	109, 500	0.00	0	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		66	24, 090	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	31.00		00	24,070	0.00	· ·	9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		19	6, 935	0.00	0	12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			385	140, 525	0.00		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	20.00						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00 26. 00	CMHC - CMHC RURAL HEALTH CLINIC							25. 00 26. 00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		385			0	27. 00
28. 00	Observation Bed Days			303			0	28. 00
29. 00	Ambul ance Tri ps						Ĭ	29.00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0				32. 00
32. 01	Total ancillary labor & delivery room			, and the second)			32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0) (0	34. 00

 Heal th Financial
 Systems
 COMMUNITY

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Peri od: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Part I
Date/Time Prepared: 5/24/2024 11:39 am Provider CCN: 15-0074

					1	5/24/2024 11:	39 am
		I/P Days	/ O/P Visits	/ Trips	Trips Full Time Equivalents		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA					•	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	12, 263	6, 143	82, 464			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)	25, 111	35, 004				2.00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	O	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	10.070	0	02.444			6.00
7. 00	Total Adults and Peds. (exclude observation	12, 263	6, 143	82, 464			7. 00
9 00	beds) (see instructions)	2 410	974	15 224			8. 00
8. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	2, 618	9/4	15, 234			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	NEONATAL INTENSIVE CARE UNIT	0	417	3, 009			12.00
13. 00	NURSERY	o _l	1, 345	1, 592			13. 00
14. 00	Total (see instructions)	14, 881	8, 879	102, 299		2, 999. 64	
15. 00	CAH visits	14, 001	0, 0, 7	02, 277		2, 777.04	15. 00
15. 10	REH hours and visits	0	Ö	0			15. 10
16. 00	SUBPROVI DER - I PF		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)			126			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				52. 02	2, 999. 64	
28. 00	Observation Bed Days	_	1, 792	7, 083			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			771			30.00
31. 00	Employee discount days - IRF		F.0	0			31.00
32.00	Labor & delivery days (see instructions)	0	59	531			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days						33. 00
33. 00	LTCH site neutral days and discharges		-				33. 00
	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00
31.00	1. Simportal of Expansion Covid 17 The Moute Care	١	٩	1	l .	I	1 3 1. 00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Heal th Fi nancialSystemsCOMMUNITYHOSPITALANDHOSPITAL HEALTH CARE COMPLEXSTATISTICAL DATA Provi der CCN: 15-0074

				To	12/31/2023	Date/Time Prep 5/24/2024 11:	
		Full Time		Di sch	arges	37 247 2024 11.	J7 dili
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA			1			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	3, 244	1, 265	21, 252	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)			4, 477	6, 729		2. 00
3.00	HMO IPF Subprovider			7, 777	0, 727		3. 00
4. 00	HMO IRF Subprovider				ol		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		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	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT						12. 00
13.00	NURSERY					04 050	13.00
14.00	Total (see instructions)	0. 00	0	3, 244	1, 265	21, 252	14. 00
15.00	CAH visits						15.00
15. 10 16. 00	REH hours and visits SUBPROVIDER - IPF						15. 10 16. 00
17. 00	SUBPROVIDER - 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)						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	Ambulance Trips						29. 00 30. 00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF						30.00
32.00	Labor & delivery days (see instructions)			•			32.00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. U1	outpatient days (see instructions)						52.01
33. 00	LTCH non-covered days			0	ļ		33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34. 00
		·		· ·	·		

| Period: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0074

					Т	o 12/31/2023		
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	39 dili
		1. 00	2. 00	A-6) 3.00	3) 4. 00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA		2.00	1 0.00	11.00	0.00	0.00	
1. 00	SALARIES Total salaries (see	200. 00	265, 640, 126	-1, 359, 530	264, 280, 596	6, 239, 253. 00	42. 36	1. 00
1.00	instructions)	200.00	203, 040, 120	-1, 337, 330	204, 200, 370	0, 237, 233. 00	42.30	1.00
2. 00	Non-physician anesthetist Part		C	0	0	0.00	0.00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0.00	0.00	3. 00
4. 00	Physician-Part A -		1, 865, 663	0	1, 865, 663	12, 607. 00	147. 99	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		888, 362 13, 077, 022	I .	,	· ·	1	4. 01 5. 00
	Physician-Part B					·		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		C	0	0	0.00	0.00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	4, 256, 054	-47, 554	4, 208, 500	136, 483. 00	30. 84	7. 00
7. 01	Contracted interns and residents (in an approved		C	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	11, 888, 93 <i>6</i>	0 -65, 681	0 11, 823, 255	0. 00 420, 761. 00		
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		5, 877, 587	0	5, 877, 587	46, 837. 00	125. 49	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		2, 137, 810	0	2, 137, 810	15, 144. 00	141. 17	12. 00
13. 00	services Contract Labor: Physician-Part		2, 246, 792	2 0	2, 246, 792	16, 708. 00	134. 47	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		C	0	О	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		88, 914, 899	0	88, 914, 899	1, 937, 114. 00	45 90	14. 01
14. 02	Related organization salaries		00, 711, 077	Ö	00,711,077	0.00	0.00	14. 02
15. 00	Home office: Physician Part A - Administrative		C	0	0	0.00	0.00	15. 00
16. 00	Home office and Contract		C	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		C	0	0	0.00	0.00	16. 01
16. 02	- Teaching Home office contract		C	0	0	0. 00	0. 00	16. 02
	Physicians Part A - Teaching							l
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		62, 271, 990	0	62, 271, 990			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		4, 310, 662	0	4, 310, 662			19. 00
20. 00	Non-physician anesthetist Part A		C	0	0			20. 00
21. 00	Non-physician anesthetist Part B		C	0	0			21. 00
22. 00	Physician Part A - Administrative		173, 854		,			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		75, 957 1, 787, 334	l l	75, 957 1, 787, 334			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		1, 039, 353	0	1, 039, 353			24. 00 25. 00
25. 50	approved program) Home office wage-related		23, 460, 420	0	23, 460, 420			25. 50
25. 51	(core) Related organization		C	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		C	0	0			25. 52

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0074

					Ť	o 12/31/2023	Date/Time Pre	
		14/1 1 4 1 1		D 1 : 6: 1:	A 11 1 1	D : 1 II	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)	
		1.00	2.00	A-6) 3. 00	3) 4.00	col . 4 5.00	/ 00	
25. 53	Hama affica. Dhyai ai ana Dant A	1.00	2.00	3.00	4.00	5.00	6. 00	25. 53
25. 53	Home office: Physicians Part A		U	U	0			25. 53
	- Teaching - wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARII	<u> </u>						
26. 00	Employee Benefits Department	4.00	40, 847	0	40, 847	1, 489. 00	27. 43	26. 00
27. 00	Administrative & General	5. 00	12, 501, 202	-1, 035, 956		· ·		
28. 00	Administrative & General under	3.00	14, 781, 546		14, 781, 546	· ·		
20.00	contract (see inst.)		14, 701, 340	O	14, 701, 340	100, 070. 00	130. 30	20.00
29. 00	Maintenance & Repairs	6, 00	0	0	0	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	2, 401, 282	-5, 986	2, 395, 296			
31. 00	Laundry & Linen Service	8. 00	2, 101, 202	0, 700	2,070,270	0.00		31. 00
32. 00	Housekeepi ng	9. 00	4, 301, 560	-25, 377	4, 276, 183			
33. 00	Housekeeping under contract	7. 00	609, 226	20,077	609, 226			
33. 00	(see instructions)		007, 220	0	007, 220	11, 510. 00	32. 70	33.00
34.00	Di etary	10. 00	3, 429, 207	-2, 469, 282	959, 925	43, 638. 00	22 00	34. 00
35. 00	Dietary under contract (see		468, 069	0	468, 069	· ·		
00.00	instructions)		1007 007	Ŭ	100,007	12,010.00	00.77	00.00
36.00	Cafeteri a	11. 00	207, 100	2, 453, 635	2, 660, 735	119, 522. 00	22. 26	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38.00	Nursing Administration	13. 00	3, 847, 950	-8, 810	3, 839, 140	87, 894. 00	43. 68	38. 00
39. 00	Central Services and Supply	14. 00	710, 785		705, 353	22, 929. 00	30. 76	39. 00
40.00	Pharmacy	15. 00	12, 365, 667			i i		40. 00
41.00	Medical Records & Medical	16. 00	106, 303			i i		
	Records Library		,	,		,		
42.00	Social Service	17. 00	1, 993, 368	-1, 596	1, 991, 772	45, 733. 00	43. 55	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

Health Financial Systems COMMUNITY HEALTH NETWORK, INC. In Lieu of Form CMS-2552-10

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0074 Peri od: Worksheet S-3 From 01/01/2023 To 12/31/2023 Part III Date/Time Prepared: 5/24/2024 11:39 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . Salaries in col . 5) (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 263, 277, 529 -1, 311, 976 261, 965, 553 6, 098, 058. 00 42. 96 1.00 instructions) 2.00 11, 888, 936 420, 761.00 28. 10 2.00 Excluded area salaries (see -65, 681 11, 823, 255 instructions) 3.00 Subtotal salaries (line 1 251, 388, 593 -1, 246, 295 250, 142, 298 5, 677, 297. 00 44.06 3.00 minus line 2) 4.00 Subtotal other wages & related 99, 177, 088 99, 177, 088 2, 015, 803. 00 49. 20 4.00 costs (see inst.) Subtotal wage-related costs 5.00 85, 906, 264 C 85, 906, 264 0.00 34. 34 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 436, 471, 945 -1, 246, 295 435, 225, 650 7, 693, 100. 00 56. 57

-3, 278, 493

54, 485, 619

1, 201, 247. 00

45. 36

7.00

57, 764, 112

7.00

Total overhead cost (see

instructions)

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS	5-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0074	Peri od: Worksheet S-	-3
		From 01/01/2023 Part IV	
		T- 10/01/0000 D-+-/T: D.	

	To 12/31/2023	Date/Time Prep 5/24/2024 11:3	pared: 39 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	10, 282, 738	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	621, 119	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	6, 116, 290	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)	23, 908, 042	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	5, 928, 283	9. 00
10.00	Dental, Hearing and Vision Plan	203, 541	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	100, 718	11. 00
	Accident Insurance (If employee is owner or beneficiary)	0	1
	Disability Insurance (If employee is owner or beneficiary)	2, 883, 004	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		781, 661	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	18, 830, 680	17. 00
18. 00	Medicare Taxes - Employers Portion Only	O	18. 00
19. 00	Unemployment Insurance	o	19. 00
20.00	State or Federal Unemployment Taxes	o	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	8, 215	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	69, 664, 291	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
	•	'	

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0074	Peri od: Worksheet S-3 From 01/01/2023 Part V To 12/31/2023 Date/Time Prepared:

		To 12/31/2023	Date/Time Pre 5/24/2024 11:	
	Cost Center Description	Contract Labor		37 diii
		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	5, 877, 587	69, 664, 291	1. 00
2.00	Hospi tal	5, 877, 587	65, 353, 629	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			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	0ther	0	4, 310, 662	18. 00

Heal th	Financial Systems	COMMUNITY HEALTH NETW	VORK, INC.		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	P	rovider CC	CN: 15-0074	Period: From 01/01/2023 To 12/31/2023		pared:
						1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DAT	ΓΔ				1.00	
	Uncompensated and Indigent Care Cost-to-Ch						1
1.00	Cost to charge ratio (see instructions)	iai ge nati e				0. 234949	1.00
1.00	Medicaid (see instructions for each line)					0. 201717	1.00
2.00	Net revenue from Medicaid					202, 792, 791	2.00
3.00	Did you receive DSH or supplemental paymen	nts from Medicaid?				Υ Υ	3.00
4. 00	If line 3 is yes, does line 2 include all		al payment:	s from Medica	ıi d?	N	4.00
5. 00	If line 4 is no, then enter DSH and/or sup					-9, 460, 632	
6. 00	Medi cai d charges	PP: P=5				803, 637, 870	
7. 00	Medicaid cost (line 1 times line 6)					188, 813, 914	1
8.00	Difference between net revenue and costs	for Medicaid program (s	see instru	ctions)		0	8.00
	Children's Health Insurance Program (CHIP)	(see instructions for	each line	e)			1
9.00	Net revenue from stand-alone CHIP					0	9.00
10.00	Stand-alone CHIP charges					0	10.00
11.00	Stand-alone CHIP cost (line 1 times line	10)				0	11. 00
12.00	Difference between net revenue and costs to					0	12. 00
	Other state or local government indigent of						
	Net revenue from state or local indigent of					0	
	Charges for patients covered under state (10)	<u> </u>		Not included	in lines 6 or	0	
	State or local indigent care program cost					0	
16. 00	Difference between net revenue and costs					0	16. 00
	Grants, donations and total unreimbursed of instructions for each line)	·			ent care progran		
	Private grants, donations, or endowment in					0	
	Government grants, appropriations or trans					0	
19. 00	Total unreimbursed cost for Medicaid , CHI 8, 12 and 16)	IP and state and local	indigent (0	19. 00
				Uni nsured	Insured	Total (col. 1	
				pati ents	pati ents	+ col . 2)	
	Uncompensated care cost (see instructions	for each Line)		1. 00	2. 00	3. 00	
20.00	Charity care charges and uninsured discour			24, 074, 57	9, 991, 645	34, 066, 224	20.00
21. 00	Cost of patients approved for charity care		nts (see	5, 656, 29		12, 226, 405	
21.00	instructions)	c and uninsured discoul	113 (300	5, 050, 2	0, 370, 107	12, 220, 403	21.00
22. 00	Payments received from patients for amoun-	ts previously written o	off as	24	12 0	242	22. 00
23 00	charity care Cost of charity care (see instructions)			5, 656, 05	6, 570, 107	12, 226, 163	23 00
23.00	Toost or charity care (see Thistructions)			5, 050, 00	0, 370, 107	12, 220, 103	23.00

PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio Cost to charge ratio (see instructions) Medical d (see instructions for each line) 1.00 Net revenue from stand-al one CHIP Net revenue from stand-al one CHIP Net revenue from state or local government indigent care program (See instructions) Stand-al one CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (see instructions) ON the revenue from state or local indigent care program (see instructions) Charges for patients covered under state or local indigent care program (see instructions) Charges for patients covered under state or local indigent care program (see instructions) Difference between net revenue and costs for State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care program (see instructions) From 01/2/31/2023 Difference between net revenue and costs for state or local indigent care program (see instructions) Difference between net revenue and costs for state or local indigent care program (see instructions) Difference between net revenue and costs for state or local indigent care program (see instructions) Difference between net revenue and costs for state or local indigent care program (see instructions) Difference between net revenue and costs for State or local indigent care program (see instructions) Difference between net revenue and costs for State or local indigent care program (see instructions) Difference between net revenue and costs for State or local indigent care program (see instructions) Difference between net revenue and costs for State or local indigent care program (see instructions) Difference between net revenue	lealth Financial Systems		TH NETWORK, INC.			u of Form CMS-2	
PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio Cost to charge ratio (see instructions) 0.234949 1.	HOSPITAL UNCOMPENSATED AND INDIGENT CA	RE DATA	Provi der CC			Parts I & II Date/Time Pre	pared:
PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio Cost to charge ratio (see instructions) 0.234949 1.						4.00	
Incompensated and Indigent Care Cost-to-Charge Ratio 0.234949	DADT II HOSDITAI DATA					1.00	
Cost to charge ratio (see instructions) Medicaid (see instructions for each line)		Cost-to-Charge Patio					ł
Medical d (see Instructions for each line) 2.00 Net revenue from Medicaid 2.00 Did you receive DSH or supplemental payments from Medicaid? 3.3 1f line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? 4.5 3.5 1f line 4 is no, then enter DSH and/or supplemental payments from Medicaid? 5.5 3.5						0.234040	1.0
Net revenue from Medicaid 2.						0. 234747	1.0
Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? Medicaid charges Medicaid charges Difference between net revenue and costs for Medicaid program (see instructions) Children's Health Insurance Program (CHIP) (see instructions for each line) Net revenue from stand-al one CHIP (see instructions for each line) Difference between net revenue and costs for stand-al one CHIP (see instructions) Difference between net revenue and costs for stand-al one CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) Difference between net revenue and costs for stand-al one CHIP (see instructions) Other state or local indigent care program (Not included on lines 2, 5 or 9) 13. Other state or local indigent care program (see instructions for each line) State or local indigent care program cost (line 1 times line 14) Charges for patients covered under state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) Difference between net revenue and costs for state or local indigent care programs (see instructions for each line) Covernment grants, appropriations or transfers for support of hospital operations Difference between net revenue and costs for support of hospital operations Difference between net revenue and costs for support of hospital operations Difference between net revenue and costs for support of hospital operations Difference between net revenue and costs for support of hospital operations Difference between net revenue and costs for support of hospital operations Difference between net revenue and costs for support of hospital operations Difference between net revenue and costs for support of hospital operations Difference between ne		each fille)					2.0
If I ine 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? 4.		ntal navments from Medicai	42				3.0
If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 5.				from Medica	i d2		4.0
Medicaid charges Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (see instructions) Children's Health Insurance Program (CHIP) (see instructions for each line) Net revenue from stand-al one CHIP cost (line 1 times line 10) Stand-al one CHIP cost (line 1 times line 10) Net revenue from stand-al one child gent care program (see instructions for each line) Net revenue from stand-al one child gent care program (see instructions for each line) Net revenue from stand-al one child gent care program (see instructions for each line) Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 13. 14. 15. 16. 17. 18. 18. 19. 19. 19. 10. 10. 10. 11. 11					ı u :		5.0
Medicaid cost (line 1 times line 6) 7. 1. 1. 1. 1. 1. 1. 1.		and/or suppremental payme	into in oil wear care	4			6.0
Difference between net revenue and costs for Medicaid program (see instructions) Stand-al one CHIP cost (line 1 times line 10) Stand-al one CHIP cost (line 1 times line 10) Other state or local indigent care program (see instructions for each line) Other state or local indigent care program (Not included in lines 2, 5 or 9) 13. Other state or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program cost (line 1 times line 14) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10) State or local indigent care program (Not included in lines 6 or 10		e 6)					7.0
Children's Health Insurance Program (CHIP) (see instructions for each line) Net revenue from stand-alone CHIP Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (see instructions) 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) Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 7.00 Private grants, donations, or endowment income restricted to funding charity care 8.00 Government grants, appropriations or transfers for support of hospital operations 10. Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Ocharity care charges and uninsured discounts (see instructions) 1.00 (Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as 242 0 242 2.22 charity care			naram (see instruc	rtions)			8.0
Net revenue from stand-alone CHIP 0.00 Stand-alone CHIP charges 10. Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) 3.00 Net revenue from stand-alone CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) 3.00 Charges for patients covered under state or local indigent care program (Not included on lines 2, 5 or 9) 4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 5.00 State or local indigent care program cost (line 1 times line 14) 6.00 Difference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 7.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 10. 10. 11. 12. 12. 13. 14. 15. 16. 17. 18. 19. 10. 10. 11. 11. 11. 12. 12. 13. 14. 15. 16. 16. 17. 18. 19. 10. 10. 10. 11. 11. 11. 11							0.0
Stand-al one CHIP charges 1.00 Stand-al one CHIP cost (line 1 times line 10) 2.00 Difference between net revenue and costs for stand-al one CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) 3.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 5.00 State or local indigent care program cost (line 1 times line 14) 6.00 Difference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 7.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 9.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) 17. Charity care charges and uninsured discounts (see instructions) 18. Ocost of patients approved for charity care and uninsured discounts (see 5, 656, 298 6, 570, 107 12, 226, 405 21, 100 Cost of patients approved for charity care and uninsured discounts (see instructions) 2. Ocost of patients approved for charity care and uninsured discounts (see instructions) 2. Ocost of patients approved for charity care and uninsured discounts (see instructions) 2. Ocost of patients approved for charity care and uninsured discounts (see instructions) 2. Ocost of patients approved for charity care and uninsured discounts (see instructions) 2. Ocost of patients approved for charity care and uninsured discounts (see instructions) 2. Ocost of patients approved for charity care and uninsured discounts (see instructions) 2. Ocost of patients approved for charity care and uninsured discounts (see instructions) 2. Ocost of patients approved for charity care and uninsured discounts (see instructi			0.10 101 0001 11110				9.0
1.00 Stand-alone CHIP cost (line 1 times line 10) 2.00 Difference between net revenue and costs for stand-alone CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) 3.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 5.00 State or local indigent care program cost (line 1 times line 14) 6.00 Difference between net revenue and costs for state or local indigent care program (see instructions) 6.00 Frence between net revenue and costs for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 7.00 Private grants, donations, or endowment income restricted to funding charity care 8.00 Government grants, appropriations or transfers for support of hospital operations 9.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 19. 8.12 and 16) Uninsured patients patients patients 19. 10.00 Local patients patients 19. 11.00 2.00 3.00 Uncompensated care cost (see instructions for each line) 12.226, 405 21. 13. 14. 15. 15. 16. 17. 18. 19. 19. 10. 10. 10. 10. 11. 11. 12. 12. 13. 13. 14. 15. 15. 16. 16. 17. 18. 19. 19. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10		••					10.0
2.00 Difference between net revenue and costs for stand-alone CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) 3.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 5.00 State or local indigent care program cost (line 1 times line 14) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 7.00 Private grants, donations, or endowment income restricted to funding charity care 8.00 Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 10. Uninsured patients patients patients the col. 2) 10. Uncompensated care cost (see instructions for each line) 11. Occording to the control of the c		imes line 10)					11.0
Other state or local government indigent care program (see instructions for each line) 3. 00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 4. 00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 5. 00 State or local indigent care program cost (line 1 times line 14) 6. 00 Difference between net revenue and costs for state or local indigent care program (see instructions) 6. 00 Difference between net revenue and costs for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 7. 00 Private grants, donations, or endowment income restricted to funding charity care 8. 00 Government grants, appropriations or transfers for support of hospital operations 9. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1.2 and 16) Uninsured patients patients 1.2 and 16) Uninsured patients 1.2 and 16 Uninsured patients 1.2 and 16 Uninsured patients 1.2 and 16 Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see 1.5, 656, 298 6, 570, 107 12, 226, 405 11. 00 1. 12, 226, 405 11. 00 1. 12, 226, 405 11. 00 1. 12, 226, 405 11. 00 1. 00		, ,					12.0
Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 13.							
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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

Cost Centrol Description Soliarios Provider (CN: 15 0074 Period (CN: 15 0074				DWWUNIIY HEALIH		CN: 15 0074 D	eri od:	Worksheet A	2332-10
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17. 00 07100 MPIDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 41, 471, 515 41, 471, 515 71, 00				· · · · · · · · · · · · · · · · · · ·		1			1
73. 01 07300 DRUGS CHARGED TO PATIENTS 0 0 0 209, 689, 560 209, 689, 560 73. 00 73. 01 07301 SPECIALTY PHARMACY 0 21, 967, 212 21, 967, 212 0 21, 21, 21, 21, 21, 21, 21, 21, 21, 21,		07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	i i		1			
73. 01 07301 SPECIALTY PHARMACY 0 0 0 0 91, 322, 401 91, 322, 401 73. 01 73. 02 07302 CONTRACTED PHARMACY 0 21, 967, 212 21, 967, 212 21, 967, 212 73. 02 07400 RENAL DI ALYSIS 111, 364 2, 337, 110 2, 448, 474 -62, 925 2, 385, 549 74. 00 76. 00 07330 ENDOSCOPY 555, 617 556, 194 1, 111, 811 -174, 652 937, 159 76. 00 76. 01 03350 PSYCHI LATRIC C/PSYCHOLOGI CAL SERVI CES 29, 789, 780 12, 951, 906 42, 750, 686 -1, 748, 274 41, 002, 412 76. 01 76. 03 03951 LUTHERWOOD PARTNERSHI P 4, 017, 956 5, 081, 476 9, 099, 432 -179, 537 8, 919, 895 76. 03 76. 04 03952 WOUND CARE CENTER 11, 183, 449 2, 224, 371 3, 407, 820 -852, 612 2, 555, 208 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 16, 338, 642 16, 822, 608 32, 621, 250 -6, 292, 338 26, 328, 912 76. 05 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 16, 338, 642 16, 822, 608 32, 621, 250 -6, 292, 338 26, 328, 912 76. 05 76. 07 03954 BREAST DI AGNOSTI C CENTER 0, 2, 750, 692 2, 750, 692 -95, 587 2, 655, 105 76. 07 76. 97 03954 BREAST DI AGNOSTI C CENTER 963, 973 505, 275 1, 469, 248 -192, 656 1, 276, 592 77. 00 76. 98 07699 CARDI AC REHABI LITATION 963, 973 505, 275 1, 469, 248 -192, 656 1, 276, 592 77. 00 77. 00 07690 CARDI AC REHABI LITATION 963, 973 505, 275 1, 469, 248 -192, 656 1, 276, 592 77. 00 77. 00 07690 CARDI AC REHABI LITATION 963, 973 505, 275 1, 469, 248 -192, 656 1, 276, 592 77. 00 78. 00 07690 CARDI AC REHABI LITATION 963, 973 505, 275 1, 469, 248 -192, 656 1, 276, 592 77. 00 78. 00 07690 CARDI AC REHABI LITATION 97. 00 0 0 0 0 0 0 0 78. 00 07690 CARDI AC REHABI LITATION 97. 00 0 0 0 0 0 0 0 0 78. 00 07690 CARDI AC REHABI LITATION 97. 00 0 0 0 0 0 0 0 0 0	72.00			0	0	0	41, 854, 961	41, 854, 961	72. 00
73. 02 O7302 CONTRACTED PHARMACY				0			209, 689, 560	209, 689, 560	
74. 00 07400 RENAL DI ALYSIS 111, 364 2, 337, 110 2, 448, 474 -62, 925 2, 385, 549 74, 00 76. 00 03350 ENDOSCOPY 555, 617 556, 194 1, 111, 811 -174, 652 937, 159 76. 00 76. 0				0					
76. 00 03330 ENDOSCOPY				· ·					
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 29, 798, 780 12, 951, 906 42, 750, 686 -1, 748, 274 41, 002, 412 76. 01 76. 03 03951 LUTHERWOOD PARTNERSHI P 4, 017, 956 5, 081, 476 9, 099, 432 -179, 537 8, 919, 895 76. 03 76. 04 03952 WOUND CARE CENTER 1, 183, 449 2, 224, 371 3, 407, 820 -852, 612 2, 555, 208 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 16, 338, 642 16, 282, 608 32, 621, 250 -6, 292, 338 26, 328, 912 76. 05 76. 07 03954 BREAST DI AGROSTI C CENTER 2, 256, 268 7. 290, 700 11, 256, 386 -4, 293, 700 6, 962, 686 76. 06 76. 07 03954 BREAST DI AGROSTI C CENTER 0, 2, 750, 692 2, 750, 692 2, 750, 692 -95, 587 2, 655, 105 76. 07 76. 97 07697 CARDI AC REHABILITATI ON 963, 973 505, 275 1, 469, 248 -192, 656 1, 276, 592 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0, 0 0 0 567, 511 567, 511 76. 98 07690 CAR T-CELL I IMMUNOTHERAPY 0, 0 0 0 0 567, 511 567, 511 76. 98 07000 CLORENIC HSCT ACQUISITION 0, 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1							1
76. 03 03951 LUTHERWOOD PARTNERSHIP		1							1
76. 04 03952 WOUND CARE CENTER		1		l		1			1
76. 05 03480 ONCOLOGY-CANCER CARE CENTER 16, 338, 642 16, 282, 608 32, 621, 250 -6, 292, 338 26, 328, 912 76. 05 76. 07 03954 BREAST DI AGNOSTIC CENTER 0 2, 750, 692 2, 750, 692 -95, 587 2, 655, 105 76. 07 76. 97 O7697 O7697				l		1			
76. 06 03953 IMAGI NG CENTERS 3, 965, 686 7, 290, 700 11, 256, 386 -4, 293, 700 6, 962, 686 76. 06 76. 07 70. 07 7				l					1
76. 07 03954 BREAST DI AGNOSTI C CENTER 0 2,750,692 2,750,692 -95,587 2,655,105 76. 07 76. 97 07697 CARDI AG REHABI LITATION 963, 973 505, 275 1,469, 248 -192,656 1,276,592 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 567,511 567,511 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 77. 00 00 0 0 0 0 0 0 0		1		l					1
76. 98				0					
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 00 00 0 0 0 0 0 0				963, 973				1, 276, 592	76. 97
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0	76. 98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	567, 511	567, 511	76. 98
90. 00 0700	77. 00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		l	
90. 00	78. 00			0	0	0	0	0	78. 00
90. 01				_1		1	T	г <u>-</u>	
90. 02				· ·					1
90. 03				i i					1
90. 04 04953 SPI NE CENTER 0 0 0 0 0 0 0 0 90. 04 90. 05 04954 INFUSI ON CENTERS 474, 803 14, 814, 992 15, 289, 795 -14, 598, 824 690, 971 90. 05 90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 0 0 0 0 90. 07 09003 KNEE CENTER 2, 090, 693 2, 544, 030 4, 634, 723 -227, 152 4, 407, 571 90. 07 91. 00 09100 EMERGENCY 12, 960, 307 8, 179, 637 21, 139, 944 -1, 037, 388 20, 102, 556 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00				2, 122, 373	070, 330	3,000,903	-221, 370		1
90. 05 04954 INFUSION CENTERS 474, 803 14, 814, 992 15, 289, 795 -14, 598, 824 690, 971 90. 05 90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 0 0 0 90. 06 90. 07 09003 KNEE CENTER 2, 090, 693 2, 544, 030 4, 634, 723 -227, 152 4, 407, 571 90. 07 91. 00 09100 EMERGENCY 12, 960, 307 8, 179, 637 21, 139, 944 -1, 037, 388 20, 102, 556 91. 00 92. 00 SUBTOTALS (SUM OF LINES 1 through 117) 253, 751, 190 874, 849, 775 1, 128, 600, 965 1, 737, 210 1, 130, 338, 175 18. 00 SUBTOTALS (SUM OF LINES 1 through 117) 253, 751, 190 874, 849, 775 1, 128, 600, 965 1, 737, 210 1, 130, 338, 175 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 0 0 0 192. 00					0		0	1	1
90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 0 90. 06 90. 07 09003 KNEE CENTER 2,090,693 2,544,030 4,634,723 -227,152 4,407,571 90. 07 91. 00 09100 EMERGENCY 12,960,307 8,179,637 21,139,944 -1,037,388 20,102,556 91. 00 92. 00 SPERVATION BEDS (NON-DISTINCT PART) 92. 00				474. 803	14, 814, 992	15, 289, 795	-14, 598, 824		1
90. 07 09003 KNEE CENTER 2,090,693 2,544,030 4,634,723 -227,152 4,407,571 90.07 91.00 09100 EMERGENCY 12,960,307 8,179,637 21,139,944 -1,037,388 20,102,556 91.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 18.00 SUBTOTALS (SUM OF LINES 1 through 117) 253,751,190 874,849,775 1,128,600,965 1,737,210 1,130,338,175 118.00 NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 1		1		0	0	0	0	1	1
91. 00 09100 EMERGENCY 12, 960, 307 8, 179, 637 21, 139, 944 -1, 037, 388 20, 102, 556 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LI NES 1 through 117) 253, 751, 190 874, 849, 775 1, 128, 600, 965 1, 737, 210 1, 130, 338, 175 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192. 00				2, 090, 693	2, 544, 030	4, 634, 723	-227, 152	4, 407, 571	1
SPECIAL PURPOSE COST CENTERS	91. 00								1
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 253, 751, 190 874, 849, 775 1, 128, 600, 965 1, 737, 210 1, 130, 338, 175 18. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00	92. 00		,						92. 00
NONREI MBURSABLE COST CENTERS 0 0 0 0 192.00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00									
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 00	118.00			253, 751, 190	874, 849, 775	1, 128, 600, 965	1, 737, 210	1, 130, 338, 175	1118. 00
	100.00					J	_	_	102.00
174. 00 07730 110HE 01110E 0 0 0 194. 00				l I					
	1 74. 00	101700	HOME OFFICE	<u>ı</u>			1 0	1 0	1174.00

Health Financial Systems CO	DMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Period: From 01/01/2023	Worksheet A	
				o 12/31/2023		pared: 39 am
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
194.01 07951 GROUP HOMES AND MISC. N_R CTRS	7, 666, 784	3, 204, 049	10, 870, 833	-205, 556	10, 665, 277	194. 01
194. 02 07952 ACCOUNTABLE CARE	140, 473	37, 953	178, 420	0	178, 426	194. 02
194. 03 07953 SCHOOL BASED CLINICS	63, 562	58, 427	121, 989	0	121, 989	194. 03
194.04 07954 SMO-NON PROVIDER BASED	639, 349	178, 324	817, 673	0	817, 673	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	3, 378, 768	3, 719, 003	7, 097, 77°	-1, 531, 654	5, 566, 117	194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	265, 640, 126	882, 047, 531	1, 147, 687, 65	0	1, 147, 687, 657	200. 00

Heal th	Financial Systems	COMMUNITY HEALTH	H NETWORK, INC.		In Lieu of	Form CMS-2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN:	15-0074		ksheet A
					From 01/01/2023 To 12/31/2023 Date	e/Time Prepared:
						4/2024 11:39 am
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			
		6. 00	7.00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT	-7, 740, 243				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	6, 990, 357	1			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	11, 657, 399	1			4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-134, 201, 676 7, 168, 116	1			5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	7, 100, 110				8. 00
9. 00	00900 HOUSEKEEPI NG	C	1			9. 00
10.00	01000 DI ETARY	C	2, 413, 105			10. 00
11. 00	01100 CAFETERI A	-2, 908, 532				11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 048, 211				13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	4, 529, 988 -200, 121	1			14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	5, 456, 879	1			16. 00
	01700 SOCIAL SERVICE	0, 100, 07,	1			17. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	-1, 419, 883				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	-3, 096, 621	11, 245, 571			22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	-13, 986, 372	1 1			30.00
31. 00 35. 00	03100 NTENSI VE CARE UNIT 02060 NEONATAL NTENSI VE CARE UNIT	-115, 000	1			31. 00 35. 00
43. 00	04300 NURSERY	-115,000	1			43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		027,700			10.00
50.00	05000 OPERATING ROOM	-670, 265	22, 073, 764			50.00
51. 00	05100 RECOVERY ROOM	C				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-1, 287, 921	1			52. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	182, 786	1 1			54.00
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	-4, 354	1			55. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		1			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-156, 411	.,,			59. 00
60.00	06000 LABORATORY	C				60.00
64.00	06400 I NTRAVENOUS THERAPY	-45, 194	2, 713, 766			64. 00
65.00	06500 RESPI RATORY THERAPY	C	7, 110, 903			65. 00
66.00	06600 PHYSI CAL THERAPY	716, 830				66. 00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	C	2, .00, 0.0			67.00
68. 00 69. 00	06900 ELECTROCARDI OLOGY	-237, 571	1, 283, 970 4, 353, 233			68. 00 69. 00
		130, 750	1			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	1			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	1 1			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 726, 282				73. 00
73. 01	07301 SPECIALTY PHARMACY	C				73. 01
	07302 CONTRACTED PHARMACY	C				73. 02
	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	C	1			74. 00 76. 00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	-6, 981, 458	1			76. 01
	03951 LUTHERWOOD PARTNERSHIP	-129, 169	1 ' ' 1			76. 03
	03952 WOUND CARE CENTER	C	2, 555, 208			76. 04
	03480 ONCOLOGY-CANCER CARE CENTER	20, 476, 890	1 1			76. 05
	03953 I MAGI NG CENTERS	C	6, 962, 686			76. 06
		40.776	2, 655, 105			76. 07 76. 97
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	-48, 668				76. 97
	07700 ALLOGENEIC HSCT ACQUISITION		1			77. 00
	07800 CAR T-CELL IMMUNOTHERAPY		1			78. 00
	OUTPATIENT SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·			
90.00	09000 CLI NI C	C	0			90.00
	04950 MULTI DI SCI PLI NARY CLI NI C	C	3, 528			90. 01
	04951 HEALTHY HEARTS CENTER	-1, 421, 009	1, 358, 320			90. 02
	09001 PALLIATIVE CARE		0			90. 03
90.04	04953 SPINE CENTER		0 600 071			90. 04 90. 05
	04954 I NFUSI ON CENTERS 09002 MEDCHECK CLI NI CS		690, 971			90.05
	09003 KNEE CENTER	-177, 049	4, 230, 522			90.07
	09100 EMERGENCY	1, 188, 279	1			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
	SPECIAL PURPOSE COST CENTERS	.				
118.00		7) -108, 554, 750	1, 021, 783, 425			118. 00
100.00	NONREI MBURSABLE COST CENTERS					100.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 HOME OFFICE	C	1 1			192. 00 194. 00
	07951 GROUP HOMES AND MISC. N_R CTRS		1 1			194. 00
	07952 ACCOUNTABLE CARE	Č				194. 02

Health Financial Systems COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0074	Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared:

			3/24/2024 11.	39 alli
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7. 00		
194. 03 07953 SCHOOL BASED CLINICS	0	121, 989		194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	817, 673		194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	5, 566, 117		194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	-108, 554, 750	1, 039, 132, 907		200.00

Health Financial Systems COMMUNITY HEALTH NETWORK, INC. In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0074 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 11: 39 am

					5/24/2024 1	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
1 00	A - Chargeable Medical Suppli MEDICAL SUPPLIES CHARGED TO			41 471 515		1.00
1. 00	PATIENTS	71. 00	0	41, 471, 515		1. 00
2.00	FATTENTS	0.00	O	o		2. 00
3.00		0.00	0	1		3. 00
4. 00		0.00	0			4. 00
5. 00		0.00	0	1		5. 00
6. 00		0.00	0			6. 00
7.00		0.00	0	o		7. 00
8.00		0.00	0	1		8. 00
9.00		0.00	0	o		9. 00
10.00		0.00	0	o		10. 00
11.00		0.00	0	О		11. 00
12.00		0.00	0			12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	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
18.00		0.00	0			18. 00
19.00		0.00	0			19. 00
20. 00		0.00	0			20. 00
21. 00		0.00	0			21. 00
22. 00		0.00	0			22. 00
23. 00		0.00	0			23. 00
24. 00		0.00	0			24. 00
25. 00		0.00	0			25. 00
26. 00		0.00	0	_		26. 00
27. 00		0.00	0			27. 00
28. 00		0.00	0	_		28. 00
29. 00		0.00	0			29. 00
30. 00	TOTAL C — — — — —	0.00	<u> </u>			30. 00
	TOTALS		0	41, 471, 515		
1.00	B - Implantable Device Reclas	72.00	0	41, 854, 961		1.00
1.00	PATIENTS	72.00	U	41, 634, 901		1.00
2.00	FATTENTS	0.00	0	o		2. 00
3.00		0.00	Ö			3. 00
4. 00		0.00	0			4. 00
5. 00		0.00	Ö			5. 00
6.00		0.00	Ö	1		6. 00
0.00	TOTALS — — — — —		— — <u> </u>			0.00
	C - Drugs Charges to Pat			11/001/701		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	C	209, 689, 560		1.00
2.00	DRUGS CHARGED TO PATIENTS	73. 00	0			2. 00
3.00		0.00	Ō	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0			5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11. 00		0.00	0			11. 00
12.00		0.00	0			12. 00
13.00		0.00	0			13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0			15. 00
16. 00		0.00	0			16. 00
17. 00		0.00	0			17. 00
18. 00		0.00	0			18. 00
19. 00		0. 00	0			19. 00
20.00		0.00	0			20.00
21. 00		0.00	0			21. 00
22. 00		0.00	0			22. 00
23. 00		0.00	0			23. 00
24. 00		0.00	0	_		24. 00
25. 00		0.00	0			25. 00
26. 00	TOTALS — — — — —		<u> </u>			26. 00
	D - Depreciation Expense			ı ∠∪9, 089, 56U		
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	29, 885, 263		1.00
2.00	ON REL COSTS-WINDLE EQUIP	0.00	0			2. 00
3.00		0.00	0			3. 00
	I	3.00		<u> </u>		1 3. 55

Health Financial Systems RECLASSIFICATIONS COMMUNITY HEALTH NETWORK, INC.

