

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 11/30/2016 Time: 13:29
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION


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 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 the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL (15-0125) (Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, 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.

ECR Encryption: 11/30/2016 13:29
2JWvgyFy5nY4F5X9NAR,ihC6W,uA0
9a1Sd0i0phus3W8ULi3AFpALvoY6iw
J:U31kmlzh09uT67

PI Encryption: 11/30/2016 13:29
RbWpKd25XD5FxDj9dzzTfLb0dBQPQ80
ZMW8l0oruln6pNeiau1wXflaDHJgmz
Fu290ZjlgK0CjyxR

(Signed) 
Officer or Administrator of Provider(s)
Title Chief Financial Officer
Date 11/30/16

PART III - SETTLEMENT SUMMARY

		TITLE XVIII						
		TITLE V	PART A	PART B	HIT	TITLE XIX		
		1	2	3	4	5		
1	HOSPITAL		732,312	109,646		2,198	1	
2	SUBPROVIDER - IPF						2	
3	SUBPROVIDER - IRF		56,747	60		24	3	
4	SUBPROVIDER (OTHER)						4	
5	SWING BED - SNF						5	
6	SWING BED - NF						6	
7	SKILLED NURSING FACILITY						7	
8	NURSING FACILITY						8	
9	HOME HEALTH AGENCY						9	
10	HEALTH CLINIC - RHC						10	
11	HEALTH CLINIC - FQHC						11	
12	OUTPATIENT REHABILITATION PROVIDER						12	
200	TOTAL		789,059	109,706		2,222	200	

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this 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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 901 MACARTHUR BOULEVARD	P.O. Box:		1
2	City: MUNSTER	State: IN	ZIP Code: 46321	County: LAKE

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	COMMUNITY HOSPITAL	15-0125	23844	1	10 / 03 / 1973	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF	THE REHAB CENTER AT COMMUNITY	15-T125	23844	5	06 / 30 / 1996	N	P	P	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTG									11
12	Hospital-Based HHA	COMMUNITY HOME HEALTH SERVICES	15-7487	23844		01 / 07 / 1997	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2015	To: 06 / 30 / 2016	20
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21	Type of control (see instructions)	2		21
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Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments 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§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be 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.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to 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.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,867	237	1,293	587	11,995		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	25	177		14	145		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status is in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N						37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N
46	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.	N	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	Y			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

Of the FTEs in line 61.05, specify each expanded 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 and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)						
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2	3	4	5	
65						65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					66
Enter in lines 67-67.49, column 1 the program name. 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)						
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2	3	4	5	
67						67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N			76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N			80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N			81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N			85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.				86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N			87

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**WORKSHEET S-2
PART I**

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	1			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134

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**WORKSHEET S-2
PART I**

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	15H054	140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name: COMMUNITY FOUNDATION OF NW IN, Contractor's Name: WPS Contractor's Number: 00450			141
142	Street: 10100 DON POWERS DRIVE P.O. Box:			142
143	City: MUNSTER State: IN ZIP Code: 46321			143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and '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.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N	N	N	160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N					165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)						166
	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)					169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)				N	171

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.**

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation					
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3

		Y/N	Type	Date	
Financial Data and Reports					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts			
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for 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)	Y	11/02/2016	Y	11/02/2016
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.**

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost		
22	Have assets been relieved for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	31

Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	35

Home Office Costs		Y/N	Date	
		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: CONNIE	Last name: BIEGEL	Title: DIRECTOR OF REIMBURSEMENT	41
42	Employer: COMMUNITY HOSPITAL			42
43	Phone number: 12198366789	E-mail Address: CBIEGEL@COMHS.ORG		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	336	122,976			40,962	828	73,053	1
2	HMO and other (see instructions)						5,919	13,821		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						350	336		4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		336	122,976			40,962	828	73,053	7
8	Intensive Care Unit	31	39	14,274			5,543	81	11,020	8
9	Coronary Care Unit	32								9
9.01	NEONATAL INTENSIVE CARE	32.01	32	11,712				663	4,811	9.01
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						298	3,933	13
14	Total (see instructions)		407	148,962			46,505	1,870	92,817	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	54	19,764			14,573	25	16,639	17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					35,137		42,565	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		461							27
28	Observation Bed Days								17,424	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							288	614	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					8,354	350	17,289	1
2	HMO and other (see instructions)					969	3,172		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider						36		4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
9.01	NEONATAL INTENSIVE CARE								9.01
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		2,422.86			8,354	350	17,289	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF		79.76			1,421	2	1,624	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		42.64						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		2,545.26						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

KPMG LLP Compu-Max 2552-10

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HOSPITAL WAGE INDEX INFORMATION

**WORKSHEET S-3
PARTS II-III**

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	161,183,534		161,183,534	5,151,214.00	31.29	1
2							2
3		2,958,738		2,958,738	38,278.00	77.30	3
4							4
4.01							4.01
5		7,092,935		7,092,935	38,231.00	185.53	5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		9,424,787	105,985	9,530,772	353,289.00	26.98	10
OTHER WAGES & RELATED COSTS							
11		1,116,349		1,116,349	9,758.00	114.40	11
12							12
13		621,831		621,831	4,059.00	153.20	13
14		20,365,428		20,365,428	518,956.00	39.24	14
15							15
16							16
WAGE-RELATED COSTS							
17		40,279,018		40,279,018			17
18							18
19		2,708,858		2,708,858			19
20							20
21		720,337		720,337			21
22							22
22.01							22.01
23		1,313,399		1,313,399			23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		792,639		792,639	33,039.00	23.99	26
27		14,479,275	-34,791	14,444,484	528,888.00	27.31	27
28		3,319,815		3,319,815	23,750.00	139.78	28
29							29
30		4,902,623		4,902,623	177,291.00	27.65	30
31		106,395		106,395	7,495.00	14.20	31
32		3,411,629		3,411,629	213,811.00	15.96	32
33							33
34		3,674,314	-1,258,191	2,416,123	140,708.00	17.17	34
35							35
36			1,258,191	1,258,191	78,422.00	16.04	36
37							37
38		2,317,042		2,317,042	37,162.00	62.35	38
39			34,791	34,791	2,288.00	15.21	39
40		3,975,912	-72,000	3,903,912	106,714.00	36.58	40
41		110,885		110,885	4,131.00	26.84	41
42		669,188		669,188	25,477.00	26.27	42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	154,451,676		154,451,676	5,098,455.00	30.29	1
2	Excluded area salaries (see instructions)	9,424,787	105,985	9,530,772	353,289.00	26.98	2
3	Subtotal salaries (line 1 minus line 2)	145,026,889	-105,985	144,920,904	4,745,166.00	30.54	3
4	Subtotal other wages & related costs (see instructions)	22,103,608		22,103,608	532,773.00	41.49	4
5	Subtotal wage-related costs (see instructions)	40,279,018		40,279,018		27.79%	5
6	Total (sum of lines 3 through 5)	207,409,515	-105,985	207,303,530	5,277,939.00	39.28	6
7	Total overhead cost (see instructions)	37,759,717	-72,000	37,687,717	1,379,176.00	27.33	7

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	2,019,762	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	16,204,761	3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan	229,372	6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	20,247,948	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	1,143,840	10
11	Life Insurance (If employee is owner or beneficiary)	118,725	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	62,635	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	530,850	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	8,681,568	17
18	Medicare Taxes - Employers Portion Only	2,122,466	18
19	Unemployment Insurance	161,951	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	186,654	23
24	Total Wage Related cost (Sum of lines 1-23)	51,710,532	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 15-7487

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

County: LAKE

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		4,200	10	316	4,526	1
2	Unduplicated Census Count (see instructions)		1,166.00	56.00	421.00	1,576.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)		0.53		0.53
5	Other Administrative Personnel		12.83		12.83
6	Direct Nursing Service		8.16		8.16
7	Nursing Supervisor				
8	Physical Therapy Service			7.09	7.09
9	Physical Therapy Supervisor				
10	Occupational Therapy Service			1.56	1.56
11	Occupational Therapy Supervisor				
12	Speech Pathology Service		0.18		0.18
13	Speech Pathology Supervisor				
14	Medical Social Service		0.02		0.02
15	Medical Social Service Supervisor				
16	Home Health Aide		2.16		2.16
17	Home Health Aide Supervisor				
18	PRIVATE DUTY		12.59		12.59

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.		1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).		23844	20

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	13,135	2,256	314	308	16,013	21
22	Skilled Nursing Visit Charges	2,143,965	368,079	51,327	50,469	2,613,840	22
23	Physical Therapy Visits	10,667	688	104	226	11,685	23
24	Physical Therapy Visit Charges	2,034,299	131,360	19,812	43,354	2,228,825	24
25	Occupational Therapy Visits	2,496	301	12	129	2,938	25
26	Occupational Therapy Visit Charges	475,868	57,369	2,288	24,753	560,278	26
27	Speech Pathology Visits	185	92	3	11	291	27
28	Speech Pathology Visit Charges	34,965	17,388	567	2,079	54,999	28
29	Medical Social Service Visits	6	1		3	10	29
30	Medical Social Service Visit Charges	1,294	219		653	2,166	30
31	Home Health Aide Visits	2,999	1,089	2	110	4,200	31
32	Home Health Aide Visit Charges	364,967	132,581	242	13,446	511,236	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	29,488	4,427	435	787	35,137	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	5,055,358	706,996	74,236	134,754	5,971,344	35
36	Total Number of Episodes (standard/non-outlier)	1,411		177	38	1,626	36
37	Total Number of Outlier Episodes		95		9	104	37
38	Total Non-Routine Medical Supply Charges	193,379	68,568	9,931	8,682	280,560	38

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.261376	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		20,599,796	2
3	Did you receive DSH or supplemental payments from Medicaid?		N	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid			5
6	Medicaid charges		183,660,831	6
7	Medicaid cost (line 1 times line 6)		48,004,533	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		27,404,737	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP			9
10	Stand-alone SCHIP charges			10
11	Stand-alone SCHIP cost (line 1 times line 10)			11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.			12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		1,000	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		12,566	14
15	State or local indigent care program cost (line 1 times line 14)		3,284	15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		2,284	16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care			17
18	Government grants, appropriations of transfers for support of hospital operations			18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		27,407,022	19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)
		1	2	3
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	24,249,704		24,249,704
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	6,338,291		6,338,291
22	Partial payment by patients approved for charity care	52,611		52,611
23	Cost of charity care (line 21 minus line 22)	6,285,680		6,285,680