Provider CCN: 15-0074

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

Date/Time Prepared: 5/24/2024 11:39 am

					5/24/2024 11:	39 am
	Cost Center	Increases Line #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 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 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	o	Ö		10.00
11. 00		0.00	o	Ö		11. 00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	Ö	Ö		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 23. 00		0. 00 0. 00	0 0	0		22. 00 23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	O	Ö		25. 00
26.00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00 29. 00		0. 00 0. 00	0 0	0		28. 00 29. 00
30.00		0.00	0	0		30.00
31.00		0.00	O	0		31.00
32. 00		0.00	0	0		32. 00
33. 00		0.00	0	0		33. 00
34. 00 35. 00		0. 00 0. 00	0	0		34. 00 35. 00
36. 00		0.00	0	0		36.00
37. 00		0.00	o	Ö		37. 00
38. 00		0.00	O	0		38. 00
39. 00		0.00	0	0		39. 00
40. 00 41. 00		0. 00 0. 00	0	0		40. 00 41. 00
42. 00		0.00	0	0		42. 00
43. 00		0.00	0	0		43. 00
	TOTALS		0	29, 885, 263		
1. 00	E - Interest Expense CAP REL COSTS-BLDG & FIXT	1.00	0	12, 995, 376		1. 00
1.00	TOTALS — — — — —		— — ŏ	12, 995, 376		1.00
	F - Other Capital Rental					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12, 114, 306		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	O	Ö		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	o	Ö		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 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	o	Ö		16. 00
17.00		0.00	O	0		17. 00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	0	Ö		22. 00
23.00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
26. 00 27. 00		0.00	0	0		27. 00
28.00		0.00	0	Ö		28. 00
29. 00		0.00	0	0		29. 00

Provider CCN: 15-0074

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 11:39 am

					10 1.	2/31/2023	5/24/2024 1	
		Increases						
	Cost Center	Li ne #	Salary	0ther				
20.00	2. 00	3.00	4. 00	5. 00				20.00
30. 00 31. 00		0. 00 0. 00	0	0				30. 00 31. 00
32. 00		0.00	0	0				32.00
33. 00		0.00	o	0				33. 00
34. 00		0.00	o	O				34. 00
35.00		0.00	0	0				35. 00
36.00	L	0.00	0_	0				36. 00
	TOTALS		0	12, 114, 306				
4 00	G - STD BENEFIT RECLASS	F 00		07.445				1 00
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37, 145				1.00
2. 00 3. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	5, 986 25, 377				2. 00 3. 00
	DI ETARY	10.00	o	14, 788				4. 00
5. 00	CAFETERI A	11.00	o	859				5. 00
6.00	NURSING ADMINISTRATION	13. 00	0	8, 810				6. 00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	5, 432				7. 00
8.00	PHARMACY	15. 00	0	52, 319				8. 00
	MEDICAL RECORDS & LIBRARY	16.00	0	2, 679				9. 00
	SOCIAL SERVICE	17. 00 21. 00	0	1, 596				10. 00 11. 00
11. 00	I &R SERVICES-SALARY & FRINGES APPRVD	21.00	U	47, 554				11.00
12. 00	I&R SERVICES-OTHER PRGM	22. 00	O	105, 507				12. 00
50	COSTS APPRVD		٩					55
13.00	ADULTS & PEDIATRICS	30.00	0	289, 435				13. 00
	INTENSIVE CARE UNIT	31. 00	0	70, 408				14. 00
	NEONATAL INTENSIVE CARE UNIT	35. 00	0	16, 779				15. 00
	OPERATING ROOM	50.00	0	34, 874				16. 00
	RECOVERY ROOM	51.00	0	11, 910				17. 00 18. 00
	RADI OLOGY-DI AGNOSTI C CT SCAN	54. 00 57. 00	0	21, 888 17, 627				19. 00
	CARDIAC CATHETERIZATION	59.00	o	41, 974				20.00
	INTRAVENOUS THERAPY	64.00	o	3, 407				21. 00
22. 00	RESPIRATORY THERAPY	65.00	0	7, 728				22. 00
23.00	PHYSI CAL THERAPY	66.00	0	35, 877				23. 00
24. 00	SPEECH PATHOLOGY	68. 00	0	3, 868				24. 00
	ELECTROCARDI OLOGY	69.00	0	14, 335				25. 00
	ENDOSCOPY	76.00	0	4, 955				26. 00
27. 00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76. 01	0	166, 935				27. 00
28. 00	LUTHERWOOD PARTNERSHIP	76. 03	O	7, 693				28. 00
	WOUND CARE CENTER	76. 04	o	12, 298				29. 00
	ONCOLOGY-CANCER CARE CENTER	76. 05	0	143, 755				30. 00
31.00	I MAGING CENTERS	76.06	0	15, 931				31. 00
32.00	CARDIAC REHABILITATION	76. 97	0	5, 923				32. 00
	HEALTHY HEARTS CENTER	90.02	0	11, 515				33. 00
	INFUSION CENTERS KNEE CENTER	90.05	0	9, 441				34. 00
	EMERGENCY	90. 07 91. 00	0	4, 139 33, 102				35. 00 36. 00
	ACCOUNTABLE CARE	194. 02	0	33, 102				37. 00
	SMO-NON PROVIDER BASED	194. 04	Ö	3, 927				38. 00
39. 00	FAMILY PRACTICE MEDICINE	194. 05	0	8, 335				39. 00
	GROUP HOMES AND MISC. N_R	194. 01	0	53, 088				40. 00
	CTRS	+						
	TOTALS H - Labor and Delivery		0	1, 359, 530				
1.00	NURSERY	43.00	499, 830	0				1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	2, 165, 688	o				2. 00
	NURSERY	43.00	0	330, 075				3. 00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	<u>1, 430, 1</u> 70				4. 00
	TOTALS		2, 665, 518	1, 760, 245				
4 00	I - Cafeteria	44.00	0 454 404					4 00
1. 00 2. 00	CAFETERI A CAFETERI A	11. 00 11. 00	2, 454, 494	3, 622, 113				1. 00 2. 00
2.00	CAFETERIA		2, 454, 494	3, 622, 113				2.00
	J - Therapy Reclass		۷, ۲۵۲, ۲۶۴	5,022,115				
1.00	OCCUPATI ONAL THERAPY	67.00	1, 694, 671	0				1.00
2.00	SPEECH PATHOLOGY	68.00	718, 710	0				2. 00
3.00	OCCUPATI ONAL THERAPY	67. 00	0	791, 177				3. 00
4.00	SPEECH PATHOLOGY		0	335, 538				4. 00
	TOTALS		2, 413, 381	1, 126, 715				
1. 00	K - Builiding Depreciation CAP REL COSTS-BLDG & FIXT	1.00	0	15, 208, 197				1.00
1.00	TOTALS		}	15, 208, 197				1.00
	1	ı	9	, - 30,				ı

					10 12/31/2023 Date/Time Prepared: 5/24/2024 11:39 am
		Increases			072172021 11.07 dim
	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3. 00	4. 00	5. 00	
	L - Capital Insurance Costs				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	743, 354	1.00
	TOTALS		0	743, 354	
	M - Radi ol ogy Support				
1.00	RADI OLOGY-THERAPEUTI C	55.00	311, 002	0	1.00
2.00	CT SCAN	57.00	161, 268	0	2. 00
3.00	MAGNETIC RESONANCE IMAGING	58.00	25, 425	0	3.00
	(MRI)				
4.00	I MAGING CENTERS	76.06	111, 557	0	4.00
5.00	RADI OLOGY-THERAPEUTI C	55.00	0	124, 521	5. 00
6.00	CT SCAN	57.00	0	64, 569	6. 00
7.00	MAGNETIC RESONANCE IMAGING	58.00	0	10, 180	7. 00
	(MRI)				
8.00	I MAGING CENTERS	76.06	0	44, 666	8.00
	TOTALS		609, 252	243, 936	
	N - Hyperbaric Oxygen Therapy	1			
1.00	HYPERBARIC OXYGEN THERAPY	76. 98	192, 147		1.00
2.00	HYPERBARIC OXYGEN THERAPY	76. 98		375, 364	2. 00
		- $ -$	192, 147	375, 364	
	0 - IHH Cat Scan				
1.00	CT SCAN	57.00	1, 023, 848		1.00
2.00	CT SCAN	57.00		360, 728	2. 00
			1, 023, 848	360, 728	
	P - Specialty Pharmacy				
1.00	SPECIALTY PHARMACY	73. 01	2, 167, 588		1.00
2.00	SPECIALTY PHARMACY	73. 01		0	2. 00
3.00	SPECIALTY PHARMACY	73. 01		87, 871, 426	3.00
4.00					4.00
			2, 167, 588	87, 871, 426	
	Q - FELLOWS				
1.00	I&R SERVICES-SALARY &	21. 00	266, 362	39, 523	1.00
	FRI NGES APPRVD				
	TOTALS		266, 362	39, 523	
	R - SPECIALTY PHARMACY HO COS	TS RECLASS			
1.00	SPECIALTY PHARMACY	73. 01	955, 914		1. 00
2.00	SPECIALTY_PHARMACY	73. 01		327, 473	2. 00
			955, 914	327, 473	
500.00	Grand Total: Increases		12, 748, 504	461, 049, 585	500.00
			·		'

Provider CCN: 15-0074

| Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/24/2024 11: 39 am

						5/24/2024 1	1:39 am
		Decreases		1		I	
	Cost Center	Li ne #	Sal ary	Other 0.00	Wkst. A-7 Ref.		
	6.00 A - Chargeable Medical Suppli	7.00	8. 00	9. 00	10. 00		
1. 00	CENTRAL SERVICES & SUPPLY	14.00	0	59, 189	0		1.00
2. 00	PHARMACY	15. 00	0	· ·	0		2. 00
3. 00	ADULTS & PEDIATRICS	30.00	0				3. 00
4.00	INTENSIVE CARE UNIT	31.00	0				4. 00
5.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	37, 252	0		5. 00
6.00	OPERATING ROOM	50.00	0	9, 524, 279	0		6. 00
7.00	RECOVERY ROOM	51.00	0		0		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	0				8. 00
9.00	RADI OLOGY-THERAPEUTI C	55.00	0				9. 00
10.00	CT SCAN MAGNETIC RESONANCE IMAGING	57.00	0	1			10.00
11. 00	(MRI)	58. 00	U	21, 315	0		11. 00
12. 00	CARDIAC CATHETERIZATION	59.00	0	19, 657, 260	0		12. 00
13. 00	I NTRAVENOUS THERAPY	64.00	0				13. 00
14.00	RESPIRATORY THERAPY	65.00	0				14. 00
15.00	PHYSI CAL THERAPY	66.00	0	5, 792	0		15. 00
16.00	SPEECH PATHOLOGY	68. 00	0	3, 771	0		16. 00
17.00	ELECTROCARDI OLOGY	69. 00	0		0		17. 00
18. 00	ELECTROENCEPHALOGRAPHY	70.00	0				18. 00
19.00	RENAL DI ALYSI S	74.00	0				19. 00
20.00	ENDOSCOPY	76.00	0				20.00
21. 00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76. 01	U	356	0		21. 00
22. 00	LUTHERWOOD PARTNERSHIP	76. 03	0	1, 443	0		22. 00
23. 00	WOUND CARE CENTER	76.04	0		0		23. 00
24. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0		0		24. 00
25. 00	I MAGING CENTERS	76.06	0				25. 00
26.00	CARDIAC REHABILITATION	76. 97	0	7, 506	0		26. 00
27. 00	HEALTHY HEARTS CENTER	90. 02	0	30, 802	0		27. 00
28. 00	INFUSION CENTERS	90. 05	0	_,	0		28. 00
29. 00	KNEE CENTER	90. 07	0				29. 00
30. 00	EMERGENCY	91.00	0				30. 00
	TOTALS B - Implantable Device Reclas		0	41, 471, 515			
1. 00	OPERATING ROOM	50.00	0	16, 487, 388	0		1.00
2.00	RADI OLOGY-THERAPEUTI C	55.00	0	1	0	1	2. 00
3.00	CARDIAC CATHETERIZATION	59. 00	0	24, 880, 011	0		3. 00
4.00	ENDOSCOPY	76.00	0			•	4. 00
5.00	WOUND CARE CENTER	76. 04	0				5. 00
6. 00	KNEE CENTER	90.07	0		0		6. 00
	C - Drugs Charges to Pat		0	41, 854, 961			_
1. 00	PHARMACY	15.00	0	192, 500, 338	0		1.00
2. 00	ADULTS & PEDIATRICS	30.00	0			•	2. 00
3.00	INTENSIVE CARE UNIT	31.00	0				3. 00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	185			4. 00
5.00	OPERATING ROOM	50.00	0	45, 080	0		5. 00
6. 00	RECOVERY ROOM	51. 00	0			1	6. 00
7.00	RADI OLOGY - DI AGNOSTI C	54.00	0				7. 00
8.00	RADI OLOGY-THERAPEUTI C	55.00	0		0		8. 00
9. 00 10. 00	CT SCAN MAGNETIC RESONANCE IMAGING	57. 00 58. 00	0			1	9. 00 10. 00
10.00	(MRI)	36.00	U	30, 990	0		10.00
11. 00	CARDIAC CATHETERIZATION	59. 00	0	21, 855	0		11. 00
12.00	I NTRAVENOUS THERAPY	64.00	0		0		12. 00
13.00	RESPIRATORY THERAPY	65. 00	0	19	0		13. 00
14.00	PHYSI CAL THERAPY	66.00	0				14. 00
15. 00	SPEECH PATHOLOGY	68. 00	0				15. 00
16.00	ELECTROCARDI OLOGY	69.00	0				16.00
17. 00	ELECTROENCEPHALOGRAPHY	70.00	0	1	0		17. 00
18. 00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76. 01	U	9, 628	0		18. 00
19. 00	LUTHERWOOD PARTNERSHIP	76. 03	0	328	0		19. 00
20. 00	WOUND CARE CENTER	76.03	0				20.00
21. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0		0		21. 00
22. 00	I MAGING CENTERS	76.06	0		0		22. 00
23. 00	HEALTHY HEARTS CENTER	90. 02	0				23. 00
24. 00	INFUSION CENTERS	90. 05	0			•	24. 00
25. 00	KNEE CENTER	90.07	0			•	25. 00
26. 00	EMERGENCY	91.00	0		0	1	26. 00
	TOTALS		0	209, 689, 560	Ί	I	I

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provider CCN: 15-0074

						o 12/31/2023 Date/lime Pr 5/24/2024 1	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00 D - Depreciation Expense	7. 00	8. 00	9. 00	10. 00		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	737	9		1.00
2. 00	ADMI NI STRATI VE & GENERAL	5. 00	Ö	14, 180, 606			2. 00
3.00	OPERATION OF PLANT	7. 00	o	287, 310	O		3. 00
4.00	HOUSEKEEPI NG	9. 00	0	7, 452	0		4. 00
5.00	DIETARY	10.00	0	215, 940			5. 00
6. 00 7. 00	CAFETERIA NURSING ADMINISTRATION	11. 00 13. 00	0	12, 184 43, 371	0		6. 00 7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	202, 698			8. 00
9. 00	PHARMACY	15. 00	o	93, 553			9. 00
10.00	I&R SERVICES-OTHER PRGM	22. 00	o	57, 781	0		10. 00
11. 00	COSTS APPRVD ADULTS & PEDIATRICS	30.00	0	1, 562, 742	0		11. 00
12. 00	INTENSIVE CARE UNIT	31.00	o	1, 204, 963			12. 00
13.00	NEONATAL INTENSIVE CARE UNIT	35. 00	o	33, 054	O		13. 00
14.00	OPERATING ROOM	50. 00	0	2, 263, 249			14. 00
15. 00	RECOVERY ROOM	51.00	0	117, 305			15. 00
16. 00 17. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00	0	783, 791 37, 305	0		16. 00 17. 00
18. 00	CT SCAN	57. 00	0	481, 154	0		18. 00
19. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	O	671, 672	_		19. 00
20. 00	CARDIAC CATHETERIZATION	59. 00	0	1, 427, 903	О		20. 00
21. 00	LABORATORY	60.00	O	8, 882	0		21. 00
22.00	I NTRAVENOUS THERAPY	64. 00	0	9, 209	o		22. 00
23. 00	RESPIRATORY THERAPY	65.00	0	78, 150	1		23. 00
24. 00	PHYSI CAL THERAPY	66.00	0	46, 219	1		24. 00
25. 00 26. 00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68. 00 69. 00	0	2, 998	0		25. 00 26. 00
27. 00	ELECTROCARDI OLOGY	70.00	0	621, 637 98, 827	0		27. 00
28. 00	RENAL DI ALYSI S	74. 00	o	229			28. 00
29.00	ENDOSCOPY	76. 00	o	70, 835			29. 00
30. 00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76. 01	0	213, 112	0		30. 00
31.00	LUTHERWOOD PARTNERSHIP	76. 03	0	152, 689	0		31. 00
32.00	WOUND CARE CENTER	76. 04	0	9, 105			32. 00
33. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	3, 022, 246			33. 00
34. 00 35. 00	I MAGING CENTERS BREAST DIAGNOSTIC CENTER	76. 06 76. 07	0	931, 780 587	0		34. 00 35. 00
36. 00	CARDIAC REHABILITATION	76. 07 76. 97	0	43, 497	0		36. 00
37. 00	HEALTHY HEARTS CENTER	90. 02	ő	22, 762	o		37. 00
38. 00	INFUSION CENTERS	90. 05	O	64, 959	O		38. 00
39. 00	KNEE CENTER	90. 07	0	177, 796			39. 00
40.00	MULTIDISCIPLINARY CLINIC	90. 01	0	15, 663	1		40. 00
41. 00	EMERGENCY	91.00	0	396, 635			41.00
42. 00 43. 00	FAMILY PRACTICE MEDICINE GROUP HOMES AND MISC. N_R	194. 05 194. 01	0	168, 453 44, 223	0		42. 00 43. 00
43.00	CTRS	174.01	ŏ	44, 225	Ĭ		45.00
	TOTALS			29, 885, 263			
1. 00	E - Interest Expense ADMINISTRATIVE & GENERAL	5. 00	O	12, 995, 376	11		1.00
1.00	TOTALS		<u> </u>	12, 995, 376			
	F - Other Capital Rental						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	24, 672			1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	0	628, 517 191, 144	0		2. 00 3. 00
4. 00	HOUSEKEEPI NG	9. 00	0	28, 807	0		4. 00
5.00	DI ETARY	10. 00	0	8, 556			5. 00
6.00	CAFETERI A	11. 00	o	12, 733			6. 00
7.00	NURSING ADMINISTRATION	13. 00	0	36			7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 560, 522			8. 00
9. 00 10. 00	PHARMACY I&R SERVICES-SALARY &	15. 00 21. 00	0	873, 085 2, 360			9. 00 10. 00
10.00	FRINGES APPRVD	21.00	ď	2, 300	٥		10.00
11. 00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22. 00	О	5, 010	0		11. 00
12. 00	ADULTS & PEDIATRICS	30.00	o	601, 619	0		12. 00
13. 00	INTENSIVE CARE UNIT	31.00	o	116	1		13. 00
14. 00	OPERATING ROOM	50. 00	O	1, 066, 668	0		14. 00
15. 00	RECOVERY ROOM	51. 00	0	243			15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	797			16. 00
17. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	0	68	0		17. 00
18. 00	CARDIAC CATHETERIZATION	59. 00	0	3, 089	0		18. 00
	1		۳ <u>ا</u>	5, 507	١		

Health Financial Systems RECLASSIFICATIONS

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

Date/Time Prepared: 5/24/2024 11: 39 am

		Decreases				5/24/2024 11:	. 39 alli
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10.00		
19. 00	LABORATORY	60, 00	0.00	53, 213			19. 00
20. 00	RESPI RATORY THERAPY	65. 00	0		1		20.00
21. 00	PHYSI CAL THERAPY	66.00	0	1, 121, 591			21. 00
22. 00	ELECTROCARDI OLOGY	69. 00	0	182, 706	-		22. 00
23. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	31, 683	1		23. 00
24. 00	ENDOSCOPY	76. 00	0	77, 670			24. 00
25. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	1, 525, 178			25. 00
20.00	SERVI CES	70.0.	J	1,020,170			20.00
26.00	LUTHERWOOD PARTNERSHIP	76. 03	0	25, 077	0		26. 00
27. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	516, 039	1		27. 00
28. 00	I MAGING CENTERS	76. 06	0	474, 718	1		28. 00
29. 00	BREAST DIAGNOSTIC CENTER	76. 07	0	95, 000			29. 00
30. 00	CARDI AC REHABI LI TATI ON	76. 97	0	141, 653	-		30.00
31. 00	HEALTHY HEARTS CENTER	90. 02	0	167, 670	1		31. 00
32. 00	INFUSION CENTERS	90. 05	0	166, 701	-		32. 00
33. 00	KNEE CENTER	90. 07	0	2, 034	1		33. 00
34. 00	EMERGENCY	91. 00	0	436			34. 00
35. 00	FAMILY PRACTICE MEDICINE	194. 05	0	1, 363, 201			35. 00
36. 00	GROUP HOMES AND MISC. N_R	194. 01	0	161, 333			36. 00
00.00	CTRS	.,	ŭ	1017 000			00.00
	TOTALS		— — — _ō	12, 114, 306			
	G - STD BENEFIT RECLASS		-	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1
1.00	ADMINISTRATIVE & GENERAL	5. 00	37, 145	C	0		1.00
2. 00	OPERATION OF PLANT	7. 00	5, 986	-	-		2. 00
3.00	HOUSEKEEPI NG	9. 00	25, 377	C			3. 00
4. 00	DI ETARY	10. 00	14, 788	Ö	-		4. 00
5. 00	CAFETERI A	11. 00	859	Ö	-		5. 00
6. 00	NURSING ADMINISTRATION	13. 00	8, 810	Ö	o		6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	5, 432	Ö	o		7. 00
8.00	PHARMACY	15. 00	52, 319	Ö	o		8. 00
9. 00	MEDICAL RECORDS & LIBRARY	16. 00	2, 679	C	o o		9. 00
10. 00	SOCI AL SERVI CE	17. 00	1, 596	C	-		10.00
11. 00	I&R SERVICES-SALARY &	21. 00	47, 554	C	-		11. 00
	FRI NGES APPRVD	200	.,, 55.				1 00
12.00	I&R SERVICES-OTHER PRGM	22. 00	105, 507	C	o		12. 00
	COSTS APPRVD						
13.00	ADULTS & PEDIATRICS	30.00	289, 435	C	o		13.00
14.00	INTENSIVE CARE UNIT	31.00	70, 408	C	o		14.00
15. 00	NEONATAL INTENSIVE CARE UNIT	35.00	16, 779	C	o		15. 00
16. 00	OPERATING ROOM	50.00	34, 874	C	o		16. 00
17. 00	RECOVERY ROOM	51.00	11, 910	C	0		17. 00
18. 00	RADI OLOGY-DI AGNOSTI C	54.00	21, 888	C	o		18. 00
19. 00	CT SCAN	57.00	17, 627	C	0		19. 00
20. 00	CARDIAC CATHETERIZATION	59.00	41, 974	C	0		20.00
21. 00	INTRAVENOUS THERAPY	64. 00	3, 407	Ö	o		21. 00
22. 00	RESPIRATORY THERAPY	65.00	7, 728	C	0		22. 00
23. 00	PHYSI CAL THERAPY	66.00	35, 877	C	0		23. 00
24.00	SPEECH PATHOLOGY	68. 00	3, 868	C	o		24. 00
	ELECTROCARDI OLOGY	69.00	14, 335	C	1		25. 00
26.00	ENDOSCOPY	76. 00	4, 955	C	o		26. 00
27. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	166, 935	C	o		27. 00
	SERVI CES						
28. 00	LUTHERWOOD PARTNERSHIP	76. 03	7, 693	C	o		28. 00
29. 00	WOUND CARE CENTER	76. 04	12, 298	C	1		29. 00
30. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	143, 755	C	-		30.00
31. 00	I MAGING CENTERS	76. 06	15, 931	d	0		31. 00
32. 00	CARDIAC REHABILITATION	76. 97	5, 923	C	0		32. 00
33. 00	HEALTHY HEARTS CENTER	90. 02	11, 515	C	0		33. 00
34. 00	INFUSION CENTERS	90. 05	9, 441	C	0		34. 00
35. 00	KNEE CENTER	90. 07	4, 139	C	0		35. 00
36. 00	EMERGENCY	91. 00	33, 102	a	o o		36. 00
37. 00	ACCOUNTABLE CARE	194. 02	331	Ö	o		37. 00
38. 00	SMO-NON PROVIDER BASED	194. 04	3, 927	a	Ö		38. 00
39. 00	FAMILY PRACTICE MEDICINE	194. 05	8, 335	a	Ö		39. 00
40. 00	GROUP HOMES AND MISC. N_R	194. 01	53, 088	O			40.00
. 5. 50	CTRS		20, 000				
	TOTALS		1, 359, 530	<u> </u>	 		1
	H - Labor and Delivery		.,,		'		1
1.00	ADULTS & PEDIATRICS	30.00	2, 665, 518	C	0		1. 00
2. 00		0.00	0	C	-		2. 00
3. 00	ADULTS & PEDIATRICS	30.00	0	1, 760, 245	1		3. 00
4.00		0.00	0	C	0		4. 00
	TOTALS — — — —		2, 665, 518	1, 760, 245			
					, '		

Peri od: Worksheet A-6
From 01/01/2023
To 12/31/2023 Date/Time Prepared: Provider CCN: 15-0074

						То	12/31/2023	Date/Time	Prepared: 11:39 am
		Decreases						07 2 17 202 1	11.07 dill
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	· _			
	6. 00	7. 00	8. 00	9. 00	10. 00				
	I - Cafeteria								
1.00	DI ETARY	10. 00	2, 454, 494						1. 00
2.00	DI ETARY	10. 00		<u>3, 622, 1</u> 13					2. 00
			2, 454, 494	3, 622, 113	3				
	J - Therapy Reclass								
1. 00	PHYSI CAL THERAPY	66. 00	2, 413, 381	C		0			1. 00
2.00		0.00	0	C		0			2. 00
3.00	PHYSI CAL THERAPY	66. 00	0	1, 126, 715		0			3. 00
4.00		0.00	0	0		<u>o</u>			4. 00
	TOTALS		2, 413, 381	1, 126, 715	5				
	K - Builiding Depreciation				_				
1. 00	CAP REL COSTS-MVBLE EQUIP		0	<u>15, 208, 1</u> 97		9			1. 00
	TOTALS		O	15, 208, 197	′				
	L - Capital Insurance Costs			7.0 05.					
1.00	ADMI NI STRATI VE & GENERAL			<u>743, 3</u> 54		2			1. 00
	TOTALS		O	743, 354					
4 00	M - Radi ol ogy Support	F4 00	(00.050		<u> </u>				1 00
1.00	RADI OLOGY-DI AGNOSTI C	54.00	609, 252	0		0			1.00
2.00		0.00	0	0		0			2. 00
3.00		0.00	0	0		0			3. 00
4.00	DADI OLOOV, DI AONOCTI O	0.00	0	0.40, 00.4)	0			4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	243, 936		0			5. 00
6.00		0.00	0	C	1	0			6. 00
7.00		0.00	0	O		0			7. 00
8.00	TOTALS		609, 252	243, 936	 — — —	덱			8. 00
			609, 252	243, 936	0				
1.00	N - Hyperbaric Oxygen Therapy WOUND CARE CENTER	76. 04	192, 147						1.00
2.00	WOUND CARE CENTER	76. 04 76. 04	192, 147	375, 364		-			2.00
2.00	WOUND CARE CENTER		192, 147	37 <u>5, 3</u> 64 375, 364		+			2.00
	0 - IHH Cat Scan		172, 147	373, 304	i				
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	1, 023, 848						1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	1, 023, 646	360, 728					2. 00
2.00	RADI OLOGI - DI AGNOSTI C		1, 023, 848	36 <u>0, 7</u> 28		+			2.00
	P - Specialty Pharmacy		1, 023, 040	300, 720	<u>'</u>				
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	42, 897						1.00
2. 00	PHARMACY	15. 00	2, 124, 691	C					2. 00
3.00	ADMINISTRATIVE & GENERAL	5. 00	2, 124, 071	246, 551					3. 00
4. 00	PHARMACY	15. 00		87, 624, 875					4. 00
1. 00		— — 10. 00	2, 167, 588	87, 871, 426		+			1.00
	Q - FELLOWS		27 1077 000	0770717120	1				
1. 00	I &R SERVI CES-SALARY &	21.00	266, 362	39, 523	3	0			1.00
	FRI NGES APPRVD	200	200, 002	37,020		-			100
	TOTALS	+	266, 362	39, 523		1			
	R - SPECIALTY PHARMACY HO COS	TS RECLASS		21,020					
1.00	ADMINISTRATIVE & GENERAL	5.00	955, 914						1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00		327, 473	В				2. 00
		+	955, 914	327, 473		1			
	Grand Total: Decreases		14, 108, 034	459, 690, 055		-			500.00

238, 651, 068

817, 056, 415

817, 056, 415

0

0

0

0

6.00 7. 00

8.00

9.00

10.00

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

6.00

7.00

8.00

9.00

Heal th	Financial Systems C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-0074		CN: 15-0074	Peri od: From 01/01/2023	Worksheet A-7	
						Date/Time Pre	pared:
		_	-			5/24/2024 11:	39 am
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY OF	CAPITAL		<u>.</u>		
	Cost Center Description	0ther	Total (1) (sum				
	'	Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	3 ,				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	0				3. 00
				'			•

Heal th	n Financial Systems Co	OMMUNITY HEALTH	I NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-0074		Peri od: Worksheet A-7 From 01/01/2023 Part III To 12/31/2023 Date/Time Pre 5/24/2024 11:		pared:
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	DART III DECONCILIATION OF CARLTAL COCTO	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT	578, 405, 347	1	578, 405, 34	7 0. 707914	0	1.00
2.00	CAP REL COSTS-BEDG & TTXT	238, 651, 067	l .	238, 651, 06			2.00
3.00	Total (sum of lines 1-2)	817, 056, 414	l .	817, 056, 41			3. 00
3, 32	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					3. 33
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7.00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			_		
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 15, 208, 197		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 21, 667, 423		1
3.00	Total (sum of lines 1-2)	0	0	I JMMARY OF CAPI	36, 875, 620	12, 114, 306	3. 00
			50	JIMIMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see	Total (2) (sum of cols. 9 through 14)	
					instructions)		
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						_
1.00	CAP REL COSTS-BLDG & FLXT	5, 255, 133		1	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	ļ		0	, ,	
3. 00	Total (sum of lines 1-2)	5, 255, 133	743, 354	I	0	54, 988, 413	3. 00

Provider CCN: 15-0074

				t	o 12/31/2023		
				Expense Classification on		5/24/2024 11:3	39 am
				To/From Which the Amount is	to be Adjusted		
		D : (0 1 (0)		0 1 0 1	1	W . A 7 D C	
	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 COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	o	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
	discounts (chapter 8)		0				
5. 00	Refunds and rebates of expenses (chapter 8)	В	-42, 217	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	o	6. 00
7.00	Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	l	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-10, 347, 487			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	7, 671, 202			O	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	O	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-2, 687, 481	CAFETERI A	11. 00 0. 00	l	14. 00 15. 00
	and others		0				
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17. 00	Sale of drugs to other than		0		0.00	О	17. 00
18. 00	patients Sale of medical records and		0		0.00	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	l .	
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		9		0.00	Ĭ	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 therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
27.00	(chapter 21)		0	CAD DEL COSTS DIDO 0 FIVE	1 00		27.00
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT			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 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	l .	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	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 Depreciation and Interest		0		0.00	0	32. 00
	1-1- 30. 41. 6 44 116. 651	1		ı	ı		

In Lieu of Form CMS-2552-10 COMMUNITY HEALTH NETWORK, INC. ADJUSTMENTS TO EXPENSES Provider CCN: 15-0074 Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 11:39 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4. 00 5.00 33.00 OTHER ADJUSTMENTS (SPECIFY) 33. 00 0.00 (3)33.01 Space Rental Income В -122, 125 ADMI NI STRATI VE & GENERAL 5.00 33.01 33.02 Space Rental Income В -498, 663 OPERATION OF PLANT 7.00 33.02 -8, 144 PSYCHI ATRI C/PSYCHOLOGI CAL 33.03 Space Rental Income В 76.01 33.03 SFRVI CFS -160 EMPLOYEE BENEFITS DEPARTMENT 33.04 Misc Revenue 33.04 R 4.00 33.05 Misc Revenue В -577, 436 ADMI NI STRATI VE & GENERAL 5.00 33.05 33.06 Misc Revenue В -552, 057 OPERATION OF PLANT 7.00 33.06 33.07 Mi sc. Revenue В -34, 465 CAFETERI A 11.00 33.07 33.08 Misc Revenue В -198, 254 PHARMACY 15.00 33.08 33.09 Misc Revenue В -123, 026 RADI OLOGY-DI AGNOSTI C 54.00 33.09 33. 10 Misc Revenue -4, 354 RADI OLOGY-THERAPEUTI C 33.10 В 55.00 -75 PHYSI CAL THERAPY 33.11 Misc Revenue R 66.00 33.11 33. 12 Misc Revenue В -10, 733 CARDIAC REHABILITATION 76.97 33.12 -15, 134 KNEE CENTER 33.13 Misc Revenue В 90.07 33.13 -44, 299, 733 ADMI NI STRATI VE & GENERAL HAF Tax Offset 34.00 Α 5.00 34.00 -7, 655, 311 ADULTS & PEDIATRICS 34.01 Hospitalist Loss Α 30.00 0 34.01 34.02 Loss on Assets Α -3, 783 PSYCHI ATRI C/PSYCHOLOGI CAL 76.01 34.02 SERVI CES 34.03 Sponsorshi p Α -27 PSYCHI ATRI C/PSYCHOLOGI CAL 76.01 34.03 SFRVI CFS -804, 082 ADULTS & PEDIATRICS 34.04 APP 34.04 Δ 30.00 34.05 APP -669, 410 OPERATING ROOM 50.00 34.05 Α -2, 692, 512 PSYCHI ATRI C/PSYCHOLOGI CAL 34.06 APP Α 76.01 34.06 SERVI CES APP -124, 796 LUTHERWOOD PARTNERSHIP 34 07 34 07 76 03 0 Α 34.08 APP Α -481, 770 ONCOLOGY-CANCER CARE CENTER 76.05 0 34.08 34.09 APP Α -37, 935 CARDIAC REHABILITATION 76.97 34.09 34.10 APP -1, 421, 009 HEALTHY HEARTS CENTER 90.02 34.10 Α -142, 919 KNEE CENTER -29, 845, 634 ADMI NI STRATI VE & GENERAL APP 90.07 O 34.11 Α 34.11 35.00 Bad Debt Α 5.00 0 35.00 -1, 867 PHARMACY 35.01 Bad Debt Α 15.00 35.01 -194, 013 | L&R SERVICES-SALARY & Bad Debt 35.02 21.00 35.02 Α FRINGES APPRVD Bad Debt 35.03 Α -198, 719 &R SERVICES-OTHER PRGM 22.00 35.03 COSTS APPRVD Bad Debt -305, 701 ADULTS & PEDIATRICS 30.00 35.04 35.04 Α 35.05 Bad Debt -855 OPERATING ROOM 50.00 35.05 Α 0 **Bad Debt** -45, 194 I NTRAVENOUS THERAPY 35.06 Α 64.00 35 06 35.07 Bad Debt -1, 302, 447 PSYCHI ATRI C/PSYCHOLOGI CAL 76.01 35.07 Α SERVI CES 35.08 Bad Debt Α -4, 373 LUTHERWOOD PARTNERSHIP 76.03 35.08 Bad Debt -18, 996 KNEE CENTER 35.09 90.07 0 35.09 Α -186, 586 CAFETERI A Meals on Wheels Cost 36.00 Α 11.00 36.00 Non Allow Marketing Expense -618, 245 ADMI NI STRATI VE & GENERAL 36.01 5.00 36.01 36.02 Pavi I I i ons Α -849, 705 ADMINI STRATI VE & GENERAL 5.00 36.02 OB Laborist Loss -1, 287, 921 DELIVERY ROOM & LABOR ROOM 36, 03 Α 52.00 0 36, 03 36.05 Debt Issuance Expense Α -81, 805 ADMI NI STRATI VE & GENERAL 5.00 36.05 36.06 PNC Non-Allow Interest Expense Α -34,559 CAP REL COSTS-BLDG & FIXT 1.00 11 36.06 2012A Non-Allow Interest -19,776 CAP REL COSTS-BLDG & FIXT 36.07 11 36.07 1.00 Α Expense 2012B Non-Allow Interest -334, 915 CAP REL COSTS-BLDG & FLXT 11 36.08 36.08 Α 1.00 Expense 2018A Non-Allow Interest -3, 926, 228 CAP REL COSTS-BLDG & FIXT 11 36.09 Α 1.00 36.09 Expense -2, 765, 178 CAP REL COSTS-BLDG & FIXT 36.10 2020A Non-Allow Interest 1.00 36.10 Α 11 Expense 2022A Non- Allow Interest -659, 587 CAP REL COSTS-BLDG & FIXT 36. 11 Α 1.00 11 36, 11 Expense EPIC Amortization 405, 432 CAP REL COSTS-MVBLE EQUIP 2.00 36. 12 -156, 411 CARDI AC CATHETERI ZATI ON SHARED SERVICES 59.00 0 36. 13 36.13 Α -237, 571 ELECTROCARDI OLOGY SHARED SERVICES 69.00 36.14 Α 0 36.14 36. 15 OTHER ADJUSTMENTS (SPECIFY) 0.00 36.15 Α OTHER ADJUSTMENTS (SPECIFY) 36. 16 0.00 36. 16

-108, 554, 750

50.00

(3)

50.00

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

Health Financial Systems	CC	MMUNITY HEALTH	NETWORK, INC.	In Lie	eu of Form CMS-	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/24/2024 11:	
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1 00	2 00	3 00	4 00	5.00	

- (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 OFFICE COSTS

Peri od: From 01/01/2023

				To 12/31/2023	Date/Time Prep 5/24/2024 11:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00		I&R SERVICES-SALARY & FRINGE		4, 627, 702		1. 00
2.00		I&R SERVICES-OTHER PRGM COST		10, 939, 686		2. 00
3.00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	6, 584, 925		3. 00
3. 01		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	11, 667, 034		3. 01
3.02		ADMINISTRATIVE & GENERAL	HOME OFFICE	115, 153, 255		3. 02
3.03		OPERATION OF PLANT	HOME OFFICE	8, 218, 836		3. 03
3.04		NURSING ADMINISTRATION	HOME OFFICE	5, 066, 192		3. 04
3.05		CENTRAL SERVICES & SUPPLY	HOME OFFICE	4, 529, 988		3. 05
3.06	16. 00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	5, 456, 879	0	3. 06
3.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	266, 953	0	3. 07
3.08	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	305, 812	0	3. 08
3.09	66. 00	PHYSI CAL THERAPY	HOME OFFICE	716, 905	0	3. 09
3. 10	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	130, 750	0	3. 10
3. 11	73. 00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	2, 726, 282	0	3. 11
3. 12	76. 05	ONCOLOGY-CANCER CARE CENTER	HOME OFFICE	20, 958, 660	0	3. 12
4.00	91. 00	EMERGENCY	HOME OFFICE	551, 173	0	4.00
4.01	5. 00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	96, 517	0	4. 01
4.02	91.00	EMERGENCY	CPN CALL	1, 277, 106	0	4. 02
5.00	TOTALS (sum of lines 1-4).			199, 274, 655	191, 603, 453	5.00
	Transfer column 6, line 5 to				1	
	Worksheet A-8, column 2,				ı	
	line 12.					
* The	amounts on lines 1-4 (and sub	ecripte as appropriato) are t	ransformed in detail to Work	shoot A column	6 lines as	

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

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

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

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

6.00	С	0. 00 CHNW	100.00	6. 00
7.00		0.00	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

							10 12/31/2023	Date/IIme Pre 5/24/2024 11:	
	Net	Wkst. A-7 Ref.						072172021 11.	0, 4,,,,
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTM	ENTS REQUIRED AS A	RESULT OF TR	ANSACTIONS WITH	RELATED 0	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO								
1.00	-1, 225, 870								1. 00
2.00	-2, 897, 902								2. 00
3.00	6, 584, 925								3. 00
3. 01	11, 667, 034	0							3. 01
3.02	-56, 759, 038	0							3. 02
3.03	8, 218, 836	0							3. 03
3.04	5, 066, 192	0							3. 04
3.05	4, 529, 988	0							3. 05
3.06	5, 456, 879	0							3. 06
3.07	266, 953	0							3. 07
3.08	305, 812	0							3. 08
3.09	716, 905	0							3. 09
3. 10	130, 750								3. 10
3. 11	2, 726, 282	0							3. 11
3. 12	20, 958, 660	0							3. 12
4.00	551, 173	0							4. 00
4.01	96, 517	0							4. 01
4.02	1, 277, 106	0							4. 02
5.00	7, 671, 202								5. 00
* The	amaunta an lin	aa 1 4 (and aub	serinte de appropr			.: 4- 1/11		/ 1:	

* 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		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HEALTHCARE	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10.00
8. 00 9. 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.

| Period: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0074

					٦	Го 12/31/2023	Date/Time Pre 5/24/2024 11:	epared: 39 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
1.00	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	1 00
1.00		EMPLOYEE BENEFITS DEPARTMENT	9, 475			0	0	1. 00
2.00		ADMINISTRATIVE & GENERAL	1, 102, 255			0	Ĭ	2. 00 3. 00
3. 00 4. 00		NURSING ADMINISTRATION ADULTS & PEDIATRICS	52, 248 5, 488, 231		47, 273	211, 500 0		4. 00
5. 00		NEONATAL INTENSIVE CARE UNIT	115, 000	1	0	0		5. 00
6. 00		PSYCHI ATRI C/PSYCHOLOGI CAL	2, 974, 545			0	·	6. 00
0.00	70.01	SERVI CES	2, 774, 343	2, 774, 545	0	0		0.00
7.00	91.00	EMERGENCY	640, 000	640, 000	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			10, 381, 754	10, 334, 481	47, 273		337	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		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		EMPLOYEE BENEFITS DEPARTMENT	0.00					1. 00
2. 00		ADMINISTRATIVE & GENERAL		0	_	0		2. 00
3.00		NURSING ADMINISTRATION	34, 267	· ·	_	0	_	3. 00
4. 00		ADULTS & PEDIATRICS	0.7207	0	0	0	o o	4. 00
5. 00	•	NEONATAL INTENSIVE CARE UNIT	l o	Ō	0	0	o	5. 00
6.00	•	PSYCHI ATRI C/PSYCHOLOGI CAL	o c	Ó	0	0	0	6. 00
		SERVI CES						
7.00	l l	EMERGENCY	0	0	0	0	0	7. 00
8.00	0.00	1	0	0	0	0	0	8. 00
9. 00	0.00	↓	0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10100
200.00	Wkot Alino#	Coot Conton (Dhyoi oi on	34, 267		RCE	Adiustment	Ü	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	Di sal I owance	Adjustment		
		i denti i i ei	Share of col.	LIIIII	DI Sai i Owalice			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	9, 475		1. 00
2.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	1, 102, 255		2.00
3.00		NURSING ADMINISTRATION	0	34, 267	13, 006	17, 981		3. 00
4.00	•	ADULTS & PEDIATRICS	0	0	0	5, 488, 231		4. 00
5.00	•	NEONATAL INTENSIVE CARE UNIT	0	0	_	115, 000		5. 00
6.00	76. 01	PSYCHI ATRI C/PSYCHOLOGI CAL	0	0	0	2, 974, 545		6. 00
7 00	01.00	SERVI CES			0	(40,000		7.00
7. 00 8. 00	91.00	EMERGENCY				640, 000 0		7. 00 8. 00
8. 00 9. 00	0.00	MI CONTRACTOR OF THE CONTRACTO						8. 00 9. 00
10. 00	0.00	1						10. 00
200.00	0.00			34, 267	13, 006	10, 347, 487		200. 00
200.00	I	I .	١	1 31, 207	15,000	10,017,407		230.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0074 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:39 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 21, 206, 684 00100 CAP REL COSTS-BLDG & FLXT 21, 206, 684 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 33, 781, 729 33, 781, 729 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 094, 802 159, 449 16, 789, 773 29, 044, 024 4.00 00500 ADMINISTRATIVE & GENERAL 4, 810, 180 5 00 975, 255 1, 260, 203 144, 156, 069 5 00 137, 110, 431 7.00 00700 OPERATION OF PLANT 22, 423, 895 2, 833, 899 117, 844 263, 279 25, 638, 917 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1, 407, 045 1, 407, 045 8.00 00900 HOUSEKEEPI NG 7, 336, 751 268, 401 16, 563 470,017 8, 091, 732 9.00 9.00 01000 DI ETARY 10.00 2, 750, 694 220, 599 105, 510 10 00 2, 413, 105 11, 480 11.00 01100 CAFETERI A 3, 697, 068 610, 539 92, 557 292, 455 4, 692, 619 11.00 01300 NURSING ADMINISTRATION 421, 979 10, 659, 718 13.00 10, 002, 638 213, 455 21,646 13.00 01400 CENTRAL SERVICES & SUPPLY 4, 919, 287 428, 765 1, 377, 970 77, 529 6, 803, 551 14.00 14.00 233, 694 1, 119, 886 15, 492, 607 15.00 01500 PHARMACY 13, 669, 555 469, 472 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 6, 440, 174 29, 596 11, 390 6, 481, 160 16.00 C 01700 SOCIAL SERVICE 17.00 2, 638, 192 69, 465 218, 926 2, 926, 583 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 4, 321, 817 1, 177 462, 577 4, 785, 571 21.00 21.00 22.00 02200 & SERVICES-OTHER PRGM COSTS APPRVD 11, 245, 571 112, 893 31, 313 1, 277, 986 12, 667, 763 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 69, 172, 485 4, 693, 916 783, 724 6, 522, 088 81, 172, 213 30.00 03100 INTENSIVE CARE UNIT 31.00 19, 140, 907 1, 223, 111 523, 999 1, 559, 373 22, 447, 390 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 3, 136, 316 68, 194 16, 483 244, 318 3, 465, 311 35.00 04300 NURSERY 829, 905 54, 939 43.00 51, 158 24, 211 960, 213 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 22, 073, 764 2, 263, 483 1, 464, 880 1, 125, 612 26, 927, 739 50.00 51.00 05100 RECOVERY ROOM 1, 216, 612 208, 929 58, 619 100, 394 1, 584, 554 51.00 05200 DELIVERY ROOM & LABOR ROOM 4, 704, 756 52.00 4, 087, 975 221, 642 104, 900 290, 239 52.00 6, 567, 363 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 146, 045 705, 659 370, 892 344, 767 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 2,013,959 3, 890 18, 603 92, 538 2, 128, 990 55.00 05700 CT SCAN 4, 855, 109 239, 943 290, 505 5, 417, 696 57.00 32, 139 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 1, 486, 269 305 334, 985 89, 542 1, 911, 101 58.00 349, 308 05900 CARDIAC CATHETERIZATION 630, 927 8, 748, 394 59 00 7, 272, 680 495, 479 59 00 60.00 06000 LABORATORY 16, 881, 168 115, 258 26, 842 17, 023, 268 60.00 06400 INTRAVENOUS THERAPY 2, 928, 811 64.00 2, 713, 766 56, 192 4,584 154, 269 64.00 06500 RESPIRATORY THERAPY 7, 110, 903 23, 214 39, 045 582, 172 7, 755, 334 65.00 65.00 06600 PHYSI CAL THERAPY 7, 038, 193 574, 943 8, 304, 320 66.00 136, 896 554, 288 66.00 67.00 06700 OCCUPATI ONAL THERAPY 2, 485, 848 45, 666 5, 213 186, 270 2, 722, 997 67.00 68.00 06800 SPEECH PATHOLOGY 1, 283, 970 19, 375 3, 706 91, 169 1, 398, 220 68.00 392, 251 06900 ELECTROCARDI OLOGY 4, 353, 233 54, 209 389, 442 5, 189, 135 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 260, 843 2, 187 64, 762 87, 322 1, 415, 114 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 41, 471, 515 41, 471, 515 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 41, 854, 961 0 0 0 41, 854, 961 72.00 07300 DRUGS CHARGED TO PATIENTS 212, 415, 842 73 00 212, 415, 842 O 0 73 00 Ω 73.01 07301 SPECIALTY PHARMACY 91, 322, 401 0 343, 320 91, 665, 721 73.01 07302 CONTRACTED PHARMACY 21, 967, 212 0 21, 967, 212 73.02 73.02 74.00 07400 RENAL DIALYSIS 2, 385, 549 10.374 12, 241 2, 408, 164 74.00 0 03330 ENDOSCOPY 1, 071, 741 76.00 937, 159 74.056 60, 526 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 34, 020, 954 121, 233 866, 650 3, 256, 984 38, 265, 821 76.01 03951 LUTHERWOOD PARTNERSHIP 8, 790, 726 440, 788 76.03 81, 176 9, 312, 690 76.03 03952 WOUND CARE CENTER 3, 674 76.04 2, 555, 208 106, 104 107.607 2, 772, 593 76.04 03480 ONCOLOGY-CANCER CARE CENTER 1, 227, 138 76.05 46, 805, 802 1, 990, 429 1, 780, 061 51, 803, 430 76.05 03953 I MAGING CENTERS 6, 962, 686 77, 754 696, 015 446, 399 8, 182, 854 76.06 76.06 03954 BREAST DIAGNOSTIC CENTER 76.07 2, 655, 105 137, 430 47, 375 2, 839, 910 76.07 07697 CARDIAC REHABILITATION 76. 97 1, 227, 924 150, 575 105, 304 1, 568, 036 76.97 84. 233 76. 98 07698 HYPERBARI C OXYGEN THERAPY 567, 511 25, 020 866 21, 120 614, 517 76.98 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 C 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 0 04950 MULTIDISCIPLINARY CLINIC 90.01 3,528 7,811 256 11, 595 90.01 90.02 04951 HEALTHY HEARTS CENTER 1, 358, 320 84. 441 232, 015 90.02 87, 437 1, 762, 213 90.03 09001 PALLIATIVE CARE 5, 696 C 0 5,696 90.03 0 04953 SPINE CENTER 90.04 90.04 90.05 04954 INFUSION CENTERS 690, 971 Ω 105, 453 51, 150 847, 574 90.05 09002 MEDCHECK CLINICS 90.06 0 90.06 90.07 09003 KNEE CENTER 4, 230, 522 372, 726 7, 287 229.344 4, 839, 879 90.07 91.00 09100 EMERGENCY 21, 290, 835 1, 694, 161 189, 136 1, 420, 894 24, 595, 026 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,021,783,425 21, 206, 684 32, 901, 794 27, 744, 472 1, 019, 603, 938 118. 00

Health Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od: From 01/01/2023	Worksheet B Part I	
				To 12/31/2023	Date/Time Pre 5/24/2024 11:	
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	BENEFI TS	Subtotal	
	Allocation (from Wkst A col. 7)			DEPARTMENT		
	0	1.00	2.00	4. 00	4A	
NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192. 00
194.00 07950 HOME OFFICE	0	0		0 0		194. 00
194.01 07951 GROUP HOMES AND MISC. N_R CTRS	10, 665, 277	0	107, 66	1 836, 859	11, 609, 797	194. 01
194. 02 07952 ACCOUNTABLE CARE	178, 426			0 15, 404		1
194. 03 07953 SCH00L BASED CLINICS	121, 989	0		0 6, 986		1
194. 04 07954 SMO-NON PROVIDER BASED	817, 673	0		0 69, 842	887, 515	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	5, 566, 117	0	772, 27	4 370, 461		
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 039, 132, 907	21, 206, 684	33, 781, 72	9 29, 044, 024	1, 039, 132, 907	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0074

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

5/24/2024 11:39 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 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 5 00 144, 156, 069 5 00 7.00 00700 OPERATION OF PLANT 4, 233, 626 29, 872, 543 7.00 00800 LAUNDRY & LINEN SERVICE 1, 639, 383 8.00 232, 338 8.00 9.00 00900 HOUSEKEEPI NG 1, 336, 147 465, 123 819, 689 10, 712, 691 9.00 3, 726, 448 01000 DI ETARY 139, 261 10.00 454, 208 382, 285 10.00 01100 CAFETERI A 774, 869 1,058,026 385, 423 1, 863, 215 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 1, 760, 186 369, 904 0 134, 751 0 13.00 01400 CENTRAL SERVICES & SUPPLY 743, 024 0 270, 673 14 00 1, 123, 436 0 14.00 15.00 01500 PHARMACY 2, 558, 217 404, 977 0 147, 527 0 15.00 1, 070, 202 16.00 01600 MEDICAL RECORDS & LIBRARY 51, 289 0 18,684 0 16.00 01700 SOCIAL SERVICE 17.00 483. 252 0 43, 852 17.00 120, 378 0 0 02100 & SERVICES-SALARY & FRINGES APPRVD 790, 217 21.00 0 21.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 2, 091, 764 195, 637 71, 268 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 403, 562 405, 523 2, 963, 196 8, 134, 269 1, 567, 829 30.00 03100 INTENSIVE CARE UNIT 31.00 3, 706, 625 2, 119, 578 70, 762 772, 131 295, 404 31.00 02060 NEONATAL INTENSIVE CARE UNIT 572, 209 118, 175 43,050 35.00 0 35.00 43.00 04300 NURSERY 158, 555 88, 654 7,082 32, 295 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 446, 443 3, 922, 479 91, 717 1, 428, 901 0 50.00 51.00 05100 RECOVERY ROOM 261, 649 362, 061 131, 893 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 776, 873 30, 694 139, 919 52.00 384.092 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1,084,436 1, 222, 864 56, 730 445, 471 Λ 54.00 6, 742 55.00 05500 RADI OLOGY-THERAPEUTI C 351, 549 0 2, 456 0 55.00 57.00 05700 CT SCAN 894, 597 55, 695 0 20, 289 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 529 58.00 315.571 C 193 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 1.444.579 605, 329 8, 432 220, 513 0 59.00 60.00 06000 LABORATORY 2, 810, 967 199, 735 C 72, 760 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 483, 620 97, 378 0 35, 473 0 64.00 65 00 06500 RESPIRATORY THERAPY 1 280 600 40 229 O 14, 655 0 65 00 06600 PHYSI CAL THERAPY 66.00 1, 371, 251 237, 232 0 86, 420 0 66.00 06700 OCCUPATIONAL THERAPY 449, 635 79, 136 28, 828 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 230, 881 33.576 0 12, 231 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 856, 856 93, 941 34, 221 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 233, 671 3, 789 0 1, 380 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 6, 847, 984 0 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 6 911 300 0 0 Ω Ω 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 35, 075, 521 C 0 0 73.00 07301 SPECIALTY PHARMACY 15, 136, 302 0 0 73.01 73.01 73.02 07302 CONTRACTED PHARMACY 0 0 0 73.02 07400 RENAL DIALYSIS 397, 648 17, 977 74 00 6, 549 74 00 0 0 76.00 03330 ENDOSCOPY 176, 971 19,658 0 76.00 210, 090 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 6.318.644 C 76, 533 0 76.01 03951 LUTHERWOOD PARTNERSHIP 76.03 1.537.758 76.03 0 18, 314 66, 982 03952 WOUND CARE CENTER 183, 872 76.04 457.824 0 76.04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 8, 554, 041 3, 449, 293 C 1, 256, 527 0 76.05 03953 I MAGING CENTERS 76.06 1, 351, 194 134, 743 0 49,085 0 76.06 86, 757 03954 BREAST DIAGNOSTIC CENTER 468, 940 76.07 238, 157 0 0 76.07 07697 CARDIAC REHABILITATION 76 97 258 922 260, 938 0 95,056 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 101, 472 15, 794 76.98 76.98 43, 357 0 77 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 04950 MULTIDISCIPLINARY CLINIC 90. 01 1, 915 0 0 0 90.01 290, 985 90.02 04951 HEALTHY HEARTS CENTER 146, 331 1, 498 53, 306 0 90.02 90.03 09001 PALLIATIVE CARE 941 9,870 0 3, 595 0 90.03 90.04 04953 SPINE CENTER 0 0 90.04 04954 INFUSION CENTERS 90.05 139, 956 0 0 0 0 90.05 90.06 09002 MEDCHECK CLINICS 0 0 0 90.06 645, 911 09003 KNEE CENTER 799, 185 235, 296 90.07 90.07 91.00 09100 EMERGENCY 4, 061, 254 109, 284 1, 069, 497 91.00 2, 935, 878 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 140, 931, 348 10, 712, 691 3, 726, 448 118. 00 118.00 29, 872, 543 1, 639, 383 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES n 192. 00 194.00 07950 HOME OFFICE 0 0 0 0 0 194.00 194. 01 07951 GROUP HOMES AND MISC. N_R CTRS 0 0 0 194. 01 1, 917, 068 0 194. 02 07952 ACCOUNTABLE CARE 0 o 0 194. 02 32 006

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0074	From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/24/2024 11:39 am

				5/24/2024 11:	39 am
ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
& GENERAL	PLANT	LINEN SERVICE			
5. 00	7. 00	8. 00	9. 00	10.00	
21, 297	0	0	0	0	194. 03
146, 551	0	0	0	0	194. 04
1, 107, 799	0	0	0	0	194. 05
					200.00
0	0	0	0	0	201.00
144, 156, 069	29, 872, 543	1, 639, 383	10, 712, 691	3, 726, 448	202. 00
	8 GENERAL 5.00 21,297 146,551 1,107,799	& GENERAL PLANT 5.00 7.00 21,297 0 146,551 0 1,107,799 0	& GENERAL PLANT LI NEN SERVI CE 5.00 7.00 8.00 21, 297 0 0 146, 551 0 0 1, 107, 799 0 0 0 0 0	& GENERAL PLANT LINEN SERVICE 5.00 7.00 8.00 9.00 21, 297 0 0 0 146, 551 0 0 0 1, 107, 799 0 0 0 0 0 0 0	ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPING DIETARY & GENERAL PLANT LINEN SERVICE 5.00 7.00 8.00 9.00 10.00 21, 297 0 0 0 0 0 0 146, 551 0 0 0 0 0 1, 107, 799 0 0 0 0 0 0 0 0 0 0

Provider CCN: 15-0074

| 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: 39 am

						5/24/2024 11:	39 am
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDICAL RECORDS &	
			ADMI NI STRATI ON	SERVICES & SUPPLY		LI BRARY	
		11. 00	13.00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A	8, 774, 152					11. 00
13.00	01300 NURSING ADMINISTRATION	193, 515	1				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	48, 379	6, 559, 035	15, 548, 098			14. 00
15. 00	01500 PHARMACY	523, 370	1	7, 774, 017	26, 900, 715		15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	4, 398	1	35	13, 450, 357	21, 076, 125	
17. 00	01700 SOCIAL SERVICE	96, 758	1	157	0	0	17. 00
21. 00 22. 00	O2100 I &R SERVICES-SALARY & FRINGES APPRVD O2200 I &R SERVICES-OTHER PRGM COSTS APPRVD	290, 273 215, 505	1	294 2, 070	0	0	
22.00	I NPATIENT ROUTINE SERVICE COST CENTERS	215, 505	ıl U	2,070	0	0	22.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 524, 495	3, 766, 738	387, 471	0	1, 280, 511	30.00
31. 00	03100 INTENSIVE CARE UNIT	624, 526		135, 799	0		1
35.00	02060 NEONATAL INTENSIVE CARE UNIT	101, 156	o	20, 974	0	141, 893	
43.00	04300 NURSERY	21, 990	35, 741	5, 965	0	13, 915	43. 00
	ANCILLARY SERVICE COST CENTERS		, ,				
50.00	05000 OPERATING ROOM	505, 778		635, 923	0	1, 205, 056	1
51.00	05100 RECOVERY ROOM	35, 185		5, 994	0	89, 849	
52. 00 54. 00	O5200 DELIVERY ROOM & LABOR ROOM O5400 RADIOLOGY-DIAGNOSTIC	105, 554 92, 359		25, 845 8, 637	0	60, 293 351, 006	
55. 00	05500 RADI OLOGY-THERAPEUTI C	43, 981	1	9, 000	0	184, 103	
57. 00	05700 CT SCAN	162, 729	1	43, 623	0	696, 283	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	30, 786	1	2, 470	0	108, 874	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	206, 709	1	42, 874	0	1, 865, 461	59. 00
60.00	06000 LABORATORY	C	o	364, 593	0	658, 231	60.00
64.00	06400 I NTRAVENOUS THERAPY	70, 369	0	12, 884	0	50, 185	64. 00
65.00	06500 RESPI RATORY THERAPY	215, 505	1	43, 929	0	235, 439	
66. 00	06600 PHYSI CAL THERAPY	149, 534	1	13, 568	0	115, 276	
67. 00	06700 OCCUPATI ONAL THERAPY	79, 165	1	3, 786	0	39, 772	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	39, 583	1	11, 321 21, 850	0	18, 046 313, 498	
70. 00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	202, 311 39, 583		10, 931	0	43, 785	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 303	l öl	5, 262, 984	0	569, 923	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	i c	ol ol	0	0	576, 487	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	o	0	13, 450, 358		
73. 01	07301 SPECIALTY PHARMACY	26, 388	0	0	0	644, 441	73. 01
73. 02	07302 CONTRACTED PHARMACY	C	1 -1	0	0	186, 616	
74. 00	07400 RENAL DI ALYSI S	4, 398	1	725	0	29, 573	
76. 00	03330 ENDOSCOPY	21, 990		4, 324	0	27, 290	
76. 01 76. 03	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03951 LUTHERWOOD PARTNERSHI P	255, 088	0	31, 356 24, 654	0	103, 674 2, 256	
76. 03	03952 WOUND CARE CENTER	52, 777		22, 862	0	73, 635	
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	844, 430		170, 292	0	1, 582, 470	
76. 06	03953 I MAGI NG CENTERS	C	1	67, 825	0	463, 283	
76. 07	03954 BREAST DIAGNOSTIC CENTER	C	o	0	0	34, 196	76. 07
76. 97	07697 CARDIAC REHABILITATION	65, 971	0	3, 545	0	26, 386	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	13, 194	. 0	4, 975	0	17, 340	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	C	1	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	C	0	0	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS		ا		0	0	00.00
90. 00 90. 01	09000 CLI NI C 04950 MULTI DI SCI PLI NARY CLI NI C	C		0	0	0 74	90. 00 90. 01
90. 01	04951 HEALTHY HEARTS CENTER	96, 758	1	9, 733	0	29, 509	1
90. 03	09001 PALLI ATI VE CARE	70, 700	ol ol	0, 700	0	2, 736	1
90. 04	04953 SPI NE CENTER	C	o	0	0	2	90. 04
90. 05	04954 INFUSION CENTERS	C	o	6, 520	0	13, 199	
90.06	09002 MEDCHECK CLINICS	C	o	0	0	0	90. 06
90. 07	09003 KNEE CENTER	149, 534	1	4, 056	0	30, 817	90. 07
91. 00	09100 EMERGENCY	620, 128	921, 875	251, 905	0	1, 669, 717	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
110 00	SPECIAL PURPOSE COST CENTERS	0 774 450	12 110 074	15 440 777	24 000 715	21 07/ 105	110 00
118. 00		8, 774, 152	13, 118, 074	15, 449, 766	26, 900, 715	21, 076, 125	1118.00
192 00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	С	ol ol	0	0	n	192. 00
	07950 HOME OFFICE		1	0	0		194. 00
	07951 GROUP HOMES AND MISC. N_R CTRS	Ċ	1	31, 947	0		194. 01
			·	'			

| 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: 39 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HEALTH NETWORK, INC. Provider CCN: 15-0074

					5/24/2024 11:	39 alli
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14.00	15. 00	16.00	
194. 02 07952 ACCOUNTABLE CARE	0	0	66	0	0	194. 02
194.03 07953 SCHOOL BASED CLINICS	0	0	3, 155	0	0	194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	0	13	0	0	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	0	63, 151	0	0	194. 05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	8, 774, 152	13, 118, 074	15, 548, 098	26, 900, 715	21, 076, 125	202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part I
To 1/21/2022 Part/Time Propagate Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0074

			T	o 12/31/2023	Date/Time Pre	pared:
		I NTERNS &	RESI DENTS		5/24/2024 11:	39 am
Cost Center Description	SOCIAL SERVICE	SEDVI CES_SALAD	SEDVI CES_OTHED	Subtotal	Intern &	
oost ochter beschiptron	SOOTAL SERVICE	Y & FRI NGES	PRGM COSTS	Subtotal	Residents Cost	
					& Post Stepdown	
					Adjustments	
GENERAL SERVICE COST CENTERS	17. 00	21. 00	22.00	24. 00	25. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 OO200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A						11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY						14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00 01700 SOCI AL SERVI CE	3, 670, 980					17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	5, 866, 355	15, 244, 007			21. 00 22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0		13, 244, 007			22.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 959, 205	3, 089, 271				30.00
31. 00 03100 INTENSI VE CARE UNIT 35. 00 02060 NEONATAL INTENSI VE CARE UNIT	546, 669 107, 977	142, 116 97, 850				31. 00 35. 00
43. 00 04300 NURSERY	57, 129	77,030	· ·	1, 381, 539	0	43. 00
ANCILLARY SERVICE COST CENTERS		000 400	0 400 740	40.004.000	0.000.470	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	0	808, 429 0	2, 100, 743 0	42, 824, 208 2, 471, 185		50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	ő	6, 382, 887	Ö	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	9, 828, 866	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	2, 726, 821	0	55.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	7, 290, 912 2, 369, 524	0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	51, 255	133, 188		-184, 443	59. 00
60. 00 06000 LABORATORY	0	0	0	21, 129, 554	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0	0	3, 678, 720 9, 585, 691	0	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	314, 519	817, 292	11, 409, 412		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	3, 403, 319	0	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0	0	1, 743, 858 6, 711, 812	0	68. 00 69. 00
70. 00 07000 ELECTROEARD OLOGT	0	0	0	1, 748, 253	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	54, 152, 406	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	49, 342, 748		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 SPECIALTY PHARMACY	0	0	0	268, 023, 700 107, 472, 852	0	73. 00 73. 01
73. 02 07302 CONTRACTED PHARMACY	0	0	Ö	22, 153, 828		73. 02
74. 00 07400 RENAL DI ALYSI S	0	0	0	2, 865, 034		74. 00
76. 00 03330 ENDOSCOPY 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0 1, 006, 460	0 2, 615, 334	1, 321, 974 48, 883, 000		76. 00 76. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P	0	1, 000, 400	2,013,334	10, 877, 358		76. 03
76. 04 03952 WOUND CARE CENTER	0	60, 574			-217, 978	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER 76. 06 03953 IMAGING CENTERS	0	62, 904	163, 458			76. 05
76. 06 03953 IMAGING CENTERS 76. 07 03954 BREAST DIAGNOSTIC CENTER	0	0	0	10, 248, 984 3, 667, 960	0	76. 06 76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	Ö	2, 278, 854	Ö	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	810, 649	0	76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78.00
90. 00 09000 CLI NI C	0	0		0	0	90.00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C 90. 02 04951 HEALTHY HEARTS CENTER	0	0	1	13, 584	0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER 90. 03 09001 PALLI ATIVE CARE		0	0	2, 390, 333 22, 838		90. 02 90. 03
90. 04 04953 SPI NE CENTER	0	0	ō	2	0	90. 04
90. 05 04954 INFUSION CENTERS	0	0	0	1, 007, 249	0	90.05
90. 06 09002 MEDCHECK CLINICS 90. 07 09003 KNEE CENTER		0	0	0 6, 704, 678	0	90. 06 90. 07
91. 00 09100 EMERGENCY	0	232, 977	605, 401	37, 072, 942		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 670, 980	5, 866, 355	15 244 007	1, 016, 280, 885	-21, 110, 362	118 00
	5,5.5,750	3, 330, 330	.5,271,557	, , , , , , , , , , , , , , , , , , , ,		1

Health Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Li∈	eu of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	_	Provider Co	CN: 15-0074	Period: From 01/01/2023 To 12/31/2023		
Cost Center Description	SOCIAL SERVICE	SERVI CES-SALAR			Intern &	
		Y & FRINGES	PRGM COSTS		Residents Cost & Post Stepdown Adjustments	
	17. 00	21. 00	22. 00	24. 00	25. 00	
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	1	0	0	192. 00
194.00 07950 HOME OFFICE	0	0)	0 0	0	194. 00
194.01 07951 GROUP HOMES AND MISC. N_R CTRS	0	0)	0 13, 558, 812	0	194. 01
194. 02 07952 ACCOUNTABLE CARE	0	0)	0 225, 902	0	194. 02
194.03 07953 SCHOOL BASED CLINICS	0	0)	0 153, 427	0	194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	0)	0 1, 034, 079	0	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	0)	0 7, 879, 802	0	194. 05
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202.00 TOTAL (sum lines 118 through 201)	3, 670, 980	5, 866, 355	15, 244, 00	07 1, 039, 132, 907	-21, 110, 362	202. 00

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 11:39 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0074

SAMPHAN PROFILE ONLY OR PLANE 70.00				10 12/31/2023 Date/11 PI 5/24/2024 1°	
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15.00 01500 PARAMACY		1 1			•
16.00 01-600 MEDICAL RECORDS & LIBRARY					
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118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 995, 170, 523 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 194. 00 194. 01 07951 GROUP HOMES AND MI SC. N_R CTRS 13, 558, 812 194. 01 194. 02 07952 ACCOUNTABLE CARE 225, 902 194. 02	92. 00	· · ·			→ ^{92.00}
NONRE MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.01 194.02 195.02 194.01 194.02 195	110 00		005 170 522		110 00
192.00	118.U(770, 170, 523		-118.00
194. 00 07950 HOME OFFI CE 0 194. 00 194. 01 07951 GROUP HOMES AND MISC. N_R CTRS 13, 558, 812 194. 02 07952 ACCOUNTABLE CARE 225, 902 194. 02	192 00		n		192 00
194. 01 07951 GROUP HOMES AND MISC. N_R CTRS 13, 558, 812 194. 02 07952 ACCOUNTABLE CARE 225, 902 194. 02			- 1		
194. 02 07952 ACCOUNTABLE CARE 225, 902 194. 02			13, 558, 812		
194. 03 07953 SCHOOL BASED CLINICS 153, 427 194. 03	194. 02	07952 ACCOUNTABLE CARE	225, 902		
	194. 03	B 07953 SCH00L BASED CLINICS	153, 427		194. 03

Health Financial Systems CC	MMUNITY HEALTH	NETWORK, INC.	In Lie	u of Form CMS-25	52-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0074	From 01/01/2023	Worksheet B Part I Date/Time Prepa 5/24/2024 11:39	
Cost Center Description	Total				
	26.00				

	Cost Center Description	Total	i
		26. 00	
194. 04 07954	SMO-NON PROVIDER BASED	1, 034, 079	194. 04
194. 05 07955	FAMILY PRACTICE MEDICINE	7, 879, 802	194. 05
200. 00	Cross Foot Adjustments	0	200. 00
201. 00	Negative Cost Centers	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 018, 022, 545	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074