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)			25
26	Total bad debt expense for the entire hospital complex (see instructions)		9,725,883	26
27	Medicare bad debts for the entire hospital complex (see instructions)		1,672,623	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		8,053,260	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,104,929	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		8,390,609	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		35,797,631	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				13,073,733	13,073,733	308,482	13,382,215	1
2	00200	Cap Rel Costs-Mvble Equip				8,870,639	8,870,639	4,035,143	12,905,782	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	792,639	990,335	1,782,974	33,555,781	35,338,755	8,762,107	44,100,862	4
5	00500	Administrative & General	14,479,275	111,641,306	126,120,581	-21,373,139	104,747,442	-48,349,693	56,397,749	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	4,902,623	16,952,733	21,855,356	-4,200,506	17,654,850	-25,276	17,629,574	7
8	00800	Laundry & Linen Service	106,395	1,393,342	1,499,737	-42,356	1,457,381	-5	1,457,376	8
9	00900	Housekeeping	3,411,629	2,185,049	5,596,678	-1,196,481	4,400,197	-37,236	4,362,961	9
10	01000	Dietary	3,674,314	4,481,317	8,155,631	-4,393,897	3,761,734	-162	3,761,572	10
11	01100	Cafeteria				3,252,400	3,252,400	-2,000,273	1,252,127	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	2,317,042	901,216	3,218,258	-602,010	2,616,248	-1,100	2,615,148	13
14	01400	Central Services & Supply				34,791	34,791	-10	34,781	14
15	01500	Pharmacy	3,975,912	15,794,681	19,770,593	-844,329	18,926,264		18,926,264	15
16	01600	Medical Records & Library	110,885	225,223	336,108	-18,148	317,960	5,540,368	5,858,328	16
17	01700	Social Service	669,188	249,447	918,635	-158,692	759,943		759,943	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	PARAMED ED PRGM-(SPECIFY)	86,356	22,609	108,965	62,700	171,665		171,665	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	35,745,969	16,631,585	52,377,554	-10,747,377	41,630,177	-52,531	41,577,646	30
31	03100	Intensive Care Unit	9,051,891	3,703,542	12,755,433	-2,021,852	10,733,581	-79	10,733,502	31
32.01	02060	NEONATAL INTENSIVE CARE	3,173,759	1,619,921	4,793,680	-933,485	3,860,195	-55,441	3,804,754	32.01
41	04100	Subprovider - IRF	4,237,980	3,079,292	7,317,272	-795,668	6,521,604	-37	6,521,567	41
43	04300	Nursery				1,263,200	1,263,200		1,263,200	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	26,068,357	47,925,071	73,993,428	-32,030,697	41,962,731	-13,687,974	28,274,757	50
52	05200	Delivery Room & Labor Room	2,134,904	1,304,236	3,439,140	-515,015	2,924,125	-4	2,924,121	52
54	05400	Radiology-Diagnostic	8,266,329	8,549,051	16,815,380	-1,759,211	15,056,169	-100,224	14,955,945	54
60	06000	Laboratory	6,185,038	8,933,096	15,118,134	-1,563,081	13,555,053	7,540	13,562,593	60
62	06200	Whole Blood & Packed Red Blood Cells	413,540	2,735,853	3,149,393	-85,030	3,064,363		3,064,363	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	3,658,848	1,913,546	5,572,394	-867,497	4,704,897	-15,675	4,689,222	65
66	06600	Physical Therapy	5,552,907	6,872,493	12,425,400	-1,357,954	11,067,446	-22,908	11,044,538	66
70	07000	Electroencephalography	664,302	567,863	1,232,165	-173,907	1,058,258	-33,250	1,025,008	70
71	07100	Medical Supplies Charged to Patients				15,962,618	15,962,618		15,962,618	71
72	07200	Impl. Dev. Charged to Patients				26,949,092	26,949,092		26,949,092	72
73	07300	Drugs Charged to Patients								73
76	03140	CARDIOLOGY	7,351,310	19,874,932	27,226,242	-15,233,693	11,992,549	-661,806	11,330,743	76
76.97	07697	CARDIAC REHABILITATION	439,818	153,366	593,184	-102,271	490,913	-55,960	434,953	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	2,452,100	1,295,616	3,747,716	-481,385	3,266,331	-48,410	3,217,921	90
91	09100	Emergency	6,159,773	3,683,359	9,843,132	-1,476,334	8,366,798	-35,123	8,331,675	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	2,125,700	1,749,412	3,875,112	-256,231	3,618,881	11,947	3,630,828	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	158,208,783	285,429,492	443,638,275	-205,292	443,432,983	-46,517,590	396,915,393	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
191	19100	Research	323,065	214,480	537,545	-58,365	479,180		479,180	191
192	19200	Physicians' Private Offices	257	2,168	2,425	55,120	57,545		57,545	192
194	07950	ADVERTISING				1,198,654	1,198,654		1,198,654	194
194.01	07951	FITNESS POINTE	1,612,032	1,792,260	3,404,292	-728,989	2,675,303		2,675,303	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	297,825	211,693	509,518	-71,481	438,037		438,037	194.02
194.03	07953	RETAIL PHARMACY	594,131	5,865,121	6,459,252	-112,954	6,346,298		6,346,298	194.03
194.04	07954	HOSPICE								194.04
194.05	07955	RUSH RESIDENTS								194.05
194.06	07956	EINSTEIN BAGELS	147,441	204,013	351,454	-76,693	274,761		274,761	194.06
200		TOTAL (sum of lines 118-199)	161,183,534	293,719,227	454,902,761		454,902,761	-46,517,590	408,385,171	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	OPERATING RM/CARDIOLOGY SUPPLIES	A	Medical Supplies Charged to P	71		15,136,464	1
2			Impl. Dev. Charged to Patient	72		26,949,092	2
3							3
4							4
5	NURSING UNITS ONLY	A	Medical Supplies Charged to P	71		826,154	5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications Code Letter - A					42,911,710	500
1	NURSING FLOAT SALARIES	B	Intensive Care Unit	31	52,281		1
2			NEONATAL INTENSIVE CARE	32.01	17,459		2
3			Delivery Room & Labor Room	52	12,897		3
4			Emergency	91	44,242		4
5			Subprovider - IRF	41	33,985		5
6			Nursery	43	8,407		6
500	Total reclassifications Code Letter - B				169,271		500
1	STOREROOM SALARY RECLASS	C	Central Services & Supply	14	34,791		1
500	Total reclassifications Code Letter - C				34,791		500
1	CAFETERIA EXPENSE	D	Cafeteria	11	1,258,191	1,994,209	1
500	Total reclassifications Code Letter - D				1,258,191	1,994,209	500
1	INTEREST EXPENSE	E	Cap Rel Costs-Mvble Equip	2		5,699	1
2							2
3							3
500	Total reclassifications Code Letter - E					5,699	500
1	BUILDING INSURANCE	F	Cap Rel Costs-Bldg & Fixt	1		186,896	1
2			Cap Rel Costs-Mvble Equip	2		9,447	2
500	Total reclassifications Code Letter - F					196,343	500
1	UTILITY RECLASS	G	Operation of Plant	7		950,970	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications Code Letter - G					950,970	500
1	ADVERTISING NON-REIMBURSABLE	H	ADVERTISING	194		1,198,654	1
2			Intensive Care Unit	31		3,879	2
3			Delivery Room & Labor Room	52		1,514	3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
500	Total reclassifications Code Letter - H					1,204,047	500
1	BENEFITS RECLASS	I	Employee Benefits Department	4		34,068,012	1
2							2
3							3

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
500	Total reclassifications					34,068,012	500
	Code Letter - I						
1	DEPRECIATION RECLASS	J	Cap Rel Costs-Bldg & Fixt	1		12,886,837	1
2	BUILDING	J					2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
500	Total reclassifications					12,886,837	500
	Code Letter - J						
1	RECLASS NURSERY	K	Nursery	43	1,331,490	595,348	1
2			Delivery Room & Labor Room	52	248,953	111,314	2
500	Total reclassifications				1,580,443	706,662	500
	Code Letter - K						
1	DEPRECIATION RECLASS EQUIPMENT	L	Cap Rel Costs-Mvble Equip	2		8,855,493	1
2							2
3							3
4							4
5							5

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
500	Total reclassifications					8,855,493	500
	Code Letter - L						
1	RECLASS PRECEPTOR TIME	M	PARAMED ED PRGM-(SPECIFY)	23	72,000		1
500	Total reclassifications				72,000		500
	Code Letter - M						
1	LINEN RECLASS FOR OFFSITES SJ	N	Administrative & General	5		3,578	1
2			Operation of Plant	7		1,193	2
3			Housekeeping	9		1,193	3
4			Medical Records & Library	16		1,193	4
5			Radiology-Diagnostic	54		5,964	5
6			Laboratory	60		1,193	6
7			Physical Therapy	66		2,385	7
8			CARDIOLOGY	76		1,193	8
9			Physicians' Private Offices	192		15,505	9
10							10
11	LINEN RECLASS CDC	N	Administrative & General	5		3,506	11
12			Operation of Plant	7		1,753	12
13			Radiology-Diagnostic	54		12,271	13
14			Laboratory	60		1,753	14
15			CARDIOLOGY	76		5,259	15
16			Clinic	90		1,753	16
17							17
18	LINEN RECLASS SV	N	Administrative & General	5		910	18
19			Operation of Plant	7		910	19
20			Radiology-Diagnostic	54		2,732	20
21			Laboratory	60		910	21
22			CARDIOLOGY	76		910	22
23			Clinic	90		910	23
500	Total reclassifications					66,974	500
	Code Letter - N						
1	RECLASS OFFSITE HOUSEK COSTS SJ	O	Administrative & General	5		20,767	1
2			Operation of Plant	7		7,967	2
3			Housekeeping	9		163	3
4			Medical Records & Library	16		2,483	4
5			Radiology-Diagnostic	54		13,745	5
6			Laboratory	60		4,438	6
7			Physical Therapy	66		11,384	7
8			CARDIOLOGY	76		727	8
9			Physicians' Private Offices	192		40,328	9
10							10
11	RECLASS HOUSEKEEPING SV	O	Administrative & General	5		435	11
12			Operation of Plant	7		296	12
13			Radiology-Diagnostic	54		3,197	13
14			Laboratory	60		966	14
15			CARDIOLOGY	76		207	15

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
16			Clinic	90		6,125	16
500	Total reclassifications					113,228	500
	Code Letter - O						
1	RECLASS SERVICE CONTRACT EXP	P	Administrative & General	5		15,695	1
2			Housekeeping	9		20,875	2
3			Pharmacy	15		29,025	3
4			Adults & Pediatrics	30		5,474	4
5			NEONATAL INTENSIVE CARE	32.01		5,060	5
6			Operating Room	50		832,787	6
7			Radiology-Diagnostic	54		1,043,903	7
8			Laboratory	60		156,341	8
9			Whole Blood & Packed Red Bloo	62		17,223	9
10			Respiratory Therapy	65		1,691	10
11			Physical Therapy	66		3,373	11
12			Electroencephalography	70		140	12
13			CARDIOLOGY	76		569,153	13
14			Clinic	90		45	14
15			Emergency	91		343	15
16			Home Health Agency	101		235	16
17			Research	191		1,607	17
18			FITNESS POINTE	194.01		14,164	18
19			RETAIL PHARMACY	194.03		643	19
500	Total reclassifications					2,717,777	500
	Code Letter - P						
1	RECLASS REPAIRS/MAINTENANCE EXP	Q	Administrative & General	5		1,830	1
2			Intensive Care Unit	31		18,973	2
3			Operating Room	50		402,435	3
4			Radiology-Diagnostic	54		99,323	4
5			Laboratory	60		5,200	5
6			Respiratory Therapy	65		37,671	6
7			CARDIOLOGY	76		2,755	7
8			CARDIAC REHABILITATION	76.97		4,300	8
9			Emergency	91		15,700	9
500	Total reclassifications					588,187	500
	Code Letter - Q						
	GRAND TOTAL (Increases)					3,114,696	107,266,148

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

KPMG LLP Compu-Max 2552-10

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	OPERATING RM/CARDIOLOGY SUPPLIES	A	Operating Room	50		28,157,357	1	
2			CARDIOLOGY	76		13,786,572	2	
3			Radiology-Diagnostic	54		141,626	3	
4							4	
5	NURSING UNITS ONLY	A	Adults & Pediatrics	30		413,425	5	
6			Intensive Care Unit	31		158,171	6	
7			NEONATAL INTENSIVE CARE	32.01		24,070	7	
8			Subprovider - IRF	41		41,697	8	
9			Delivery Room & Labor Room	52		75,880	9	
10			Emergency	91		112,912	10	
500	Total reclassifications					42,911,710	500	
	Code letter - A							
1	NURSING FLOAT SALARIES	B	Adults & Pediatrics	30	169,271		1	
2							2	
3							3	
4							4	
5							5	
6							6	
500	Total reclassifications				169,271		500	
	Code letter - B							
1	STOREROOM SALARY RECLASS	C	Administrative & General	5	34,791		1	
500	Total reclassifications				34,791		500	
	Code letter - C							
1	CAFETERIA EXPENSE	D	Dietary	10	1,258,191	1,994,209	1	
500	Total reclassifications				1,258,191	1,994,209	500	
	Code letter - D							
1	INTEREST EXPENSE	E	Administrative & General	5		2,784	11 1	
2			Radiology-Diagnostic	54		2,904	2	
3			Laboratory	60		11	3	
500	Total reclassifications					5,699	500	
	Code letter - E							
1	BUILDING INSURANCE	F	Administrative & General	5		186,896	12 1	
2			Administrative & General	5		9,447	12 2	
500	Total reclassifications					196,343	500	
	Code letter - F							
1	UTILITY RECLASS	G	Administrative & General	5		461,127	1	
2			Housekeeping	9		158,311	2	
3			Adults & Pediatrics	30		822	3	
4			Physical Therapy	66		13,687	4	
5			CARDIAC REHABILITATION	76.97		2,057	5	
6			Clinic	90		5,802	6	
7			Home Health Agency	101		9,298	7	
8			Research	191		3,471	8	
9			Physicians' Private Offices	192		401	9	
10			FITNESS POINTE	194.01		295,994	10	
500	Total reclassifications					950,970	500	
	Code letter - G							
1	ADVERTISING NON-REIMBURSABLE	H	Employee Benefits Department	4		5,274	1	
2			Administrative & General	5		1,113,197	2	
3			Nursing Administration	13		16,016	3	
4			Medical Records & Library	16		985	4	
5			Adults & Pediatrics	30		2,087	5	
6			Subprovider - IRF	41		505	6	
7			NEONATAL INTENSIVE CARE	32.01		834	7	
8			Operating Room	50		734	8	
9			Radiology-Diagnostic	54		3,242	9	
10			Laboratory	60		88	10	
11			Respiratory Therapy	65		278	11	
12			Physical Therapy	66		10,172	12	
13			Electroencephalography	70		378	13	
14			CARDIOLOGY	76		14,603	14	
15			Clinic	90		29,432	15	
16			Home Health Agency	101		6,222	16	
500	Total reclassifications					1,204,047	500	
	Code letter - H							
1	BENEFITS RECLASS	I	Employee Benefits Department	4		461,941	1	
2			Administrative & General	5		7,599,722	2	