COST Center Description					lo	12/31/2023	Date/lime Pre 5/24/2024 11:	
CEMBRAL SERVICE COST CENTERS 1.00 2.00 2A 4.00				CAPI TAL REI	LATED COSTS		, 0, 2 1, 202 1 111	, <u></u>
CEMBRAL SERVICE COST CENTERS 1.00 2.00 2A 4.00				DI DO A FLVE	10/01 5 50/// 5		ENDL OVEE	
Filtream Service Cont Centres		Cost Center Description	, ,	BLDG & FLXT	MVBLE EQUIP	Subtotal		
Bela Bailed Costs								
							DELAKTMENT	
1.00				1.00	2.00	2A	4. 00	
2.00								
4.00								
5.00 0.000 ADMIN INSTRATIVE & CENERAL 0 975, 265 4, 810, 180 5, 786, 435 735, 415 5.00				150 440	14 700 772	14 040 222	14 040 222	
0,0000 0,00000 0,0000 0,0000 0,0000 0,0000 0,0000 0,0000 0,00000 0,0000 0,0000 0,0000 0,0000 0,0000 0,0000 0,00000 0,0000 0,0000 0,0000 0,0000 0,0000 0,0000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,000000 0,000000 0,000000 0,000000 0,00000000			1					
8.00 0.0800 JAUNDRY & LI NEN SERVICE 0 0 0 0 0 0 0 0 0			1					
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000			1	0		0		1
11.00 01100 CAFFERIA 0 610, 539 92, 557 703, 096 170, 668 11.00 11.00 01100 CAFFERIA 0 0 213, 455 21, 466 235, 101 246, 564 31.00 11.00 01100 CENTRAL SERVICES & SUPPLY 0 428, 765 1.377, 701 1.806, 732 45, 243 14.00 11.00	9.00		O	268, 401	16, 563	284, 964	274, 287	9. 00
13.00 01300 NURSING ADMINISTRATION 0 213, 485 21, 646 235, 101 246, 254 13.00 13.00 NURSING ADMINISTRATION 0 248, 765 13,77, 970 1, 806, 735 45, 254 14.00 13.00 101500 PHARMACY 0 233, 694 469, 472 703, 166 653, 531 15.00 101500 PHARMACY 0 270, 596 663, 531 15.00 101500 PHARMACY 0 270, 596 663, 633 15.00 101500 PHARMACY 0 270, 596 670, 697 0 270, 797 0 270,	10.00	01000 DI ETARY	0	220, 599	11, 480	232, 079	61, 572	10.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 428, 765 1,377, 970 1,306, 733 45,243 14.00 15.00 01500 HISMACY 0 29,596 0 29,596 0,441 16.00 17.00 01700 01600 HEDICAL RECORDS & LIBRARY 0 29,596 0 0 29,596 0,441 16.00 01600 HEDICAL RECORDS & LIBRARY 0 0,94.665 0 0,94.665 0 0,94.665 0 0 0 0 0 0 0 0 0			1					1
15.00			1					
10.00 01000 MEDICAL RECORDS & LIBRARY 0 29, 996			1					1
17.00 01700 SOCIAL SERVICE 0 69, 465 10 1,77 569 17.00 22.00 0200 188 SERVICES-SALARY & FRINGES APPRVD 0 112, 893 31,313 144, 206 745, 793 22.00 10200 188 SERVICES-SALARY & FRINGES APPRVD 0 112, 893 31,313 144, 206 745, 793 22.00 10200 188 SERVICES-SALARY & FRINGES APPRVD 0 112, 893 31,313 144, 206 745, 795 22.00 10200			1					
21.00			1					1
22.00 0.2020 I.B. SERVI CES-OTHER PRIGU COST SAPPRVD 0 112,893 31,313 144,206 745,793 22.00			1	0,, 100				1
30.00 3000 ADULTS & PEDIATRICS 0 4,693,916 783,724 5,477,400 3,806,121 30.00 30.00 2000 INERSIYE CARE UNIT 0 68,194 16,483 84,677 142,576 35.00 35.00 2000 INERSIYE CARE UNIT 0 68,194 16,483 84,677 142,576 35.00 22,000 INERSIYE CARE UNIT 0 68,194 16,483 84,677 142,576 35.00 35.00 2000 INERSIYE CARE UNIT 0 51.158 24,211 75,369 32,061 40.00 50.00 50.00 OPERATING ROOM 0 2,263,483 1,464,880 3,728,363 656,872 50.00 50.00 PERATING ROOM 0 221,642 104,900 326,542 169,374 50.00 50.00 DELIVERY ROOM & LABOR ROOM 0 221,642 104,900 326,542 169,374 50.00 50.00 RECOVERY ROOM & LABOR ROOM 0 221,642 104,900 326,542 169,374 50.00 50.00 RECOVERY ROOM & LABOR ROOM 0 32,199 370,892 1,076,551 201,195 54.00 50.00 50.00 RECOVERY ROOM & LABOR ROOM 0 32,199 239,943 272,062 169,375 50.00 50.00 60.00 RADIOLOCY-INERAPUTI C 0 3,890 18,600 30.00	22. 00		0	112, 893				1
31.00 03100 NTENSI VE CARE UNIT 0 1.223, 111 523, 999 1,747, 110 910, 002 31, 003 33, 001 0260 04300 NURSERY 0 68, 194 16, 48 84, 477 142, 576 35, 00 32, 061 43, 00 320, 001 43, 00		INPATIENT ROUTINE SERVICE COST CENTERS						
15.00 02060 NEOMATAL INTENSIVE CARE UNIT 0 68, 194 16, 483 84, 677 142, 576 32,001 43,00 43,00 4360 NUSERY 0 51,158 24,211 75, 369 32,061 43,00 140,000 NUSERY 150,000 NUSERY			1					1
43.00 0.4300 NURSERY 0 51,158 24,211 75,369 32,061 43,00			1					
MOLILARY SERVICE COST CENTERS 0.00 DOSDO OPERATINE ROBON 0 DEPATH SERVICE COST CENTERS 1.1 A64, 880 3, 728, 363 66.68, 872 50.00 1.5 0.00 DEPATH SERVICE ROBON 0 DEPATH SERVICE ROBON 0 DELVIERY ROM & LABOR ROOM 0 DELVIERY ROM & LABOR ROOM 0 DELVIERY ROOM & LABOR ROOM 0 STOOL REOVERY ROOM 0 SHOOL REOVERY ROOM 0 SHOOL REVER ROOM & LABOR ROOM 0 SHOOL REVER ROOM & LABOR ROOM 0 SHOOL REVER REPORTED C 0 DELVIERY ROOM & LABOR ROOM 0 SHOOL REVER REPORTED C 0 DELVIERY ROOM & LABOR ROOM 0 STOOL REVER RESONANCE IMAGING (MRI) 0 DELVIERY ROOM AGNETIC RESONANCE IMAGING (MRI) 0 DESCRIPTION OF STOOL RESONANCE IMAGING (MRI) 0 DESCRIPTION OF THERAPY 0 DESCRIPTION OF STOOL RESONANCE IMAGING (MRI) 0 DESCRIPTION OF THERAPY 0 DESCRIPTION OF STOOL RESONANCE IMAGING (MRI) 0 DESCRIPTION OF THERAPY 0 DESCRIPTION OF			1					
50.00	43.00		J U	51, 158	24, 211	75, 369	32, 061	43.00
51.00 05100 RECOVERY ROOM CALBOR RAO CALBOR	50.00		0	2 263 483	1 464 880	3 728 363	656 872	50 00
52.00 05200 DELI YERY ROOM & LABOR ROOM 0 221, 642 104, 900 326, 542 109, 374 52, 00 550 00 05500 RADI DLOGY-HIERAPEUTI C 0 3, 890 18, 603 22, 493 54, 002 55, 00 05500 CT SCAN 0 05700 CT SCAN 0 0 32, 139 943 222, 082 109, 530 57, 00 05700 CT SCAN 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 349, 308 630, 927 980, 235 289, 146 500, 00 05900 CARDI ACCATHETERI ZATI ON 0 349, 308 630, 927 980, 235 289, 146 500, 00 0 0 0 0 0 0 0 0			1					
55.00 GS500 RADIOLOGY-THERAPEUTIC 0 3, 890 18, 603 22, 493 54, 002 55, 00 570, 00 570, 00 570, 00 570, 00 570, 00 570, 00 570, 00 570, 00 570, 00 570, 00 580, 00 68000 MAGNETIC RESONANCE IMAGING (MRI) 0 305 334, 985 335, 290 52, 254 58, 00 60, 00 60000 CARDI ACC CARTETERIZATI ON 0 315, 258 26, 842 142, 100 0 60, 00 6000 1080 NORANTEN 11, 100 115, 258 26, 842 142, 100 0 60, 00 60, 00 6000 INTRAVENOUS THERAPY 0 56, 192 4, 584 60, 776 90, 026 64, 00 660, 00 6600 PMSYLCAL THERAPY 0 23, 214 39, 045 62, 259 339, 738 65, 00 66, 00 6600 PMSYLCAL THERAPY 0 136, 896 574, 943 711, 839 323, 456 66, 00 660, 00 6600 PMSYLCAL THERAPY 0 45, 666 574, 943 711, 839 323, 456 66, 00 660, 00 6600 PMSYLCAL THERAPY 0 45, 666 574, 943 711, 839 323, 456 66, 00 660, 00 6600 PMSYLCAL THERAPY 0 45, 666 52, 133 50, 879 108, 701 67, 00			O					
57.00 OS700 OS70			0	705, 659	370, 892		201, 195	
58. 00 05800 MARNETIC RESOMANCE IMAGING (MRI) 0 305 334, 985 335, 290 52, 284 58. 00 590 0 05900 CARDIAC CARTHETERIZATION 0 349, 308 630, 927 980, 235 229, 146 59, 00 60. 00 0 0 0 0 0 0 0 0			1					1
59.00 0.5900 CARDI AC CATHETER IZATION 0 3.49, 308 6.30, 927 980, 235 28.91, 146 59.00 0.00			1					
60.00 0.6000 LABORATORY 0 115, 258 26, 842 142, 100 0 60.00 0.600 NTEANEROUS THERAPY 0 56, 192 4, 584 60.776 90.026 64.00 64.00 NTEANEROUS THERAPY 0 23, 214 39, 045 62, 259 339, 738 65.00 66.00 0.600 PHYSI CAL THERAPY 0 136, 896 574, 943 711, 839 323, 465 66.00 66.00 0.600 PHYSI CAL THERAPY 0 45, 666 52, 213 50.879 108, 701 67.00 67.00 0.0000 0.0000 0.0000 0.0000 0.000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000000			1					
64.00 0.0400 INTRAVENOUS THERAPY 0 56, 192 4, 584 60, 776 90, 026 64.00			1					1
65.00 0.6500 RESPI RATORY THERAPY 0 23, 214 39, 045 62, 259 339, 738 65.00			1					
66.00 06600 PHYSI CAL THERAPY 0 136, 896 574, 943 711, 839 323, 465 66. 00 67.00 6700 06			0					
68. 00 06900 DEECH PATHOLOGY 0 19, 375 3, 706 23, 081 53, 203 68. 00	66.00	06600 PHYSI CAL THERAPY	0					1
69.00 06900 ELECTROCARDIOLOGY 0 54,209 392,251 446,460 227,266 69.00	67. 00		0	45, 666	5, 213			
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 2, 187 64, 762 66, 949 50, 958 70. 00 0 0 0 0 0 0 0 0			1					1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 73.01 07301 SPECIALTY PHARMACY 0 0 0 0 0 0 0 73.02 07302 CONTRACTED PHARMACY 0 0 0 0 0 0 0 73.02 07302 CONTRACTED PHARMACY 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 10,374 0 10,374 7,143 74.00 76.01 073505 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 121,233 866,650 987,883 1,900,675 76.01 76.04 07392 WOUND CARE CENTER 0 0 0 16,104 3,674 109,778 62,796 76.04 76.05 07400 07400 07400 07400 07400 07400 07400 07400 07400 76.06 07400 07400 07400 07400 074,056 074			1					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 01 07301 SPECIALTY PHARMACY 0 0 0 0 0 0 0 73. 00 73. 02 07302 CONTRACTED PHARMACY 0 0 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 10,374 0 10,374 7,143 76. 00 03330 ENDOSCOPY 0 0 0 0 0 0 0 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 121,233 866,650 987,883 1,900,675 76. 01 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 81,176 81,176 81,176 257,230 76. 03 76. 04 03952 WOUND CARE CENTER 0 106,104 3,674 109,778 62,796 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 1,990,429 1,227,138 3,217,567 1,038,789 76. 05 76. 07 03954 BREAST DIAGNOSTIC CENTER 0 137,430 47,375 184,805 0 76. 07 76. 98 07698 HYPERBARI C DXYGEN THERAPY 0 25,020 866 25,886 12,325 76. 98 77. 00 07700 ALLOGENEIC HISCT ACQUISITION 0 150,575 84,233 234,808 61,452 76. 97 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 07900 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 79. 00 07900 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 79. 00 07900 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 79. 01 04950 MULTI DI SCI PLI NARY CLINI C 0 0 0 0 0 0 0 79. 00 07900 07900 07900 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 0 0 0 0 0 79. 00 07900 07900 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 07900 07900 07900 79. 00 07900 07900 07900 07900 07900 07900 07900 79. 00 07900 07900			1	2, 187		66, 949		1
73. 00 07300 DRUGS CHARGED TO PATILENTS			1	0	0	0		
73. 01 07301 SPECIALTY PHARMACY 0 0 0 0 0 0 0 73. 02 07302 CONTRACTED PHARMACY 0 0 0 0 0 0 73. 02 073.02 CONTRACTED PHARMACY 0 0 0 0 0 0 0 73. 02 073.02 CONTRACTED PHARMACY 0 0 10, 374 7, 143 74. 00 074.00 07400 RENAL DI ALYSIS 0 10, 374 0 10, 374 7, 143 74. 00 076.00 03330 ENDOSCOPY 0 0 0 74. 056 74. 056 35. 321 76. 00 076.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 121, 233 866, 650 987, 883 1, 900, 67 76. 01 076.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 121, 233 866, 650 987, 883 1, 900, 67 76. 01 076.03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 81, 176 81, 176 257, 230 76. 03 076.03 03951 LUTHERWOOD PARTNERSHI P 0 106, 104 3, 674 109, 778 62, 796 76. 04 076.05 03480 ONCOLOGY-CANCER CARE CENTER 0 106, 104 3, 674 109, 778 62, 796 76. 04 076.06 03953 I MAGI NG CENTERS 0 77, 754 696, 015 773, 769 260, 505 76. 06 076.07 03954 BREAST DI AGNOSTI C CENTER 0 137, 430 47, 375 184, 805 0 76. 07 076.97 07697 CARDI AC REHABI LITATI ON 0 150, 575 84, 233 234, 808 61, 452 76. 97 07697 CARDI AC REHABI LITATI ON 0 150, 575 84, 233 234, 808 61, 452 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 25, 020 866 25, 886 12, 325 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 25, 020 866 25, 886 12, 325 76. 98 07600 0700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0	Ö	Ö		
73.02 07302 CONTRACTED PHARMACY 0 0 0 0 0 373.02 74.00 07400 RENAL DILAYSIS 0 10,374 0 10,374 74,006 76.00 03330 ENDOSCOPY 0 0 0 0 74,056 76.01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 121,233 866,650 987,883 1,900,675 76.01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 121,233 866,650 987,883 1,900,675 76.04 03952 WOUND CARE CENTER 0 106,104 3,674 109,778 62,796 76.04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 0 1,990,429 1,227,138 3,217,567 1,038,789 76.05 76.06 03953 IMAGI NG CENTERS 0 77,754 696,015 773,769 260,505 76.06 76.07 03954 BREAST DI JAGNOSTI C CENTER 0 137,430 47,375 184,805 0 76.07 76.97 07697 CARDI AC REHABI LI TATI ON 0 150,575 84,233 234,808 61,452 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 25,020 866 25,886 12,225 76.98 77.00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 78.00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 78.00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 79.01 04950 MULTI DI SCI PLI NARY CLI NI C 0 0 0 0 0 0 79.02 04951 HEALTHY HEARTS CENTER 0 84,441 87,437 171,878 135,397 90.02 79.03 09001 PALLI ATI VE CARE 0 5,696 0 0 0 0 0 79.04 04953 SPINE CENTER 0 0 0 0 0 0 0 79.05 04954 INFUSION CENTERS 0 0 0 0 0 0 0 79.06 09002 MECHECK CLI NI CS 0 0 0 0 0 0 79.07 09003 KNEE CENTER 0 372,726 7,287 380,013 133,838 90.07 79.00 09000 MERGENCY 0 1,694,161 189,136 1,883,297 829,190 79.00 09000 DEBERVATI ON BEDS (NON-DISTINCT PART) 5 5 5 5 5 5 5 70.00 09000 MERGENCY 0 1,694,161 189,136 1,883,297 829,190 70.01 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 090000 09000 09000 09000 09000 09000 09000 09000			1	0	o	o		
76. 00 03330 ENDOSCOPY 0 0 0 74,056 74,056 35,321 76.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 121,233 866,650 987,883 1,900,675 76.01 76.03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 81,176 81,176 257,230 76.03 76.03 03951 LUTHERWOOD PARTNERSHI P 0 106,104 3,674 109,778 62,796 76.04 03952 WOUND CARE CENTER 0 106,104 3,674 109,778 62,796 76.04 03953 MAGI NG CENTERS 0 77,754 696,015 773,769 260,505 76.06 03953 MAGI NG CENTERS 0 77,754 696,015 773,769 260,505 76.06 76.07 03954 BREAST DI AGNOSTI C CENTER 0 137,430 47,375 184,805 0 76.07 76.97 07697 CARDI AC REHABI LI TATI ON 0 150,575 84,233 234,808 61,452 76.97 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 77.00 78.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73. 02	07302 CONTRACTED PHARMACY	0	0	0	o		
76. 01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 121, 233 866, 650 987, 883 1, 900, 675 76. 01 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 81, 176 81, 176 257, 230 76. 03 03951 WOUND CARE CENTER 0 106, 104 3, 674 109, 778 62, 796 76. 04 03952 WOUND CARE CENTER 0 1, 990, 429 1, 227, 138 3, 217, 567 1, 038, 789 76. 05 76. 06 03480 (NOCLOGY-CANCER CARE CENTER 0 1, 990, 429 1, 227, 138 3, 217, 567 1, 038, 789 76. 05 76. 06 03953 (IMAGI NG CENTERS 0 77, 754 696, 015 773, 769 260, 505 76. 06 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 137, 430 47, 375 184, 805 0 76. 07 76. 97 07697 CARDI AC REHABI LI TATI ON 0 150, 575 84, 233 234, 808 61, 452 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 25, 020 866 25, 886 12, 325 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l	0	10, 374				
76. 03 03951 LUTHERWOOD PARTNERSHIP 0 0 0 81,176 81,176 257,230 76. 03 76. 04 76. 04 03952 WOUND CARE CENTER 0 106,104 3.674 109,778 62,796 76. 04 76. 05 03480 NOCOLOGY-CANCER CANEE CENTER 0 1,990,429 1,227,138 3,217,567 1,038,789 76. 05 76. 06 77. 754 696,015 773,769 260,505 76. 06 76. 07 70. 07			0	0				
76. 04 03952 WOUND CARE CENTER 0 106, 104 3, 674 109, 778 62, 796 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 1, 990, 429 1, 227, 138 3, 217, 567 1, 038, 789 76. 05 76. 06 03953 IMAGI NG CENTERS 0 777, 754 696, 015 773, 769 260, 505 76. 06 76. 07 76. 07 03954 BREAST DI AGNOSTIC CENTER 0 137, 430 47, 375 184, 805 0 76. 07 76. 97 76. 98 76. 97 CARDI AC REHABILITATI ON 0 150, 575 84, 233 234, 808 61, 452 76. 97 76. 98 77. 00 0700 ALLOGENEI C HSCT ACQUI SITI ON 0 0 0 0 0 0 0 0 0			0	121, 233				1
76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 1, 990, 429 1, 227, 138 3, 217, 567 1, 038, 789 76. 05 76. 06 03953 IMAGI NG CENTERS 0 77, 754 696, 015 773, 769 260, 505 76. 06 76. 07 76. 07 07697 CARDI AC REHABI LITATI ON 0 150, 575 84, 233 234, 808 61, 452 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 25, 020 866 25, 886 12, 325 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0			1	106 104				1
76. 06 03953 IMAGING CENTERS 0 777, 754 696, 015 773, 769 260, 505 76. 06 76. 07 03954 BREAST DI AGNOSTIC CENTER 0 137, 430 47, 375 184, 805 0 76. 07 76. 97 07697 CARDI AC REHABI LI TATI ON 0 150, 575 84, 233 234, 808 61, 452 76. 97 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					
76. 97 07697 CARDI AC REHABI LI TATI ON 0 150, 575 84, 233 234, 808 61, 452 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 25, 020 866 25, 886 12, 325 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 77. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0 0 0 0 0 0 0			0					1
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 25,020 866 25,886 12,325 76.98 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 77.00 78.00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0 0 0 0 0 0 78.00 00 0 0 0 0 0 0 0 0	76. 07	03954 BREAST DIAGNOSTIC CENTER	0	137, 430	47, 375	184, 805	0	76. 07
77. 00			0	150, 575	84, 233	234, 808		
78. 00			0	25, 020		25, 886		1
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTER OUTPATIENT SERVICE COST CENTER SERVICE COST			1	0	_	0		
90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 00 90.	78.00		0	0	0	<u> </u>	0	78.00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C 0 0 7, 811 7, 811 149 90. 01 90. 02 04951 HEALTHY HEARTS CENTER 0 84, 441 87, 437 171, 878 135, 397 90. 02 90. 03 09001 PALLI ATI VE CARE 0 5, 696 0 5, 696 0 5, 696 0 90. 03 90. 04 04953 SPI NE CENTER 0 0 0 0 0 0 0 0 0 0 0 90. 04 90. 05 04954 INFUSI ON CENTERS 0 0 0 105, 453 105, 453 29, 850 90. 05 90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 0 0 0 0 90. 06 90. 06 90. 07 09003 KNEE CENTER 0 372, 726 7, 287 380, 013 133, 838 90. 07 91. 00 09100 EMERGENCY 0 1, 694, 161 189, 136 1, 883, 297 829, 190 91. 00 9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 SPECI AL PURPOSE COST CENTERS	90 00			0	0	٥١	0	90 00
90. 02 04951 HEALTHY HEARTS CENTER 0 84, 441 87, 437 171, 878 135, 397 90. 02 90. 03 09001 PALLI ATI VE CARE 0 5, 696 0 5, 696 0 90. 03 90. 04 04953 SPI NE CENTER 0 0 0 0 0 0 0 90. 05 04954 INFUSI ON CENTERS 0 0 0 105, 453 105, 453 29, 850 90. 05 90. 06 09002 MEDCHECK CLI NI CS 0 0 0 0 0 0 90. 07 09003 KNEE CENTER 0 372, 726 7, 287 380, 013 133, 838 90. 07 91. 00 09100 EMERGENCY 0 1, 694, 161 189, 136 1, 883, 297 829, 190 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 SPECI AL PURPOSE COST CENTERS			1	0	7 811	7 811		
90. 03 09001 PALLI ATI VE CARE 0 5, 696 0 5, 696 0 90. 03 90. 04 04953 SPI NE CENTER 0 0 0 0 0 0 90. 05 04954 INFUSI ON CENTERS 0 0 0 105, 453 90. 06 09002 MEDCHECK CLI NI CS 0 0 0 0 90. 07 09003 KNEE CENTER 0 372, 726 7, 287 380, 013 91. 00 09100 EMERGENCY 0 1, 694, 161 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 92. 00 SPECI AL PURPOSE COST CENTERS			1	84, 441				1
90. 04 04953 SPI NE CENTER 0 0 0 0 0 0 90. 04 90. 05 04954 INFUSI ON CENTERS 0 0 0 105, 453 105, 453 29, 850 90. 05 90. 06 09002 MEDCHECK CLI NI CS 0 0 0 0 0 0 0 0 0								1
90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 0 0 90. 06 90. 07 09003 KNEE CENTER 0 372, 726 7, 287 380, 013 133, 838 90. 07 91. 00 09100 EMERGENCY 0 1, 694, 161 189, 136 1, 883, 297 829, 190 92. 00 09200 09SERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00 SPECIAL PURPOSE COST CENTERS	90. 04	04953 SPI NE CENTER	0	0	0	0		90. 04
90. 07 09003 KNEE CENTER 0 372, 726 7, 287 380, 013 133, 838 90. 07 91. 00 09100 EMERGENCY 0 1, 694, 161 189, 136 1, 883, 297 829, 190 92. 00 09200 09SERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 O9200 O9200			0	0	105, 453	105, 453	29, 850	1
91. 00 09100 EMERGENCY 0 1, 694, 161 189, 136 1, 883, 297 829, 190 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 SPECI AL PURPOSE COST CENTERS		l l	0	0	0	0	0	90.06
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 SPECI AL PURPOSE COST CENTERS		l l	1					
SPECIAL PURPOSE COST CENTERS				1, 694, 161	189, 136	1, 883, 297	8∠9, 190	
	72. UU					U		72.00
	118. 00		0	21, 206, 684	32, 901, 794	54, 108, 478	16, 190, 843	118.00
			1			,		

Health Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0074	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/24/2024 11:	
Cost Contor Dosorintian	Di rectly	CAPITAL REL	ATED COSTS	Subtotal	EMPLOYEE	
Cost Center Description	Assi gned New Capi tal Rel ated Costs	BLDG & FIAI	WVBLE EQUIP	Subtotal	BENEFITS DEPARTMENT	
	0	1. 00	2. 00	2A	4. 00	
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 00
194.00 07950 HOME OFFICE	0	0		0		194. 00
194.01 07951 GROUP HOMES AND MISC. N_R CTRS	0	0	107, 66	107, 661	488, 365	1
194. 02 07952 ACCOUNTABLE CARE	0	0		0	8, 989	194. 02
194. 03 07953 SCHOOL BASED CLINICS	0	0		0	4, 077	194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	0		0	40, 758	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	0	772, 27	74 772, 274	216, 190	194. 05
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	21, 206, 684	33, 781, 72	54, 988, 413	16, 949, 222	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0074

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 39 am

					5/24/2024 11:	39 am
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE	9. 00	10.00	
GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	6, 520, 850					5. 00
7. 00 00700 OPERATION OF PLANT	191, 497	3, 296, 881				7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	10, 509		10, 509			8. 00
9. 00 00900 HOUSEKEEPI NG	60, 437	51, 333		676, 274		9. 00
10. 00 01000 DI ETARY	20, 545			8, 791	365, 178	10.00
11. 00 01100 CAFETERI A	35, 049	116, 769		24, 331	182, 588	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	79, 617	40, 824		8, 507	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	50, 816	82, 004		17, 087	0	14. 00
15. 00 01500 PHARMACY	115, 714	44, 695		9, 313	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	48, 408	5, 660		1, 179	0	16. 00
17. 00 01700 SOCIAL SERVICE	21, 859	13, 286		2, 768	0	17. 00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	35, 743		o o	O	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	94, 616	21, 591	0	4, 499	0	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			· · ·		
30. 00 03000 ADULTS & PEDI ATRI CS	606, 275	897, 740	2, 600	187, 063	153, 641	30.00
31.00 03100 INTENSIVE CARE UNIT	167, 660	233, 927	454	48, 743	28, 949	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	25, 882	13, 042	2	2, 718	0	35. 00
43. 00 04300 NURSERY	7, 172	9, 784	45	2, 039	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	201, 123	432, 904	588	90, 204	0	50. 00
51.00 05100 RECOVERY ROOM	11, 835	39, 959	0	8, 326	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	35, 140	42, 390	197	8, 833	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	49, 052	134, 961	364	28, 122	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	15, 901	744	0	155	0	55. 00
57.00 05700 CT SCAN	40, 465	6, 147	0	1, 281	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	14, 274	58	0	12	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	65, 342	66, 807	54	13, 921	0	59. 00
60. 00 06000 LABORATORY	127, 147	22, 044	0	4, 593	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	21, 875	10, 747	0	2, 239	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	57, 925	4, 440	0	925	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	62, 025	26, 182	2 0	5, 456	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	20, 338	8, 734	0	1, 820	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	10, 443	3, 706	0	772	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	38, 758	10, 368	0	2, 160	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	10, 569	418	0	87	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	309, 751	C	0	0	0	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	312, 615	C	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 586, 874	C	0	0	0	73. 00
73. 01 07301 SPECIALTY PHARMACY	684, 651	C	0	0	0	73. 01
73.02 07302 CONTRACTED PHARMACY	0	C	0	0	0	73. 02
74. 00 07400 RENAL DI ALYSI S	17, 987	1, 984		413	0	74. 00
76. 00 03330 ENDOSCOPY	8, 005	C	126	0	0	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	285, 807	23, 187	1	4, 831	0	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	69, 556			0	0	76. 03
76.04 03952 WOUND CARE CENTER	20, 708			4, 228	0	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	386, 920			79, 322	0	76. 05
76. 06 03953 I MAGI NG CENTERS	61, 118	14, 871		3, 099	0	76. 06
76. 07 03954 BREAST DI AGNOSTI C CENTER	21, 211	26, 284		5, 477	0	76. 07
76. 97 O7697 CARDI AC REHABI LI TATI ON	11, 712	28, 798		6, 001	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	4, 590			997	0	76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	C	_	0	0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	C) 0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS				ام		
90. 00 09000 CLI NI C	0		0	0	0	90.00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C	87		0	0	0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	13, 162	16, 150		3, 365	0	90. 02
90. 03 09001 PALLI ATI VE CARE	43	1, 089	1	227	0	90. 03
90. 04 04953 SPI NE CENTER	0		0	0	0	90. 04
90. 05 04954 INFUSION CENTERS	6, 331		0	0	0	90. 05
90. 06 09002 MEDCHECK CLI NI CS	0	74 00/	0	0	0	90.06
90. 07 09003 KNEE CENTER	36, 149	71, 286		14, 854	0	90. 07
91. 00 09100 EMERGENCY	183, 700	324, 018	701	67, 516	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS	/ 074 000	2 201 223	10 500	/7/ 07/1	0/5 470	110 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 374, 988	3, 296, 881	10, 509	676, 274	365, 178	1118.00
NONREI MBURSABLE COST CENTERS	_		1	ام	^	102.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		0	0		192.00
194. 00 07950 HOME OFFICE	04 714		0	O		194.00
194. 01 07951 GROUP HOMES AND MISC. N_R CTRS 194. 02 07952 ACCOUNTABLE CARE	86, 714 1, 448		1	0		194. 01 194. 02
174. UZ U/70Z MOCOUNTABLE CARE	1, 448	<u> </u>	0	·	0	174. UZ

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0074	Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/24/2024 11: 39 am

						5/24/2024 11:	39 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7.00	8. 00	9. 00	10.00	
194. 03 07953	SCHOOL BASED CLINICS	963	0	0	0	0	194. 03
194. 04 07954	SMO-NON PROVIDER BASED	6, 629	0	0	0	0	194. 04
194. 05 07955	FAMILY PRACTICE MEDICINE	50, 108	0	0	0	0	194. 05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	6, 520, 850	3, 296, 881	10, 509	676, 274	365, 178	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0074

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 39 am

					5/24/2024 11:	39 am
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	
		TOWN TVI STIGATION	SUPPLY		LI BRARY	
DENERAL OFFICE COST OFFITTERS	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS 1. 00 OO100 CAP REL COSTS-BLDG & FLXT		1				1. 00
2.00 O0200 CAP REL COSTS-BLDG & FIXT						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A	1, 232, 501	1				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	27, 183		2 227 425			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	6, 796 73, 518		2, 327, 425 1, 163, 696	2, 763, 633		14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	618		1, 103, 070	1, 381, 816	1, 473, 929	16. 00
17. 00 01700 SOCI AL SERVI CE	13, 591		23	0	0	17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	40, 774	1	44	0	0	21. 00
22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	30, 272	0	310	0	0	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	354, 615	1	58, 002	0	89, 553	30.00
31. 00 03100 I NTENSI VE CARE UNIT	87, 727		20, 328	0	30, 705	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	14, 209 3, 089		3, 140 893	0	9, 923 973	35. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	3,009	1, 13/	093	U	9/3	43.00
50. 00 05000 OPERATING ROOM	71, 046	36, 495	95, 194	0	84, 276	50. 00
51.00 05100 RECOVERY ROOM	4, 942		897	0	6, 284	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	14, 827		3, 869	0	4, 217	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 974	1	1, 293	0	24, 548	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	6, 178	1	1, 347	0	12, 875	55. 00
57. 00 05700 CT SCAN	22, 858	1	6, 530	0	48, 695	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATION	4, 325 29, 036		370 6, 418	0	7, 614 130, 462	58. 00 59. 00
60. 00 06000 LABORATORY	29, 030		54, 577	0	46, 034	60.00
64. 00 06400 I NTRAVENOUS THERAPY	9, 885		1, 929	Ö	3, 510	64. 00
65. 00 06500 RESPIRATORY THERAPY	30, 272	1	6, 576	0	16, 466	65. 00
66. 00 06600 PHYSI CAL THERAPY	21, 005	o	2, 031	0	8, 062	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	11, 120		567	0	2, 781	67. 00
68. 00 06800 SPEECH PATHOLOGY	5, 560	1	1, 695	0	1, 262	68. 00
69. 00 06900 ELECTROCARDI OLOGY	28, 419		3, 271	0	21, 925	69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 560 0	0 0	1, 636 787, 834	0	3, 062 39, 858	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	1	767, 634	0	40, 317	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	C		0	1, 381, 817	495, 240	73. 00
73. 01 07301 SPECIALTY PHARMACY	3, 707	o	0	0	45, 069	73. 01
73. 02 07302 CONTRACTED PHARMACY	C	o	0	0	13, 051	73. 02
74.00 07400 RENAL DI ALYSI S	618	1	108	0	2, 068	74.00
76. 00 03330 ENDOSCOPY	3, 089		647	0	1, 909	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	35, 832	0	4, 694	0	7, 250	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP 76. 04 03952 WOUND CARE CENTER	7, 414		3, 691 3, 422	0	158 5, 150	76. 03 76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	118, 617	1	25, 492	0	110, 671	76. 04 76. 05
76. 06 03953 MAGI NG CENTERS	110,017	1	10, 153	0	32, 400	76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	C	_	0	0	2, 392	76. 07
76. 97 07697 CARDIAC REHABILITATION	9, 267	o	531	0	1, 845	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 853	0	745	0	1, 213	76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	C		0	0	0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	C	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	C	ار	0	O	0	90. 00
90. 00 04950 MULTI DI SCI PLI NARY CLI NI C	C		0	0	5	90.00
90. 02 04951 HEALTHY HEARTS CENTER	13, 591	1 ~1	1, 457	0	2, 064	90. 02
90. 03 09001 PALLI ATI VE CARE	C	o	0	0	191	90. 03
90. 04 04953 SPI NE CENTER	C	o	0	0	0	90. 04
90. 05 04954 I NFUSI ON CENTERS	C	0	976	0	923	90. 05
90. 06 09002 MEDCHECK CLI NI CS	C	이	0	0	0	90. 06
90. 07 09003 KNEE CENTER	21, 005	1	607	0	2, 155	90. 07
91. 00 09100 EMERGENCY	87, 109	44, 799	37, 708	O	116, 773	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 232, 501	637, 486	2, 312, 706	2, 763, 633	1, 473, 929	118. 00
NONREI MBURSABLE COST CENTERS	1, 202, 301	037, 400	2, 312, 700	2, 700, 000	1, 415, 727	. 10. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	C	0	0	0		192. 00
194.00 07950 HOME OFFICE	C	1	0	0		194. 00
194.01 07951 GROUP HOMES AND MISC. N_R CTRS	C	0	4, 782	0	0	194. 01

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HEALTH NETWORK, INC. Provider CCN: 15-0074

					5/24/2024 11:	39 am_
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16.00	
194. 02 07952 ACCOUNTABLE CARE	0	0	10	0	0	194. 02
194.03 07953 SCHOOL BASED CLINICS	0	0	472	0	0	194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	0	2	0	0	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	0	9, 453	0	0	194. 05
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 232, 501	637, 486	2, 327, 425	2, 763, 633	1, 473, 929	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/24/2024 11:39 am INTERNS & RESIDENTS Cost Center Description SOCIAL SERVICE SERVICES-SALAR SERVICES-OTHER Subtotal Intern & Residents Cost Y & FRINGES PRGM COSTS & Post Stepdown Adjustments 17. 00 21.00 22.00 24. 00 25. 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 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 248, 750 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 347, 684 21.00 0 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 1, 041, 287 22 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 200, 519 12, 016, 817 n 30.00 03100 INTENSIVE CARE UNIT 31.00 37,043 3, 357, 785 31.00 0 02060 NEONATAL INTENSIVE CARE UNIT 35.00 7, 317 303, 484 0 35.00 04300 NURSERY 137, 033 0 43.00 43.00 3,871 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 5, 397, 065 50.00 0 0 05100 RECOVERY ROOM 51.00 0 398.378 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 612, 915 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 529, 060 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 113, 695 0 55.00 05700 CT SCAN 567, 588 57.00 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 414, 197 0 58.00 05900 CARDIAC CATHETERIZATION 1, 581, 421 59 00 59 00 0 60.00 06000 LABORATORY 396, 495 0 60.00 06400 INTRAVENOUS THERAPY 64.00 200, 987 0 64.00 06500 RESPIRATORY THERAPY 65.00 518, 601 0 65.00 06600 PHYSI CAL THERAPY 66.00 1, 160, 065 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 204, 940 0 67.00 68.00 06800 SPEECH PATHOLOGY 99, 722 0 68.00 06900 ELECTROCARDI OLOGY 778.627 69 00 0 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 139, 239 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 137, 443 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 352, 932 0 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 463, 931 73 00 0 73 00 73.01 07301 SPECIALTY PHARMACY 933, 778 0 73.01 07302 CONTRACTED PHARMACY 13, 051 0 73.02 73.02 74.00 07400 RENAL DIALYSIS 40, 695 0 74.00 76.00 03330 ENDOSCOPY 123, 153 0 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3, 250, 159 0 76.01 03951 LUTHERWOOD PARTNERSHIP 76.03 411, 811 76.03 03952 WOUND CARE CENTER 233, 906 76.04 76.04 0 03480 ONCOLOGY-CANCER CARE CENTER 76.05 5.358.059 0 76.05 76.06 03953 I MAGING CENTERS 1, 155, 915 0 76.06 03954 BREAST DIAGNOSTIC CENTER 76.07 240, 169 0 76.07 07697 CARDIAC REHABILITATION 76 97 354, 414 76.97 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 52, 394 0 76.98 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 8, 052 04950 MULTIDISCIPLINARY CLINIC 90 01 000000 0 90.01 04951 HEALTHY HEARTS CENTER 90.02 357.074 90.02 0 09001 PALLIATIVE CARE 90.03 7, 246 0 90.03 04953 SPINE CENTER 90.04 90.04 0 90.05 04954 INFUSION CENTERS 143, 533 0 90.05 09002 MEDCHECK CLINICS 90.06 0 90.06 90.07 09003 KNEE CENTER 659, 907 0 90.07 91.00 09100 EMERGENCY 0 3, 574, 811 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 248.750 0 0 51, 800, 547 0 118.00

Health Financial Systems (COMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co	CN: 15-0074	Period: From 01/01/2023 To 12/31/2023		
Cost Center Description	SOCIAL SERVICE		RESI DENTS SERVI CES-OTHE	R Subtotal	Intern &	
		Y & FRINGES	PRGM COSTS		Residents Cost & Post Stepdown Adjustments	
	17. 00	21. 00	22. 00	24.00	25. 00	
NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			0	0	192. 00
194.00 07950 HOME OFFICE	0			0	1	194. 00
194.01 07951 GROUP HOMES AND MISC. N_R CTRS	0			687, 522	0	194. 01
194. 02 07952 ACCOUNTABLE CARE	0			10, 447	0	194. 02
194. 03 07953 SCHOOL BASED CLINICS	0			5, 512	l	194. 03
194.04 07954 SMO-NON PROVIDER BASED	0			47, 389	0	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0			1, 048, 025	l	194. 05
200.00 Cross Foot Adjustments		347, 684	1, 041, 28	1, 388, 971	0	200. 00
201.00 Negative Cost Centers	0	0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	248, 750	347, 684	1, 041, 28	54, 988, 413	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074

			5/24/2024 1	11:39 am
	Cost Center Description	Total	0,2,,202.	11.07 (4
		26. 00		
1 00	GENERAL SERVICE COST CENTERS			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP			1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10. 00
11. 00	01100 CAFETERI A			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY			14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY			15. 00 16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD			21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD			22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	12, 016, 817		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	3, 357, 785		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	303, 484		35. 00
43. 00	04300 NURSERY	137, 033		43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	5, 397, 065		50.00
50.00	05100 RECOVERY ROOM	398, 378		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	612, 915		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 529, 060		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	113, 695		55.00
57.00	05700 CT SCAN	567, 588		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	414, 197		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 581, 421		59. 00
60.00	06000 LABORATORY	396, 495		60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY	200, 987		64. 00
66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	518, 601 1, 160, 065		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	204, 940		67.00
68. 00	06800 SPEECH PATHOLOGY	99, 722		68. 00
69.00	06900 ELECTROCARDI OLOGY	778, 627		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	139, 239		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 137, 443		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	352, 932		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 463, 931		73. 00
73. 01	07301 SPECI ALTY PHARMACY 07302 CONTRACTED PHARMACY	933, 778		73. 01
73. 02 74. 00	07400 RENAL DI ALYSI S	13, 051 40, 695		73. 02 74. 00
76.00	03330 ENDOSCOPY	123, 153		76.00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 250, 159		76. 01
	03951 LUTHERWOOD PARTNERSHIP	411, 811		76. 03
76.04	03952 WOUND CARE CENTER	233, 906		76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	5, 358, 059		76. 05
76.06	03953 I MAGI NG CENTERS	1, 155, 915		76.06
76. 07	03954 BREAST DIAGNOSTIC CENTER	240, 169		76. 07
76. 97 76. 98	O7697 CARDI AC REHABI LI TATI ON O7698 HYPERBARI C OXYGEN THERAPY	354, 414 52, 394		76. 97 76. 98
76. 98 77. 00	07700 ALLOGENEI C HSCT ACQUISITION	52, 394 0		76. 98
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		78.00
. 5. 55	OUTPATIENT SERVICE COST CENTERS	0		75.00
90.00	09000 CLI NI C	0		90.00
90. 01	04950 MULTI DI SCI PLI NARY CLI NI C	8, 052		90. 01
90. 02	04951 HEALTHY HEARTS CENTER	357, 074		90. 02
90. 03	09001 PALLI ATI VE CARE	7, 246		90. 03
90. 04	04953 SPINE CENTER	140 500		90. 04
90.05	04954 I NFUSI ON CENTERS	143, 533		90. 05
90. 06 90. 07	09002 MEDCHECK CLINICS 09003 KNEE CENTER	659, 907		90. 06 90. 07
90.07	09100 EMERGENCY	3, 574, 811		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 374, 011		92.00
, 00	SPECIAL PURPOSE COST CENTERS			72.00
118.00		51, 800, 547		118. 00
	NONREI MBURSABLE COST CENTERS			
	19200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
	07950 HOME OFFICE	0		194. 00
	07951 GROUP HOMES AND MISC. N_R CTRS	687, 522		194. 01
	07952 ACCOUNTABLE CARE	10, 447		194. 02
194. 03	07953 SCHOOL BASED CLINICS	5, 512		194. 03

Health Finar	ncial Systems (In Lie	u of Form CMS-2	552-10		
ALLOCATION (OF CAPITAL RELATED COSTS		Provider CCN: 15-0074	Period: From 01/01/2023 To 12/31/2023		
	Cost Center Description	Total				
		26. 00				
194. 04 07954	SMO-NON PROVIDER BASED	47, 389			1	194. 04
194. 05 07955	FAMILY PRACTICE MEDICINE	1, 048, 025			1	194. 05
200. 00	Cross Foot Adjustments	1, 388, 971			2	200.00
201.00	Negative Cost Centers	0			2	201. 00
202. 00	TOTAL (sum lines 118 through 201)	54, 988, 413			2	202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0074 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 11:39 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 834 042 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 67, 741, 901 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 6, 271 33, 668, 235 264, 239, 749 4.00 00500 ADMINISTRATIVE & GENERAL 9, 645, 766 11, 465, 246 5 00 38 356 873 009 626 5 00 -144, 156, 069 7.00 00700 OPERATION OF PLANT 111, 455 236, 310 2, 395, 296 25, 638, 917 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1, 407, 045 8.00 00900 HOUSEKEEPI NG 10, 556 33, 213 4, 276, 183 0 8, 091, 732 9.00 9.00 10.00 01000 DI ETARY 959, 925 0 2, 750, 694 10 00 8.676 23, 021 11.00 01100 CAFETERI A 24,012 185, 603 2, 660, 735 0 4, 692, 619 11.00 01300 NURSING ADMINISTRATION 8, 395 3, 839, 140 10, 659, 718 13.00 43, 407 0 13.00 01400 CENTRAL SERVICES & SUPPLY 16, 863 2, 763, 219 705, 353 6, 803, 551 14.00 14.00 9, 191 15.00 01500 PHARMACY 941, 424 10, 188, 657 15, 492, 607 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 164 103, 624 0 6, 481, 160 16.00 01700 SOCIAL SERVICE 0 17.00 2,732 1, 991, 772 2, 926, 583 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 4, 208, 500 0 2, 360 4, 785, 571 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 4, 440 62, 791 11, 627, 035 12, 667, 763 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 184, 608 1, 571, 587 59, 336, 564 0 81, 172, 213 30.00 03100 INTENSIVE CARE UNIT 31.00 48.104 1, 050, 765 14, 187, 082 0 22, 447, 390 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 2,682 33, 054 2, 222, 791 0 3, 465, 311 35.00 04300 NURSERY 499, 830 0 43.00 2,012 48, 549 960, 213 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 937, 498 10, 240, 749 26, 927, 739 50.00 89.021 0 51.00 05100 RECOVERY ROOM 8, 217 117, 547 913, 381 0 1, 584, 554 51.00 05200 DELIVERY ROOM & LABOR ROOM 8,717 0 52.00 210, 355 2, 640, 574 4, 704, 756 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 27, 753 743.744 3, 136, 669 6, 567, 363 54.00 05500 RADI OLOGY-THERAPEUTI C 37, 305 55.00 153 841, 901 2, 128, 990 55.00 481, 154 05700 CT SCAN 2, 642, 995 5, 417, 696 57.00 1, 264 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 12 671, 740 814, 652 0 1, 911, 101 58.00 05900 CARDIAC CATHETERIZATION 13.738 59 00 1, 265, 187 4, 507, 840 8, 748, 394 59 00 60.00 06000 LABORATORY 4,533 53, 826 17, 023, 268 60.00 06400 I NTRAVENOUS THERAPY 64.00 2, 210 9, 193 1, 403, 526 0 2, 928, 811 64.00 06500 RESPIRATORY THERAPY 913 78, 297 5, 296, 565 7, 755, 334 65.00 65.00 06600 PHYSI CAL THERAPY 1, 152, 922 5, 042, 876 8, 304, 320 66.00 5, 384 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 1,796 10, 454 1, 694, 671 2, 722, 997 67.00 68.00 06800 SPEECH PATHOLOGY 762 7, 431 829, 447 0 0 0 1, 398, 220 68.00 06900 ELECTROCARDI OLOGY 5, 189, 135 69 00 2 132 786, 574 3 543 121 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 86 129, 867 794, 450 1, 415, 114 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 41, 471, 515 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 41, 854, 961 72.00 07300 DRUGS CHARGED TO PATIENTS 0 o 212, 415, 842 73 00 73 00 Ω 73.01 07301 SPECIALTY PHARMACY 0 0 3, 123, 502 0 91, 665, 721 73.01 07302 CONTRACTED PHARMACY 0 -21, 967, 212 73.02 73.02 74.00 07400 RENAL DIALYSIS 408 111, 364 2, 408, 164 74.00 03330 ENDOSCOPY 148, 504 550, 662 76.00 0 0 1, 071, 741 76 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 4,768 1, 737, 877 29, 631, 845 0 38, 265, 821 76.01 03951 LUTHERWOOD PARTNERSHIP 76.03 162, 780 4, 010, 263 9, 312, 690 76.03 0 03952 WOUND CARE CENTER 979, 004 76.04 4.173 7, 368 2, 772, 593 76.04 03480 ONCOLOGY-CANCER CARE CENTER 16, 194, 887 76.05 78.282 2, 460, 758 51, 803, 430 76.05 0 03953 I MAGING CENTERS 3,058 1, 395, 706 4, 061, 312 8, 182, 854 76.06 76.06 03954 BREAST DIAGNOSTIC CENTER 0 76.07 5, 405 95,000 2, 839, 910 76.07 0 76 97 07697 CARDIAC REHABILITATION 5.922 168, 911 958, 050 1, 568, 036 76. 97 1, 737 76. 98 07698 HYPERBARI C OXYGEN THERAPY 984 192, 147 0 614, 517 76.98 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 C 0 04950 MULTIDISCIPLINARY CLINIC 0 90 01 0 15,663 2 327 11, 595 90.01 04951 HEALTHY HEARTS CENTER 3.321 175, 335 0 90.02 2, 110, 860 1, 762, 213 90.02 0 90.03 09001 PALLIATIVE CARE 224 C 5, 696 90.03 04953 SPINE CENTER 90.04 90.04 0 90.05 04954 INFUSION CENTERS 0 211, 463 465, 362 847, 574 90.05 09002 MEDCHECK CLINICS 0 90.06 0 C 0 90.06 90.07 09003 KNEE CENTER 14,659 14, 613 2, 086, 554 4, 839, 879 90.07 91.00 09100 EMERGENCY 66,630 379, 271 12, 927, 205 24, 595, 026 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 834.042 65, 977, 384 252, 416, 494 -166, 123, 281 853, 480, 657 118. 00