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
3			Operation of Plant	7		1,062,718		3
4			Laundry & Linen Service	8		42,356		4
5			Housekeeping	9		945,224		5
6			Dietary	10		1,041,623		6
7			Nursing Administration	13		323,112		7
8			Pharmacy	15		591,701		8
9			Medical Records & Library	16		19,987		9
10			Social Service	17		142,801		10
11			PARAMED ED PRGM-(SPECIFY)	23		9,300		11
12			Adults & Pediatrics	30		5,812,551		12
13			Intensive Care Unit	31		1,443,580		13
14			NEONATAL INTENSIVE CARE	32.01		593,498		14
15			Subprovider - IRF	41		677,117		15
16			Nursery	43		608,875		16
17			Operating Room	50		3,475,380		17
18			Delivery Room & Labor Room	52		464,398		18
19			Radiology-Diagnostic	54		1,487,815		19
20			Laboratory	60		1,332,043		20
21			Whole Blood & Packed Red Bloo	62		77,337		21
22			Respiratory Therapy	65		764,709		22
23			Physical Therapy	66		996,366		23
24			Electroencephalography	70		132,632		24
25			CARDIOLOGY	76		1,352,988		25
26			CARDIAC REHABILITATION	76.97		98,729		26
27			Clinic	90		416,639		27
28			Emergency	91		1,227,078		28
29			Home Health Agency	101		240,741		29
30			Research	191		56,283		30
31			FITNESS POINTE	194.01		356,424		31
32			FITNESS POINTE SPA/PRO SHOP/D	194.02		66,727		32
33			RETAIL PHARMACY	194.03		82,677		33
34			EINSTEIN BAGELS	194.06		62,940		34
500	Total reclassifications					34,068,012		500
	Code letter - I							
1	DEPRECIATION RECLASS	J	Employee Benefits Department	4		43,765	9	1
2	BUILDING	J	Administrative & General	5		8,704,123		2
3			Operation of Plant	7		606,125		3
4			Housekeeping	9		4,949		4
5			Dietary	10		38,124		5
6			Nursing Administration	13		9,748		6
7			Pharmacy	15		20,629		7
8			Social Service	17		15,652		8
9			Adults & Pediatrics	30		1,727,561		9
10			Intensive Care Unit	31		186,046		10
11			NEONATAL INTENSIVE CARE	32.01		184,367		11
12			Subprovider - IRF	41		94,821		12
13			Nursery	43		13,038		13
14			Operating Room	50		296,566		14
15			Delivery Room & Labor Room	52		252,230		15
16			Radiology-Diagnostic	54		225,692		16
17			Laboratory	60		46,754		17
18			Whole Blood & Packed Red Bloo	62		5,795		18
19			Respiratory Therapy	65		14,265		19
20			Physical Therapy	66		214,753		20
21			Electroencephalography	70		7,471		21
22			CARDIOLOGY	76		46,882		22
23			CARDIAC REHABILITATION	76.97		2,302		23
24			Clinic	90		27,192		24
25			Emergency	91		8,999		25
26			FITNESS POINTE	194.01		70,172		26
27			FITNESS POINTE SPA/PRO SHOP/D	194.02		915		27
28			RETAIL PHARMACY	194.03		11,185		28
29			EINSTEIN BAGELS	194.06		6,716		29
500	Total reclassifications					12,886,837		500
	Code letter - J							
1	RECLASS NURSERY	K	Adults & Pediatrics	30	1,580,443	706,662		1
2								2
500	Total reclassifications				1,580,443	706,662		500
	Code letter - K							
1	DEPRECIATION RECLASS EQUIPMENT	L	Employee Benefits Department	4		1,251	9	1
2			Administrative & General	5		3,231,088		2
3			Operation of Plant	7		185,581		3

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
4			Housekeeping	9		9,918	4	
5			Dietary	10		61,750	5	
6			Nursing Administration	13		253,134	6	
7			Pharmacy	15		189,024	7	
8			Medical Records & Library	16		852	8	
9			Social Service	17		239	9	
10			Adults & Pediatrics	30		340,029	10	
11			Intensive Care Unit	31		309,188	11	
12			NEONATAL INTENSIVE CARE	32.01		153,235	12	
13			Subprovider - IRF	41		15,513	13	
14			Nursery	43		50,132	14	
15			Operating Room	50		1,335,882	15	
16			Delivery Room & Labor Room	52		97,185	16	
17			Radiology-Diagnostic	54		1,079,067	17	
18			Laboratory	60		354,986	18	
19			Whole Blood & Packed Red Bloo	62		19,121	19	
20			Respiratory Therapy	65		127,607	20	
21			Physical Therapy	66		140,118	21	
22			Electroencephalography	70		33,566	22	
23			CARDIOLOGY	76		612,852	23	
24			CARDIAC REHABILITATION	76.97		3,483	24	
25			Clinic	90		11,153	25	
26			Emergency	91		187,630	26	
27			Home Health Agency	101		205	27	
28			Research	191		218	28	
29			Physicians' Private Offices	192		312	29	
30			FITNESS POINTE	194.01		20,563	30	
31			FITNESS POINTE SPA/PRO SHOP/D	194.02		3,839	31	
32			RETAIL PHARMACY	194.03		19,735	32	
33			EINSTEIN BAGELS	194.06		7,037	33	
500	Total reclassifications					8,855,493	500	
	Code letter - L							
1	RECLASS PRECEPTOR TIME	M	Pharmacy	15	72,000		1	
500	Total reclassifications				72,000		500	
	Code letter - M							
1	LINEN RECLASS FOR OFFSITES SJ	N	Administrative & General	5		23,455	1	
2			Housekeeping	9		9,942	2	
3							3	
4							4	
5							5	
6							6	
7							7	
8							8	
9							9	
10							10	
11	LINEN RECLASS CDC	N	Housekeeping	9		26,295	11	
12							12	
13							13	
14							14	
15							15	
16							16	
17							17	
18	LINEN RECLASS SV	N	Housekeeping	9		7,282	18	
19							19	
20							20	
21							21	
22							22	
23							23	
500	Total reclassifications					66,974	500	
	Code letter - N							
1	RECLASS OFFSITE HOUSEK COSTS SJ	O	Administrative & General	5		45,211	1	
2			Housekeeping	9		56,791	2	
3							3	
4							4	
5							5	
6							6	
7							7	
8							8	
9							9	
10							10	
11	RECLASS HOUSEKEEPING SV	O	Administrative & General	5		8,019	11	
12			Operation of Plant	7		3,207	12	

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
13								13
14								14
15								15
16								16
500	Total reclassifications					113,228		500
	Code letter - O							
1	RECLASS SERVICE CONTRACT EXP	P	Operation of Plant	7		2,717,777		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
500	Total reclassifications					2,717,777		500
	Code letter - P							
1	RECLASS REPAIRS/MAINTENANCE EXP	Q	Operation of Plant	7		588,187		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
500	Total reclassifications					588,187		500
	Code letter - Q							
	GRAND TOTAL (Decreases)					3,114,696	107,266,148	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	11,038,646	3,337,725		3,337,725		14,376,371		1
2	Land Improvements	1,286,470	99		99		1,286,569		2
3	Buildings and Fixtures	383,514,950	11,923,845		11,923,845	35,727,825	359,710,970		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	139,146,100	10,815,970		10,815,970	3,809,173	146,152,897		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	534,986,166	26,077,639		26,077,639	39,536,998	521,526,807		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	534,986,166	26,077,639		26,077,639	39,536,998	521,526,807		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	375,373,911		375,373,911	0.719760					1
2	Cap Rel Costs-Mvble Equip	146,152,896		146,152,896	0.280240					2
3	Total (sum of lines 1-2)	521,526,807		521,526,807	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	13,195,319			186,896			13,382,215	1
2	Cap Rel Costs-Mvble Equip	12,896,335			9,447			12,905,782	2
3	Total (sum of lines 1-2)	26,091,654			196,343			26,287,997	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	
2	Investment income-movable equipment (chapter 2)	B	-5,699	Cap Rel Costs-Mvble Equip	2	11
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)	B	-1,500	Administrative & General	5	
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-14,405,178			
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-18,519,266			
13	Laundry and linen service					13
14	Cafeteria - employees and guests					14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts	B	-11	Medical Records & Library	16	
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	
28	Non-physician anesthetist			Nonphysician Anesthetists	19	
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	
32	CAH HIT Adj for Depreciation					32
33						33
34						34
35	A&G OTHER INCOME	B	-470,532	Administrative & General	5	
36	OFFSET NEONATE OTHER INCOME	B	-21	NEONATAL INTENSIVE CARE	32.01	
36.01	OFFSET RADIOLOGY PHYSICIAN FEES	A	-375	CARDIOLOGY	76	36.01
36.02	OFFSET PHYSICIAN FEES	A	-24	Clinic	90	36.02
37	OFFSET MAMMO FEES	A	-16,208	Radiology-Diagnostic	54	37
38	PHYSICIAN RENTAL/X RAY SALES-RA	B	-2,231	Radiology-Diagnostic	54	38
39	OFFSET PT OTHER INCOME	B	-22,837	Physical Therapy	66	39
40	PHYSICIAN RENTAL-LAB	B	-211	Laboratory	60	40
41	REMOVE MEDICAID ASSESSMENT FEES	A	-19,063,018	Administrative & General	5	41
42	VARIOUS EH&W OFFSETS	B	-20,294	Employee Benefits Department	4	42
42.01	OTHER INCOME PLANT	B	-779	Operation of Plant	7	42.01
42.02	OTHER INCOME HOUSEKEEPING	B	-100	Housekeeping	9	42.02
42.03	OTHER INCOME LAUNDRY	B	-5	Laundry & Linen Service	8	42.03
42.04	OTHER INCOME CS	B	-10	Central Services & Supply	14	42.04
42.05	OTHER INCOME ACUTE	B	-5,522	Adults & Pediatrics	30	42.05
43	OFFSET OTHER INCOME ICU	B	-79	Intensive Care Unit	31	43
43.01	OFFSET OTHER INCOME REHAB	B	-37	Subprovider - IRF	41	43.01
43.02	OFFSET RESEARCH COSTS HEART CTR	A	-154,688	CARDIOLOGY	76	43.02
43.03	OTHER INCOME DEL RM	B	-4	Delivery Room & Labor Room	52	43.03
43.04	OTHER INCOME RESP THERAPY	B	-15	Respiratory Therapy	65	43.04
43.05	OTHER INCOME PT	B	-71	Physical Therapy	66	43.05
43.06	OTHER INCOME CLINIC	B	-339	Clinic	90	43.06
43.07	OTHER INCOME ER	B	-6,245	Emergency	91	43.07
43.08	OTHER INCOME RADIOLOGY	B	-3,719	CARDIOLOGY	76	43.08
43.09	OTHER INCOME	B	-10	Home Health Agency	101	43.09
44	OFFSET EKG FEES	A	-3,219	CARDIOLOGY	76	44
45						45
45.01	EMPLOYEE CAFETERIA REVENUE	B	-2,000,273	Cafeteria	11	45.01
45.03	OTHER INCOME DIETARY	B	-162	Dietary	10	45.03
45.04	TELEPHONE SERVICE	A	-109,354	Administrative & General	5	45.04
45.06	TELEPHONE SERVICE	A	-9,258	Cap Rel Costs-Mvble Equip	2	9

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
45.08	TELEVISION SERVICE	A	-10,777	Operation of Plant	7	45.08
45.09	TELEVISION SERVICE	A	-35,439	Cap Rel Costs-Mvble Equip	2	9 45.09
45.10	PENSION CONTRIBUTN EXCESS OF EXP	A	8,782,401	Employee Benefits Department	4	45.10
45.18	RENTAL INCOME	B	-237,675	Administrative & General	5	45.18
45.19	CAPITALIZED INTEREST	A	1,589	Cap Rel Costs-Bldg & Fixt	1	9 45.19
45.21	PARETN ASSET DEP AJE	A	-2,672	Cap Rel Costs-Bldg & Fixt	1	9 45.21
45.28	1996 ASSET LIFE ADJUSTMENT	A	3,149	Cap Rel Costs-Bldg & Fixt	1	9 45.28
45.29	OFFSET RELEASED TEMP REST OP IN	B	-34,859	Administrative & General	5	45.29
45.30	OFFSET RELEASED TEMP REST OP IN	B	-180	Clinic	90	45.30
45.31	OFFSET RELEASED TEMP REST OP IN	B	-4,080	Respiratory Therapy	65	45.31
45.32	OFFSET RELEASED TEMP REST OP IN	B	-2,000	Emergency	91	45.32
45.33	NON-PT CARE RELATED EXPENSES	A	-2,116	Administrative & General	5	45.33
45.34	OFFSET RELEASED TEMP REST OP IN	B	-1,100	Nursing Administration	13	45.34
46	OFFSET SURGERY INCOME	B	-58	Operating Room	50	46
47	OFFSET CARDIAC REHAB CLASS INCO	B	-55,960	CARDIAC REHABILITATION	76.97	47
47.01	CLEANING SERVICES-SJ SV	A	-39,439	Administrative & General	5	47.01
47.02	CLEANING SERVICES SJ SV	A	-3,864	Operation of Plant	7	47.02
47.03	CLEANING SERVICES-SJ SV	A	-37,136	Housekeeping	9	47.03
48	NENONATE AMBULANCE COVERAGE	A	-16,080	NEONATAL INTENSIVE CARE	32.01	48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-46,517,590			50

- (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.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	CFNI CORPORATE ALLOCATION	306,416		306,416	9	1
2	2	Cap Rel Costs-Mvble Equip		4,085,539		4,085,539	9	2
3	5	Administrative & General		30,768,811	48,263,015	-17,494,204		3
3.01	16	Medical Records & Library	CFNI ALLOCATION	5,540,379		5,540,379		3.01
3.02	5	Administrative & General	COMMUNICATIONS	1,213,572		1,213,572		3.02
3.04	5	Administrative & General	CDC LEASE		80,107	-80,107		3.04
3.05	7	Operation of Plant	CDC LEASE		25,063	-25,063		3.05
3.06	54	Radiology-Diagnostic	CDC LEASE		121,842	-121,842		3.06
3.07	60	Laboratory	CDC LEASE		11,630	-11,630		3.07
3.08	90	Clinic	CDC LEASE		19,370	-19,370		3.08
3.09	76	CARDIOLOGY	CDC LEASE		3,707	-3,707		3.09
3.10	5	Administrative & General	CDC LEASE DEPR	123,603		123,603		3.10
3.11	7	Operation of Plant	CDC LEASE DEPR	15,207		15,207		3.11
3.12	54	Radiology-Diagnostic	CDC LEASE DEPR	55,814		55,814		3.12
3.13	76	CARDIOLOGY	CDC LEASE DEPR	6,204		6,204		3.13
3.14	90	Clinic	CDC LEASE DEPR	6,172		6,172		3.14
3.15	60	Laboratory	CDC LEASE DEPR	2,894		2,894		3.15
3.23	5	Administrative & General	LEASE EXPENSE		74,140	-74,140		3.23
3.24	5	Administrative & General	800 MACARTHUR DEPR	77,142		77,142		3.24
3.25	5	Administrative & General	800 MACARTHUR A&G	69,010		69,010		3.25
3.26	101	Home Health Agency	800 MACARTHUR DEPR	6,311		6,311		3.26
3.27	101	Home Health Agency	800 MACARTHUR A&G	5,646		5,646		3.27
3.28	60	Laboratory	800 MACARTHUR DEPR	12,121		12,121		3.28
3.29	60	Laboratory	800 MACARTHUR A&G	10,843		10,843		3.29
3.31	5	Administrative & General	CCN COSTS		12,226,076	-12,226,076		3.31
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		42,305,684	60,824,950	-18,519,266		5