Health Financial Systems 0	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/24/2024 11:	
	CAPITAL REL	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	

						5/24/2024 11:	<u>39 am</u>
		CAPITAL REI	LATED COSTS				
			I				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4. 00	5A	5. 00	
NONRE	I MBURSABLE COST CENTERS	1.00	2.00	4.00	JA	3.00	
	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
	HOME OFFICE	0	0	0	0		194. 00
	GROUP HOMES AND MISC. N_R CTRS	0	215, 890	7, 613, 696	0	11, 609, 797	
	ACCOUNTABLE CARE	0	0	140, 142		193, 830	
194. 03 07953	SCHOOL BASED CLINICS	0	0	63, 562		128, 975	1
194. 04 07954	SMO-NON PROVIDER BASED	0	0	635, 422	0	887, 515	194. 04
194. 05 07955	FAMILY PRACTICE MEDICINE	0	1, 548, 627	3, 370, 433	0	6, 708, 852	194. 05
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	21, 206, 684	33, 781, 729	29, 044, 024		144, 156, 069	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	25. 426398	0. 498683			0. 165125	l
204. 00	Cost to be allocated (per Wkst. B,			16, 949, 222		6, 520, 850	204. 00
	Part II)					'	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 064143		0. 007469	205. 00
20/ 00	NAUE adjustment amount to be all accepted						20/ 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,	-					207. 00
207.00	Parts III and IV)						207.00
I	prairie and rv)	I	I	I		i I	I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0074

				T	0 12/31/2023	Date/Time Pre 5/24/2024 11:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(PATIENT DAYS)	(ONSITE FTES)	
		(SQUARE TEET)	LAUNDRY)				
	OFNEDAL CERVI OF COCT OFNITERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	677, 960					5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	077, 700	309, 727				8. 00
9. 00	00900 HOUSEKEEPI NG	10, 556	154, 863	667, 404			9. 00
10.00	01000 DI ETARY	8, 676	0	-,			10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	24, 012 8, 395	0	24, 012 8, 395		1, 995 44	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	16, 863	0	16, 863	0	11	14. 00
15. 00	01500 PHARMACY	9, 191	0	9, 191	0	119	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 164 2, 732	0	1, 164 2, 732	0	1 22	16. 00 17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	2, 732	0		0	66	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	4, 440	0	4, 440	0		22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	104 (00	7/ /15	104 (00	00.053	F74	1 20 00
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	184, 608 48, 104	76, 615 13, 369		80, 853 15, 234	574 142	30. 00 31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	2, 682	13, 307		13, 234	23	35. 00
43.00	04300 NURSERY	2, 012	1, 338	2, 012	0	5	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	90.021	17 220	89, 021	0	115	E0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	89, 021 8, 217	17, 328 0	·	0		50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	8, 717	5, 799		0	_	52. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	27, 753	10, 718		0		54.00
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	153 1, 264	0	153 1, 264	0	10 37	55. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 204	0	1, 204	0	7	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	13, 738	1, 593		0	47	59. 00
60.00	06000 LABORATORY	4, 533	0	.,	0	0	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 210 913	0	2, 210 913	0	16 49	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 384	0	5, 384	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 796	0	1, 796			67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	762 2, 132	0	762 2, 132	0	9 46	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	86	0	2, 132	0	9	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 73. 01	O7300 DRUGS CHARGED TO PATIENTS O7301 SPECIALTY PHARMACY		0	0	0	0	73. 00 73. 01
73. 02	07302 CONTRACTED PHARMACY	Ö	0	Ö	0	0	73. 02
74. 00	07400 RENAL DI ALYSI S	408	0	408	0		74. 00
76. 00 76. 01	03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 4, 768	3, 714 0	0 4, 768	0	5 58	76. 00 76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	4, 700	0	4, 700	0	0	•
76. 04	03952 WOUND CARE CENTER	4, 173	3, 460	4, 173	0	12	•
	03480 ONCOLOGY-CANCER CARE CENTER	78, 282	0	,		192	1
76. 06 76. 07	03953 IMAGING CENTERS 03954 BREAST DI AGNOSTIC CENTER	3, 058 5, 405	0	3, 058 5, 405		0	76. 06 76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	5, 922	0	5, 922		15	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	984	0	984		3	76. 98
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	_	0 0	77. 00 78. 00
70.00	OUTPATIENT SERVICE COST CENTERS				0		70.00
90.00	09000 CLI NI C	0	0	•			90. 00
90. 01 90. 02	04950 MULTI DI SCI PLI NARY CLI NI C 04951 HEALTHY HEARTS CENTER	0	0	_	0	0 22	90. 01 90. 02
90. 02	09001 PALLIATIVE CARE	3, 321 224	283 0		0	0	90. 02
90. 04	04953 SPI NE CENTER	o	0	0	0	0	90. 04
90.05	04954 I NFUSION CENTERS	0	0	0	0	0	90. 05
90. 06 90. 07	09002 MEDCHECK CLINICS 09003 KNEE CENTER	14, 659	0	0 14, 659	0	0 34	90. 06 90. 07
91. 00	09100 EMERGENCY	66, 630	20, 647			141	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	677.040	200 727	667 404	192, 173	1 005	118. 00
118.00	NONREIMBURSABLE COST CENTERS	677, 960	309, 727	667, 404	192, 1/3	1, 995	1110.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192. 00
194.00	07950 HOME OFFICE	0	0	0	0	0	194. 00

						5/24/2024 11:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(ONSITE FTES)	
		(SQUARE FEET)	(POUNDS OF				
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 01 07951	GROUP HOMES AND MISC. N_R CTRS	0	0	0	0	0	194. 01
194. 02 07952	ACCOUNTABLE CARE	0	0	0	0	0	194. 02
194. 03 07953	SCHOOL BASED CLINICS	0	0	0	0	0	194. 03
194. 04 07954	SMO-NON PROVIDER BASED	0	0	0	0	0	194. 04
194. 05 07955	FAMILY PRACTICE MEDICINE	0	0	0	0	0	194. 05
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	29, 872, 543	1, 639, 383	10, 712, 691	3, 726, 448	8, 774, 152	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	44. 062397	5. 292994	16. 051284	19. 391111	4, 398. 071178	203. 00
204. 00	Cost to be allocated (per Wkst. B,	3, 296, 881	10, 509	676, 274	365, 178	1, 232, 501	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	4. 862943	0. 033930	1. 013290	1. 900257	617. 794987	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 A	ALLOCATION - STATISTICAL BASIS		Provi der CC		eri od:	Worksheet B-1	
				T	rom 01/01/2023 o 12/31/2023		
	Cost Contor Dosorintian	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/24/2024 11: SOCI AL SERVI CE	
	Cost Center Description	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	SUCTAL SERVICE	
			SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT	
		(DI RECT NURS.	(COSTED		(GROSS	DAYS)	
		HRS.) 13. 00	REQUI S.) 14. 00	15. 00	CHARGES) 16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
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
7. 00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	4, 161, 069					11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 080, 534	122, 517, 129				14. 00
15.00	01500 PHARMACY	0	61, 258, 564	200			15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	276	100		1	16.00
17. 00	01700 SOCIAL SERVICE	0	1, 234	0	_	102, 299	
21. 00 22. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		2, 317 16, 311	0			
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	10, 011	0			22.00
30.00	03000 ADULTS & PEDIATRICS	1, 194, 814	3, 053, 210	0			
31. 00	03100 NTENSI VE CARE UNI T	294, 624	1, 070, 072	0		15, 234	
35. 00 43. 00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	11, 337	165, 274 47, 002	0			
43.00	ANCI LLARY SERVI CE COST CENTERS	11, 337	47,002	0	2, 770, 400	1, 372	43.00
50.00	05000 OPERATI NG ROOM	238, 218	5, 010, 977	0	242, 173, 608	0	50.00
51. 00	05100 RECOVERY ROOM	0	47, 232	0		l .	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	49, 122	203, 653	0		0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	68, 057 70, 922	0	, ,	l ~	54. 00 55. 00
57. 00	05700 CT SCAN	0	343, 742	0		l e	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	19, 462	0	21, 879, 801	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	337, 841	0	, ,	l e	
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY		2, 872, 941 101, 527	0	, ,	l e	60.00
65. 00	06500 RESPIRATORY THERAPY		346, 150	0		l e	65.00
66. 00	06600 PHYSI CAL THERAPY	O	106, 917	0		l	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	29, 837	0	7, 992, 694	l	67. 00
68.00	06800 SPEECH PATHOLOGY	0	89, 209	0	3, 626, 628	l	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	172, 173 86, 137	0	63, 001, 917 8, 799, 174	l	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		41, 471, 513	0		l	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	115, 853, 518	l	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		1, 423, 361, 034		
	07301 SPECIALTY PHARMACY	0	0	0			
74.00	07302 CONTRACTED PHARMACY 07400 RENAL DI ALYSI S		5, 710	0	37, 503, 231 5, 943, 205	0	73. 02 74. 00
76. 00	03330 ENDOSCOPY		34, 076	0	5, 484, 255		76.00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	247, 079	0		0	76. 01
76. 03		0	194, 268	0	453, 365	l e	76. 03
76. 04 76. 05	03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER	0	180, 153 1, 341, 876	0	14, 798, 116 318, 020, 426		76. 04 76. 05
76. 06	03953 I MAGING CENTERS		534, 451	0	93, 103, 518	l .	76.05
76. 07	03954 BREAST DIAGNOSTIC CENTER	0	0	0	6, 872, 156	l e	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	0	27, 935	0	5, 302, 636		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	39, 201	0	-,,	i e	76. 98
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY		0	0		0	
70.00	OUTPATIENT SERVICE COST CENTERS	١	<u> </u>	0		0	70.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	04950 MULTI DI SCI PLI NARY CLI NI C	0	0	0		l	
90. 02 90. 03		0	76, 694	0		l	
	09001 PALLI ATI VE CARE 04953 SPI NE CENTER		0	0	549, 919 340	l	90. 03 90. 04
90. 05	04954 I NFUSI ON CENTERS		51, 373	0		ő	1
90.06	09002 MEDCHECK CLINICS	0	0	0	0	0	90. 06
90. 07	09003 KNEE CENTER	0	31, 961	0	-,,	l	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	292, 420	1, 984, 971	0	335, 554, 140	0	91. 00 92. 00
7Z. UU	SPECIAL PURPOSE COST CENTERS				I		, 72.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 161, 069	121, 742, 298	200	4, 235, 689, 266	102, 299	118. 00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSICIANS'PRIVATE OFFICES	0	0	0	0	<u> </u>	192. 00

Provider CCN: 15-0074

NURSING ADMINISTRATION SERVICES SUPPLY (COSTED RECORDS & LIBRARY (GROSS CHARGES) LIB						7 12/31/2023	5/24/2024 11:	
CDIRECT NURS. SUPPLY (COSTED REQUIS.) LI BRARY (GROSS CHARGES) LI BRASED LI BRARY (GROSS CHARGES) LI BRASED LI BRASED CHARGES L		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
CDIRECT NURS. CCOSTED REQUIS. CHARGES DAYS CHARGES DAYS		•	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
HRS. REOULS. CHARGES				SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT	
13.00			(DI RECT NURS.	(COSTED		(GROSS	DAYS)	
194. 00 07950 HOME OFFICE			HRS.)	REQUI S.)		CHARGES)		
194. 01 07951 GROUP HOMES AND MISC. N_R CTRS 194. 02 07952 ACCOUNTABLE CARE 194. 03 07953 SCHOOL BASED CLINICS 194. 04 07954 SMO-NON PROVIDER BASED 194. 05 07955 FAMILY PRACTICE MEDICINE 200. 00 Cross Foot Adjustments Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. D, 207. 00 207. 00 207. 00 208. 00 209. 00 200. 0			13. 00	14.00	15. 00	16. 00		
194. 02 07952 ACCOUNTABLE CARE 0 518 0 0 194. 02 194. 03 07953 SCHOOL BASED CLINICS 0 24, 857 0 0 0 194. 03 194. 04 07954 SMO-NON PROVIDER BASED 0 102 0 0 0 194. 04 194. 05 07955 FAMILY PRACTICE MEDICINE 0 497, 619 0 0 194. 05 200. 00 Cross Foot Adjustments Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 3. 152573 0. 126906 134, 503. 575000 0. 004976 35. 884808 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 0. 153202 0. 018997 13, 818. 165000 0. 000348 2. 431598 205. 00 206. 00 NAHE adjustment amount to be allocated (per Wkst. B, 2) NAHE unit cost multiplier (Wkst. D, 207. 00			0	0	0	0		
194. 03 07953 SCHOOL BASED CLINICS 194. 04 07954 SMO-NON PROVIDER BASED 194. 04 07954 SMO-NON PROVIDER BASED 194. 05 07955 FAMILY PRACTICE MEDICINE 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wk			0			0		
194. 04 07954 SMO-NON PROVIDER BASED 0 102 0 0 194. 04 197, 619 0 0 194. 05 200. 00 Cross Foot Adjustments 200. 00 Negative Cost Centers 202. 00 Unit cost multiplier (Wkst. B, Part I) 3. 152573 0. 126906 134, 503. 575000 0. 004976 35. 884808 203. 00 Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 0. 153202 0. 018997 13, 818. 165000 0. 000348 2. 431598 205. 00 207. 00 NAHE unit cost multiplier (Wkst. D, 207. 00 207. 00 207. 00 0. 000476 207. 00 0. 000476 207. 00 0. 000476 207. 00 0. 000476 207. 00 0. 000348 2. 431598 205. 00 207. 00 207. 00 207. 00 0. 000476 207. 00 207. 00 207. 00 0. 000476 207. 00 0. 00	194. 02 07952	ACCOUNTABLE CARE	0	518	0	0	0	194. 02
194. 05 07955 FAMILY PRACTICE MEDICINE 0 497, 619 0 0 194. 05 200. 00 201. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 3. 152573 0. 126906 134, 503. 575000 0. 004976 35. 884808 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part II) 0. 153202 0. 018997 13, 818. 165000 0. 000348 2. 431598 205. 00 206. 00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 0. 153202 0. 018997 13, 818. 165000 0. 000348 2. 431598 206. 00 207. 00 NAHE unit cost multiplier (Wkst. D, Part II) 0. 153202 0. 018997 13, 818. 165000 0. 000348 2. 431598 206. 00 207. 00 207. 00 0. 000348 2. 431598 207. 00 207. 00 207. 00 0. 000348 2. 431598 207. 00 207. 00 207. 00 0. 000348 2. 431598 207. 00 207. 0	194. 03 07953	SCHOOL BASED CLINICS	0	24, 857	0	0	0	194. 03
200.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, Negative Cost Centers 200.00 201.00 201.00 202.00 201.00 201.00 201.00 202.00 201.00 202.00 202.00 203.00 204.00 205.40 206.00 206.00 207.00 208.00 209.0	194. 04 07954	SMO-NON PROVIDER BASED	0	102	0	0	0	194. 04
201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 205.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE un	194. 05 07955	FAMILY PRACTICE MEDICINE	0	497, 619	0	0	0	194. 05
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, Part III) 208.00 NAHE unit cost multiplier (Wkst. D, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	200. 00	Cross Foot Adjustments						200. 00
Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D,	201. 00	Negative Cost Centers						201. 00
204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) O. 153202 O. 018997 13,818.165000 O. 000348 2. 431598 205.00 O. 0000348 O. 0000348	202. 00		13, 118, 074	15, 548, 098	26, 900, 715	21, 076, 125	3, 670, 980	202. 00
Part II) Unit cost multiplier (Wkst. B, Part II) 205.00	203. 00	Unit cost multiplier (Wkst. B, Part I)	3. 152573	0. 126906	134, 503. 575000	0. 004976	35. 884808	203. 00
205.00 Unit cost multiplier (Wkst. B, Part 11) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	204. 00	Cost to be allocated (per Wkst. B,	637, 486	2, 327, 425	2, 763, 633	1, 473, 929	248, 750	204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00		Part II)						
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	205. 00		0. 153202	0. 018997	13, 818. 165000	0. 000348	2. 431598	205. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		1 *						
207.00 NAHE unit cost multiplier (Wkst. D,	206. 00							206. 00
		, ,						
Parts III and IV)	207. 00							207. 00
1 1		Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0074

2 20 00200 QAP RELL COSTS-MABLE EQUIP			_		5/24/2024 11: 39 am
PART COSTS PART COST CENTERS 10 27 00 10 00 00 00 00 00 0			INTERNS &	RESI DENTS	
P. S. FININGES PARK COST CANTERN		Coot Conton Decemintion	CEDVI CEC CALAD	CEDVI CEC OTHER	
CEREMAL SERVICE COST CENTERS 10.00 27.00		Cost Center Description			
1196.7 1185. 1185.					
21.00 22.00 22.00			,	,	
1.00					
2.00		GENERAL SERVICE COST CENTERS			
4.00 00400 DMPLOYEE BENEFITS GENERAL					1.00
					2. 00
2,00 0.0700 DORENTI ON GF PLANT					4.00
8.00 00800 DAJRORY & LINEN SERVICE					5. 00 7. 00
9.00 00000 00000 00100 10100 00000 0011 10100 00000 0011 10100 00000 0011 10100 00000 0011 10100 00000 0011 10100 00000 0011 10100 00000 0011 10100 00000 0011 10100 00000 0011 10100 00000 0011 10100 00000 0011 10100 00100 0011 10100 00100 0011 10100 00100 0011 10100 00100 0011 10100 00100 0011 10100 001000 001000 001000 001000 001000 001000 0010000 0010000 00100000 001000000 00100000000					8.00
10.00 01000 DETARY					9. 00
11.00 01.00 CAFETRIA					10.00
14.00 01400 CENTRAL SERVICES & SUPPLY		1			11. 00
15.00 01500 PHARMACY	13.00	01300 NURSING ADMINISTRATION			13. 00
16.00 01600 MFDICAL RECORDS & LIBRARY	14. 00				14. 00
17.00 01700 SOCIAL SERVICE 221.00 02100 IMS SERVICES-SALARY & FRI NGES APPRVD 251,800 22.1 22.00 02200 IMS SERVICES-STHER PROJUCES SERVICE SOST CENTERS 32.000 330.00					15. 00
21.00 0200 IAS SERVICES-SALARY & FRI NGES APPROV					16.00
22.0 0.0200 LAR SERVICES-OTHER PROM COST SAPPRVD 22.			251 000		17. 00
INPATI ENT ROUTINE SERVICE COST CENTERS 312,600 132,600 30. 30		1	251, 800	1	
30.00 030000 ADULTS & PEDIATRICS 132,600 132,600 31. 30.0 330.0 330.0 330.0 330.0 145.0 145.0 150.0 50.0 31. 35.0 030.0 03060 NEONATAL INTENSIVE CARE UNIT 4,200 4,200 43.3 34.3 04.0 430.0 MISFERY 0 0 43.3 36.3 36.3 36.0 430.0 MISFERY 0 0 0 45.3 36.3	22.00			231, 600	22.00
31. 00 03100 INTENSIVE CARE UNIT 4,00 4,200 4,200 35. 00 0260 NEONEMATAL INTENSIVE CARE UNIT 4,200 4,200 35. 00 0300 NEONEMATAL INTENSIVE CARE UNIT 4,200 4,200 35. 00 0300 NEONEMATAL INTENSIVE COST CENTERS 43. 00 0 0 0 0 0 0 0 0 0	30.00		132 600	132 600	30.00
35. 00 02000 NIEONATAL INTENSIVE CARE UNIT			1		31. 00
ANCILLARY SERVICE COST CENTERS 50.00 50.					35. 00
50.00 050000 0FEATT NIC ROOM	43.00	04300 NURSERY	0	0	43. 00
51.00 05100 RECOVERY ROOM					
52.00 05200 DELLYERY ROOM & LABOR ROOM 0 54.			1	i i	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 554.		1		-	51.00
55.00 05500 RADIO LOGY-THERAPEUTIC				0	52.00
57.00 05700 CT SCAN 0 0 0 0 57. SCAN 59.00 05900 CARDITIC RESONANCE IMAGING (MRI) 0 0 0 58.			1	0	55. 00
SB. 00 OSBOO MAGNETIC RESONANCE I MAGING (MRI)			١	-	57. 00
59.00 0.5900 CARDIAC CATHETERIZATION 2,200 2,200 0.00			١	-	58.00
64.00 06400 INTRAVENDUS THERAPY 0 0 0 65.00 06		, ,	2, 200	2, 200	59. 00
65.00 06500 RESPIRATORY THERAPY 0 0 0 665. 66.00 06600 PHYSICAL THERAPY 13,500 13,500 66. 67.00 06600 PHYSICAL THERAPY 0 0 0 0 67. 68.00 06600 SPECH PATHOLOGY 0 0 0 0 68. 69.00 06600 ELECTROCARDIOLOGY 0 0 0 0 69. 69.00 06000 ELECTROCARDIOLOGY 0 0 0 0 0 71.00 07000 ELECTROCARDIOLOGY 0 0 0 0 71. 72.00 07000 ELECTROCARDIOLOGY 0 0 0 77. 73.00 07300 DRUISS CHARGED TO PATIENTS 0 0 0 77. 73.00 07300 PURIS CHARGED TO PATIENTS 0 0 0 73. 73.01 07301 SPECIALTY PHARMACY 0 0 0 73. 73.01 07301 SPECIALTY PHARMACY 0 0 0 73. 73.02 07302 CONTRACTED PHARMACY 0 0 0 74. 74.00 07400 REALD IDLAYS 0 0 0 74. 75.01 07350 SPECIALTY PHARMACY 0 0 0 74. 76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 43, 200 43, 200 76. 76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 43, 200 43, 200 76. 76.04 03952 WOUND CARE CENTER 2, 600 2, 600 76. 76.05 03480 MOCOLOGY-CANCER CARE CENTER 2, 600 2, 600 76. 76.07 03954 BREAST DI AGNOSTIC CENTER 0 0 0 76. 76.09 07690 VARBOR CONTRACTED CO	60.00		1	l	60.00
66.00 06600 06700 0CCUPATI ONAL THERAPY 13,500 13,500 66.66.7.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0.6800 06800 SPECH PATHOLOGY 0 0 0 0 0.6800 0.6900	64. 00	06400 I NTRAVENOUS THERAPY	0	0	64. 00
67.00 06700 06CUPATI ONAL THERAPY 0 0 0 6880 SPEECH PATHOLOGY 0 0 0 0 6890 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0		1	_		65. 00
68.00 06800 SPEECH PATHOLOGY 0 0 0 688 68.9.00 06900 ELECTROCARDI OLOGY 0 0 0 0 70.00 07000 ELECTROCARDI OLOGY 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.73.00 07300 ORUGS CHARGED TO PATIENTS 0 0 0 73.31.01 07301 SPECI ALTY PHARMACY 0 0 0 73.31.01 07301 SPECI ALTY PHARMACY 0 0 0 74.00 07400 REVALD DIALYSIS 0 0 0 75.01 03301 DRUGS CHARGED TO PATIENTS 0 0 0 76.01 03330 ENDOSCOPY 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 43, 200 43, 200 76. 76.01 033501 LUTHERWOOD PARTINERSHI P 0 0 0 76.03 03951 LUTHERWOOD PARTINERSHI P 0 0 0 76.04 03952 WOUND CARE CENTER 2, 600 2, 600 76. 76.05 03480 ONCOLOGY-CANCER CARE CENTER 2, 700 2, 700 76. 76.07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 76.09 07967 CARDI CAR ECHABIL LITATI ON 0 0 76.09 07967 CARDI CAR ECHABIL LITATI ON 0 0 76.09 07967 CARDI CAR ECHABIL LITATI ON 0 0 76.09 07967 CARDI CAR ECHABIL LITATI ON 0 0 76.00 07000 CART T-CELL I MUNIOTHERAPY 0 0 76.01 07500 CART T-CELL I MUNIOTHERAPY 0 0 76.02 07500 CART T-CELL I MUNIOTHERAPY 0 0 76.03 07500 CART T-CELL I MUNIOTHERAPY 0 0 76.04 07500 CART T-CELL I MUNIOTHERAPY 0 0 76.05 07500 CART T-CELL I MUNIOTHERAPY 0 0 76.07 07500 CART T-CELL I MUNIOTHERAPY 0 0 76.08 07500 CART T-CELL I MUNIOTHERAPY 0 0 77.09 07500 07500 07500 07500 07500 77.00 07500 CART T-CELL I MUNIOTHERAPY 0 0 78.00 07500 07500 07500 07500 07500 78.00 07500 07500 07500 07500 07500 78.00 07500 07500 07500 07500 07500 78.00 07500 07500 07500 07500 07500 78.00 07500 07500 07500 07500 07500 78.00 075000 07500 07500 07500 78.00 075000 07500 075000 075000 78.00 07			13, 500	13, 500	66.00
69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70. 70. 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71. 72. 73. 00 7300 DRUGS CHARGED TO PATIENTS 0 0 0 73.			0	0	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72.			0	0	70.00
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 773. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 773. 10 07301 SPECI ALTY PHARIMACY 0 0 0 0 773. 10 07301 SPECI ALTY PHARIMACY 0 0 0 0 0 773. 10 07302 CONTRACTED PHARIMACY 0 0 0 0 0 0 174. 1		1	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0	o	72. 00
73. 02 07302 CONTRACTED PHARMACY 0 0 0 0 74.00 RENAL DIALYSIS 0 0 0 0 75.6 00 0330 EMBOSCOPY 0 0 0 0 75.6 0.00 0330 EMBOSCOPY 0 0 0 0 0 75.6 0.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 43, 200 43, 200 76. 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 43, 200 43, 200 76. 04. 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 43, 200 43, 200 76. 04. 03952 WOUND CARE CENTER 2, 600 2, 600 76. 04. 03952 WOUND CARE CENTER 2, 600 2, 600 76. 05. 03480 ONCOLOGY-CANCER CARE CENTER 2, 700 2, 700 76. 05. 05. 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 76. 07. 03954 BREAST DIAGNOSTIC CENTER 0 0 0 0 75. 07. 07. 07. 07. 07. 07. 07. 07. 07. 07			0	o	73. 00
74. 00 07400 RENAL DI ALYSI S 76. 00 03330 ENDOSCOPY 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 03 03951 LUTHERWOOD PARTNERSHI P 76. 04 03952 WOUND CARE CENTER 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 76. 06 03953 I MAGI NG CENTERS 76. 07 03954 BREAST DI AGNOSTI C CENTER 76. 07 03954 BREAST DI AGNOSTI C CENTER 76. 08 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 79. 00 07800 CAR T-CELL I IMMUNOTHERAPY 79. 00 07800 CAR T-CELL I IMMUNOTHERAPY 79. 00 07800 DUTPATI ENT SERVI CE COST CENTERS 79. 00 07900 PLI HEALTHY HEARTS CENTER 79. 00 07900 PLALI ATI V ECARE 79. 00 07900 PLALI ATI V ECARE 79. 00 07900 PLALI ATI V ECARE 79. 00 07900 REDECKE C LI NI C 79. 00 07900 REDECKE C LI NI CS 79. 00 07900 REMERGENCY 79	73. 01	07301 SPECIALTY PHARMACY	0	0	73. 01
76. 00 03330 ENDOSCOPY 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	73. 02	07302 CONTRACTED PHARMACY	0	0	73. 02
76. 01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES					74.00
76. 03 03951 LUTHERWOOD PARTNERSHIP		1	ı -	- 1	76.00
76. 04 03952 WOUND CARE CENTER		1	1	43, 200	
76. 05 03480 ONCOLOGY-CANCER CARE CENTER 2,700 2,700 76. 76. 76. 06 03953 IMAGING CENTERS 0 0 0 76. 76. 76. 77. 07. 07697 CARDI AC REHABILLITATI ON 0 0 0 76. 76. 78. 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 77. 78. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0		1	١	2 600	76. 03
76. 06 03953 MAGING CENTERS 0 0 0 0 76. 76. 07 03954 BREAST DIAGNOSTIC CENTER 0 0 0 0 76. 76. 07 07697 CARDI AC REHABILITATION 0 0 0 0 76. 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 776. 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 777. 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 777. 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 777. 78. 00 07900 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1			76. 05
76. 07 03954 BREAST DI AGNOSTIC CENTER 0 0 0 76. 76. 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 76. 76. 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 778. 00 07800 CAR T - CELL I IMMUNOTHERAPY 0 0 0 0 788. 00 07800 CAR T - CELL I IMMUNOTHERAPY 0 0 0 0 788. 00 07800 CAR T - CELL I IMMUNOTHERAPY 0 0 0 0 0 788. 00 07800 CAR T - CELL I IMMUNOTHERAPY 0 0 0 0 0 788. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	l	76. 06
76. 98			0	0	76. 07
77. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	0	O	76. 97
78. 00				0	76. 98
OUTPATIENT SERVICE COST CENTERS O					77. 00
90. 00 09000 CLINIC 0 0 0 90. 90. 01 04950 MULTI DI SCI PLI NARY CLINIC 0 0 0 90. 90. 02 04951 HEALTHY HEARTS CENTER 0 0 0 90. 90. 03 09001 PALLI ATI VE CARE 0 0 0 90. 90. 04 04953 SPI NE CENTER 0 0 0 90. 90. 05 04954 INFUSI ON CENTERS 0 0 90. 90. 06 09002 MEDCHECK CLINICS 0 0 90. 90. 07 09003 KNEE CENTER 0 0 0 90. 91. 00 09100 EMERGENCY 10,000 10,000 91. 92. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92.	78. 00		0	0	78. 00
90. 01	00 00				00.00
90. 02					90.00
90. 03				-	90.01
90. 04		1			90. 03
90. 05			0	o	90. 04
90. 07 09003 KNEE CENTER 0 0 0 0 10,000 10,000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92. SPECI AL PURPOSE COST CENTERS 90.	90. 05		0	0	90. 05
91. 00 09100 EMERGENCY 10,000 10,000 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. SPECIAL PURPOSE COST CENTERS			0	0	90. 06
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. SPECIAL PURPOSE COST CENTERS			0	0	90. 07
SPECIAL PURPOSE COST CENTERS			10, 000	10, 000	91.00
	92.00				92. 00
	118 00		251 800	251 800	118. 00
		1	201,300	201,000	1110.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HEALTH NETWORK, INC. Provider CCN: 15-0074

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

				10	5 12/31/2023	Date/lime Prepared: 5/24/2024 11:39 am		
	INTERNS & RESIDENTS				0,21,2021 1110, 4111			
Cost Center Description		SERVI CES-SALAR SERVI CES-OTHER						
		Y & FRINGES	PRGM COSTS					
		(ASSI GNED	(ASSI GNED					
		TIME)	TIME)					
		21.00	22. 00					
NONREI MBURSABLE COST CENTERS								
	PHYSICIANS' PRIVATE OFFICES	0	0			192. 00		
	HOME OFFICE	0	0			194. 00		
	GROUP HOMES AND MISC. N_R CTRS	0	0			194. 01		
	ACCOUNTABLE CARE	0	0			194. 02		
	SCHOOL BASED CLINICS	0	0			194. 03		
194. 04 07954 SMO-NON PROVIDER BASED		0	0			194. 04		
	FAMILY PRACTICE MEDICINE	0	0			194. 05		
200. 00	Cross Foot Adjustments					200. 00		
201. 00	Negative Cost Centers					201. 00		
202.00	Cost to be allocated (per Wkst. B,	5, 866, 355	15, 244, 007			202. 00		
	Part I)							
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 297677	60. 540139			203. 00		
204. 00	Cost to be allocated (per Wkst. B,	347, 684	1, 041, 287			204. 00		
	Part II)							
205. 00	Unit cost multiplier (Wkst. B, Part	1. 380794	4. 135373			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)			l		1		

COMPONENTIAL OF COSTS TO CHARGES			Trovider of		From 01/01/2023 Part I To 12/31/2023 Date/Time Prep 5/24/2024 11:3		pared: 39 am
			Title	XVIII	Hospi tal	PPS	
				T	Costs		
	Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	118, 565, 012		118, 565, 01	2 0	118, 565, 012	30. 00
31.00	03100 INTENSIVE CARE UNIT	32, 086, 754		32, 086, 75	4 0	32, 086, 754	31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	4, 570, 745		4, 570, 74		4, 570, 745	•
43. 00	04300 NURSERY	1, 381, 539		1, 381, 53	9 0	1, 381, 539	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	20.015.027		20.015.02	(0	20.015.027	F0 00
50.00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	39, 915, 036		39, 915, 03			
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 471, 185 6, 382, 887		2, 471, 18 6, 382, 88		2, 471, 185 6, 382, 887	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 828, 866		9, 828, 86		9, 828, 866	
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 726, 821		2, 726, 82		2, 726, 821	
57. 00	05700 CT SCAN	7, 290, 912		7, 290, 91		7, 290, 912	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 369, 524		2, 369, 52		2, 369, 524	
59.00	05900 CARDI AC CATHETERI ZATI ON	13, 142, 291		13, 142, 29	1 0	13, 142, 291	59. 00
60.00	06000 LABORATORY	21, 129, 554		21, 129, 55	4 0	21, 129, 554	60.00
64. 00	06400 I NTRAVENOUS THERAPY	3, 678, 720		3, 678, 72		3, 678, 720	
65. 00	06500 RESPI RATORY THERAPY	9, 585, 691	0	,		9, 585, 691	65. 00
66.00	06600 PHYSI CAL THERAPY	10, 277, 601	0			10, 277, 601	66. 00
67.00	06700 OCCUPATIONAL THERAPY	3, 403, 319	0	-,,		3, 403, 319	
68. 00	06800 SPEECH PATHOLOGY	1, 743, 858 6, 711, 812	0	1, 743, 85 6, 711, 81		1, 743, 858 6, 711, 812	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 748, 253		1, 748, 25		1, 748, 253	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	54, 152, 406		54, 152, 40		54, 152, 406	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	49, 342, 748		49, 342, 74		49, 342, 748	•
73. 00	07300 DRUGS CHARGED TO PATIENTS	268, 023, 700		268, 023, 70			
73. 01	07301 SPECIALTY PHARMACY	107, 472, 852		107, 472, 85		107, 472, 852	•
73. 02	07302 CONTRACTED PHARMACY	22, 153, 828		22, 153, 82		22, 153, 828	
74. 00	07400 RENAL DI ALYSI S	2, 865, 034		2, 865, 03	4 0	2, 865, 034	
76. 00	03330 ENDOSCOPY	1, 321, 974		1, 321, 97		1, 321, 974	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	45, 261, 206		45, 261, 20		45, 261, 206	•
76. 03	03951 LUTHERWOOD PARTNERSHIP	10, 877, 358		10, 877, 35		10, 877, 358	•
76. 04 76. 05	03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER	3, 648, 859		3, 648, 85		3, 648, 859	•
76. 05	03953 I MAGING CENTERS	67, 660, 483 10, 248, 984		67, 660, 48 10, 248, 98		67, 660, 483 10, 248, 984	•
76. 07	03954 BREAST DIAGNOSTIC CENTER	3, 667, 960		3, 667, 96		3, 667, 960	•
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 278, 854		2, 278, 85		2, 278, 854	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	810, 649		810, 64		810, 649	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0			0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0			0		
90. 01	04950 MULTI DI SCI PLI NARY CLI NI C	13, 584		13, 58			
	04951 HEALTHY HEARTS CENTER	2, 390, 333		2, 390, 33		2, 390, 333	
90. 03 90. 04	09001 PALLI ATI VE CARE 04953 SPI NE CENTER	22, 838		22, 83	8 0 2 0	22, 838 2	90.03
90. 04	04954 I NFUSI ON CENTERS	1, 007, 249		1, 007, 24		1, 007, 249	
90.06	09002 MEDCHECK CLINICS	1,007,249		1,007,24	ó n	1,007,249	1
90. 07	09003 KNEE CENTER	6, 704, 678		6, 704, 67	8 0	6, 704, 678	
91. 00	09100 EMERGENCY	36, 234, 564		36, 234, 56		36, 234, 564	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 378, 246		9, 378, 24		9, 378, 246	
200.00	Subtotal (see instructions)	1, 004, 548, 769	0	1, 004, 548, 76		1, 004, 548, 769	200. 00
201.00		9, 378, 246		9, 378, 24		9, 378, 246	
202.00	Total (see instructions)	995, 170, 523	0	995, 170, 52	3 0	995, 170, 523	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0074 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:39 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col. 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 243, 614, 310 243, 614, 310 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 88, 232, 701 88, 232, 701 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 28, 515, 400 28, 515, 400 35.00 43.00 04300 NURSERY 2, 796, 468 2<u>, 796, 468</u> 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 154, 147, 948 88, 025, 660 242, 173, 608 0.164820 0.000000 50.00 51.00 05100 RECOVERY ROOM 7, 561, 987 10, 494, 433 18, 056, 420 0.136859 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 12, 116, 677 0.526785 0.000000 52.00 52.00 12, 116, 677 56, 138, 462 05400 RADI OLOGY-DI AGNOSTI C 54.00 14, 401, 360 70, 539, 822 0.139338 0.000000 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 18, 397, 586 18, 600, 510 36, 998, 096 0.073702 0.000000 55.00 57.00 05700 CT SCAN 35, 283, 933 104, 644, 397 139, 928, 330 0.052105 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 16, 046, 878 21, 879, 801 0.108297 0.000000 58.00 5, 832, 923 58.00 05900 CARDIAC CATHETERIZATION 59.00 133, 130, 192 241, 761, 487 374, 891, 679 0.035056 0.000000 59.00 06000 LABORATORY 58, 389, 209 73, 891, 877 132, 281, 086 0.159732 0.000000 60.00 60.00 64.00 06400 INTRAVENOUS THERAPY 2, 918, 800 7, 166, 707 10, 085, 507 0.364753 0.000000 64.00 06500 RESPIRATORY THERAPY 42, 333, 239 4. 981. 646 47, 314, 885 0.202594 65.00 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 3, 974, 377 19, 192, 043 23, 166, 420 0.443642 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 3, 779, 286 7, 992, 694 0. 425804 0.000000 67.00 4, 213, 408 67.00 06800 SPEECH PATHOLOGY 1, 349, 904 2, 276, 724 0.480848 0.000000 68.00 3, 626, 628 68.00 06900 ELECTROCARDI OLOGY 69.00 16, 282, 346 46, 719, 571 63, 001, 917 0. 106533 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 117, 103 7, 682, 071 8, 799, 174 0.198684 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 55, 272, 690 59, 261, 752 114, 534, 442 0.472805 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 73 874 678 41, 978, 840 115, 853, 518 0 425906 0 000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 70, 124, 007 1, 353, 237, 027 1, 423, 361, 034 0.188303 0.000000 73.00 07301 SPECIALTY PHARMACY 129, 509, 892 129, 509, 892 0.829843 0.000000 73.01 73.01 73.02 07302 CONTRACTED PHARMACY 0 37, 503, 231 37, 503, 231 0.590718 0.000000 73.02 07400 RENAL DIALYSIS 5, 943, 205 0.482069 74.00 5, 943, 205 0.000000 74.00 76.00 03330 ENDOSCOPY 2, 755, 555 2, 728, 700 5, 484, 255 0. 241049 0.000000 76.00 20, 834, 767 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 499, 172 20, 335, 595 2. 172388 0.000000 76.01 76 03 03951 LUTHERWOOD PARTNERSHIP 453, 365 453 365 23. 992496 0 000000 76 03 907, 416 03952 WOUND CARE CENTER 76.04 13, 890, 700 14, 798, 116 0. 246576 0.000000 76.04 314, 909, 341 76.05 03480 ONCOLOGY-CANCER CARE CENTER 3, 111, 085 318, 020, 426 0.212755 0.000000 76.05 76.06 03953 I MAGING CENTERS 233, 252 92, 870, 266 93, 103, 518 0.110082 0.000000 76.06 76.07 03954 BREAST DIAGNOSTIC CENTER 25, 057 6, 847, 099 6, 872, 156 0.533742 0.000000 76 07 0. 429759 76.97 07697 CARDIAC REHABILITATION 8, 207 5, 294, 429 5, 302, 636 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 3, 484, 794 3, 484, 794 0. 232625 0.000000 76. 98 76.98 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 04950 MULTIDISCIPLINARY CLINIC 14, 798 14, 798 0. 917962 90.01 0.000000 90.01 0 42, 879 5, 887, 368 90.02 04951 HEALTHY HEARTS CENTER 5, 930, 247 0.403075 0.000000 90 02 90.03 09001 PALLIATIVE CARE 549, 919 549, 919 0.041530 0.000000 90.03 90 04 04953 SPINE CENTER 340 340 0.005882 0.000000 90 04 2, 652, 590 04954 INFUSION CENTERS 0.379723 0.000000 90.05 90.05 817 2, 651, 773 90.06 09002 MEDCHECK CLINICS 0.000000 0.000000 90.06 90.07 09003 KNEE CENTER 7,995 6, 193, 125 1.082600 0.000000 6, 185, 130 90.07 91.00 09100 EMERGENCY 66, 182, 802 269, 371, 338 335, 554, 140 0.107984 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 263, 882 92.00 11, 459, 247 13, 723, 129 0.683390 0.000000 92.00