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		100.00	CFNI		PARENT	6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the 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.
- G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider/ Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
	1									1
	2	5 Administrative & Gen AGGREGATE	87,478		87,478	211,500	927	94,260	4,713	2
	3	50 Operating Room CRNA ANESTHESIO	13,687,916	13,687,916						3
	4	30 Adults & Pediatrics AGGREGATE	84,225		84,225	211,500	366	37,216	1,861	4
	5	32.01 NEONATAL INTENSIVE C AGGREGATE	49,000	30,000	19,000	211,500	95	9,660	483	5
	6	54 Radiology-Diagnostic AGGREGATE	55,627		55,627	271,900	305	39,870	1,994	6
	7									7
	8	60 Laboratory	34,885		34,885	260,300	227	28,408	1,420	8
	9	65 Respiratory Therapy AGGREGATE	36,391	10,071	26,320	211,500	244	24,811	1,241	9
	10	70 Electroencephalogram AGGREGATE	33,250	33,250		211,500				10
	11	76 CARDIOLOGY AGGREGATE	557,109	441,156	115,953	211,500	539	54,807	2,740	11
	12	90 Clinic AGGREGATE	106,152		106,152	211,500	703	71,483	3,574	12
	13	91 Emergency AGGREGATE	120,833		120,833	211,500	924	93,955	4,698	13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	200	TOTAL	14,852,866	14,202,393	650,473		4,330	454,470	22,724	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2	5	Administrative & Gen AGGREGATE					94,260			2
3	50	Operating Room CRNA ANESTHESIO							13,687,916	3
4	30	Adults & Pediatrics AGGREGATE					37,216	47,009	47,009	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE					9,660	9,340	39,340	5
6	54	Radiology-Diagnostic AGGREGATE					39,870	15,757	15,757	6
7										7
8	60	Laboratory					28,408	6,477	6,477	8
9	65	Respiratory Therapy AGGREGATE					24,811	1,509	11,580	9
10	70	Electroencephalogram AGGREGATE							33,250	10
11	76	CARDIOLOGY AGGREGATE					54,807	61,146	502,302	11
12	90	Clinic AGGREGATE					71,483	34,669	34,669	12
13	91	Emergency AGGREGATE					93,955	26,878	26,878	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					454,470	202,785	14,405,178	200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	13,382,215	13,382,215					1
2	Cap Rel Costs-Mvble Equip	12,905,782		12,905,782				2
4	Employee Benefits Department	44,100,862	47,667	5,787	44,154,316			4
5	Administrative & General	56,397,749	3,317,044	716,430	3,976,451	64,407,674	64,407,674	5
6	Maintenance & Repairs							6
7	Operation of Plant	17,629,574	1,687,894	377,691	1,349,653	21,044,812	3,940,515	7
8	Laundry & Linen Service	1,457,376	18,879		29,290	1,505,545	281,904	8
9	Housekeeping	4,362,961	53,405	19,481	939,194	5,375,041	1,006,444	9
10	Dietary	3,761,572	136,226	77,647	665,139	4,640,584	868,922	10
11	Cafeteria	1,252,127	141,011	51,506	346,370	1,791,014	335,357	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,615,148	24,834	519,589	637,863	3,797,434	711,047	13
14	Central Services & Supply	34,781			9,578	44,359	8,306	14
15	Pharmacy	18,926,264	54,647	386,972	1,074,716	20,442,599	3,827,754	15
16	Medical Records & Library	5,858,328	73,393	1,755	30,526	5,964,002	1,116,724	16
17	Social Service	759,943	12,767	657	184,222	957,589	179,303	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	171,665	1,447		43,594	216,706	40,577	23
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	41,577,646	2,068,542	808,286	9,358,881	53,813,355	10,076,176	30
31	Intensive Care Unit	10,733,502	391,124	630,816	2,506,306	14,261,748	2,670,427	31
32.01	NEONATAL INTENSIVE CARE	3,804,754	106,919	313,678	878,517	5,103,868	955,669	32.01
41	Subprovider - IRF	6,521,567	296,670	32,535	1,176,038	8,026,810	1,502,972	41
43	Nursery	1,263,200	27,028		368,863	1,659,091	310,655	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	28,274,757	1,118,556	2,776,913	7,176,410	39,346,636	7,367,422	50
52	Delivery Room & Labor Room	2,924,121	196,466	201,112	659,807	3,981,506	745,513	52
54	Radiology-Diagnostic	14,955,945	551,062	2,834,833	2,275,654	20,617,494	3,860,502	54
60	Laboratory	13,562,593	231,583	731,043	1,702,691	16,227,910	3,038,579	60
62	Whole Blood & Packed Red Blood Cells	3,064,363	18,228	38,867	113,844	3,235,302	605,791	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,689,222	43,484	265,932	1,007,252	6,005,890	1,124,567	65
66	Physical Therapy	11,044,538	479,116	150,181	1,528,671	13,202,506	2,472,090	66
70	Electroencephalography	1,025,008	32,465	84,544	182,877	1,324,894	248,078	70
71	Medical Supplies Charged to Patients	15,962,618				15,962,618	2,988,904	71
72	Impl. Dev. Charged to Patients	26,949,092				26,949,092	5,046,056	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	11,330,743	360,732	1,180,036	2,023,757	14,895,268	2,789,050	76
76.97	CARDIAC REHABILITATION	434,953	34,466	7,101	121,078	597,598	111,897	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,217,921	107,703	32,482	675,044	4,033,150	755,183	90
91	Emergency	8,331,675	293,090	452,809	1,707,916	10,785,490	2,019,518	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
101	Home Health Agency	3,630,828	43,098	423	585,188	4,259,537	797,573	101
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	396,915,393	11,969,546	12,699,106	43,335,390	394,477,122	61,803,475	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen		14,912			14,912	2,792	190
191	Research	479,180		449	88,937	568,566	106,461	191
192	Physicians' Private Offices	57,545	714,810	43,583	71	816,009	152,793	192
194	ADVERTISING	1,198,654				1,198,654	224,441	194
194.01	FITNESS POINTE	2,675,303	551,243	108,531	443,780	3,778,857	707,568	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	438,037	17,866	4,318	81,989	542,210	101,526	194.02
194.03	RETAIL PHARMACY	6,346,298	21,398	35,440	163,560	6,566,696	1,229,574	194.03
194.04	HOSPICE		85,147			85,147	15,943	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	274,761	7,293	14,355	40,589	336,998	63,101	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	408,385,171	13,382,215	12,905,782	44,154,316	408,385,171	64,407,674	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	24,985,327						7
8	Laundry & Linen Service	56,628	1,844,077					8
9	Housekeeping	160,193		6,541,678				9
10	Dietary	408,619	2,530	7,619	5,928,274			10
11	Cafeteria	422,975		30,367		2,579,713		11
12	Maintenance of Personnel							12
13	Nursing Administration	74,492		1,808		35,249	4,620,030	13
14	Central Services & Supply					1,588		14
15	Pharmacy	163,918		16,991		70,700		15
16	Medical Records & Library	220,148		67,603		2,946		16
17	Social Service	38,294		15,184		17,069		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	4,339				2,715		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,204,756	795,279	1,993,422	4,592,867	826,616	2,072,249	30
31	Intensive Care Unit	1,173,207	137,538	371,844	404,985	181,617	455,300	31
32.01	NEONATAL INTENSIVE CARE	320,712	595	106,375		60,650	152,042	32.01
41	Subprovider - IRF	889,886	137,689	317,454	848,861	118,051	295,938	41
43	Nursery	81,073	21,282	37,471		29,588	74,175	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,355,197	265,442	1,363,801		386,267	968,333	50
52	Delivery Room & Labor Room	589,316	103,160	251,360	81,561	50,238	125,955	52
54	Radiology-Diagnostic	1,652,955	83,636	215,055		122,715		54
60	Laboratory	694,653		123,999		145,820		60
62	Whole Blood & Packed Red Blood Cells	54,675				7,740		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	130,433		15,184		76,650		65
66	Physical Therapy	1,437,146	13,416	80,166		59,697		66
70	Electroencephalography	97,382	8,728	11,659		5,949		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	1,082,045	149,772	405,672		143,625		76
76.97	CARDIAC REHABILITATION	103,384	1,749			9,227		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	323,062	6,632	26,327		45,820	90,797	90
91	Emergency	879,146	116,629	833,686		153,675	385,241	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	129,276		10,845				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,747,910	1,844,077	6,303,892	5,928,274	2,554,212	4,620,030	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	44,731						190
191	Research					6,498		191
192	Physicians' Private Offices	2,144,130		237,786				192
194	ADVERTISING							194
194.01	FITNESS POINTE	1,653,497						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	53,591						194.02
194.03	RETAIL PHARMACY	64,186				12,043		194.03
194.04	HOSPICE	255,405						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	21,877				6,960		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,985,327	1,844,077	6,541,678	5,928,274	2,579,713	4,620,030	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMED EDUCATION	SUBTOTAL	
		14	15	16	17	23	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	54,253						14
15	Pharmacy		24,521,962					15
16	Medical Records & Library			7,371,423				16
17	Social Service				1,207,439			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)					264,337		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			621,666	951,112		81,947,498	30
31	Intensive Care Unit			105,547	210,796		19,973,009	31
32.01	NEONATAL INTENSIVE CARE			111,458	20,236		6,831,605	32.01
41	Subprovider - IRF			78,745			12,216,406	41
43	Nursery			23,366	6,745		2,243,446	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			1,051,008			54,104,106	50
52	Delivery Room & Labor Room			48,735			5,977,344	52
54	Radiology-Diagnostic			1,349,297			27,901,654	54
60	Laboratory			919,848			21,150,809	60
62	Whole Blood & Packed Red Blood Cells			53,415			3,956,923	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			165,267			7,517,991	65
66	Physical Therapy			258,297			17,523,318	66
70	Electroencephalography			51,033			1,747,723	70
71	Medical Supplies Charged to Patients	54,253		228,848			19,234,623	71
72	Impl. Dev. Charged to Patients			295,543			32,290,691	72
73	Drugs Charged to Patients		24,521,962	612,377		264,337	25,398,676	73
76	CARDIOLOGY			699,628			20,165,060	76
76.97	CARDIAC REHABILITATION			9,870			833,725	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			45,735			5,326,706	90
91	Emergency			609,273	18,550		15,801,208	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			32,467			5,229,698	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	54,253	24,521,962	7,371,423	1,207,439	264,337	387,372,219	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						62,435	190
191	Research						681,525	191
192	Physicians' Private Offices						3,350,718	192
194	ADVERTISING						1,423,095	194
194.01	FITNESS POINTE						6,139,922	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						697,327	194.02
194.03	RETAIL PHARMACY						7,872,499	194.03
194.04	HOSPICE						356,495	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS						428,936	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	54,253	24,521,962	7,371,423	1,207,439	264,337	408,385,171	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		81,947,498				30
31	Intensive Care Unit		19,973,009				31
32.01	NEONATAL INTENSIVE CARE		6,831,605				32.01
41	Subprovider - IRF		12,216,406				41
43	Nursery		2,243,446				43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		54,104,106				50
52	Delivery Room & Labor Room		5,977,344				52
54	Radiology-Diagnostic		27,901,654				54
60	Laboratory		21,150,809				60
62	Whole Blood & Packed Red Blood Cells		3,956,923				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		7,517,991				65
66	Physical Therapy		17,523,318				66
70	Electroencephalography		1,747,723				70
71	Medical Supplies Charged to Patients		19,234,623				71
72	Impl. Dev. Charged to Patients		32,290,691				72
73	Drugs Charged to Patients		25,398,676				73
76	CARDIOLOGY		20,165,060				76
76.97	CARDIAC REHABILITATION		833,725				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		5,326,706				90
91	Emergency		15,801,208				91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		5,229,698				101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)		387,372,219				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		62,435				190
191	Research		681,525				191
192	Physicians' Private Offices		3,350,718				192
194	ADVERTISING		1,423,095				194
194.01	FITNESS POINTE		6,139,922				194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		697,327				194.02
194.03	RETAIL PHARMACY		7,872,499				194.03
194.04	HOSPICE		356,495				194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS		428,936				194.06
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)		408,385,171				202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	16,944	47,667	5,787	70,398	70,398		4
5	Administrative & General	188,861	3,317,044	716,430	4,222,335	6,341	4,228,676	5
6	Maintenance & Repairs							6
7	Operation of Plant	13,154	1,687,894	377,691	2,078,739	2,152	258,704	7
8	Laundry & Linen Service	18,863	18,879		37,742	47	18,508	8
9	Housekeeping	1,104	53,405	19,481	73,990	1,498	66,075	9
10	Dietary	24,857	136,226	77,647	238,730	1,061	57,047	10
11	Cafeteria		141,011	51,506	192,517	552	22,017	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,511	24,834	519,589	545,934	1,017	46,682	13
14	Central Services & Supply					15	545	14
15	Pharmacy	11,278	54,647	386,972	452,897	1,714	251,301	15
16	Medical Records & Library	627	73,393	1,755	75,775	49	73,315	16
17	Social Service		12,767	657	13,424	294	11,772	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)		1,447		1,447	70	2,664	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	166,641	2,068,542	808,286	3,043,469	14,909	661,689	30
31	Intensive Care Unit	15,383	391,124	630,816	1,037,323	3,997	175,320	31
32.01	NEONATAL INTENSIVE CARE	2,111	106,919	313,678	422,708	1,401	62,742	32.01
41	Subprovider - IRF	10,312	296,670	32,535	339,517	1,875	98,674	41
43	Nursery		27,028		27,028	588	20,395	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	892,130	1,118,556	2,776,913	4,787,599	11,444	483,688	50
52	Delivery Room & Labor Room		196,466	201,112	397,578	1,052	48,945	52
54	Radiology-Diagnostic	686,973	551,062	2,834,833	4,072,868	3,629	253,451	54
60	Laboratory	15,310	231,583	731,043	977,936	2,715	199,490	60
62	Whole Blood & Packed Red Blood Cells		18,228	38,867	57,095	182	39,772	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	95,858	43,484	265,932	405,274	1,606	73,830	65
66	Physical Therapy	206,042	479,116	150,181	835,339	2,438	162,298	66
70	Electroencephalography	221,675	32,465	84,544	338,684	292	16,287	70
71	Medical Supplies Charged to Patients						196,228	71
72	Impl. Dev. Charged to Patients						331,285	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	509,618	360,732	1,180,036	2,050,386	3,227	183,108	76
76.97	CARDIAC REHABILITATION		34,466	7,101	41,567	193	7,346	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	61,992	107,703	32,482	202,177	1,076	49,580	90
91	Emergency	1,966	293,090	452,809	747,865	2,724	132,586	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		43,098	423	43,521	933	52,362	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,163,210	11,969,546	12,699,106	27,831,862	69,091	4,057,706	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		14,912		14,912		183	190
191	Research			449	449	142	6,989	191
192	Physicians' Private Offices		714,810	43,583	758,393		10,031	192
194	ADVERTISING						14,735	194
194.01	FITNESS POINTE	144	551,243	108,531	659,918	708	46,453	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		17,866	4,318	22,184	131	6,665	194.02
194.03	RETAIL PHARMACY		21,398	35,440	56,838	261	80,724	194.03
194.04	HOSPICE		85,147		85,147		1,047	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS		7,293	14,355	21,648	65	4,143	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,163,354	13,382,215	12,905,782	29,451,351	70,398	4,228,676	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	2,339,595						7
8	Laundry & Linen Service	5,303	61,600					8
9	Housekeeping	15,000		156,563				9
10	Dietary	38,263	85	182	335,368			10
11	Cafeteria	39,607		727		255,420		11
12	Maintenance of Personnel							12
13	Nursing Administration	6,975		43		3,490	604,141	13
14	Central Services & Supply					157		14
15	Pharmacy	15,349		407		7,000		15
16	Medical Records & Library	20,614		1,618		292		16
17	Social Service	3,586		363		1,690		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	406				269		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	581,003	26,565	47,708	259,823	81,844	270,977	30
31	Intensive Care Unit	109,858	4,594	8,899	22,910	17,982	59,538	31
32.01	NEONATAL INTENSIVE CARE	30,031	20	2,546		6,005	19,882	32.01
41	Subprovider - IRF	83,328	4,599	7,598	48,021	11,688	38,699	41
43	Nursery	7,592	711	897		2,930	9,700	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	314,177	8,867	32,640		38,245	126,625	50
52	Delivery Room & Labor Room	55,183	3,446	6,016	4,614	4,974	16,471	52
54	Radiology-Diagnostic	154,781	2,794	5,147		12,150		54
60	Laboratory	65,046		2,968		14,438		60
62	Whole Blood & Packed Red Blood Cells	5,120				766		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	12,214		363		7,589		65
66	Physical Therapy	134,573	448	1,919		5,911		66
70	Electroencephalography	9,119	292	279		589		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	101,321	5,003	9,709		14,220		76
76.97	CARDIAC REHABILITATION	9,681	58			914		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	30,251	222	630		4,537	11,873	90
91	Emergency	82,322	3,896	19,953		15,216	50,376	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	12,105		260				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,942,808	61,600	150,872	335,368	252,896	604,141	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	4,189						190
191	Research					643		191
192	Physicians' Private Offices	200,774		5,691				192
194	ADVERTISING							194
194.01	FITNESS POINTE	154,831						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	5,018						194.02
194.03	RETAIL PHARMACY	6,010				1,192		194.03
194.04	HOSPICE	23,916						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	2,049				689		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,339,595	61,600	156,563	335,368	255,420	604,141	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMED EDUCATION	SUBTOTAL	
		14	15	16	17	23	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	717						14
15	Pharmacy		728,668					15
16	Medical Records & Library			171,663				16
17	Social Service				31,129			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)					4,856		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			14,498	24,520		5,027,005	30
31	Intensive Care Unit			2,461	5,435		1,448,317	31
32.01	NEONATAL INTENSIVE CARE			2,599	522		548,456	32.01
41	Subprovider - IRF			1,836			635,835	41
43	Nursery			545	174		70,560	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			24,511			5,827,796	50
52	Delivery Room & Labor Room			1,137			539,416	52
54	Radiology-Diagnostic			31,221			4,536,041	54
60	Laboratory			21,452			1,284,045	60
62	Whole Blood & Packed Red Blood Cells			1,246			104,181	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			3,854			504,730	65
66	Physical Therapy			6,024			1,148,950	66
70	Electroencephalography			1,190			366,732	70
71	Medical Supplies Charged to Patients	717		5,337			202,282	71
72	Impl. Dev. Charged to Patients			6,892			338,177	72
73	Drugs Charged to Patients		728,668	14,281			742,949	73
76	CARDIOLOGY			16,316			2,383,290	76
76.97	CARDIAC REHABILITATION			230			59,989	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			1,067			301,413	90
91	Emergency			14,209	478		1,069,625	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			757			109,938	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	717	728,668	171,663	31,129		27,249,727	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						19,284	190
191	Research						8,223	191
192	Physicians' Private Offices						974,889	192
194	ADVERTISING						14,735	194
194.01	FITNESS POINTE						861,910	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						33,998	194.02
194.03	RETAIL PHARMACY						145,025	194.03
194.04	HOSPICE						110,110	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS						28,594	194.06
200	Cross Foot Adjustments					4,856	4,856	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	717	728,668	171,663	31,129	4,856	29,451,351	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		5,027,005				30
31	Intensive Care Unit		1,448,317				31
32.01	NEONATAL INTENSIVE CARE		548,456				32.01
41	Subprovider - IRF		635,835				41
43	Nursery		70,560				43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		5,827,796				50
52	Delivery Room & Labor Room		539,416				52
54	Radiology-Diagnostic		4,536,041				54
60	Laboratory		1,284,045				60
62	Whole Blood & Packed Red Blood Cells		104,181				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		504,730				65
66	Physical Therapy		1,148,950				66
70	Electroencephalography		366,732				70
71	Medical Supplies Charged to Patients		202,282				71
72	Impl. Dev. Charged to Patients		338,177				72
73	Drugs Charged to Patients		742,949				73
76	CARDIOLOGY		2,383,290				76
76.97	CARDIAC REHABILITATION		59,989				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		301,413				90
91	Emergency		1,069,625				91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		109,938				101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)		27,249,727				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		19,284				190
191	Research		8,223				191
192	Physicians' Private Offices		974,889				192
194	ADVERTISING		14,735				194
194.01	FITNESS POINTE		861,910				194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		33,998				194.02
194.03	RETAIL PHARMACY		145,025				194.03
194.04	HOSPICE		110,110				194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS		28,594				194.06
200	Cross Foot Adjustments		4,856				200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)		29,451,351				202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,110,064						1
2	Cap Rel Costs-Mvble Equip		9,393,120					2
4	Employee Benefits Department	3,954	4,212	160,390,895				4
5	Administrative & General	275,151	521,434	14,444,484	-64,407,674	343,977,497		5
6	Maintenance & Repairs							6
7	Operation of Plant	140,012	274,892	4,902,623		21,044,812	690,947	7
8	Laundry & Linen Service	1,566		106,395		1,505,545	1,566	8
9	Housekeeping	4,430	14,179	3,411,629		5,375,041	4,430	9
10	Dietary	11,300	56,513	2,416,123		4,640,584	11,300	10
11	Cafeteria	11,697	37,487	1,258,191		1,791,014	11,697	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,060	378,169	2,317,042		3,797,434	2,060	13
14	Central Services & Supply			34,791		44,359		14
15	Pharmacy	4,533	281,647	3,903,912		20,442,599	4,533	15
16	Medical Records & Library	6,088	1,277	110,885		5,964,002	6,088	16
17	Social Service	1,059	478	669,188		957,589	1,059	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	120		158,356		216,706	120	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	171,587	588,289	33,996,255		53,813,355	171,587	30
31	Intensive Care Unit	32,444	459,122	9,104,172		14,261,748	32,444	31
32.01	NEONATAL INTENSIVE CARE	8,869	228,302	3,191,218		5,103,868	8,869	32.01
41	Subprovider - IRF	24,609	23,680	4,271,965		8,026,810	24,609	41
43	Nursery	2,242		1,339,897		1,659,091	2,242	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	92,785	2,021,100	26,068,357		39,346,636	92,785	50
52	Delivery Room & Labor Room	16,297	146,374	2,396,754		3,981,506	16,297	52
54	Radiology-Diagnostic	45,711	2,063,255	8,266,329		20,617,494	45,711	54
60	Laboratory	19,210	532,070	6,185,038		16,227,910	19,210	60
62	Whole Blood & Packed Red Blood Cells	1,512	28,288	413,540		3,235,302	1,512	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,607	193,551	3,658,848		6,005,890	3,607	65
66	Physical Therapy	39,743	109,305	5,552,907		13,202,506	39,743	66
70	Electroencephalography	2,693	61,533	664,302		1,324,894	2,693	70
71	Medical Supplies Charged to Patients					15,962,618		71
72	Impl. Dev. Charged to Patients					26,949,092		72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	29,923	858,857	7,351,310		14,895,268	29,923	76
76.97	CARDIAC REHABILITATION	2,859	5,168	439,818		597,598	2,859	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	8,934	23,641	2,452,100		4,033,150	8,934	90
91	Emergency	24,312	329,565	6,204,015		10,785,490	24,312	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,575	308	2,125,700		4,259,537	3,575	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	992,882	9,242,696	157,416,144	-64,407,674	330,069,448	573,765	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,237				14,912	1,237	190
191	Research		327	323,065		568,566		191
192	Physicians' Private Offices	59,294	31,721	257		816,009	59,294	192
194	ADVERTISING					1,198,654		194
194.01	FITNESS POINTE	45,726	78,991	1,612,032		3,778,857	45,726	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	1,482	3,143	297,825		542,210	1,482	194.02
194.03	RETAIL PHARMACY	1,775	25,794	594,131		6,566,696	1,775	194.03
194.04	HOSPICE	7,063				85,147	7,063	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	605	10,448	147,441		336,998	605	194.06
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	13,382,215	12,905,782	44,154,316		64,407,674	24,985,327	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.055354	1.373961	0.275292		0.187244	36.160989	203
204	Cost to be allocated (Per Wkst. B, Part II)			70,398		4,228,676	2,339,595	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000439		0.012293	3.386070	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE POUNDS	HOUSE-KEEPING TIME SPENT	DIETARY PATIENT MEALS	CAFETERIA FTES	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY COSTED REQ	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	207,700						8
9	Housekeeping		723,810					9
10	Dietary	285	843	351,362				10
11	Cafeteria		3,360		178,645			11
12	Maintenance of Personnel							12
13	Nursing Administration		200		2,441	2,654,530		13
14	Central Services & Supply				110		100	14
15	Pharmacy		1,880		4,896			15
16	Medical Records & Library		7,480		204			16
17	Social Service		1,680		1,182			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)				188			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	89,573	220,564	272,214	57,243	1,190,651		30
31	Intensive Care Unit	15,491	41,143	24,003	12,577	261,602		31
32.01	NEONATAL INTENSIVE CARE	67	11,770		4,200	87,359		32.01
41	Subprovider - IRF	15,508	35,125	50,311	8,175	170,037		41
43	Nursery	2,397	4,146		2,049	42,619		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	29,897	150,899		26,749	556,375		50
52	Delivery Room & Labor Room	11,619	27,812	4,834	3,479	72,370		52
54	Radiology-Diagnostic	9,420	23,795		8,498			54
60	Laboratory		13,720		10,098			60
62	Whole Blood & Packed Red Blood Cells				536			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,680		5,308			65
66	Physical Therapy	1,511	8,870		4,134			66
70	Electroencephalography	983	1,290		412			70
71	Medical Supplies Charged to Patients						100	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	16,869	44,886		9,946			76
76.97	CARDIAC REHABILITATION	197			639			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	747	2,913		3,173	52,169		90
91	Emergency	13,136	92,244		10,642	221,348		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,200					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	207,700	697,500	351,362	176,879	2,654,530	100	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research				450			191
192	Physicians' Private Offices		26,310					192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY				834			194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS				482			194.06
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,844,077	6,541,678	5,928,274	2,579,713	4,620,030	54,253	202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.878560	9.037839	16.872268	14.440443	1.740432	542.530000	203
204	Cost to be allocated (Per Wkst. B, Part II)	61,600	156,563	335,368	255,420	604,141	717	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.296582	0.216304	0.954480	1.429763	0.227589	7.170000	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQ	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	PARAMED EDUCATION ASSIGNED TIME			
	15	16	17	23			

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	10,000					15
16	Medical Records & Library		1,482,049,691				16
17	Social Service			143,200			17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)					100	23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		124,983,166	112,800			30
31	Intensive Care Unit		21,219,649	25,000			31
32.01	NEONATAL INTENSIVE CARE		22,408,204	2,400			32.01
41	Subprovider - IRF		15,831,331				41
43	Nursery		4,697,578	800			43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		211,300,293				50
52	Delivery Room & Labor Room		9,797,881				52
54	Radiology-Diagnostic		271,328,566				54
60	Laboratory		184,931,312				60
62	Whole Blood & Packed Red Blood Cells		10,738,796				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		33,226,191				65
66	Physical Therapy		51,929,499				66
70	Electroencephalography		10,260,028				70
71	Medical Supplies Charged to Patients		46,008,897				71
72	Impl. Dev. Charged to Patients		59,417,667				72
73	Drugs Charged to Patients	10,000	123,115,548			100	73
76	CARDIOLOGY		140,656,995				76
76.97	CARDIAC REHABILITATION		1,984,321				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	Clinic		9,194,894				90
91	Emergency		122,491,525	2,200			91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		6,527,350				101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,000	1,482,049,691	143,200		100	118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
191	Research						191
192	Physicians' Private Offices						192
194	ADVERTISING						194
194.01	FITNESS POINTE						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03	RETAIL PHARMACY						194.03
194.04	HOSPICE						194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS						194.06
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	24,521,962	7,371,423	1,207,439		264,337	202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,452.196200	0.004974	8.431837		2,643.370000	203
204	Cost to be allocated (Per Wkst. B, Part II)	728,668	171,663	31,129		4,856	204
205	Unit Cost Multiplier (Wkst. B, Part II)	72.866800	0.000116	0.217381		48.560000	205

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POST STEPDOWN ADJUSTMENTS**WORKSHEET B-2**

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	81,947,498		81,947,498	47,009	81,994,507	30
31	Intensive Care Unit	19,973,009		19,973,009		19,973,009	31
32.01	NEONATAL INTENSIVE CARE	6,831,605		6,831,605	9,340	6,840,945	32.01
41	Subprovider - IRF	12,216,406		12,216,406		12,216,406	41
43	Nursery	2,243,446		2,243,446		2,243,446	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	54,104,106		54,104,106		54,104,106	50
52	Delivery Room & Labor Room	5,977,344		5,977,344		5,977,344	52
54	Radiology-Diagnostic	27,901,654		27,901,654	15,757	27,917,411	54
60	Laboratory	21,150,809		21,150,809	6,477	21,157,286	60
62	Whole Blood & Packed Red Blood Cells	3,956,923		3,956,923		3,956,923	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	7,517,991		7,517,991	1,509	7,519,500	65
66	Physical Therapy	17,523,318		17,523,318		17,523,318	66
70	Electroencephalography	1,747,723		1,747,723		1,747,723	70
71	Medical Supplies Charged to Patients	19,234,623		19,234,623		19,234,623	71
72	Impl. Dev. Charged to Patients	32,290,691		32,290,691		32,290,691	72
73	Drugs Charged to Patients	25,398,676		25,398,676		25,398,676	73
76	CARDIOLOGY	20,165,060		20,165,060	61,146	20,226,206	76
76.97	CARDIAC REHABILITATION	833,725		833,725		833,725	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	5,326,706		5,326,706	34,669	5,361,375	90
91	Emergency	15,801,208		15,801,208	26,878	15,828,086	91
92	Observation Beds (Non-Distinct Part)	15,790,500		15,790,500		15,790,500	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	5,229,698		5,229,698		5,229,698	101
200	Subtotal (sum of lines 30 thru 199)	403,162,719		403,162,719	202,785	403,365,504	200
201	Less Observation Beds	15,790,500		15,790,500		15,790,500	201
202	Total (line 200 minus line 201)	387,372,219		387,372,219		387,575,004	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	89,558,927		89,558,927				30
31	Intensive Care Unit	21,219,649		21,219,649				31
32.01	NEONATAL INTENSIVE CARE	22,408,204		22,408,204				32.01
41	Subprovider - IRF	15,831,331		15,831,331				41
43	Nursery	4,697,578		4,697,578				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	83,986,497	127,313,796	211,300,293	0.256053	0.256053	0.256053	50
52	Delivery Room & Labor Room	6,862,643	2,935,238	9,797,881	0.610065	0.610065	0.610065	52
54	Radiology-Diagnostic	60,296,424	211,032,142	271,328,566	0.102833	0.102833	0.102892	54
60	Laboratory	65,981,195	118,950,117	184,931,312	0.114371	0.114371	0.114406	60
62	Whole Blood & Packed Red Blood Cells	7,411,730	3,327,066	10,738,796	0.368470	0.368470	0.368470	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	29,866,713	3,359,478	33,226,191	0.226267	0.226267	0.226312	65
66	Physical Therapy	28,746,055	23,183,444	51,929,499	0.337444	0.337444	0.337444	66
70	Electroencephalography	1,314,780	8,945,248	10,260,028	0.170343	0.170343	0.170343	70
71	Medical Supplies Charged to Patients	21,493,982	24,514,915	46,008,897	0.418063	0.418063	0.418063	71
72	Impl. Dev. Charged to Patients	39,115,522	20,302,145	59,417,667	0.543453	0.543453	0.543453	72
73	Drugs Charged to Patients	85,763,756	37,351,792	123,115,548	0.206300	0.206300	0.206300	73
76	CARDIOLOGY	52,492,326	88,164,669	140,656,995	0.143363	0.143363	0.143798	76
76.97	CARDIAC REHABILITATION	401,297	1,583,024	1,984,321	0.420156	0.420156	0.420156	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	500,311	8,694,583	9,194,894	0.579311	0.579311	0.583082	90
91	Emergency	35,060,159	87,431,366	122,491,525	0.128998	0.128998	0.129218	91
92	Observation Beds (Non-Distinct Part)	5,434,335	29,989,904	35,424,239	0.445754	0.445754	0.445754	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		6,527,350	6,527,350				101
200	Subtotal (sum of lines 30 thru 199)	678,443,414	803,606,277	1,482,049,691				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	678,443,414	803,606,277	1,482,049,691				202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	5,027,005		5,027,005	90,477	55.56	40,962	2,275,849	30
31	Intensive Care Unit	1,448,317		1,448,317	11,020	131.43	5,543	728,516	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	548,456		548,456	4,811	114.00			32.01
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF	635,835		635,835	16,639	38.21	14,573	556,834	41
42	Subprovider I								42
43	Nursery	70,560		70,560	3,933	17.94			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,730,173		7,730,173	126,880		61,078	3,561,199	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0125