1, 155, 428, 788 3, 080, 260, 478

1, 155, 428, 788 3, 080, 260, 478 4, 235, 689, 266

4, 235, 689, 266

200.00

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Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Peri od: Worksheet C
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/24/2024 11: 39 am

		Title XVIII	Hospi tal	PPS	aiii
Cost Center Description	PPS Inpatient	THE ATTE	nospi tui	113	
555 5511 55551 Pt 1511	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30	0.00
31.00 03100 INTENSIVE CARE UNIT				3	1.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT				3!	5.00
43. 00 04300 NURSERY				4:	3.00
ANCILLARY SERVICE COST CENTERS	<u> </u>				
50. 00 05000 OPERATING ROOM	0. 164820			50	0.00
51.00 05100 RECOVERY ROOM	0. 136859			5	1.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 526785			5:	2.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 139338			5-	4.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 073702			5	5.00
57. 00 05700 CT SCAN	0. 052105			5	7.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 108297			5	8.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 035056			5	9.00
60. 00 06000 LABORATORY	0. 159732			60	0.00
64.00 06400 INTRAVENOUS THERAPY	0. 364753			6.	4. 00
65. 00 06500 RESPIRATORY THERAPY	0. 202594			6!	5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 443642			6	6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 425804			6	7. 00
68. 00 06800 SPEECH PATHOLOGY	0. 480848			68	8. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 106533			6	9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 198684			70	0.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 472805			7	1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 425906			7:	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 188303			7:	3.00
73. 01 07301 SPECIALTY PHARMACY	0. 829843			7:	3. 01
73.02 07302 CONTRACTED PHARMACY	0. 590718			7:	3. 02
74.00 07400 RENAL DIALYSIS	0. 482069			7.	4. 00
76. 00 03330 ENDOSCOPY	0. 241049			7.0	6. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2. 172388			7.0	6. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P	23. 992496			7.0	6. 03
76.04 03952 WOUND CARE CENTER	0. 246576			7.0	6. 04
76.05 03480 ONCOLOGY-CANCER CARE CENTER	0. 212755			7.0	6. 05
76.06 03953 I MAGING CENTERS	0. 110082			7.0	6.06
76. 07 03954 BREAST DIAGNOSTIC CENTER	0. 533742			7.0	6. 07
76. 97 07697 CARDIAC REHABILITATION	0. 429759			7.0	6. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 232625			7.0	6. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			7	7. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78	8.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000			90	0.00
90.01 04950 MULTIDISCIPLINARY CLINIC	0. 917962			· · · · · · · · · · · · · · · · · · ·	0. 01
90. 02 04951 HEALTHY HEARTS CENTER	0. 403075			· · · · · · · · · · · · · · · · · · ·	0. 02
90. 03 09001 PALLI ATI VE CARE	0. 041530			90	0. 03
90. 04 04953 SPI NE CENTER	0. 005882			· · · · · · · · · · · · · · · · · · ·	0. 04
90.05 04954 INFUSION CENTERS	0. 379723				0. 05
90. 06 09002 MEDCHECK CLINICS	0. 000000			•	0.06
90. 07 09003 KNEE CENTER	1. 082600			•	0. 07
91. 00 09100 EMERGENCY	0. 107984			•	1. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 683390				2.00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds					1. 00
202.00 Total (see instructions)				20:	2. 00

COMPUT	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	Provider CCN: 15-0074		Worksheet C Part I Date/Time Prepared:	
			T; +1	o VIV	Hospi tal	5/24/2024 11: PPS	39 am_
			11 (1	e XIX	Hospi tal Costs	PP3	
	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	T			.1		
30.00	03000 ADULTS & PEDI ATRI CS	129, 681, 906	ł	129, 681, 90		129, 681, 906	
31.00	03100 I NTENSI VE CARE UNI T	32, 598, 165		32, 598, 16!		32, 598, 165	1
35. 00 43. 00	02060 NEONATAL INTENSIVE CARE UNIT	4, 922, 864 1, 381, 539		4, 922, 864 1, 381, 539		4, 922, 864 1, 381, 539	35. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1,301,339		1, 301, 33	7 0	1, 301, 339	43.00
50. 00	05000 OPERATI NG ROOM	42, 824, 208		42, 824, 208	3 0	42, 824, 208	50.00
51. 00	05100 RECOVERY ROOM	2, 471, 185	ł .	2, 471, 18		2, 471, 185	
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 382, 887		6, 382, 88		6, 382, 887	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 828, 866		9, 828, 866	6 0	9, 828, 866	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 726, 821		2, 726, 82	1 0	2, 726, 821	55. 00
57. 00	05700 CT SCAN	7, 290, 912		7, 290, 912	0	7, 290, 912	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 369, 524		2, 369, 524		2, 369, 524	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	13, 326, 734	l	13, 326, 73		13, 326, 734	59. 00
60.00	06000 LABORATORY	21, 129, 554		21, 129, 55		21, 129, 554	60.00
64. 00	06400 I NTRAVENOUS THERAPY	3, 678, 720	l .	3, 678, 720		3, 678, 720	1
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	9, 585, 691	0			9, 585, 691	65. 00
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	11, 409, 412 3, 403, 319	l .			11, 409, 412 3, 403, 319	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 743, 858		3, 403, 31 ⁹ 1, 743, 858		1, 743, 858	1
69. 00	06900 ELECTROCARDI OLOGY	6, 711, 812		6, 711, 812		6, 711, 812	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 748, 253	l	1, 748, 253		1, 748, 253	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	54, 152, 406	l e	54, 152, 400		54, 152, 406	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	49, 342, 748		49, 342, 748		49, 342, 748	1
73.00	07300 DRUGS CHARGED TO PATIENTS	268, 023, 700		268, 023, 700		268, 023, 700	1
73. 01	07301 SPECIALTY PHARMACY	107, 472, 852		107, 472, 852	0	107, 472, 852	73. 01
73. 02	07302 CONTRACTED PHARMACY	22, 153, 828		22, 153, 828	0	22, 153, 828	73. 02
74.00	07400 RENAL DI ALYSI S	2, 865, 034		2, 865, 034		2, 865, 034	
76. 00	03330 ENDOSCOPY	1, 321, 974		1, 321, 97		1, 321, 974	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	48, 883, 000	ł	48, 883, 000		48, 883, 000	1
76. 03	03951 LUTHERWOOD PARTNERSHIP	10, 877, 358	ł	10, 877, 358		10, 877, 358	
76. 04 76. 05	03952 WOUND CARE CENTER	3, 866, 837	ł .	3, 866, 83		3, 866, 837	76. 04
76. 05 76. 06	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS	67, 886, 845 10, 248, 984	l e	67, 886, 845 10, 248, 984		67, 886, 845 10, 248, 984	76. 05 76. 06
76. 00	03954 BREAST DIAGNOSTIC CENTER	3, 667, 960	l e	3, 667, 960		3, 667, 960	1
76. 97	07697 CARDI AC REHABILITATION	2, 278, 854	l e	2, 278, 854		2, 278, 854	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	810, 649		810, 649		810, 649	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	l e			0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0			0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0		(0	0	90.00
90. 01	04950 MULTI DI SCI PLI NARY CLI NI C	13, 584		13, 58		13, 584	90. 01
	04951 HEALTHY HEARTS CENTER	2, 390, 333		2, 390, 333			
90. 03	09001 PALLI ATI VE CARE	22, 838		22, 838		22, 838	
90. 04	04953 SPI NE CENTER	2		4 227 - 1	0	2	90.04
90. 05	04954 I NFUSI ON CENTERS	1, 007, 249		1, 007, 249		1, 007, 249	1
90.06	09002 MEDCHECK CLINICS	0		(704 / 7	0	0	90.06
90. 07	09003 KNEE CENTER 09100 EMERGENCY	6, 704, 678	ł	6, 704, 678		6, 704, 678	
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	37, 072, 942 9, 378, 246		37, 072, 942 9, 378, 240		37, 072, 942 9, 378, 246	
200.00		1, 025, 659, 131		1, 025, 659, 13		1, 025, 659, 131	
201.00		9, 378, 246	ł	9, 378, 240		9, 378, 246	
202.00		1, 016, 280, 885		1, 016, 280, 88		1, 016, 280, 885	
			'		•		

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0074 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:39 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 243, 614, 310 243, 614, 310 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 88, 232, 701 88, 232, 701 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 28, 515, 400 28, 515, 400 35.00 43.00 04300 NURSERY 2, 796, 468 2<u>, 796, 468</u> 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 154, 147, 948 88, 025, 660 242, 173, 608 0.176833 0.000000 50.00 51.00 05100 RECOVERY ROOM 7, 561, 987 10, 494, 433 18, 056, 420 0.136859 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 12, 116, 677 0.526785 0.000000 52.00 52.00 12, 116, 677 56, 138, 462 05400 RADI OLOGY-DI AGNOSTI C 54.00 14, 401, 360 70, 539, 822 0.139338 0.000000 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 18, 397, 586 18, 600, 510 36, 998, 096 0.073702 0.000000 55.00 57.00 05700 CT SCAN 35, 283, 933 104, 644, 397 139, 928, 330 0.052105 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 16, 046, 878 21, 879, 801 0.108297 0.000000 58.00 5, 832, 923 58.00 05900 CARDIAC CATHETERIZATION 59.00 133, 130, 192 241, 761, 487 374, 891, 679 0.035548 0.000000 59.00 06000 LABORATORY 58, 389, 209 73, 891, 877 132, 281, 086 0.159732 0.000000 60.00 60.00 64.00 06400 INTRAVENOUS THERAPY 2, 918, 800 7, 166, 707 10, 085, 507 0.364753 0.000000 64.00 06500 RESPIRATORY THERAPY 42, 333, 239 4. 981. 646 47, 314, 885 0.202594 65.00 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 3, 974, 377 19, 192, 043 23, 166, 420 0. 492498 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 3, 779, 286 7, 992, 694 0. 425804 0.000000 67.00 4, 213, 408 67.00 06800 SPEECH PATHOLOGY 1, 349, 904 2, 276, 724 0.480848 0.000000 68.00 3, 626, 628 68.00 06900 ELECTROCARDI OLOGY 69.00 16, 282, 346 46, 719, 571 63, 001, 917 0. 106533 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 117, 103 7, 682, 071 8, 799, 174 0.198684 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 55, 272, 690 59, 261, 752 114, 534, 442 0.472805 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 73 874 678 41, 978, 840 115, 853, 518 0 425906 0 000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 70, 124, 007 1, 353, 237, 027 1, 423, 361, 034 0.188303 0.000000 73.00 07301 SPECIALTY PHARMACY 129, 509, 892 129, 509, 892 0.829843 0.000000 73.01 73.01 73.02 07302 CONTRACTED PHARMACY 0 37, 503, 231 37, 503, 231 0.590718 0.000000 73.02 07400 RENAL DIALYSIS 5, 943, 205 0.482069 74.00 5, 943, 205 0.000000 74.00 76.00 03330 ENDOSCOPY 2, 755, 555 2, 728, 700 5, 484, 255 0. 241049 0.000000 76.00 20, 834, 767 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 499, 172 20, 335, 595 2.346223 0.000000 76.01 76 03 03951 LUTHERWOOD PARTNERSHIP 453, 365 453 365 23. 992496 0 000000 76 03 907, 416 03952 WOUND CARE CENTER 76.04 13, 890, 700 14, 798, 116 0. 261306 0.000000 76.04 314, 909, 341 76.05 03480 ONCOLOGY-CANCER CARE CENTER 3, 111, 085 318, 020, 426 0.213467 0.000000 76.05 76.06 03953 I MAGING CENTERS 233, 252 92, 870, 266 93, 103, 518 0.110082 0.000000 76.06 76.07 03954 BREAST DIAGNOSTIC CENTER 25, 057 6, 847, 099 6, 872, 156 0.533742 0.000000 76 07 0. 429759 76.97 07697 CARDIAC REHABILITATION 8, 207 5, 294, 429 5, 302, 636 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 3, 484, 794 3, 484, 794 0. 232625 0.000000 76. 98 76.98 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 04950 MULTIDISCIPLINARY CLINIC 14, 798 14, 798 0. 917962 90.01 0.000000 90.01 0 42, 879 5, 887, 368 90.02 04951 HEALTHY HEARTS CENTER 5, 930, 247 0.403075 0.000000 90 02 90.03 09001 PALLIATIVE CARE 549, 919 549, 919 0.041530 0.000000 90.03 90 04 04953 SPINE CENTER 340 340 0.005882 0.000000 90 04 2, 652, 590 04954 INFUSION CENTERS 0.379723 0.000000 90.05 90.05 817 2, 651, 773 90.06 09002 MEDCHECK CLINICS 0.000000 0.000000 90.06 90. 07 09003 KNEE CENTER 7,995 6, 185, 130 6, 193, 125 1.082600 0.000000 90.07 91.00 09100 EMERGENCY 66, 182, 802 269, 371, 338 335, 554, 140 0.110483 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 263, 882 92.00 11, 459, 247 13, 723, 129 0.683390 0.000000 92.00 1, 155, 428, 788 3, 080, 260, 478

4, 235, 689, 266

1, 155, 428, 788 3, 080, 260, 478 4, 235, 689, 266

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/24/2024 11:39 am

		Title XIX	Hospi tal	5/24/2024 11: PPS	39 am_
Cost Center Description	PPS Inpatient	I tte xix	поѕрітаі	PP3	
cost center bescription	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDIATRICS					30. 00
31. 00 03100 I NTENSI VE CARE UNI T					31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT					35. 00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM	0. 176833				50. 00
51. 00 05100 RECOVERY ROOM	0. 136859				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 526785				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 139338				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 073702				55.00
57. 00 05700 CT SCAN	0.073702				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 032103				58.00
59. 00 05900 CARDIAC CATHETERIZATION	0. 108247				59.00
60. 00 06000 LABORATORY	0. 035546				60.00
64. 00 06400 NTRAVENOUS THERAPY	0. 154752				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 304753				65.00
66. 00 06600 PHYSI CAL THERAPY	1				66.00
	0. 492498				
67. 00 06700 OCCUPATIONAL THERAPY	0. 425804				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 480848				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 106533				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 198684				70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 472805				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 425906				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 188303				73.00
73. 01 07301 SPECIALTY PHARMACY	0. 829843				73. 01
73. 02 07302 CONTRACTED PHARMACY	0. 590718				73. 02
74. 00 07400 RENAL DI ALYSI S	0. 482069				74.00
76. 00 03330 ENDOSCOPY	0. 241049				76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2. 346223				76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	23. 992496				76. 03
76. 04 03952 WOUND CARE CENTER	0. 261306				76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0. 213467				76. 05
76. 06 03953 I MAGI NG CENTERS	0. 110082				76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	0. 533742				76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 429759				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 232625				76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
OUTPATIENT SERVICE COST CENTERS					4
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C	0. 917962				90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0. 403075				90. 02
90. 03 09001 PALLI ATI VE CARE	0. 041530				90. 03
90. 04 04953 SPI NE CENTER	0. 005882				90. 04
90. 05 04954 I NFUSI ON CENTERS	0. 379723				90. 05
90. 06 09002 MEDCHECK CLINICS	0. 000000				90. 06
90. 07 09003 KNEE CENTER	1. 082600				90. 07
91. 00 09100 EMERGENCY	0. 110483				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 683390				92. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Heal th Financial Systems COMMUNITY HEAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: Provider CCN: 15-0074

					10 12/01/2020	5/24/2024 11:	39 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cos		Operating Cost	
	, , , , , , , , , , , , , , , , , , ,	(Wkst. B, Part				Reduction	
		I, col. 26)	11 col. 26)	Cost (col. 1		Amount	
		, ,	,	col . 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				1		
50.00	05000 OPERATING ROOM	42, 824, 208	5, 397, 065	37, 427, 14	3 0	0	50.00
51. 00	05100 RECOVERY ROOM	2, 471, 185					51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 382, 887	612, 915		.	_	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 828, 866					54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 726, 821	113, 695	1			55. 00
57. 00	05700 CT SCAN	7, 290, 912	567, 588	1	-	_	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 369, 524	414, 197				58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	13, 326, 734		1			59.00
60.00	06000 LABORATORY	21, 129, 554	396, 495	1			60.00
64. 00	06400 I NTRAVENOUS THERAPY	3, 678, 720					64. 00
65. 00	06500 RESPIRATORY THERAPY				-	_	65.00
66.00	1 1	9, 585, 691	518, 601				66.00
	06600 PHYSI CAL THERAPY	11, 409, 412	1, 160, 065				
67. 00	06700 OCCUPATI ONAL THERAPY	3, 403, 319	204, 940				67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 743, 858		1			68. 00
69. 00	06900 ELECTROCARDI OLOGY	6, 711, 812	778, 627				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 748, 253	139, 239			_	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	54, 152, 406					71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	49, 342, 748				_	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	268, 023, 700					73. 00
73. 01	07301 SPECI ALTY PHARMACY	107, 472, 852					73. 01
73. 02	07302 CONTRACTED PHARMACY	22, 153, 828					73. 02
74. 00	07400 RENAL DI ALYSI S	2, 865, 034		1		_	74. 00
76. 00	03330 ENDOSCOPY	1, 321, 974					76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	48, 883, 000		1			76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	10, 877, 358					76. 03
76. 04	03952 WOUND CARE CENTER	3, 866, 837	233, 906				76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	67, 886, 845					76. 05
76. 06	03953 I MAGI NG CENTERS	10, 248, 984	1, 155, 915	9, 093, 06		_	76. 06
76. 07	03954 BREAST DI AGNOSTI C CENTER	3, 667, 960	240, 169	3, 427, 79			76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 278, 854	354, 414	1, 924, 440	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	810, 649	52, 394	758, 25	5 0	0	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	(1	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	()	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	()	0		90.00
90. 01	04950 MULTI DI SCI PLI NARY CLI NI C	13, 584	8, 052	5, 53	2 0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	2, 390, 333	357, 074	2, 033, 25	9 0	0	90. 02
90. 03	09001 PALLI ATI VE CARE	22, 838	7, 246	15, 59:	2 0	0	90. 03
90. 04	04953 SPI NE CENTER	2	()	2 0	0	90. 04
90. 05	04954 I NFUSI ON CENTERS	1, 007, 249	143, 533	863, 71	6 0	0	90. 05
90.06	09002 MEDCHECK CLINICS	0	(9		90. 06
90. 07	09003 KNEE CENTER	6, 704, 678	659, 907	6, 044, 77	1 0	0	90. 07
91.00	09100 EMERGENCY	37, 072, 942	3, 574, 811	33, 498, 13	1 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 378, 246	950, 504	8, 427, 74	2 0	0	92. 00
200.00	Subtotal (sum of lines 50 thru 199)	857, 074, 657	36, 935, 932	820, 138, 72	5 0	0	200. 00
201.00	Less Observation Beds	9, 378, 246	950, 504	8, 427, 74	2 0	0	201. 00
202.00	Total (line 200 minus line 201)	847, 696, 411	35, 985, 428	811, 710, 98	3 0	0	202. 00
		·					

Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/24/2024 11:39 am REDUCTIONS FOR MEDICALD ONLY

					5/24/2024 11:39 am
	_		e XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	Capital and	(Worksheet C,	Cost to Charge		
		Part I, column			
	Reduction	8)	/ col. 7)		
	6. 00	7. 00	8. 00		
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	42, 824, 208	242, 173, 608	0. 176833		50.00
51.00 05100 RECOVERY ROOM	2, 471, 185	18, 056, 420	0. 136859		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 382, 887	12, 116, 677	0. 526785		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 828, 866				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 726, 821				55. 00
57. 00 05700 CT SCAN	7, 290, 912				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 369, 524		0. 108297		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	13, 326, 734				59.00
60. 00 06000 LABORATORY	21, 129, 554				60.00
64. 00 06400 I NTRAVENOUS THERAPY	3, 678, 720				64. 00
65. 00 06500 RESPIRATORY THERAPY	9, 585, 691				65. 00
66. 00 06600 PHYSI CAL THERAPY	11, 409, 412				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 403, 319				67. 00
	1, 743, 858				68.00
69. 00 06900 ELECTROCARDI OLOGY	6, 711, 812				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 748, 253				70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS	54, 152, 406				71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	49, 342, 748				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	268, 023, 700				73. 00
73. 01 07301 SPECIALTY PHARMACY	107, 472, 852				73. 01
73.02 07302 CONTRACTED PHARMACY	22, 153, 828	37, 503, 231	0. 590718		73. 02
74. 00 07400 RENAL DI ALYSI S	2, 865, 034	5, 943, 205	0. 482069		74.00
76. 00 03330 ENDOSCOPY	1, 321, 974	5, 484, 255	0. 241049		76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	48, 883, 000	20, 834, 767	2. 346223		76. 0
76. 03 03951 LUTHERWOOD PARTNERSHIP	10, 877, 358	453, 365	23. 992496		76. 03
76. 04 03952 WOUND CARE CENTER	3, 866, 837	14, 798, 116	0. 261306		76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	67, 886, 845	318, 020, 426	0. 213467		76. 05
76.06 03953 I MAGING CENTERS	10, 248, 984				76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	3, 667, 960				76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 278, 854				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	810, 649				76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0.0,017				77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	Ö				78. 00
OUTPATIENT SERVICE COST CENTERS			0.000000		70.00
90. 00 09000 CLI NI C	0	0	0.000000		90.00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C	13, 584	_			90. 0
90. 02 04951 HEALTHY HEARTS CENTER	2, 390, 333		0. 403075		90. 02
90. 03 09001 PALLI ATI VE CARE	2, 340, 333				90. 03
90. 04 04953 SPI NE CENTER	22,030	349, 919			90.00
	1 007 240				90. 05
	1, 007, 249				
90. 06 09002 MEDCHECK CLINICS	1 , 704 , 70	(102 125	0.000000		90.06
90. 07 09003 KNEE CENTER	6, 704, 678				90. 07
91. 00 09100 EMERGENCY	37, 072, 942				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 378, 246				92. 00
200.00 Subtotal (sum of lines 50 thru 199)	857, 074, 657				200. 00
201.00 Less Observation Beds	9, 378, 246				201. 00
202.00 Total (line 200 minus line 201)	847, 696, 411	3, 872, 530, 387			202.00

Health Financial Systems	COMMUNITY HEALTH	H NETWORK, INC.		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provi der C		Period: From 01/01/2023 To 12/31/2023		
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	12, 016, 817	' C	12, 016, 81			
31.00 INTENSIVE CARE UNIT	3, 357, 785		3, 357, 78	5 15, 234	220. 41	31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	303, 484		303, 48	4 3, 009	100. 86	35. 00
43. 00 NURSERY	137, 033		137, 03	1, 592	86.08	43.00
200.00 Total (lines 30 through 199)	15, 815, 119		15, 815, 11	9 109, 382		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 & PEDI ATRI CS	12, 263					30. 00
31.00 INTENSIVE CARE UNIT	2, 618	577, 033				31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	0) C)			35. 00
43. 00 NURSERY	0) C)			43. 00
200.00 Total (lines 30 through 199)	14, 881	2, 222, 728	3			200. 00

Health Financial Systems COMMUNITY HEALTH NETWORK, INC. In Lieu of Form CMS-2552-						2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2023	Part II	
				To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared:
		T' 11	V0 (1 1 1			39 am_
	1 2 11 1		XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	·	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOLILARY REDWINE ROOT REVIERS	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS		T	T		T	
50.00 05000 OPERATING ROOM	5, 397, 065					50.00
51.00 05100 RECOVERY ROOM	398, 378				31, 718	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	612, 915	12, 116, 677			0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 529, 060	70, 539, 822	0. 02167	7 2, 920, 526	63, 308	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	113, 695	36, 998, 096	0. 00307	3 4, 021, 154	12, 357	55. 00
57. 00 05700 CT SCAN	567, 588	139, 928, 330	0.00405	6 7, 455, 063	30, 238	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	414, 197		0. 01893			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 581, 421		0. 00421			59. 00
60. 00 06000 LABORATORY	396, 495					60.00
64. 00 06400 I NTRAVENOUS THERAPY	200, 987		0.01992			64. 00
65. 00 06500 RESPI RATORY THERAPY			0.01992			65. 00
	518, 601					l
66. 00 06600 PHYSI CAL THERAPY	1, 160, 065					
67. 00 06700 OCCUPATI ONAL THERAPY	204, 940		0. 02564			67. 00
68. 00 06800 SPEECH PATHOLOGY	99, 722					68. 00
69. 00 06900 ELECTROCARDI OLOGY	778, 627		0. 01235			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	139, 239	8, 799, 174	0. 01582	4 250, 610	3, 966	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 137, 443	114, 534, 442	0. 00993	1 13, 405, 142	133, 126	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	352, 932	115, 853, 518	0.00304	6 23, 677, 121	72, 121	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 463, 931	1, 423, 361, 034	0.00243	4 12, 488, 628	30, 397	73. 00
73. 01 07301 SPECIALTY PHARMACY	933, 778		0. 00721			73. 01
73. 02 07302 CONTRACTED PHARMACY	13, 051		0.00034		0	73. 02
74. 00 07400 RENAL DI ALYSI S	40, 695		0. 00684		9, 405	74. 00
76. 00 03330 ENDOSCOPY	123, 153		0. 02245		1, 616	76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 250, 159		0. 15599		3, 292	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P	411, 811		0. 90834		0, 272	76. 03
76. 04 03952 WOUND CARE CENTER					-	
	233, 906					1
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	5, 358, 059				10, 990	76. 05
76. 06 03953 I MAGI NG CENTERS	1, 155, 915					1
76. 07 03954 BREAST DI AGNOSTI C CENTER	240, 169		0. 03494			76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	354, 414					76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	52, 394		0. 01503			76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0.00000	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C	8, 052	14, 798	0. 54412	8 0	0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	357, 074	5, 930, 247	0. 06021		0	90. 02
90. 03 09001 PALLI ATI VE CARE	7, 246					90. 03
90. 04 04953 SPI NE CENTER	1,210	340	0. 00000			90. 04
90. 05 04954 NFUSION CENTERS	143, 533		0.05411			90.04
90. 06 09002 MEDCHECK CLINICS	143, 333	2,052,590	0. 00000		-	90.05
	450.007	4 102 125				
90. 07 09003 KNEE CENTER	659, 907				0	90. 07
91. 00 09100 EMERGENCY	3, 574, 811					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	950, 504					92.00
200.00 Total (lines 50 through 199)	36, 935, 932	3, 872, 530, 387	l	184, 654, 589	1, 873, 271	J200. 00

	OMMUNITY HEALTH				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	S Provi der CO		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	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-Stepdown	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 & PEDI ATRI CS	0	0		0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	35. 00
43. 00 04300 NURSERY	0	0		0	0	
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	89, 54			1
31. 00 03100 INTENSIVE CARE UNIT		0	15, 23			1
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	3, 00			
43. 00 04300 NURSERY		0	1, 59:			43. 00
200.00 Total (lines 30 through 199)		0	109, 38:	2	14, 881	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					

30.00

31. 00 35. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02000 NEONATAL INTENSIVE CARE UNIT

43. 00 | 04300 | NURSERY 200. 00 | Total (lines 30 through 199)

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 Provider CCN: 15-0074 THROUGH COSTS

					10	12/31/2023	5/24/2024 11:	
-			Ti t	le XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi n	9	Allied Health	Allied Health	
		Anestheti st	Program	Prograi	n	Post-Stepdown		
		Cost	Post-Stepdov	/n		Adjustments		
			Adjustments					
		1.00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_						
50.00	05000 OPERATI NG ROOM	0		0	0	0	0	
51.00	05100 RECOVERY ROOM	0		0	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0		0	0	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	0	55.00
57. 00	05700 CT SCAN	0		0	0	0	0	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE MAGING (MRI)	0			0	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0			0	0	0	59.00
60.00	06000 LABORATORY	0			0	0	0	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0		ol	0	0	0	64.00
	06600 PHYSI CAL THERAPY	0			0	0	0	65. 00 66. 00
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	0			0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0			0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0			0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		o	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0		70.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS				0	0		73.00
73. 00	07301 SPECIALTY PHARMACY				0	0		73. 00
73. 01	07302 CONTRACTED PHARMACY			0	0	0	0	73. 01
74.00	07400 RENAL DI ALYSI S				0	0	0	74.00
76. 00	03330 ENDOSCOPY	0		o	0	0	0	76.00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0	0	0	0	76. 00
76. 01	03951 LUTHERWOOD PARTNERSHIP	0		0	0	0	0	76. 03
76. 04	03952 WOUND CARE CENTER	0		o	0	0	ĺ	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0		0	0	0	Ö	76. 05
76. 06	03953 I MAGI NG CENTERS	0		o	0	0	Ö	76.06
76. 07	03954 BREAST DIAGNOSTIC CENTER	0		0	0	0	Ö	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	0		o	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		o	0	0	Ō	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		o	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		o	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	,						
90.00	09000 CLI NI C	0		0	0	0	0	90.00
90. 01	04950 MULTI DI SCI PLI NARY CLI NI C	0		o	0	0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	0		o	0	0	0	90. 02
90. 03	09001 PALLIATIVE CARE	0		0	0	0	0	90. 03
90.04	04953 SPI NE CENTER	0		0	0	0	0	90. 04
90. 05	04954 I NFUSI ON CENTERS	0		0	0	0	0	90. 05
90. 06	09002 MEDCHECK CLINICS	0		0	0	0	0	90. 06
90. 07	09003 KNEE CENTER	0		0	0	0	0	90. 07
91. 00	09100 EMERGENCY	0		0	0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1	0		0	92. 00
200.00	Total (lines 50 through 199)	0		o	0	0	0	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HEALTH NETWORK, INC. APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0074 Peri od: Worksheet D From 01/01/2023 Part IV THROUGH COSTS Date/Time Prepared: 12/31/2023 5/24/2024 11: 39 am Title XVIII Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 4) 8) col s. 2. 3. 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 242, 173, 608 0.000000 50.00 05100 RECOVERY ROOM 0 0 0 18, 056, 420 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 12, 116, 677 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 70, 539, 822 0.000000 54 00 54 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 36, 998, 096 0.000000 55.00 57.00 05700 CT SCAN 139, 928, 330 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 21, 879, 801 0.000000 58 00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0 374, 891, 679 0.000000 59.00 60.00 06000 LABORATORY 132, 281, 086 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 10, 085, 507 0.000000 64.00 06500 RESPIRATORY THERAPY 0 47, 314, 885 0.000000 65 00 Ω 65 00 66.00 06600 PHYSI CAL THERAPY 0 23, 166, 420 0.000000 66.00 06700 OCCUPATIONAL THERAPY 7, 992, 694 0.000000 67.00 06800 SPEECH PATHOLOGY 0 3, 626, 628 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 69 00 0 63, 001, 917 0.000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 8, 799, 174 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 114, 534, 442 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 115, 853, 518 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 1, 423, 361, 034 0.000000 73.00 73. 01 07301 SPECIALTY PHARMACY 129, 509, 892 0.000000 73.01 07302 CONTRACTED PHARMACY 37, 503, 231 73.02 0.000000 73.02 07400 RENAL DIALYSIS 74.00 0 5, 943, 205 0.000000 74.00 03330 ENDOSCOPY 0 0 0.000000 76.00 5, 484, 255 76 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 20, 834, 767 0.000000 76.01 76.01 76. 03 03951 LUTHERWOOD PARTNERSHIP 453, 365 0.000000 76.03 03952 WOUND CARE CENTER 0 0 14, 798, 116 0.000000 76.04 76.04 0 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 318, 020, 426 0.000000 76.05 03953 I MAGING CENTERS 93, 103, 518 0.000000 76.06 76.06 0 76. 07 03954 BREAST DIAGNOSTIC CENTER 0 6, 872, 156 0.000000 76.07 76.97 07697 CARDIAC REHABILITATION 0 0 5, 302, 636 0.000000 76.97 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 3, 484, 794 0.000000 76.98 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION Ω 0 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 000000000000 0.000000 90.00 04950 MULTIDISCIPLINARY CLINIC 0 0 14, 798 0.000000 90.01 90.01

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200.00

04951 HEALTHY HEARTS CENTER

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

09001 PALLIATIVE CARE

04954 INFUSION CENTERS

09002 MEDCHECK CLINICS

04953 SPINE CENTER

90. 07 | 09003 KNEE CENTER

09100 EMERGENCY

COMMUNITY HEALTH NETWORK, INC. In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0074 Peri od: Worksheet D From 01/01/2023 THROUGH COSTS Part IV Date/Time Prepared: 12/31/2023 5/24/2024 11:39 am Title XVIII Hospi tal PPS Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col Costs (col. Costs (col. x col. 10) x col. 12) 7) 13. 00 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 37, 213, 473 50.00 05000 OPERATING ROOM 0.000000 14, 762, 895 50.00 0 0 51.00 05100 RECOVERY ROOM 0.000000 1, 437, 595 4, 849, 894 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2, 920, 526 0 9, 279, 358 54.00 0 54.00 4, 021, 154 0 05500 RADI OLOGY-THERAPEUTI C 0.000000 4, 638, 268 55.00 0 55.00 57.00 05700 CT SCAN 0.000000 7, 455, 063 0 11, 207, 108 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 1, 057, 032 0 2, 048, 074 0 58.00 67, 779, 353 05900 CARDIAC CATHETERIZATION 38, 729, 246 0 59.00 59 00 0.000000 0 0 06000 LABORATORY 12, 128, 370 60.00 0.000000 11, 070, 162 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 382, 652 1, 974, 357 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0.000000 7, 518, 469 323, 926 0 65.00 06600 PHYSI CAL THERAPY 0 0.000000 81, 842 66 00 943, 881 0 66.00 οĺ 67.00 06700 OCCUPATIONAL THERAPY 0.000000 849, 413 11, 010 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.000000 248, 435 1, 435 0 68.00 10, 786, 452 06900 ELECTROCARDI OLOGY 0 69 00 0.000000 4 096 109 0 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 250, 610 911, 995 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 13, 405, 142 0 14, 707, 618 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 23, 677, 121 9, 516, 919 0 72.00 07300 DRUGS CHARGED TO PATIENTS 12, 488, 628 73 00 0.000000 393, 283, 349 73 00 0 07301 SPECIALTY PHARMACY 0 73.01 0.000000 0 0 73.01 07302 CONTRACTED PHARMACY 0.000000 0 0 73.02 73.02 0 74.00 07400 RENAL DIALYSIS 0.000000 1, 373, 579 o 0 74.00 0 03330 ENDOSCOPY 0.000000 76.00 76.00 71.967 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 01 0.000000 21, 101 665, 702 0 76.01 03951 LUTHERWOOD PARTNERSHIP 0 76.03 76.03 0.000000 0 03952 WOUND CARE CENTER 229, 830 0 2, 842, 357 76.04 0.000000 0 76.04 0 73, 983, 143 03480 ONCOLOGY-CANCER CARE CENTER 76.05 0.000000 652, 321 0 76.05 47, 833 03953 I MAGING CENTERS 0.000000 0 18, 151, 883 0 76.06 76.06 03954 BREAST DIAGNOSTIC CENTER 0 137, 161 76 07 0.000000 563 0 76.07 76. 97 07697 CARDIAC REHABILITATION 0.000000 1, 116 0 0 76. 97 1, 543, 029 0 07698 HYPERBARI C OXYGEN THERAPY 76.98 0.000000 C 0 0 76.98 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0.000000 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0.000000 0 0 Λ 90.01 04950 MULTIDISCIPLINARY CLINIC 0.000000 0 0 0 90.01 04951 HEALTHY HEARTS CENTER 0.000000 0 1, 518, 886 90.02 90.02 0 0 90.03 09001 PALLIATIVE CARE 0.000000 0 90.03 0 Λ

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13, 645, 054

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04953 SPINE CENTER

09003 KNEE CENTER

09100 EMERGENCY

04954 INFUSION CENTERS

09002 MEDCHECK CLINICS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared:
			Title	XVIII	Hospi tal	PPS	
	0 1 0 1 0 1 1	0 1 1 01	DDC D : 1 1	Charges	0 1	Costs	
	Cost Center Description	Cost to Charge Ratio From	Services (see	Cost Reimbursed	Cost Reimbursed	PPS Services (see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9		Subject To	Subject To		
		Tart 1, cor. 7		Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 164820			0 0	2, 433, 220	50. 00
51.00	05100 RECOVERY ROOM	0. 136859			0	663, 752	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 526785			0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 139338			0	1, 292, 967	
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 073702	4, 638, 268		0	341, 850	55. 00
57.00	05700 CT SCAN	0. 052105			0	583, 946	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 108297	2, 048, 074		0	221, 800	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 035056	67, 779, 353		0	2, 376, 073	59. 00
60.00	06000 LABORATORY	0. 159732	12, 128, 370		0	1, 937, 289	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 364753			0	720, 153	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 202594			0	65, 625	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 443642			0	36, 309	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 425804			0	4, 688	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 480848			0	690	
69. 00	06900 ELECTROCARDI OLOGY	0. 106533			0	1, 149, 113	
70.00		0. 198684	911, 995		0	181, 199	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 472805	14, 707, 618		0	6, 953, 835	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 425906	9, 516, 919		0	4, 053, 313	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 188303	393, 283, 349		0 144, 967	74, 056, 434	73. 00
73. 01	07301 SPECIALTY PHARMACY	0. 829843	0		0	0	73. 01
73. 02	07302 CONTRACTED PHARMACY	0. 590718	0		0	0	73. 02
74.00	07400 RENAL DI ALYSI S	0. 482069	0		0	0	74. 00
76. 00	03330 ENDOSCOPY	0. 241049			0	0	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2. 172388			0	1, 446, 163	
	03951 LUTHERWOOD PARTNERSHIP	23. 992496			0	0	
76. 04	03952 WOUND CARE CENTER	0. 246576			0	700, 857	
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 212755			0 8, 085	15, 740, 284	
76. 06	03953 I MAGI NG CENTERS	0. 110082			0	1, 998, 196	
76. 07	03954 BREAST DIAGNOSTIC CENTER	0. 533742	137, 161		0	73, 209	
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 429759	1, 543, 029		0	663, 131	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 232625	0		0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0. 000000			0 0	0	
90. 01	04950 MULTI DI SCI PLI NARY CLI NI C	0. 917962			0	0	
90. 02		0. 403075		ı	0	612, 225	
	09001 PALLI ATI VE CARE	0. 041530	0		0	0	
	04953 SPI NE CENTER	0. 005882	0		0	0	1
	04954 I NFUSION CENTERS	0. 379723	664, 093		0 0	252, 171	
90.06	l l	0. 000000	0		0	0	
90. 07	09003 KNEE CENTER	1. 082600	534, 749		0 0	578, 919	
91.00	09100 EMERGENCY	0. 107984	18, 652, 797		0 3, 579		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 683390			0 0	379, 276	1
200.00			677, 541, 015		0 156, 631	121, 530, 891	
201.00					0		201. 00
202.00	Only Charges Net Charges (line 200 - line 201)		677, 541, 015		0 156, 631	121, 530, 891	202 00
202.00	Thet oldinges (Title 200 - Title 201)	I	077, 541, 015	I	0 100,001	121, 030, 091	1202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0074 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/24/2024 11:39 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 60.00 0 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 27, 298 73.00 07301 SPECIALTY PHARMACY 73.01 0 73.01 07302 CONTRACTED PHARMACY 73.02 0 73.02 07400 RENAL DIALYSIS 74.00 0 74 00 76.00 03330 ENDOSCOPY 0 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 01 76.01 76.03 03951 LUTHERWOOD PARTNERSHIP 0 76.03 03952 WOUND CARE CENTER 76.04 C 76.04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 76.05 1,720 76.06 03953 I MAGING CENTERS 0 76.06 76.07 03954 BREAST DIAGNOSTIC CENTER 0 76.07 76. 97 07697 CARDIAC REHABILITATION 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76. 98 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0000000000000 04950 MULTIDISCIPLINARY CLINIC 90.01 0 90.01 90.02 04951 HEALTHY HEARTS CENTER 0 90.02 90. 03 09001 PALLIATIVE CARE 0 90.03 90. 04 04953 SPINE CENTER 0 90.04 04954 INFUSION CENTERS 90.05 0 90.05 90.06 09002 MEDCHECK CLINICS 0 90.06 09003 KNEE CENTER 90.07 90.07

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91. 00 09100 EMERGENCY

200.00

201.00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	!	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: 39 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		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	12, 016, 817	0	12, 016, 81	7 89, 547	134. 20	30. 00
31.00 INTENSIVE CARE UNIT	3, 357, 785		3, 357, 78	5 15, 234	220. 41	31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	303, 484		303, 48	4 3, 009	100. 86	35. 00
43. 00 NURSERY	137, 033		137, 03	1, 592	86. 08	43.00
200.00 Total (lines 30 through 199)	15, 815, 119		15, 815, 11	9 109, 382		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	6, 143	824, 391				30. 00
31.00 INTENSIVE CARE UNIT	974					31. 00
35. 00 NEONATAL INTENSIVE CARE UNIT	417				ļ	35. 00
43. 00 NURSERY	1, 345				l	43.00
200.00 Total (lines 30 through 199)	8, 879					200. 00

Health Financial Systems C	OMMUNITY HEALTH	I NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	CN: 15-0074	Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023		pared:
					5/24/2024 11:	39 am_
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 397, 065	242, 173, 608	0. 02228	6 2, 507, 358	55, 879	50.00
51.00 05100 RECOVERY ROOM	398, 378	18, 056, 420	0. 02206	3 411, 858	9, 087	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	612, 915	12, 116, 677	0. 05058	598, 507	30, 275	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 529, 060					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	113, 695					55. 00
57. 00 05700 CT SCAN	567, 588					57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	414, 197	21, 879, 801	0. 01893		6, 972	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 581, 421					59. 00
60. 00 06000 LABORATORY	396, 495					60.00
64. 00 06400 I NTRAVENOUS THERAPY	200, 987					64.00
		10, 085, 507				
65. 00 06500 RESPIRATORY THERAPY	518, 601	47, 314, 885				65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 160, 065					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	204, 940					67. 00
68. 00 06800 SPEECH PATHOLOGY	99, 722					68. 00
69. 00 06900 ELECTROCARDI OLOGY	778, 627	63, 001, 917	0. 01235			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	139, 239	8, 799, 174	0. 01582	88, 335	1, 398	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 137, 443	114, 534, 442	0.00993	1, 326, 750	13, 176	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	352, 932	115, 853, 518	0. 00304	6 578, 927	1, 763	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 463, 931	1, 423, 361, 034	0.00243	4, 440, 657	10, 809	73.00
73. 01 07301 SPECIALTY PHARMACY	933, 778	129, 509, 892	0. 00721	0 0	0	73. 01
73. 02 07302 CONTRACTED PHARMACY	13, 051	37, 503, 231	0.00034		l 0	73. 02
74. 00 07400 RENAL DIALYSIS	40, 695		•		1, 861	74.00
76. 00 03330 ENDOSCOPY	123, 153					76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 250, 159		0. 15599			76. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P	411, 811	453, 365			0, 120	76. 03
76. 04 03952 WOUND CARE CENTER	233, 906	1	•		1, 001	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	5, 358, 059					76. 05
76. 06 03953 I MAGING CENTERS	1, 155, 915					76.05
76. 06 03953 TWAGTING CENTERS 76. 07 03954 BREAST DI AGNOSTI C CENTER						76.00
	240, 169					
	354, 414				1	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	52, 394					76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0				_	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0				_	90. 00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C	8, 052	14, 798			_	90. 01
90.02 04951 HEALTHY HEARTS CENTER	357, 074	5, 930, 247	0. 06021	2 270	16	90. 02
90. 03 09001 PALLIATIVE CARE	7, 246	549, 919	0. 01317	6 0	0	90. 03
90. 04 04953 SPI NE CENTER	0	340			0	90. 04
90. 05 04954 I NFUSI ON CENTERS	143, 533	2, 652, 590			l 0	90. 05
90. 06 09002 MEDCHECK CLINICS	0		0.00000		0	90.06
90. 07 09003 KNEE CENTER	659, 907	-			0	90. 07
91. 00 09100 EMERGENCY	3, 574, 811	335, 554, 140			_	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	950, 504					
200.00 Total (lines 50 through 199)		3, 872, 530, 387		28, 648, 804		
200.00 10tal (11163 30 till ough 199)	1 30, 733, 732	1 3, 312, 330, 301	I	20, 040, 804	301,774	1200.00

Health Financial Systems	COMMUNITY HEALTH	I NETWORK INC		In lie	eu of Form CMS-	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER				Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					0.00	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNIT	0	0		0 0	0	31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0)	0	0	
43. 00 04300 NURSERY	0	0	1	0	0	
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swing-Bed Adjustment	Total Costs (sum of cols.	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	Amount (see	1 through 3,	Days	5 - (01. 0)	Frogram Days	
	instructions)					
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			<u>"</u>		
30. 00 03000 ADULTS & PEDIATRICS	0	0	89, 54	7 0.00	6, 143	30.00
31.00 03100 INTENSIVE CARE UNIT		0	15, 23			
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	3, 00			
43. 00 04300 NURSERY		0	1, 59:			
200.00 Total (lines 30 through 199)		0	109, 38	2	8, 879	200. 00
Cost Center Description	Inpatient Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					

9. 00

30.00

31. 00 35. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2023 Part IV
To 12/31/2023 Date/Time Prepared: 5/24/2024 11: 39 am Provider CCN: 15-0074 THROUGH COSTS

						5/24/2024 11:	39 am
		1	itle XIX		Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	Allied Health	
	Anestheti st	Program	Program	ı	Post-Stepdown		
	Cost	Post-Stepde	own		Adjustments		
		Adjustmen	S				
	1. 00	2A	2.00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0)	0	О	0	0	50. 00
51.00 05100 RECOVERY ROOM	0		0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		0	0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0)	o	0	0	0	55. 00
57.00 05700 CT SCAN	0)	o	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0)	o	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0)	o	0	0	0	59. 00
60. 00 06000 LABORATORY	0)	o	0	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0)	o	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0)	ol	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	d	o	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		d	ol	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		d	ol	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY			o	0	0	l o	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY			o	0	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			o	0	0	Ö	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS				0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS				0	0	0	73.00
73. 01 07301 SPECIALTY PHARMACY				0	0	l ő	73. 00
73. 02 07302 CONTRACTED PHARMACY				0	0	0	73. 02
74. 00 07400 RENAL DIALYSIS				0	0	0	74.00
76. 00 03330 ENDOSCOPY				0	0	0	76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				0	0	0	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P				0	0	0	76. 03
76. 04 03952 WOUND CARE CENTER				0	0	0	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER				0	0	0	76. 05
76. 06 03953 I MAGING CENTERS				0	0	0	76.05
76. 07 03954 BREAST DIAGNOSTIC CENTER				0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON				0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY				0	0	0	76. 98
77. 00 07700 ALLOGENEI C HSCT ACQUISITION			0	0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		1		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS		1		O _I	0	0	76.00
90. 00 09000 CLINIC	T 0	1	ol	0	0	0	90.00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C		l l	0	0	0		90.00
90. 02 04951 HEALTHY HEARTS CENTER				0	0	0	90.01
90. 02 04931 HEALTHY HEARTS CENTER 90. 03 09001 PALLI ATI VE CARE		()		0	0	0	90.02
90. 03 09001 PALLI ATT VE CARE 90. 04 04953 SPI NE CENTER		()		0	0		90.03
				0	0		
90. 05 04954 I NFUSI ON CENTERS			0	U	ŭ	0	90.05
90. 06 09002 MEDCHECK CLINICS				0	0	0	90.06
90. 07 09003 KNEE CENTER		(U	0	0	90. 07
91. 00 09100 EMERGENCY		(٧	U	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		(0	^	0	92.00
200.00 Total (lines 50 through 199)	1	Ί	0	U	0	ı	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HEALTH NETWORK, INC. APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0074 Peri od: Worksheet D From 01/01/2023 Part IV THROUGH COSTS Date/Time Prepared: 12/31/2023 5/24/2024 11: 39 am Title XIX Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 242, 173, 608 0.000000 50.00 05100 RECOVERY ROOM 0 0 0 18, 056, 420 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 12, 116, 677 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 70, 539, 822 0.000000 54 00 54 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 36, 998, 096 0.000000 55.00 57.00 05700 CT SCAN 139, 928, 330 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 21, 879, 801 0.000000 58 00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0 374, 891, 679 0.000000 59.00 60.00 06000 LABORATORY 132, 281, 086 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 10, 085, 507 0.000000 64.00 06500 RESPIRATORY THERAPY 0 47, 314, 885 0.000000 65 00 Ω 65 00 66.00 06600 PHYSI CAL THERAPY 0 23, 166, 420 0.000000 66.00 06700 OCCUPATIONAL THERAPY 7, 992, 694 0.000000 67.00 06800 SPEECH PATHOLOGY 0 3, 626, 628 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 69 00 0 63, 001, 917 0.000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 8, 799, 174 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 114, 534, 442 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 115, 853, 518 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 1, 423, 361, 034 0.000000 73.00 73. 01 07301 SPECIALTY PHARMACY 129, 509, 892 0.000000 73.01 07302 CONTRACTED PHARMACY 37, 503, 231 73.02 0.000000 73.02

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared:
 Heal th Financial
 Systems
 COMMUNITY
 HEALTH N

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0074 THROUGH COSTS

					To 1	2/31/2023	Date/Time Pre 5/24/2024 11:	
			Titl	e XIX	Hos	spi tal	PPS	<u> </u>
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	0ut	pati ent	Outpati ent	
		Ratio of Cost	Program	Program	Pi	rogram	Program	
		to Charges	Charges	Pass-Through	n CI	narges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8		Costs (col. 9	
		7)		x col. 10)			x col. 12)	
	ANOULLARY OFFICE COOT OFFITERS	9. 00	10. 00	11. 00		12.00	13. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS	0.000000	0 507 050	1				F0 00
50.00	05000 OPERATI NG ROOM	0. 000000	2, 507, 358	•	0	0	0	
51.00	05100 RECOVERY ROOM	0.000000	411, 858	•	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	598, 507	•	0	0	0	52. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0. 000000	753, 224		0	0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0.000000	953, 439		0	0	0	55. 00 57. 00
57. 00 58. 00	05700 CT SCAN	0. 000000 0. 000000	2, 162, 578		0	0	0	58.00
59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0. 000000	368, 311		0	0	0	
60.00	06000 LABORATORY	0. 000000	1, 942, 260 3, 640, 715		0	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	183, 394		0	0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	2, 415, 359		0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	179, 786		0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	165, 022		0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	90, 689		0	0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	638, 742		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	88, 335		0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 326, 750		0	0	Ö	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	578, 927	1	0	0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 440, 657	•	Ö	0	ő	
73. 01	07301 SPECIALTY PHARMACY	0. 000000	0	1	Ö	0	Ö	
73. 02	07302 CONTRACTED PHARMACY	0. 000000	0	•	0	0	0	73. 02
74.00	07400 RENAL DIALYSIS	0. 000000	271, 796		0	0	0	74. 00
76.00	03330 ENDOSCOPY	0. 000000	136, 174		0	0	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	32, 854		0	0	0	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	0. 000000	0		0	0	0	76. 03
76.04	03952 WOUND CARE CENTER	0. 000000	63, 357		0	0	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 000000	165, 705		0	0	0	76. 05
76. 06	03953 I MAGI NG CENTERS	0. 000000	5, 882		0	0	0	76. 06
76. 07	03954 BREAST DI AGNOSTI C CENTER	0. 000000	0		0	0	0	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			ı				
90.00	09000 CLINIC	0. 000000	0		0	0	0	1
90. 01	04950 MULTI DI SCI PLI NARY CLI NI C	0.000000	0		0	0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	0.000000	270		0	0	0	90. 02
90. 03 90. 04	09001 PALLI ATI VE CARE 04953 SPI NE CENTER	0. 000000 0. 000000	0		0	0	0	90. 03 90. 04
	1 1	l l	0	•	-	0	_	
90. 05 90. 06	04954 I NFUSI ON CENTERS 09002 MEDCHECK CLI NI CS	0. 000000 0. 000000	0		0	0	0	90. 05 90. 06
90.06	09002 MEDCHECK CLINICS	0. 000000	0		0	0	0	90.06
91.00	09100 EMERGENCY	0. 000000	4, 366, 807		0	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	160, 048	1	0	0	0	1
200.00		0.000000	28, 648, 804		0	0		200. 00
200.00	/ [(111105 00 till odgil 177)	1 1	20, 010, 004	ı	~	O	·	1-30.00

APPOR	FIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0074	Peri od: From 01/01/2023	Worksheet D Part V	
					To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: 39 am
			Titl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	9	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	0. 176833	0		0 1, 827, 720	0	50.00
51. 00	05100 RECOVERY ROOM	0. 136859	1		0 312, 083	Ö	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 526785			0 012,000	o o	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 139338			0 1, 998, 467	Ö	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 073702			0 506, 966	0	55. 00
57. 00	05700 CT SCAN	0. 052105	1		0 6, 103, 063	0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 108297			0 511, 794	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 108247			0 1, 628, 405	0	1
60.00	06000 LABORATORY	0. 055546	1			0	60.00
64. 00	06400 I NTRAVENOUS THERAPY		1			1	1
	1	0. 364753			2.177.10	1	
65. 00	06500 RESPIRATORY THERAPY	0. 202594			,	0	
66.00	06600 PHYSI CAL THERAPY	0. 492498	1		0777010	l	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 425804			0 166, 873	0	
68. 00	06800 SPEECH PATHOLOGY	0. 480848			0 122, 749	1	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 106533			0 494, 925	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 198684			0 215, 155	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 472805	l t		0 498, 580	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 425906	1		0 761, 469		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 188303	1		0 31, 291, 468	l	73. 00
73. 01	07301 SPECI ALTY PHARMACY	0. 829843			0	0	
73. 02	07302 CONTRACTED PHARMACY	0. 590718	•		0	0	
74. 00	07400 RENAL DI ALYSI S	0. 482069			0	0	1
76. 00	03330 ENDOSCOPY	0. 241049			0 39, 350	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2. 346223	 		0 628, 561	0	1
76. 03	03951 LUTHERWOOD PARTNERSHIP	23. 992496	1		0 134, 301	0	1
76. 04	03952 WOUND CARE CENTER	0. 261306	1		0 698, 718	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 213467	1		0 8, 235, 811	0	1
76. 06	03953 I MAGI NG CENTERS	0. 110082	1		0 1, 059, 116		1
76. 07	03954 BREAST DIAGNOSTIC CENTER	0. 533742			0 102, 419	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 429759	0		0 6, 498	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 232625	0		0	0	76. 98
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						
90. 00	1	0. 000000	1		0	0	1
90. 01	04950 MULTI DI SCI PLI NARY CLI NI C	0. 917962	1		0	0	1
90. 02	04951 HEALTHY HEARTS CENTER	0. 403075	1		0 124, 681	0	1
	09001 PALLI ATI VE CARE	0. 041530	1		0 18, 647	0	
	04953 SPI NE CENTER	0. 005882	1		0	0	1 ,0.0.
	04954 I NFUSI ON CENTERS	0. 379723			0 22, 444	0	
90. 06	09002 MEDCHECK CLINICS	0. 000000	0		0	0	90. 06
90. 07	09003 KNEE CENTER	1. 082600	0		0 18, 352	0	90. 07
91.00	09100 EMERGENCY	0. 110483	0		0 18, 579, 621	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 683390	0		0 684, 077	0	92.00
200.0	Subtotal (see instructions)		0		0 80, 540, 586	0	200. 00
201.0	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges						
202. 0	Net Charges (line 200 - line 201)		0		0 80, 540, 586	0	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0074 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/24/2024 11:39 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 323, 201 50.00 51.00 05100 RECOVERY ROOM 0 0 0 42, 711 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 C 54.00 05400 RADI OLOGY-DI AGNOSTI C 278, 462 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 37, 364 55.00 57.00 05700 CT SCAN 57.00 318 000 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 55, 426 58.00 59.00 05900 CARDIAC CATHETERIZATION 57, 887 59.00 06000 LABORATORY 60.00 465, 374 60.00 06400 I NTRAVENOUS THERAPY 77 236 64 00 64 00 06500 RESPIRATORY THERAPY 65.00 45, 667 65.00 06600 PHYSI CAL THERAPY 195, 840 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 71, 055 67.00 68.00 06800 SPEECH PATHOLOGY 59,024 68 00 69.00 06900 ELECTROCARDI OLOGY 52, 726 69.00 07000 ELECTROENCEPHALOGRAPHY 42, 748 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 235, 731 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 324, 314 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 892, 277 73.00 07301 SPECIALTY PHARMACY 73.01 0 73.01 07302 CONTRACTED PHARMACY 73.02 73.02 0 07400 RENAL DIALYSIS 74.00 74 00 76.00 03330 ENDOSCOPY 9, 485 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 01 1, 474, 744 76.01 76.03 03951 LUTHERWOOD PARTNERSHIP 3, 222, 216 76.03 03952 WOUND CARE CENTER 76.04 182, 579 76.04 03480 ONCOLOGY-CANCER CARE CENTER 1, 758, 074 76.05 76.05 76.06 03953 I MAGING CENTERS 116, 590 76.06 76.07 03954 BREAST DIAGNOSTIC CENTER 54, 665 76.07 76. 97 07697 CARDIAC REHABILITATION 2, 793 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0 76. 98 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0000000000000 90.01 04950 MULTI DI SCI PLI NARY CLI NI C 90 01 Ω 90.02 04951 HEALTHY HEARTS CENTER 50, 256 90.02 90.03 09001 PALLIATIVE CARE 774 90.03 90. 04 04953 SPINE CENTER 90.04 0 04954 INFUSION CENTERS 90.05 8, 523 90.05 90.06 09002 MEDCHECK CLINICS 90.06 09003 KNEE CENTER 90.07 19,868 90.07 91. 00 09100 EMERGENCY 2, 052, 732 91 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 467, 491 92.00 200.00 Subtotal (see instructions) 17, 995, 833 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

17, 995, 833

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0074	Peri od: From 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/24/2024 11:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		Title XVIII	Hospi tal	PPS	39 alli
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days			89, 547	1.00
2.00	Inpatient days (including private room days, excluding swing-b			89, 547	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pri	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		82, 464	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	02, 101	1
	reporting period	3 .			
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	daya) +brayab Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 Of the Cost	U	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	n davs) after December 3	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	12, 263	9. 00
10.00	newborn days) (see instructions)	alv. (i polydina privoto r	nom doug)	0	10 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		Joili days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI>	(only (including private	room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar ye			Ü	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT	- +b	C +L+	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	r the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00					19. 00
20. 00	reporting period	ofter December 21 of th		0.00	20.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s arter becember 31 or tr	le cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	5)		118, 565, 012	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	na period (line	0	24. 00
2 00	7 x line 19)	or or the dest report.	.g po ou (ŭ	2 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
27, 00	x line 20)			0	24 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)		0 118, 565, 012	26.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Time 21 minus iine 20)		110, 303, 012	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 =	- line 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	ı
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	ı
35. 00	Average per diem private room cost differential (line 34 x lin		/	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	118, 565, 012	37. 00
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 324. 05	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		16, 236, 825	
40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		16, 236, 825	41.00

		COMMUNITY HEALTH N				u of Form CMS-2			
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN		Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre			
			Title >			5/24/2024 11:			
	Cost Center Description	Total Inpatient Costlr	Total	Average Per	Hospital Program Days	PPS Program Cost (col. 3 x col. 4)			
		1.00	2. 00	3. 00	4. 00	5. 00			
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0	0	42.00		
43. 00	INTENSIVE CARE UNIT	32, 086, 754	15, 234	2, 106. 2	6 2, 618	5, 514, 189	43. 00		
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00		
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00		
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	4, 570, 745	3, 009	1, 519. 0	2 0	0	47. 00		
48. 00 48. 01	Program inpatient ancillary service cost (We Program inpatient cellular therapy acquisiti			L line 10	column 1)	35, 463, 959 0	1		
49. 00	Total Program inpatient costs (sum of lines				COLUMN 1)	57, 214, 973			
FO 00	PASS THROUGH COST ADJUSTMENTS	ationt moutine of	and one (from W	Uco+ D cum	of Donto L and	2 222 720	FO 00		
50. 00	Pass through costs applicable to Program inp	batrent routine se	ervices (from w	IKSt. D, Sulli	or Parts r and	2, 222, 728	50.00		
51. 00	Pass through costs applicable to Program inpand IV)	patient ancillary	services (from	n Wkst. D, si	um of Parts II	1, 873, 271	51.00		
52.00	Total Program excludable cost (sum of lines					4, 095, 999	1		
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-physi	cran anesth	etist, and	53, 118, 974	53. 00		
54. 00	Program di scharges						54. 00		
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0.00	55. 00 55. 01		
55. 02	Adjustment amount per discharge (contractor	use only)					55. 02		
56.00	Target amount (line 54 x sum of lines 55, 55		rot amount (lin	o E4 minus I	ino E2)	0			
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tart	get amount (iii	ie so iiii rius i	THE 53)	0	1		
59. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost report	ing period (endi ng 1996,	0.00	59. 00		
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		prior year cos	st report, u	odated by the	0.00	60.00		
61. 00	market basket) Continuous improvement bonus payment (if lir					0	61. 00		
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)								
62. 00 63. 00		ment (see instruct	tions)				62. 00 63. 00		
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Decemb	ner 31 of the c	nst renortii	na period (See	0	64. 00		
	instructions)(title XVIII only)	Ü							
	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)						65. 00		
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line 64	1 plus line 65)	(title XVIII	only); for	0	66. 00		
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	ne costs through [December 31 of	the cost rep	porting period	0	67. 00		
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after Dec	cember 31 of th	ne cost repo	rting period	0	68. 00		
69. 00	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 routi	ne service cos	st (line 37)			70. 00		
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line 2)				71. 00 72. 00		
73. 00	Medically necessary private room cost applic	cable to Program (•	35)			73. 00		
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)			ksheet B, Pa	art II, column		74. 00 75. 00		
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00		
77. 00	,	•					77. 00		
78. 00 79. 00	1 .	,	ovi der records)				78. 00 79. 00		
80.00	Total Program routine service costs for comp	parison to the cos			us line 79)		80. 00		
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00		
83. 00	Reasonable inpatient routine service costs ((see instructions))				83. 00		
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. 00 85. 00		
86. 00	Total Program inpatient operating costs (sum						86.00		
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					7, 083	87. 00		
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ l	ine 2)			1, 324. 05	88. 00		
89. 00	Observation bed cost (line 87 x line 88) (se	ee instructions)				9, 378, 246	89. 00		

Health Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		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	12, 016, 817	118, 565, 012	0. 10135	9, 378, 246	950, 504	90.00
91.00 Nursing Program cost	0	118, 565, 012	0.00000	9, 378, 246	0	91.00
92.00 Allied health cost	0	118, 565, 012	0.00000	9, 378, 246	0	92.00
93 00 All other Medical Education	0	118 565 012	0.00000	9 378 246	0	93 00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0074	Peri od: From 01/01/2023		
		To 12/31/2023	Date/Time Prep 5/24/2024 11:	pared: 39 am
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1 00	

		Title XIX	Hospi tal	5/24/2024 11:: PPS	39 am_	
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT 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 days)	ed and newborn days)	vate room days	89, 547 89, 547 0	1.00 2.00 3.00	
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	, , ,	vate room days,	82, 464	4. 00	
5. 00						
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	3 .		0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	3 .		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)			6, 143	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	nter O on this line)		0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period			0	12.00	
13. 00 14. 00	Swing-bed NF type inpatient days applicable to titles V or XI) 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 line	e)	0	13. 00 14. 00	
15. 00	Total nursery days (title V or XIX only)	iii (excruding swing-bed t	lays)	1, 592		
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			1, 345	16. 00	
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	f the cost	0.00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00	
19. 00	, , ,					
20. 00						
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	129, 681, 906 0	21. 00 22. 00	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00	
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reportin	ng period (line	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)		0 129, 681, 906	26. 00 27. 00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	28. 00 29. 00	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			Ö	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 =	line 28)		0.000000	31.00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00	
34. 00	Average per diem private room charge differential (line 32 mir	, ,	(i ons)	0.00	34.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	35. 00 36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost did	ferential (line	129, 681, 906	37.00	
200	27 minus line 36) PART II - HOSPI TAL AND SUBPROVI DERS ONLY	, ,		, 30., 700		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 448. 20	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	38)		8, 896, 293	39. 00	
40. 00	Medically necessary private room cost applicable to the Progra	,		0	40.00	
41. 00	Total Program general inpatient routine service cost (line 39	+ IIne 40)		8, 896, 293	41.00	

COMPUT	Financial Systems CO ATION OF INPATIENT OPERATING COST	J	NETWORK, INC. Provider CO	CN: 15-0074	Peri od:	worksheet D-1				
01					From 01/01/2023 To 12/31/2023		pared:			
				e XIX	Hospi tal	PPS				
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)				
		1.00	2.00	3.00	4. 00	5. 00				
42. 00	NURSERY (title V & XIX only)	1, 381, 539	1, 592	867.8	1, 345	1, 167, 191	42. 00			
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	32, 598, 165	15, 234	2, 139. 8	83 974	2, 084, 194	43.00			
44. 00	CORONARY CARE UNIT	32, 390, 103	15, 254	2, 139. (9/4	2,004,194	44. 00			
45. 00	BURN INTENSIVE CARE UNIT						45. 00			
46. 00	SURGICAL INTENSIVE CARE UNIT	URGICAL INTENSIVE CARE UNIT								
47. 00	NEONATAL INTENSIVE CARE UNIT	4, 922, 864	3, 009	1, 636. (05 417	682, 233	47. 00			
	Cost Center Description					1. 00				
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			5, 233, 158	48. 00			
48. 01	Program inpatient cellular therapy acquisiti	column 1)	0							
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instruc	tions)		18, 063, 069	49. 00			
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	convices (from	Wkst D sur	m of Dorte L and	1, 196, 907]]			
30.00	Pass through costs appricable to Program The	attent routine	services (IIOIII	WKSt. D, Sui	ii 01 Pai tS I aliu	1, 190, 907	30.00			
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	301, 774	51.00			
	and IV)	50 1 54)								
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non nhv	sician anos+	netist and	1, 498, 681 16, 564, 388				
55.00	medical education costs (line 49 minus line		rateu, non-pny	si ci ali allesti	letist, and	10, 304, 300	33.00			
	TARGET AMOUNT AND LIMIT COMPUTATION									
	Program di scharges					0				
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					l e	55. 00 55. 01			
55. 02	Adjustment amount per discharge (contractor	use onl v)				l e	55. 02			
56. 00	Target amount (line 54 x sum of lines 55, 55					0	1			
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0				
58. 00	Bonus payment (see instructions)	0	58. 00 59. 00							
59. 00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)									
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year c	ost report, ι	updated by the	0.00	60.00			
61. 00	market basket) Continuous improvement bonus payment (if Lin	a 53 ± lina 54	ie lace than t	he lowest of	linge 55 nlue	0	61. 00			
01.00	O Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						01.00			
	enter zero. (see instructions)					_				
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				62. 00 63. 00			
00. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	(300 1113114	0110113)			<u> </u>	00.00			
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00			
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the c	ost renortino	neriod (See	0	65. 00			
00.00	instructions)(title XVIII only)	to arter become	01 01 01 110 0	ost roporting	g perrou (occ	Ĭ	00.00			
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only); for	0	66. 00			
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost re	eporting period	0	67. 00			
	(line 12 x line 19)	0								
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter D	ecemper 31 of	the cost repo	ording period	0	68. 00			
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00			
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70. 00			
71. 00	Adjusted general inpatient routine service c						71.00			
72.00	Program routine service cost (line 9 x line	,	Z11	05)			72.00			
73.00	Medically necessary private room cost applic		•	ne 35)			73.00			
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		orksheet B	Part II. column		74. 00 75. 00			
	26, line 45)				. ,					
76.00	Per diem capital-related costs (line 75 ÷ li						76.00			
77. 00 78. 00	Program capital-related costs (line 9 x line						77. 00 78. 00			
79. 00							79.00			
	Total Program routine service costs for comp			•	nus line 79)		80. 00			
81. 00	Inpatient routine service cost per diem limi						81.00			
82.00	Inpatient routine service cost limitation (I						82.00			
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00			
85. 00	Utilization review - physician compensation		ns)				85. 00			
	Total Program inpatient operating costs (sum	of lines 83 th					86.00			
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					7.000	07.00			
87. 00	Total observation bed days (see instructions)				7, 083	1			
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 448. 20	1 88 NN			

Health Financial Systems	COMMUNITY HEALTH	I NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	12, 016, 817	129, 681, 906	0. 09266	4 10, 257, 601	950, 510	90.00
91.00 Nursing Program cost	0	129, 681, 906	0.00000	0 10, 257, 601	0	91.00
92.00 Allied health cost	0	129, 681, 906	0.00000	0 10, 257, 601	0	92. 00
93 00 All other Medical Education	0	129 681 906	0 00000	0 10 257 601	0	93 00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0074	Period: Worksheet D-3 From 01/01/2023
		To 12/31/2023 Date/Time Prepared:

THE ATTENT AND LEART SERVICE COST ATTORTIONNENT	Trovider e		From 01/01/2023	WOLKSHEET D 3	
			Γο 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: 39 am
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	· ·	Ratio of Cost	Inpati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			onal goo	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			32, 736, 545		30.00
31. 00 03100 NTENSI VE CARE UNI T			14, 587, 128		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			14, 307, 120		35.00
			0		•
43. 00 O4300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0.1(402)	27 212 472	/ 122 F2F	E0 00
		0. 164820			50.00
51. 00 05100 RECOVERY ROOM		0. 136859		196, 748	•
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 52678!		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 139338		406, 940	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 073702		296, 367	55. 00
57.00 05700 CT SCAN		0. 05210!		388, 446	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 10829	1, 057, 032	114, 473	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 035056	38, 729, 246	1, 357, 692	59. 00
60. 00 06000 LABORATORY		0. 159732	11, 070, 162	1, 768, 259	60.00
64.00 06400 INTRAVENOUS THERAPY		0. 364753	382, 652	139, 573	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 202594	7, 518, 469	1, 523, 197	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 443642		418, 745	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 425804		361, 683	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 480848		119, 459	1
69. 00 06900 ELECTROCARDI OLOGY		0. 106533		436, 371	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 198684		49, 792	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 47280!		6, 338, 018	•
					1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 42590		10, 084, 228	
		0. 188303		2, 351, 646	
73. 01 07301 SPECI ALTY PHARMACY		0. 829843		0	73. 01
73. 02 07302 CONTRACTED PHARMACY		0. 590718		0	73. 02
74. 00 07400 RENAL DI ALYSI S		0. 482069		662, 160	1
76. 00 03330 ENDOSCOPY		0. 241049		17, 348	1
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		2. 172388		45, 840	1
76. 03 03951 LUTHERWOOD PARTNERSHI P		23. 992490		0	76. 03
76. 04 03952 WOUND CARE CENTER		0. 246576		56, 671	1
76. 05 03480 ONCOLOGY-CANCER CARE CENTER		0. 21275!	652, 321	138, 785	
76. 06 03953 I MAGI NG CENTERS		0. 110082	47, 833	5, 266	76. 06
76.07 03954 BREAST DIAGNOSTIC CENTER		0. 533742	563	300	76. 07
76.97 O7697 CARDIAC REHABILITATION		0. 429759	1, 116	480	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 23262	5 0	0	76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.000000	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0.000000		0	78. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.00000	0	0	90. 00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C		0. 917962		Ö	90. 01
90. 02 04951 HEALTHY HEARTS CENTER		0. 40307!			90. 02
90. 03 09001 PALLI ATI VE CARE		0. 041530		0	•
					•
90. 04 04953 SPI NE CENTER		0.005882			
90. 05 04954 I NFUSI ON CENTERS		0. 379723		0	
90. 06 09002 MEDCHECK CLI NI CS		0.000000		0	90.06
90. 07 09003 KNEE CENTER		1. 082600		0	90. 07
91. 00 09100 EMERGENCY		0. 10798		1, 473, 448	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 683390		578, 499	1
200.00 Total (sum of lines 50 through 94 and 96 through			184, 654, 589	35, 463, 959	1
201.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			184, 654, 589		202. 00

Health Financial Systems	COMMUNITY HEALTH NE	TWORK, INC.		In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0074	Peri od:	Worksheet D_3

Health Financial Systems COMMUNITY HEALTH NE	TWORK, INC.		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0074	Peri od:	Worksheet D-3	
			From 01/01/2023		
			To 12/31/2023		
	T. 11	VI V		5/24/2024 11:	39 am_
	liti	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			17, 344, 921		30.00
31.00 03100 INTENSIVE CARE UNIT			4, 636, 769		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			2, 541, 351		35. 00
43. 00 04300 NURSERY			1, 936, 241		43.00
ANCILLARY SERVICE COST CENTERS		1			1
50. 00 05000 OPERATI NG ROOM		0. 17683	33 2, 507, 358	443, 384	50.00
51. 00 05100 RECOVERY ROOM		0. 1368			1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 52678		315, 285	1
		1		l	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 13933		104, 953	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 07370		1	1
57. 00 05700 CT SCAN		0. 05210		1	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 10829	368, 311	39, 887	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 03554	1, 942, 260	69, 043	59. 00
60. 00 06000 LABORATORY		0. 15973	3, 640, 715	581, 539	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 36475	183, 394	66, 894	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 2025			1
66. 00 06600 PHYSI CAL THERAPY		0. 49249			1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 42580		70, 267	1
68. 00 06800 SPEECH PATHOLOGY		0. 48084			1
		1			1
69. 00 06900 ELECTROCARDI OLOGY		0. 10653			1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 19868		1	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 47280			1
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 42590	578, 927	246, 568	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 18830	03 4, 440, 657	836, 189	73. 00
73. 01 07301 SPECIALTY PHARMACY		0. 82984	13 0	0	73. 01
73. 02 07302 CONTRACTED PHARMACY		0. 5907	18 0	0	73. 02
74. 00 07400 RENAL DIALYSIS		0. 4820	59 271, 796	131, 024	74.00
76. 00 03330 ENDOSCOPY		0. 24104		32, 825	1
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		2. 34622		77, 083	1
76. 03 03951 LUTHERWOOD PARTNERSHI P		23. 99249		0	1
76. 04 03952 WOUND CARE CENTER		0. 26130		16, 556	
76. 05 03480 ONCOLOGY-CANCER CARE CENTER		0. 21346		35, 373	1
		1			1
76. 06 03953 I MAGI NG CENTERS		0. 11008		648	1
76. 07 03954 BREAST DI AGNOSTI C CENTER		0. 53374		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 4297		0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 23262		0	
77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON		0.00000	00	0	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY		0.00000	00	0	78. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.00000	00 0	0	90.00
90. 01 04950 MULTI DI SCI PLI NARY CLI NI C		0. 91796	52 0	0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER		0. 4030		109	
90. 03 09001 PALLI ATI VE CARE		0. 04153		0	1
90. 04 04953 SPI NE CENTER		0. 00588		0	1
		1		0	
90. 05 04954 INFUSION CENTERS		0. 37972		l	1
90. 06 09002 MEDCHECK CLI NI CS		0.00000		0	
90. 07 09003 KNEE CENTER		1. 08260		0	
91. 00 09100 EMERGENCY		0. 11048		482, 458	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 68339			1
200.00 Total (sum of lines 50 through 94 and 96 through 98)			28, 648, 804	5, 233, 158	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			28, 648, 804		202. 00
		•	•	-	-

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0074	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/24/2024 11:39 am	

	T: H - WILL	11	5/24/2024 11:	39 am
	Title XVIII	Hospi tal	PPS	
			1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1	(see	0 30, 925, 473	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October instructions)	1 (see	10, 457, 186	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring 1 (see instructions)	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring October 1 (see instructions)	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2. 00 2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		319, 898	2. 03
2. 04 3. 00	Outlier payments for discharges occurring on or after October 1 (see instructions) Managed Care Simulated Payments		39, 564 61, 931, 064	2. 04 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instru	uctions)	365. 25	4. 00
	Indirect Medical Education Adjustment			
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting or before 12/31/1996. (see instructions)		32. 51	5. 00
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instruction FTE count for allopathic and osteopathic programs that meet the criteria for an add-		0. 00 0. 00	5. 01 6. 00
6. 26	new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap-building window close	ed under §127 of	0. 00	6. 26
7. 00 7. 01	the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(i)		2. 69 0. 00	7. 00 7. 01
7. 01	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitation.	, , , , ,	0.00	7.01
7.02	track programs with a rural track for Medicare GME affiliated programs in accordance and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic proaffiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 2634		-9. 27	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the report straddles July 1, 2011, see instructions.	ACA. If the cost	12. 01	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teachiunder § 5506 of ACA. (see instructions)	ng hospital	0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the C/linstructions)	AA 2021 (see	0. 00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	•	32. 56	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current year from your reco	rds	48. 94	
11. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)		3. 08	ı
12. 00 13. 00	Total allowable FTE count for the prior year.		35. 64 32. 95	
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after Sepotherwise enter zero.	otember 30, 1997,	31. 81	
15. 00	Sum of lines 12 through 14 divided by 3.			15. 00
	Adjustment for residents in initial years of the program (see instructions)			16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		33. 47	17. 00 18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).		0. 091636	
20.00	Prior year resident to bed ratio (see instructions)		0. 089567	1
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0. 089567	
22. 00	IME payment adjustment (see instructions)		1, 974, 987	ı
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		2, 955, 660	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 ($(f)(1)(iv)(c)$).	CFR 412. 105	0. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)		16. 38	1
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line instructions)	e 24 (see	0.00	
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4)		0. 000000 0. 000000	26. 00 27. 00
28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)		0.000000	28.00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)		1, 974, 987	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment		2, 955, 660	
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instruc	ctions)	9. 62	
31.00	Percentage of Medicaid patient days (see instructions)		42. 41	1
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)		52. 03 32. 14	1
34. 00	Disproportionate share adjustment (see instructions)		3, 325, 097	

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0074	Peri od: From 01/01/2023	Worksheet E Part A	
			To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Payment Adjustment				
35. 00	Total uncompensated care amount (see instructions)			5, 938, 006, 757	
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (see instructions)		0. 000611991 4, 207, 070	0. 000620341 3, 683, 591	1
35. 02	Pro rata share of the hospital UCP, including supplemental UCF	O (see instructions)	3, 146, 657	925, 930	
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	(See Tristi de trons)	4, 072, 587	725, 750	36. 0
00.00	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throu			1 00.0
40. 00	Total Medicare discharges (see instructions)	<u> </u>	0		40.0
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.0
41. 01	Total ESRD Medicare covered and paid discharges (see instructi	ons)	0		41.0
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualit	fy for adjustment)	0.00		42.0
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.0
44. 00	Ratio of average length of stay to one week (line 43 divided below)	by line 41 divided by 7	0. 000000		44. 0
45. 00	days) Average weekly cost for dialysis treatments (see instructions)		0.00		45. 0
46. 00	Total additional payment (line 45 times line 44 times line 41.		0.00		46. 0
47. 00	Subtotal (see instructions)	01)	51, 114, 792		47. 0
48. 00	Hospital specific payments (to be completed by SCH and MDH, sr	mall rural hospitals	01,111,772		48. 0
.0.00	only. (see instructions)	.a.r. rarar nesprears			
				Amount	
49. 00	Total payment for inpatient operating costs (see instructions)			1. 00 54, 070, 452	49. 0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			3, 380, 026	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0, 300, 020	51.0
52. 00	Direct graduate medical education payment (from Wkst. E-4, lir			340, 854	1
53. 00	Nursing and Allied Health Managed Care payment	,		0	1
54. 00	Special add-on payments for new technologies			37, 864	54.0
54. 01	Islet isolation add-on payment			0	54.0
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	9)		0	
55. 01	Cellular therapy acquisition cost (see instructions)			0	
56. 00	Cost of physicians' services in a teaching hospital (see intru		h	0	
57. 00 58. 00	Routine service other pass through costs (from Wkst. D. Pt. II		nrough 35).	0	
59.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58)	v, coi. II IIIle 200)		57, 829, 196	
50.00	Primary payer payments			12, 086	
51.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		57, 817, 110	•
62. 00	Deductibles billed to program beneficiaries	/		3, 690, 012	
63. 00	Coinsurance billed to program beneficiaries			68, 400	1
54. 00	Allowable bad debts (see instructions)			899, 901	64.0
55.00	Adjusted reimbursable bad debts (see instructions)			584, 936	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		180, 769	
57. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			54, 643, 634	•
8. 00	Credits received from manufacturers for replaced devices for a			0	
59.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see Instruction	S)	0	
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr	cation) adjustment (cas	instructions)	0	
70. 50	N95 respirator payment adjustment amount (see instructions)	ation, adjustment (see	1 113 L1 UC L1 UHS)	0	1
70. 75	Demonstration payment adjustment amount (see Instructions)			0	
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	
70. 89	Pioneer ACO demonstration payment adjustment amount (see insti	ructions)		· ·	70.8
	HSD honus navment HVRD adjustment amount (see instructions)	•		0	

70. 91

0 70. 92 28, 216 70. 93 -390, 670 70. 94 0 70. 95

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

70.95 Recovery of accelerated depreciation

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0074	
		From 01/01/2023 Part A
		To 12/21/2022 Doto/Time Dropored.