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,827,796	211,300,293	0.027581	38,858,285	1,071,750	50
52	Delivery Room & Labor Room	539,416	9,797,881	0.055054	15,068	830	52
54	Radiology-Diagnostic	4,536,041	271,328,566	0.016718	30,357,619	507,519	54
60	Laboratory	1,284,045	184,931,312	0.006943	34,433,440	239,071	60
62	Whole Blood & Packed Red Blood	104,181	10,738,796	0.009701	3,634,406	35,257	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	504,730	33,226,191	0.015191	17,017,129	258,507	65
66	Physical Therapy	1,148,950	51,929,499	0.022125	7,638,444	169,001	66
70	Electroencephalography	366,732	10,260,028	0.035744	685,048	24,486	70
71	Medical Supplies Charged to Pat	202,282	46,008,897	0.004397	12,124,597	53,312	71
72	Impl. Dev. Charged to Patients	338,177	59,417,667	0.005692	21,494,233	122,345	72
73	Drugs Charged to Patients	742,949	123,115,548	0.006035	42,993,234	259,464	73
76	CARDIOLOGY	2,383,290	140,656,995	0.016944	31,020,977	525,619	76
76.97	CARDIAC REHABILITATION	59,989	1,984,321	0.030231	215,722	6,521	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	301,413	9,194,894	0.032780	232,281	7,614	90
91	Emergency	1,069,625	122,491,525	0.008732	19,000,322	165,911	91
92	Observation Beds (Non-Distinct	968,100	35,424,239	0.027329			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	20,377,716	1,321,806,652		259,720,805	3,447,207	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check [] Title V [XX] PPS
Applicable [XX] Title XVIII, Part A [] TEFRA
Boxes: [] Title XIX [] Other

(A)	Cost Center Description	1 Nursing School	2 Allied Health Cost	3 All Other Medical Education Cost	4 Swing-Bed Adjust- ment Amount (see instruct- ions)	5 Total Costs (sum of cols. 1 through 3 minus col 4.)	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
32.01	NEONATAL INTENSIVE CARE						32.01
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	90,477		40,962		30
31	Intensive Care Unit	11,020		5,543		31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE	4,811				32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	16,639		14,573		41
42	Subprovider I					42
43	Nursery	3,933				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	126,880		61,078		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0125

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			264,337		264,337	264,337	73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			264,337		264,337	264,337	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0125

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	211,300,293			38,858,285		39,665,678		50
52	Delivery Room & Labor Room	9,797,881			15,068				52
54	Radiology-Diagnostic	271,328,566			30,357,619		75,621,762		54
60	Laboratory	184,931,312			34,433,440		19,098,364		60
62	Whole Blood & Packed Red Blood	10,738,796			3,634,406		1,113,713		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,226,191			17,017,129		1,643,111		65
66	Physical Therapy	51,929,499			7,638,444		497,833		66
70	Electroencephalography	10,260,028			685,048		2,891,792		70
71	Medical Supplies Charged to Pat	46,008,897			12,124,597		11,900,129		71
72	Impl. Dev. Charged to Patients	59,417,667			21,494,233		10,895,471		72
73	Drugs Charged to Patients	123,115,548	0.002147	0.002147	42,993,234	92,306	14,582,599	31,309	73
76	CARDIOLOGY	140,656,995			31,020,977		46,711,263		76
76.97	CARDIAC REHABILITATION	1,984,321			215,722		887,506		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	9,194,894			232,281		4,660,280		90
91	Emergency	122,491,525			19,000,322		19,364,215		91
92	Observation Beds (Non-Distinct	35,424,239					11,150,596		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,321,806,652			259,720,805	92,306	260,684,312	31,309	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.256053	39,665,678			10,156,516			50
52	Delivery Room & Labor Room	0.610065							52
54	Radiology-Diagnostic	0.102833	75,621,762			7,776,413			54
60	Laboratory	0.114371	19,098,364		2,982	2,184,299		341	60
62	Whole Blood & Packed Red Blood	0.368470	1,113,713			410,370			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.226267	1,643,111			371,782			65
66	Physical Therapy	0.337444	497,833			167,991			66
70	Electroencephalography	0.170343	2,891,792			492,597			70
71	Medical Supplies Charged to Pat	0.418063	11,900,129			4,975,004			71
72	Impl. Dev. Charged to Patients	0.543453	10,895,471			5,921,176			72
73	Drugs Charged to Patients	0.206300	14,582,599		133,518	3,008,390		27,545	73
76	CARDIOLOGY	0.143363	46,711,263			6,696,667			76
76.97	CARDIAC REHABILITATION	0.420156	887,506			372,891			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.579311	4,660,280			2,699,751			90
91	Emergency	0.128998	19,364,215			2,497,945			91
92	Observation Beds (Non-Distinct	0.445754	11,150,596			4,970,423			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		260,684,312		136,500	52,702,215		27,886	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		260,684,312		136,500	52,702,215		27,886	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T125

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,827,796	211,300,293	0.027581	313,830	8,656	50
52	Delivery Room & Labor Room	539,416	9,797,881	0.055054			52
54	Radiology-Diagnostic	4,536,041	271,328,566	0.016718	1,593,315	26,637	54
60	Laboratory	1,284,045	184,931,312	0.006943	3,051,390	21,186	60
62	Whole Blood & Packed Red Blood	104,181	10,738,796	0.009701	229,849	2,230	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	504,730	33,226,191	0.015191	1,719,366	26,119	65
66	Physical Therapy	1,148,950	51,929,499	0.022125	14,435,372	319,383	66
70	Electroencephalography	366,732	10,260,028	0.035744	123,980	4,432	70
71	Medical Supplies Charged to Pat	202,282	46,008,897	0.004397	1,425,581	6,268	71
72	Impl. Dev. Charged to Patients	338,177	59,417,667	0.005692	55,279	315	72
73	Drugs Charged to Patients	742,949	123,115,548	0.006035	6,568,228	39,639	73
76	CARDIOLOGY	2,383,290	140,656,995	0.016944	721,284	12,221	76
76.97	CARDIAC REHABILITATION	59,989	1,984,321	0.030231			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	301,413	9,194,894	0.032780	16,226	532	90
91	Emergency	1,069,625	122,491,525	0.008732	923	8	91
92	Observation Beds (Non-Distinct		35,424,239				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	19,409,616	1,321,806,652		30,254,623	467,626	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T125

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			264,337		264,337	264,337	73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			264,337		264,337	264,337	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T125

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	211,300,293			313,830				50
52	Delivery Room & Labor Room	9,797,881							52
54	Radiology-Diagnostic	271,328,566			1,593,315		8,168		54
60	Laboratory	184,931,312			3,051,390				60
62	Whole Blood & Packed Red Blood	10,738,796			229,849				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,226,191			1,719,366				65
66	Physical Therapy	51,929,499			14,435,372				66
70	Electroencephalography	10,260,028			123,980		125		70
71	Medical Supplies Charged to Pat	46,008,897			1,425,581		2,409		71
72	Impl. Dev. Charged to Patients	59,417,667			55,279		390		72
73	Drugs Charged to Patients	123,115,548	0.002147	0.002147	6,568,228	14,102	28,334	61	73
76	CARDIOLOGY	140,656,995			721,284				76
76.97	CARDIAC REHABILITATION	1,984,321							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	9,194,894			16,226				90
91	Emergency	122,491,525			923				91
92	Observation Beds (Non-Distinct	35,424,239							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,321,806,652			30,254,623	14,102	39,426	61	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [XX] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.256053							50
52	Delivery Room & Labor Room	0.610065							52
54	Radiology-Diagnostic	0.102833	8,168			840			54
60	Laboratory	0.114371							60
62	Whole Blood & Packed Red Blood	0.368470							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.226267							65
66	Physical Therapy	0.337444							66
70	Electroencephalography	0.170343	125			21			70
71	Medical Supplies Charged to Pat	0.418063	2,409			1,007			71
72	Impl. Dev. Charged to Patients	0.543453	390			212			72
73	Drugs Charged to Patients	0.206300	28,334			5,845			73
76	CARDIOLOGY	0.143363							76
76.97	CARDIAC REHABILITATION	0.420156							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.579311							90
91	Emergency	0.128998							91
92	Observation Beds (Non-Distinct	0.445754							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		39,426			7,925			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		39,426			7,925			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	5,027,005		5,027,005	90,477	55.56	828	46,004	30
31	Intensive Care Unit	1,448,317		1,448,317	11,020	131.43	81	10,646	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	548,456		548,456	4,811	114.00	663	75,582	32.01
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF	635,835		635,835	16,639	38.21	25	955	41
42	Subprovider I								42
43	Nursery	70,560		70,560	3,933	17.94	298	5,346	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,730,173		7,730,173	126,880		1,895	138,533	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0125

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,827,796	211,300,293	0.027581	474,534	13,088	50
52	Delivery Room & Labor Room	539,416	9,797,881	0.055054	150,104	8,264	52
54	Radiology-Diagnostic	4,536,041	271,328,566	0.016718	610,045	10,199	54
60	Laboratory	1,284,045	184,931,312	0.006943	901,991	6,263	60
62	Whole Blood & Packed Red Blood	104,181	10,738,796	0.009701	96,883	940	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	504,730	33,226,191	0.015191	257,785	3,916	65
66	Physical Therapy	1,148,950	51,929,499	0.022125	165,799	3,668	66
70	Electroencephalography	366,732	10,260,028	0.035744	28,850	1,031	70
71	Medical Supplies Charged to Pat	202,282	46,008,897	0.004397	235,231	1,034	71
72	Impl. Dev. Charged to Patients	338,177	59,417,667	0.005692	142,016	808	72
73	Drugs Charged to Patients	742,949	123,115,548	0.006035	1,023,610	6,177	73
76	CARDIOLOGY	2,383,290	140,656,995	0.016944	446,376	7,563	76
76.97	CARDIAC REHABILITATION	59,989	1,984,321	0.030231	1,050	32	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	301,413	9,194,894	0.032780	16,441	539	90
91	Emergency	1,069,625	122,491,525	0.008732	275,558	2,406	91
92	Observation Beds (Non-Distinct	968,100	35,424,239	0.027329			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	20,377,716	1,321,806,652		4,826,273	65,928	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	1 Nursing School	2 Allied Health Cost	3 All Other Medical Education Cost	4 Swing-Bed Adjustment Amount (see instructions)	5 Total Costs (sum of cols. 1 through 3 minus col 4.)
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE					32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	90,477		828		30
31	Intensive Care Unit	11,020		81		31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE	4,811		663		32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	16,639		25		41
42	Subprovider I					42
43	Nursery	3,933		298		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	126,880		1,895		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0125

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			264,337		264,337	264,337	73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			264,337		264,337	264,337	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0125

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	211,300,293			474,534				50
52	Delivery Room & Labor Room	9,797,881			150,104				52
54	Radiology-Diagnostic	271,328,566			610,045				54
60	Laboratory	184,931,312			901,991				60
62	Whole Blood & Packed Red Blood	10,738,796			96,883				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,226,191			257,785				65
66	Physical Therapy	51,929,499			165,799				66
70	Electroencephalography	10,260,028			28,850				70
71	Medical Supplies Charged to Pat	46,008,897			235,231				71
72	Impl. Dev. Charged to Patients	59,417,667			142,016				72
73	Drugs Charged to Patients	123,115,548	0.002147	0.002147	1,023,610	2,198			73
76	CARDIOLOGY	140,656,995			446,376				76
76.97	CARDIAC REHABILITATION	1,984,321			1,050				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	9,194,894			16,441				90
91	Emergency	122,491,525			275,558				91
92	Observation Beds (Non-Distinct	35,424,239							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,321,806,652			4,826,273	2,198			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART V