	ATTON OF RETWINDONSEWENT SETTLEMENT	Trovider co	F	rom 01/01/2023 o 12/31/2023	5/24/2024 11:	pared: 39 am
		Title	XVIII	Hospi tal	PPS	
				(уууу)	Amount	
70.01	() (5)			0	1. 00	70.01
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
70.07	the corresponding federal year for the period prior to 10/1)			_		70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
70.00	the corresponding federal year for the period ending on or aft	er 10/1)		_		70.00
70. 98	Low Volume Payment-3			0	0	70. 98
70. 99	HAC adjustment amount (see instructions)	0 0 70)			0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			54, 281, 180	
	Sequestration adjustment (see instructions)				1, 085, 624	
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	, ,				FO 004 400	71. 03
	Interim payments				52, 001, 182	
	Interim payments-PARHM					72. 01
73. 00	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM (for contractor use only)	. 70 .			4 404 074	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			1, 194, 374	74. 00
7. 0.	73)					
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan	ice with			2, 257, 575	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					l
00.00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	£ 2 02	1			00.00
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	OT 2.03			0	90. 00
01 00	plus 2.04 (see instructions)					01 00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instru	,			0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instruct				0	93.00
	The rate used to calculate the time value of money (see instru	icti ons)			0.00	
	Time value of money for operating expenses (see instructions)	.:>			0	95.00
96.00	Time value of money for capital related expenses (see instruct	.1 0115)		Prior to 10/1	0n /Aften 10 /1	96. 00
				1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
100 00	HSP bonus amount (see instructions)			O	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			<u> </u>		100.00
101 00	HVBP adjustment factor (see instructions)			0.0000000000	0.000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions	:)		0.0000000000		102. 00
102.00	HRR Adjustment for HSP Bonus Payment	,,		٩	J	102.00
103 00	HRR adjustment factor (see instructions)			0.0000	0.0000	100 00
	HRR adjustment amount for HSP bonus payment (see instructions)					11() 4 ()()
101.00				l OI		
	Rural Community Hospital Demonstration Project (\$410A Demonstr		stment	0		103.00
200 00	Rural Community Hospital Demonstration Project (§410A Demonstration per	ation) Adju		0	0	104. 00
200.00	Is this the first year of the current 5-year demonstration per	ation) Adju		0	0	
200.00	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	ation) Adju		0	0	104. 00
	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ation) Adju iod under t		0	0	104. 00 200. 00
201. 00	Is this the first year of the current 5-year demonstration per Century 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	0	104. 00 200. 00 201. 00
201. 00 202. 00	Is this the first year of the current 5-year demonstration per 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)	ation) Adju iod under t		0	0	104. 00 200. 00 201. 00 202. 00
201. 00 202. 00	Is this the first year of the current 5-year demonstration per 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)	ation) Adju iod under t e 49)	he 21st		0	104. 00 200. 00 201. 00
201. 00 202. 00	Is this the first year of the current 5-year demonstration per 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	ation) Adju iod under t e 49)	he 21st		0	104. 00 200. 00 201. 00 202. 00
201. 00 202. 00 203. 00	Is this the first year of the current 5-year demonstration per 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 period)	ation) Adju iod under t e 49)	he 21st		0 ration	104. 00 200. 00 201. 00 202. 00 203. 00
201. 00 202. 00 203. 00 204. 00	Is this the first year of the current 5-year demonstration per 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 period) Medicare target amount	ation) Adju iod under t e 49)	he 21st		0 :ration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
201. 00 202. 00 203. 00 204. 00 205. 00	Is this the first year of the current 5-year demonstration per 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 period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ation) Adju iod under t e 49)	he 21st		o ration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
201. 00 202. 00 203. 00 204. 00 205. 00	Is this the first year of the current 5-year demonstration per 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 period) 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 iod under t e 49)	he 21st		o ration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	Is this the first year of the current 5-year demonstration per 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 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	ration) Adjuriod under t	he 21st		o ration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	Is this the first year of the current 5-year demonstration per 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 period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ration) Adjuriod under te 49) first year	he 21st		o cration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	Is this the first year of the current 5-year demonstration per 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 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)	ration) Adjuriod under te 49) first year	he 21st		cration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	Is this the first year of the current 5-year demonstration per 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 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)	ration) Adjuriod under te 49) first year	he 21st		cration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Is this the first year of the current 5-year demonstration per 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 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	ration) Adjuriod under te 49) first year	he 21st		o:ration	104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Is this the first year of the current 5-year demonstration per 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 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 Total adjustment to Medicare IPPS payments (see instructions)	ration) Adjuriod under te 49) first year	he 21st		o:ration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Is this the first year of the current 5-year demonstration per 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 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 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	first year ructions)	he 21st		o:ration	104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Is this the first year of the current 5-year demonstration per 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 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 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	first year ructions)	he 21st		cration	104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	Is this the first year of the current 5-year demonstration per 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 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 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	first year ructions) line 59)	of the current		cration	104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	Is this the first year of the current 5-year demonstration per 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 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 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	first year ructions) line 59)	of the current		cration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00

Health Financial Systems	COMMUNITY HEALTH NE	ETWORK, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0074	From 01/01/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 11:39 am
		T: +1 - \(\lambda \tau \tau \tau \tau \tau \tau \tau \ta	11! +-1	DDC

Name State Martical And Direct Health Statistics 1.00		Ti tl o V	\/I.I.I	Hooni tol	5/24/2024 11:	39 am
Next 1 Not Discussion Next 2 Not Dis			VIII	Hospi tal	PPS	
Medical and other services (see instructions)					1. 00	
Notice modern services reinbursed under PRPS (see instructions) 121,50,898 2.00		PART B - MEDICAL AND OTHER HEALTH SERVICES				
13.00 OPES or FRIP payment (see instructions) 30.779 4.01						
Section Sect		,				
Dutilier reconstitution amount (see instructions)						
Enter the hospit dai specific payment to cost ratio (see instructions)		, , , , , , , , , , , , , , , , , , , ,				
Line 2 Times I Inn 5		1			-	
Transit foral corridor payment (see instructions)	6.00	Line 2 times line 5			0	
Ancil lary service other pass through costs including REH direct graduate medical education costs from 0 9.00						
Miss. b. Pr. I. V. col. 13, line 200 10.00					-	
10.00 Organ acquisitions 29,404 11.00	9.00		dical educ	ation costs from	0	9.00
1.00	10 00				0	10 00
COMPUTATION OF ITSSER OF COST OR CHARGES 12.00 Ancil Tarry service charges 156, 637 13.00					-	
12.00 Ancillary service charges 15.6,631 12.00 13.00 Organ acquisition charges (from West D-4, Pt. III, col. 4, line 69) 13.00					2.7.12.1	
13.00 Organ acquisition charges (crom Wist. D.4., Pt. III, col. 4, line 69) 13.00 15.0						
14.00						
Constraints						
5.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00	14. 00				156, 631	14. 00
16.00 Amount's that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Nation payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	15 00	<i>y</i> 0	mul 000 0n	a ahanga basi s	0	15 00
had such payment been made in accordance with 42 CFR \$413.13(e)		, 66 6				
17.00	10.00		ser vices o	ii a chargebasi's	O	10.00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 127, 227 19.00	17. 00	1 3			0.000000	17. 00
Instructions	18.00				156, 631	18. 00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 29, 404 21.00	19. 00		exceeds li	ne 11) (see	127, 227	19. 00
instructions				10) (
21.00 Lesser of cost or charges (see instructions) 29.404 21.00 22.00 Interns and residents (see instructions) 0.20.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 114,175,943 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 114,175,943 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 114,175,943 24.00 CoMPUTATION OF RELIBERISHENT SETTLEMENT 114,175,943 24.00 Deductibles and Colinsurance amounts (For CAH, see instructions) 0.25.00 Deductibles and Colinsurance amounts relating to amount on line 24 (for CAH, see instructions) 16,443,898 26.00 Instructions 16,443,898 26.00 26.00 Instructions 1724,142 28.00 Instructions 1724,142 28.00 Each of the control of	20.00		exceeds II	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0.22.00 0.23.00 0.2	21 00				29 404	21 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 11,175,943 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 114,175,943 24.00 25.00 24.00 CoMPUTATION OF RELIBEURSHENT SETILEMENT		, , , , , , , , , , , , , , , , , , ,				
COMPUTATION OF REIMBURSEMENT SETTLEMENT					0	23. 00
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0, 25.00	24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			114, 175, 943	24. 00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 16,943,898 26.00 27.00 28.50 27.20 27.00 28.50						
27.00 Subtotal ((i) res 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 77, 261, 449 27.00 1						
Instructions						
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 724, 142 28. 00 28. 50 REH facility payment amount (see instructions) 28. 50 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 97. 98. 59. 79 30. 00 Subtotal (sum of lines 27, 28, 28. 50 and 29) 97. 98.5 981 33. 10 31. 00 Imary payer payments 33. 10 31. 10 32. 00 Subtotal (line 30 minus line 31) 97. 952, 481 32. 00 33. 00 Composite rate ESRD (from Wkst. I -5, line 11) 0 33. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 1, 203, 774 34. 00 36. 00 Allowable bad debts (see instructions) 782, 453 35. 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 98, 734, 934 37. 00 38. 00 MSP-LCC reconciliation amount from PSR 98, 334, 934 37. 00 39. 00 THER ADJUSTMENTS (SEE InSTRUCTIONS) (SPECIFY) 93. 50 39. 75 NS respirator payment adjustment amount (see instructions) 93. 50 39. 75 Demonstration payment adj	27.00		I IIIles 22	and 25] (See	97, 201, 449	27.00
28.50 REH facility payment amount (see instructions) 28.50 0.00 29.0	28. 00				724, 142	28. 00
Subtotal (sum of lines 27, 28, 28.50 and 29) 97, 985, 591 30.00 20.00 Primary payer payments 33.110 31.00 33.110 31.00 33.110 31.00 33.110 31.00 33.110 31.00 33.110 31.00 33.100 33.100 33.00 Composite rate ESRD (From West. I-5, line 11) 0 33.00 3	28. 50					28. 50
31. 00					-	
32.00						
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 All owable bad debts (see instructions) 1, 203, 774 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 782, 453 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 98, 734, 934 37.00 38.00 MSP-LCC reconciliation amount from PS&R 305 38.00 MSP-LCC reconciliation amount from PS&R 305 38.00 MSP-LCC reconciliation amount from PS&R 305 38.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.75 39.75 Pioneer ACO demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 Apartial or full credits received from manufacturers for replaced devices (see instructions) 0 40.00 40.00 40.00 40.00						
33.00 Composite rate ESRD (from Wkst i -5, line 11) 0 33.00 0 0 0 0 0 0 0 0 0	32.00				97, 952, 481	32.00
34.00	33. 00				0	33. 00
36. 00	34.00	Allowable bad debts (see instructions)			1, 203, 774	34.00
37.00 Subtotal (see instructions) 98,734,934 37.00 38.00 MSP-LCC reconciliation amount from PS&R 335 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 97.0						
38.00 MSP-LCC reconciliation amount from PS&R 305 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0.39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.75 39.50 39.75 39.77 5						
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 39.00 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.75 39.97 39.98 39.99 39.99 39.99 39.90						
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50 39.75 N95 respirator 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 Subtotal (see instructions) 0.39.99 40.00 Sequestration adjustment (see instructions) 0.39.99 40.00 Sequestration adjustment (see instructions) 0.39.99 40.00 Sequestration adjustment (see instructions) 0.39.99 40.00 20.00						
39.75 N95 respirator 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 Subtotal (see instructions) 98,734,629 40.00 40.01 Demonstration adjustment (see instructions) 1,974,693 40.01 40.02 Sequestration adjustment amount after sequestration 0 40.02 40.03 Sequestration payment adjustment amount after sequestration 0 40.00 40.02 Sequestration adjustment (see instructions) 0 40.01 41.00 Interim payments 96,241,101 41.00 41.01 Interim payments-PARHM 96,241,101 41.00 42.01 Tentative settlement (for contractor use only) 0 42.01 43.00 Balance due provider/program (see instructions) 518,835 43.00 44.00 Fils.2 0 45.01 45.15.2 0 70.00		, , , , ,			U	
39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97					0	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 98, 734, 629 40. 00 40. 01 Sequestration adjustment (see instructions) 1, 974, 693 40. 00 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 96, 241, 101 41. 00 41. 01 Interim payments-PARHM 96, 241, 101 41. 00 42. 01 Tentative settlement (for contractors use only) 0 42. 00 43. 01 Bal ance due provider/program (see instructions) 518, 835 43. 00 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 90. 00 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 90. 00 The rate used to calculate the Time Value of Money 0. 00						
40.00 Subtotal (see instructions) 98,734,629 40.00 40.01 Sequestration adjustment (see instructions) 1,974,693 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 96,241,101 41.01 42.00 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) 518,835 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 0 44.00 70.00 Original outlier amount (see instructions) 0 90.00 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00	39. 98		ee instruc	tions)	0	39. 98
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (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 I owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 The rate used to calculate the Time Value of Money 94.00 1,974,693 40.01 94.00 40.02 95.01 40.02 96.241,101 41.00 97.02 42.00 97.03 41.00 97.04 41.00 97.04 42.00 97.04 40.00 97.05 42.00					-	
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 (nonal I owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 \$\frac{1}{2}\$ \$1						
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41. 00					U	
41. 01 Interim payments-PARHM					96 241 101	
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 (nonal lowable 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) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 Tentative settlement (for contractors use only) 42.00 42.00 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 43.00 43.01 44.00 5115-2, chapter 1, 0 5115-2, chapter 1, 0 615-2, chapter 1, 0 700-2, chapter 1, 0 700-2		' '				
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{1}{5}115.2\$ TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Start Complete (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money					0	
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44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f		, , , , , , , , , , , , , , , , , , , ,			518, 835	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 The rate used to calculate the Time Value of Money 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)			ub 15 0	abantar 1	_	
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	44.00		up. 15-2,	cnapter I,	0	44.00
90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0 91.00 0.00 92.00	90.00				0	90.00
		Outlier reconciliation adjustment amount (see instructions)				
93.00 It me value of Money (see instructions) 0 93.00						
	93.00	II me value or money (see instructions)			0	93.00

Health Financial Systems	COMMUNITY HEALTH NE	TWORK, INC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0074	Peri od: From 01/01/2023 To 12/31/2023		pared:
				5/24/2024 11:	
		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 COMMUNIANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Period: Worksheet E-1
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/24/2024 11:39 am Provider CCN: 15-0074

					5/24/2024 11: 3	39 am_
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt 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		52, 001, 18	2	96, 241, 101	1. 00
2.00	Interim payments payable on individual bills, either			2	0	2. 00
2.00	submitted or to be submitted to the contractor for				Ĭ	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.04	Program to Provider					0.04
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				O	0	3. 02
3.03				O	0	3. 03
3.04				O	0	3. 04
3.05				O	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			O	0	3. 50
3.51			(O	0	3. 51
3.52				O	0	3. 52
3.53				o	l ol	3. 53
3.54					l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
0. , ,	3. 50-3. 98)					0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		52, 001, 18	2	96, 241, 101	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
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			O	0	5. 01
5. 02	TENTAL TO TROVIDER			Ö	l ől	5. 02
5. 03				0	l ől	5. 02
5.05	Provider to Program			<u> </u>	0	5. 05
5. 50	TENTATI VE TO PROGRAM			O	0	5. 50
5. 51	IENTATIVE TO FROGRAM			0		5. 51
5. 51				0		5. 52
				~		
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		'	O	0	5. 99
	5. 50-5. 98)					,
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1, 194, 37		518, 835	6. 01
6. 02	SETTLEMENT TO PROGRAM			O	0	6. 02
7.00	Total Medicare program liability (see instructions)		53, 195, 55		96, 759, 936	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8.00	Name of Contractor					8.00

Heal th	Financial Systems	COMMUNITY HEALTH N	ETWORK, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der CCN: 15-0074	Peri od: From 01/01/2023 To 12/31/2023		pared:
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA					1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTI					
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1. 00	
2.00	2.00 Medicare days (see instructions)				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 W	kst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred foline 168	r the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instr	uctions)				9. 00
10.00	Calculation of the HIT incentive payment a	fter sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS		,			
30.00	Initial/interim HIT payment adjustment (se	e instructions)				30.00
	Other Adjustment (specify)	,				31.00
						22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

DIRFC	n Financial Systems COMMUNITY HEALTH NETWOR T GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Pro	RK, INC. ovider CCN: 15-0074	Peri		u of Form CMS-2 Worksheet E-4	2552-10
	AL EDUCATION COSTS	ovider con. 15-0072	From	01/01/2023		
			То	12/31/2023	Date/Time Prep 5/24/2024 11:3	
		Title XVIII		Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic progending on or before December 31, 1996.	rams for cost repo	orting p	eri ods	26. 92	1. 00
1. 01 2. 00	FTE cap adjustment under §131 of the CAA 2021 (see instructions) Unweighted FTE resident cap add-on for new programs per 42 CFR 41	2 70(a)(1) (see ir	etructi	one)	0. 00 0. 00	1. 01 2. 00
2. 26	Rural track program FTE cap limitation adjustment after the cap-bithe CAA 2021 (see instructions)				0.00	2. 26
3. 00	Amount of reduction to Direct GME cap under section 422 of MMA				2. 82	3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance with	h 42 CFR §413.79 ((m). (se	e	0.00	3. 01
3. 02	instructions for cost reporting periods straddling 7/1/2011) Adjustment (increase or decrease) to the hospital's rural track F programs with a rural track Medicare GME affiliation agreement in				0.00	3. 02
4. 00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and oste	opathic programs o	lue to a	Medi care	-9. 27	4. 00
4. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) ACA Section 5503 increase to the Direct GME FTE Cap (see instruct straddling 7/1/2011)	ions for cost repo	orting p	eri ods	10. 93	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots (periods straddling 7/1/2011)	see instructions f	or cost	reporting	0. 00	4. 02
4. 21	The amount of increase if the hospital was awarded FTE cap slots instructions)	under §126 of the	CAA 202	1 (see	0. 00	4. 21
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4		minus I	ines 3 and	25. 76	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic progrecords (see instructions)	rams for the curre	ent year	from your	48. 94	6. 00
7. 00	Enter the lesser of line 5 or line 6	15:		011	25. 76	7. 00
		Pri mary (1.00	zare	0ther 2.00	<u>Total</u> 3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteopathic		35. 59	12. 10	47. 69	8. 00
	program for the current year.					
9. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount	on line	19. 22	6. 54	25. 76	9. 00
	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions.	on line 22, or	19. 22		25. 76	
10. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20, if Worksheet S-2, Part I, line 68, is "Y", see instructions.	on line 22, or year	19. 22	6. 54 3. 08 3. 08	25. 76	10. 00
10. 00 10. 01 11. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count	on line 22, or year t year	19. 22	3. 08 3. 08 9. 62	25. 76	10. 00 10. 01 11. 00
10. 00 10. 01 11. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count	on line 22, or year t year		3. 08 3. 08	25. 76	10. 00 10. 01 11. 00
10. 00 10. 01 11. 00 12. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count	on line 22, or year t year ar (see	19. 22	3. 08 3. 08 9. 62	25. 76	10. 00 10. 01 11. 00 12. 00
10. 00 10. 01 11. 00 12. 00 13. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions)	on line 22, or year t year ar (see	19. 22 17. 01	3. 08 3. 08 9. 62 8. 64 8. 40	25. 76	10. 00 10. 01 11. 00 12. 00
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs	on line 22, or year t year ar (see ing 3).	19. 22 17. 01 16. 39 17. 54 0. 00	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00	25. 76	10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs	on line 22, or year t year ar (see ing 3).	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00	25. 76	10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure	on line 22, or year t year ar (see ing 3).	19. 22 17. 01 16. 39 17. 54 0. 00	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00	25. 76	10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 01	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure	on line 22, or year t year ar (see ing 3).	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00 0. 00	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00 0. 00	25. 76	10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 01
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 01 17. 00 18. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital source Adjusted rolling average FTE count	on line 22, or year t year ar (see ing 3).	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00 0. 00 0. 00 0. 00 17. 54 13. 10	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00 0. 00 0. 00 8. 89 104, 794. 97	25. 76	10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 17. 00 18. 00
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospiclosure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	on line 22, or year t year ar (see ing 3). ams tal	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 17. 54 13. 10 0. 00	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00 0. 00 0. 00 0. 00 8. 89 104, 794, 97 0. 00		10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital source Adjusted rolling average FTE count	on line 22, or year t year ar (see ing 3). ams	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 17. 54 13. 10 0. 00	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00 0. 00 0. 00 8. 89 104, 794. 97	2, 752, 509	10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 17. 00 18. 01 19. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	on line 22, or year t year ar (see ing 3). ams tal 103,8	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00 0. 00 0. 00 17. 54 13. 10 0. 00 0, 882	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00 0. 00 0. 00 8. 89 104, 794. 97 0. 00 931, 627	2, 752, 509	10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 17. 00 18. 00 18. 01 19. 00
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 01 19. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program. Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE resec. 413.79(c)(4)	on line 22, or year t year ar (see ing 3). ams tal 103,8° 1,820	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00 0. 00 0. 00 17. 54 13. 10 0. 00 0, 882	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00 0. 00 0. 00 8. 89 104, 794. 97 0. 00 931, 627	2, 752, 509 1. 00 0. 00	10. 000 10. 01 11. 000 12. 000 13. 000 14. 000 15. 001 16. 001 17. 000 18. 001 19. 000
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program. Unweighted adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospiclosure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE resections.	on line 22, or year t year ar (see ing 3). ams tal 103,8° 1,820 esident cap slots ns)	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00 0. 00 0. 00 17. 54 13. 10 0. 00 0, 882	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00 0. 00 0. 00 8. 89 104, 794. 97 0. 00 931, 627	2, 752, 509 1. 00 0. 00 23. 18	10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 01 17. 00 18. 01 19. 00 20. 00
16. 01 17. 00 18. 00 18. 01	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE resident GME FTE unweighted resident count over cap (see instruction Allowable additional direct GME FTE Resident Count (see instruction Allowable additional direct GME FTE Resident Count (see instruction and content of the count over cap (see instruction allowable additional direct GME FTE Resident Count (see instruction and content count over cap (see instruction and content count count co	on line 22, or year t year ar (see ing 3). ams tal 103,8° 1,820 esident cap slots ns) ons)	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00 0. 00 0. 00 17. 54 13. 10 0. 00 0, 882	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00 0. 00 0. 00 8. 89 104, 794. 97 0. 00 931, 627	2, 752, 509 1. 00 0. 00 23. 18 0. 00	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00
10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current Unweighted dental and podiatric resident FTE count for the current Total weighted FTE count Total weighted resident FTE count for the prior cost reporting yeinstructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE resident Count (see instructional long and lines) Additional unweighted resident count over cap (see instructional long and lines) Additional direct GME FTE Resident Count (see instructional long and lines) Allowable additional direct GME FTE Resident Count (see instructional long and lines)	on line 22, or year t year ar (see ing 3). ams tal 103,8° 1,820 esident cap slots ns) ons)	19. 22 17. 01 16. 39 17. 54 0. 00 0. 00 0. 00 0. 00 17. 54 13. 10 0. 00 0, 882	3. 08 3. 08 9. 62 8. 64 8. 40 8. 89 0. 00 0. 00 0. 00 0. 00 8. 89 104, 794. 97 0. 00 931, 627	2, 752, 509 1. 00 0. 00 23. 18 0. 00	10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider Co	CN: 15-0074	Peri od: From 01/01/2023	Worksheet E-4	
IEDI CA	L EDUCATION COSTS			To 12/31/2023	Date/Time Prep 5/24/2024 11:	
			XVIII	Hospi tal	PPS	
			Inpatient Pa	rt Managed Care	Total	
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00	
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	K, line	14, 8	31 25, 111		26. 00
	3. 02, col umn 2)					
27. 00	Total Inpatient Days (see instructions)		101, 2			27.00
28. 00	Ratio of inpatient days to total inpatient days		0. 1469			28.00
9. 00	Program di rect GME amount		404, 59		1, 087, 321	
	Percent reduction for MA DGME			3. 27	00.005	29. 0
	Reduction for direct GME payments for Medicare Advantage			22, 325	22, 325	
31.00	Net Program direct GME amount				1, 064, 996	31.00
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE	XVIII ONLY	' (NURSING PRO	OGRAM AND PARAMED		
	EDUCATION COSTS)		(
2. 00	Renal dialysis direct medical education costs (from Wkst. B, F	Pt. I, sum o	of col. 20 and	d 23, lines 74	0	32.0
	and 94)					
3. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I			74 and 94)	5, 943, 205	1
4. 00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line	33)		0. 000000	
	Medicare outpatient ESRD charges (see instructions)	0.4 1.1 0	vE)		0	35.0
6. 00	Medicare outpatient ESRD direct medical education costs (line APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII		55)		0	36.0
	Part A Reasonable Cost	UNLY				ł
7. 00	Reasonable cost (see instructions)				57, 214, 973	37 0
8. 00	Organ acquisition and HSCT acquisition costs (see instructions	5)			07,211,770	38.0
9. 00	Cost of physicians' services in a teaching hospital (see instr				0	39.0
0. 00	Primary payer payments (see instructions)	,			12, 086	
1. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)			57, 202, 887	
	Part B Reasonable Cost	·				
2. 00	Reasonable cost (see instructions)				121, 560, 295	42.0
3.00	Primary payer payments (see instructions)				33, 110	43.00
	Total Part B reasonable cost (line 42 minus line 43)				121, 527, 185	
5. 00	Total reasonable cost (sum of lines 41 and 44)				178, 730, 072	
6. 00	Ratio of Part A reasonable cost to total reasonable cost (line				0. 320052	
7. 00	Ratio of Part B reasonable cost to total reasonable cost (line		45)		0. 679948	47.0
0 00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	KI R			1.0(4.00(40.0
8. 00 9. 00	Total program GME payment (line 31) Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(soo instan	ictions)		1, 064, 996 340, 854	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)				724, 142	
iu. uu	rait b wedicare dwil payment (inter 47 x 40) (title XVIII dilly).	(SEE THISTIU	ICTIONS/		124, 142	1 (1)(), (

Heal th	Health Financial Systems COMMUNITY HEALTH NETWORK, INC. In Lieu		u of Form CMS-2	552-10	
			Worksheet E-5		
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 11:3	
		Title XVIII		PPS	
				1. 00	
TO BE COMPLETED BY CONTRACTOR					
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				0	1.00
2.00 Capital outlier from Wkst. L. Pt. I, line 2				0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00	The rate used to calculate the time value of money (see instr	ructions)		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	ctions)		0	7.00

Health Financial Systems

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

Provider CCN: 15-0074 Period: From 01

oni y)				12/01/2020	5/24/2024 11:	39 am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	10, 520			0	
2. 00 3. 00	Temporary investments Notes receivable	134, 699	0	0	0	2. 00 3. 00
4.00	Accounts recei vable	556, 397, 547	l .	0	0	
5. 00	Other recei vabl e	-6, 316, 605	1	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	45, 091, 626	1	0	0	
7.00	Inventory	25, 385, 739	0	0	0	7. 00
8.00	Prepai d expenses	13, 163, 115		-	0	1
9.00	Other current assets	0	0	-	0	
10. 00 11. 00	Due from other funds	0	0	-	0	1
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	633, 866, 641	1 0	U	U] 11.00
12. 00	Land	2, 743, 049	0	0	0	12. 00
13. 00	Land improvements	4, 974, 162	1		0	
14. 00	Accumulated depreciation	0	0	0	0	14. 00
15. 00	Bui I di ngs	556, 853, 858	1	0	0	
16.00	Accumulated depreciation	0	0	0	0	
17. 00 18. 00	Leasehold improvements Accumulated depreciation	13, 834, 278	0	0	0	17. 00 18. 00
19. 00	Fi xed equi pment	238, 057, 986		0	0	
20. 00	Accumulated depreciation	230,037,700	0	0	0	1
21. 00	Automobiles and trucks	534, 183	Ō	0	0	1
22. 00	Accumulated depreciation	0		0	0	22. 00
23. 00	Major movable equipment	0	0	0	0	1
24. 00	Accumulated depreciation	-460, 116, 306	0	0	0	24. 00
25. 00	Mi nor equipment depreciable	0	0	0	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation		Ö	0	0	1
29. 00	Mi nor equi pment-nondepreci abl e	58, 900		-	0	1
30.00	Total fixed assets (sum of lines 12-29)	356, 940, 110	0	0	0	30. 00
	OTHER ASSETS	,				
31.00	Investments	0	1		0	1
32. 00	Deposits on Leases	0	0	0	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	278, 862, 031	0	0	0	1
35. 00	Total other assets (sum of lines 31-34)	278, 862, 031	1	_	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	1, 269, 668, 782	1		0	1
	CURRENT LIABILITIES					
37. 00	Accounts payable	1, 159, 272	0	0	0	1
38. 00	Salaries, wages, and fees payable	0	0	0	0	
39. 00	Payroll taxes payable Notes and loans payable (short term)	0	0	0	0	1
40. 00 41. 00	Deferred income	0	0	0	0	40. 00 41. 00
42. 00	Accel erated payments			J	0	42.00
43. 00	Due to other funds	0	О	0	0	1
44.00	Other current liabilities	20, 835, 880	0	0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	21, 995, 152	0	0	0	45. 00
47.00	LONG TERM LIABILITIES	1 0	ı	1		47.00
46. 00 47. 00	Mortgage payable Notes payable	0	_		0	
48. 00	Unsecured Loans		0		0	1
49. 00	Other long term liabilities	9, 870, 728		0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 870, 728	l .	0	0	1
51.00	Total liabilities (sum of lines 45 and 50)	31, 865, 880	0	0	0	51.00
	CAPI TAL ACCOUNTS	,				
52.00	General fund balance	1, 237, 802, 902	1			52.00
53. 00 54. 00	Specific purpose fund		0	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted 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	1
58. 00	Plant fund balance - reserve for plant improvement,				0	1
	repl acement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	1, 237, 802, 902	1	0	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	1, 269, 668, 782	0	O	0	60.00
	1917	ı	ı		l	I

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0074

Peri od: Worksheet G-1 From 01/01/2023

12/31/2023 Date/Time Prepared: 5/24/2024 11:39 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 906, 694, 263 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 331, 108, 639 2.00 3.00 Total (sum of line 1 and line 2) 1, 237, 802, 902 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 5.00 0 0 0 0 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 1, 237, 802, 902 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 0 0 0 0 0 13.00 13.00 14.00 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 1, 237, 802, 902 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 19.00 Fund balance at end of period per balance 19.00 sheet (line 11 minus line 18)

Health Financial Systems COM STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0074

			10	5 12/31/2023	5/24/2024 11:	
	Cost Center Description	Inpatient		Outpati ent	Total	37 dili
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	232, 385,	580		232, 385, 580	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)	232, 385,	580		232, 385, 580	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	82, 619,	360		82, 619, 360	11. 00
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T					14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	28, 782,			28, 782, 798	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	s 111, 402,	158		111, 402, 158	16. 00
47.00	11-15)	0.40 707			0.40 707 700	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	343, 787,		0.054.040.043	343, 787, 738	17. 00
18.00	Ancillary services	783, 277,			4, 034, 327, 278	18.00
19. 00	Outpatient services		0	0	-	19. 00
20. 00 21. 00	RURAL HEALTH CLINIC		0	0		20. 00 21. 00
	FEDERALLY QUALIFIED HEALTH CENTER		U	U	U	21.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULANCE SERVICES					23. 00
24. 00	CMHC SERVICES					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPICE					26. 00
27. 00	PROFESSIONAL FEES OP		0	29, 492, 166	29, 492, 166	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to W	cst 1 127 065			4, 407, 607, 182	28. 00
20.00	G-3, line 1)	1, 127, 003,	17/	3, 200, 342, 033	4, 407, 007, 102	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			1, 147, 687, 657		29. 00
30. 00	ADD (SPECIFY)		0	., , ,		30.00
31. 00			0			31. 00
32.00			0			32. 00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ansfer		1, 147, 687, 657		43.00
	to Wkst. G-3, line 4)					

Heal t	n Financial Systems COMMUNITY HEALTH N	ETWORK, INC.	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0074	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 11:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	,		4, 407, 607, 182	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	nts		2, 953, 574, 207	2. 00
3.00	Net patient revenues (line 1 minus line 2)			1, 454, 032, 975	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		1, 147, 687, 657	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)			306, 345, 318	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			4, 293, 652	6. 00
7.00	Income from investments			0	7. 00
8. 00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00				0	10. 00
11. 00				0	11. 00
12. 00				0	12. 00
13. 00	1			0	13. 00
14. 00	3			2, 679, 374	
15. 00	3 1			0	15. 00
16. 00		than patients		0	16. 00
17. 00	1			34, 800	
18. 00				0	18. 00
19. 00				0	19. 00
20. 00				0	20. 00
21. 00	1			0	21. 00
22. 00	· ·			628, 932	
23. 00	The state of the s			0	23. 00
	MI SC: ALL OTHER REVENUE			17, 126, 563	
2/1 50				Λ.	

0 24, 50 24, 763, 321 25, 00 331, 108, 639 26, 00

0 28.00 331, 108, 639 29.00

27. 00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)

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

26.00 Total (line 5 plus line 25)

27. 00 OTHER EXPENSE

Hoal th	Financial Systems COMMUNITY HEALTH N	IETWODY INC	In Lie	u of Form CMS-2	0552 1A		
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0074	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/24/2024 11:3	pared:		
		Title XVIII	Hospi tal	PPS			
			Urban Post 10/1	Rural Pre 10/1			
			1. 00	1. 01			
	PART I - FULLY PROSPECTIVE METHOD						
	CAPITAL FEDERAL AMOUNT						
1.00	Capital DRG other than outlier		808, 071	2, 340, 286	1. 00		
1. 01	Model 4 BPCI Capital DRG other than outlier		0	0	1. 01		
2. 00 2. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments		33, 509		2. 00 2. 01		
3.00	Total inpatient days divided by number of days in the cost re	enorting period (see	279. 48		3. 00		
3.00	instructions)	por tring perrou (see	277.40		3.00		
4.00	Number of interns & residents (see instructions)		33. 47		4. 00		
5.00	Indirect medical education percentage (see instructions)		3. 44		5. 00		
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, 108, 303		6. 00		
7.00	columns 1 and 1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	, 9. 62		7. 00		
	part A line 30) (see instructions)						
8. 00 9. 00	Percentage of Medicaid patient days to total days (see instru Sum of lines 7 and 8	ictions)	42. 41 52. 03		8. 00 9. 00		
9. 00 10. 00	Allowable disproportionate share percentage (see instructions	-)	11. 12		9. 00 10. 00		
11. 00	Disproportionate share adjustment (see instructions)	•)	89, 857		11. 00		
12. 00			3, 380, 026		12. 00		
	PART II - PAYMENT UNDER REASONABLE COST			1. 00			
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 circumstance	ces (see instructions)		0	2.00		
3.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0 0. 00	3. 00 4. 00		
4. 00 5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	4. 00 5. 00		
6. 00	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0.00	6. 00		
7. 00	Adjustment to capital minimum payment level for extraordinary		line 6)	0.00	7. 00		
8.00	Capital minimum payment level (line 5 plus line 7)		,	0	8. 00		
9.00	Current year capital payments (from Part I, line 12, as appli	cabl e)		0	9. 00		
10.00	Current year comparison of capital minimum payment level to c			0	10.00		
11. 00	Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 00		
12. 00	Net comparison of capital minimum payment level to capital pa			0	12. 00		
13.00	Current year exception payment (if line 12 is positive, enter			0	13. 00		
14. 00	Carryover of accumulated capital minimum payment level over o	capital payment for the fo	ollowing period	0	14. 00		
15. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see ins	structions)		0	15. 00		
	Current year operating and capital costs (see instructions)	50 450 003)		0	16. 00		
	Current year exception offset amount (see instructions)			Ö			