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.256053						50
52	Delivery Room & Labor Room	0.610065						52
54	Radiology-Diagnostic	0.102833						54
60	Laboratory	0.114371						60
62	Whole Blood & Packed Red Blood	0.368470						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.226267						65
66	Physical Therapy	0.337444						66
70	Electroencephalography	0.170343						70
71	Medical Supplies Charged to Pat	0.418063						71
72	Impl. Dev. Charged to Patients	0.543453						72
73	Drugs Charged to Patients	0.206300						73
76	CARDIOLOGY	0.143363						76
76.97	CARDIAC REHABILITATION	0.420156						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	0.579311						90
91	Emergency	0.128998						91
92	Observation Beds (Non-Distinct	0.445754						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T125

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,827,796	211,300,293	0.027581			50
52	Delivery Room & Labor Room	539,416	9,797,881	0.055054			52
54	Radiology-Diagnostic	4,536,041	271,328,566	0.016718	3,616	60	54
60	Laboratory	1,284,045	184,931,312	0.006943	2,340	16	60
62	Whole Blood & Packed Red Blood	104,181	10,738,796	0.009701			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	504,730	33,226,191	0.015191	8,934	136	65
66	Physical Therapy	1,148,950	51,929,499	0.022125	26,083	577	66
70	Electroencephalography	366,732	10,260,028	0.035744			70
71	Medical Supplies Charged to Pat	202,282	46,008,897	0.004397	2,159	9	71
72	Impl. Dev. Charged to Patients	338,177	59,417,667	0.005692			72
73	Drugs Charged to Patients	742,949	123,115,548	0.006035	11,389	69	73
76	CARDIOLOGY	2,383,290	140,656,995	0.016944	285	5	76
76.97	CARDIAC REHABILITATION	59,989	1,984,321	0.030231			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	301,413	9,194,894	0.032780	244	8	90
91	Emergency	1,069,625	122,491,525	0.008732			91
92	Observation Beds (Non-Distinct		35,424,239				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	19,409,616	1,321,806,652		55,050	880	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T125

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			264,337		264,337	264,337	73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			264,337		264,337	264,337	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T125

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	211,300,293							50
52	Delivery Room & Labor Room	9,797,881							52
54	Radiology-Diagnostic	271,328,566			3,616				54
60	Laboratory	184,931,312			2,340				60
62	Whole Blood & Packed Red Blood	10,738,796							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,226,191			8,934				65
66	Physical Therapy	51,929,499			26,083				66
70	Electroencephalography	10,260,028							70
71	Medical Supplies Charged to Pat	46,008,897			2,159				71
72	Impl. Dev. Charged to Patients	59,417,667							72
73	Drugs Charged to Patients	123,115,548	0.002147	0.002147	11,389	24			73
76	CARDIOLOGY	140,656,995			285				76
76.97	CARDIAC REHABILITATION	1,984,321							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	9,194,894			244				90
91	Emergency	122,491,525							91
92	Observation Beds (Non-Distinct	35,424,239							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,321,806,652			55,050	24			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [XX] Title XIX - O/P [XX] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.256053						50
52	Delivery Room & Labor Room	0.610065						52
54	Radiology-Diagnostic	0.102833						54
60	Laboratory	0.114371						60
62	Whole Blood & Packed Red Blood	0.368470						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.226267						65
66	Physical Therapy	0.337444						66
70	Electroencephalography	0.170343						70
71	Medical Supplies Charged to Pat	0.418063						71
72	Impl. Dev. Charged to Patients	0.543453						72
73	Drugs Charged to Patients	0.206300						73
76	CARDIOLOGY	0.143363						76
76.97	CARDIAC REHABILITATION	0.420156						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	0.579311						90
91	Emergency	0.128998						91
92	Observation Beds (Non-Distinct	0.445754						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

**WORKSHEET D-1
PART I**

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	90,477	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	90,477	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	25,218	3
4	Semi-private room days (excluding swing-bed private room days)	47,835	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	40,962	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	81,994,507	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	81,994,507	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	60,375,827	28
29	Private room charges (excluding swing-bed charges)	20,114,954	29
30	Semi-private room charges (excluding swing-bed charges)	40,260,873	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.358068	31
32	Average private room per diem charge (line 29 ÷ line 3)	797.64	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	841.66	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	81,994,507	37

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						906.25	38
39	Program general inpatient routine service cost (line 9 x line 38)						37,121,813	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						37,121,813	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)							42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit						19,973,009	43
44	Coronary Care Unit							44
44.01	NEONATAL INTENSIVE CARE						6,840,945	44.01
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						57,667,978	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						104,836,090	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						3,004,365	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						3,539,513	51
52	Total Program excludable cost (sum of lines 50 and 51)						6,543,878	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						98,292,212	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					17,424	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					906.25	88
89	Observation bed cost (line 87 x line 88) (see instructions)					15,790,500	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	5,027,005	81,994,507	0.061309	15,790,500	968,100	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

**WORKSHEET D-1
PART I**

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,639	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,639	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,524	3
4	Semi-private room days (excluding swing-bed private room days)	15,115	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	14,573	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)	1,317	14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	12,216,406	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,216,406	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	5,447,659	28
29	Private room charges (excluding swing-bed charges)	646,362	29
30	Semi-private room charges (excluding swing-bed charges)	4,801,297	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.242506	31
32	Average private room per diem charge (line 29 ÷ line 3)	424.12	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	317.65	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	106.47	34
35	Average per diem private room cost differential (line 34 x line 31)	238.76	35
36	Private room cost differential adjustment (line 3 x line 35)	363,870	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,852,536	37

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	734,20	38
39	Program general inpatient routine service cost (line 9 x line 38)	10,699,497	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	10,699,497	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,053,796	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	18,753,293	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	556,834	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	481,728	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,038,562	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	17,714,731	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

**WORKSHEET D-1
PART I**

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	90,477	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	90,477	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	25,218	3
4	Semi-private room days (excluding swing-bed private room days)	47,835	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	828	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	3,933	15
16	Nursery days (title V or XIX only)	298	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	81,994,507	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	81,994,507	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	60,375,827	28
29	Private room charges (excluding swing-bed charges)	20,114,954	29
30	Semi-private room charges (excluding swing-bed charges)	40,260,873	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.358068	31
32	Average private room per diem charge (line 29 ÷ line 3)	797.64	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	841.66	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	81,994,507	37

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					906.25	38	
39	Program general inpatient routine service cost (line 9 x line 38)					750,375	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					750,375	41	
42	Nursery (Titles V and XIX only)	2,243,446	3,933	570.42	298	169,985	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	19,973,009	11,020	1,812.43	81	146,807	43	
44	Coronary Care Unit						44	
44.01	NEONATAL INTENSIVE CARE	6,840,945	4,811	1,421.94	663	942,746	44.01	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,030,454	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					3,040,367	49	
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					137,578	50	
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					68,126	51	
52	Total Program excludable cost (sum of lines 50 and 51)					205,704	52	
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					2,834,663	53	
TARGET AMOUNT AND LIMIT COMPUTATION								
54	Program discharges						54	
55	Target amount per discharge						55	
56	Target amount (line 54 x line 55)						56	
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57	
58	Bonus payment (see instructions)						58	
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59	
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60	
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61	
62	Relief payment (see instructions)						62	
63	Allowable Inpatient cost plus incentive payment (see instructions)						63	
PROGRAM INPATIENT ROUTINE SWING BED COST								
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64	
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65	
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66	
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67	
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68	
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69	

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					17,424	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

WORKSHEET D-1
PART I

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,639	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,639	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,524	3
4	Semi-private room days (excluding swing-bed private room days)	15,115	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	25	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	12,216,406	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,216,406	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	5,447,659	28
29	Private room charges (excluding swing-bed charges)	646,362	29
30	Semi-private room charges (excluding swing-bed charges)	4,801,297	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2,242,506	31
32	Average private room per diem charge (line 29 ÷ line 3)	424.12	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	317.65	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	106.47	34
35	Average per diem private room cost differential (line 34 x line 31)	238.76	35
36	Private room cost differential adjustment (line 3 x line 35)	363,870	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,852,536	37

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

**WORKSHEET D-1
PART II**

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	734.20	38
39	Program general inpatient routine service cost (line 9 x line 38)	18,355	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	18,355	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	14,900	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	33,255	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	955	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	904	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,859	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	31,396	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

KPMG LLP Compu-Max 2552-10

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0125

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		54,457,775		30
31	Intensive Care Unit		13,071,399		31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.256053	38,858,285	9,949,780	50
52	Delivery Room & Labor Room	0.610065	15,068	9,192	52
54	Radiology-Diagnostic	0.102892	30,357,619	3,123,556	54
60	Laboratory	0.114406	34,433,440	3,939,392	60
62	Whole Blood & Packed Red Blood Cells	0.368470	3,634,406	1,339,170	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.226312	17,017,129	3,851,180	65
66	Physical Therapy	0.337444	7,638,444	2,577,547	66
70	Electroencephalography	0.170343	685,048	116,693	70
71	Medical Supplies Charged to Patients	0.418063	12,124,597	5,068,845	71
72	Impl. Dev. Charged to Patients	0.543453	21,494,233	11,681,105	72
73	Drugs Charged to Patients	0.206300	42,993,234	8,869,504	73
76	CARDIOLOGY	0.143798	31,020,977	4,460,754	76
76.97	CARDIAC REHABILITATION	0.420156	215,722	90,637	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.583082	232,281	135,439	90
91	Emergency	0.129218	19,000,322	2,455,184	91
92	Observation Beds (Non-Distinct Part)	0.445754			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		259,720,805	57,667,978	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		259,720,805		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T125

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF		14,374,655		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.256053	313,830	80,357	50
52	Delivery Room & Labor Room	0.610065			52
54	Radiology-Diagnostic	0.102892	1,593,315	163,939	54
60	Laboratory	0.114406	3,051,390	349,097	60
62	Whole Blood & Packed Red Blood Cells	0.368470	229,849	84,692	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.226312	1,719,366	389,113	65
66	Physical Therapy	0.337444	14,435,372	4,871,130	66
70	Electroencephalography	0.170343	123,980	21,119	70
71	Medical Supplies Charged to Patients	0.418063	1,425,581	595,983	71
72	Impl. Dev. Charged to Patients	0.543453	55,279	30,042	72
73	Drugs Charged to Patients	0.206300	6,568,228	1,355,025	73
76	CARDIOLOGY	0.143798	721,284	103,719	76
76.97	CARDIAC REHABILITATION	0.420156			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.583082	16,226	9,461	90
91	Emergency	0.129218	923	119	91
92	Observation Beds (Non-Distinct Part)	0.445754			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		30,254,623	8,053,796	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		30,254,623		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0125

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		912,732		30
31	Intensive Care Unit		149,510		31
32.01	NEONATAL INTENSIVE CARE		2,770,720		32.01
41	Subprovider - IRF				41
43	Nursery		282,580		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.256053	474,534	121,506	50
52	Delivery Room & Labor Room	0.610065	150,104	91,573	52
54	Radiology-Diagnostic	0.102892	610,045	62,769	54
60	Laboratory	0.114406	901,991	103,193	60
62	Whole Blood & Packed Red Blood Cells	0.368470	96,883	35,698	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.226312	257,785	58,340	65
66	Physical Therapy	0.337444	165,799	55,948	66
70	Electroencephalography	0.170343	28,850	4,914	70
71	Medical Supplies Charged to Patients	0.418063	235,231	98,341	71
72	Impl. Dev. Charged to Patients	0.543453	142,016	77,179	72
73	Drugs Charged to Patients	0.206300	1,023,610	211,171	73
76	CARDIOLOGY	0.143798	446,376	64,188	76
76.97	CARDIAC REHABILITATION	0.420156	1,050	441	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.583082	16,441	9,586	90
91	Emergency	0.129218	275,558	35,607	91
92	Observation Beds (Non-Distinct Part)	0.445754			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,826,273	1,030,454	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,826,273		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T125

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF		23,370		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.256053			50
52	Delivery Room & Labor Room	0.610065			52
54	Radiology-Diagnostic	0.102892	3,616	372	54
60	Laboratory	0.114406	2,340	268	60
62	Whole Blood & Packed Red Blood Cells	0.368470			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.226312	8,934	2,022	65
66	Physical Therapy	0.337444	26,083	8,802	66
70	Electroencephalography	0.170343			70
71	Medical Supplies Charged to Patients	0.418063	2,159	903	71
72	Impl. Dev. Charged to Patients	0.543453			72
73	Drugs Charged to Patients	0.206300	11,389	2,350	73
76	CARDIOLOGY	0.143798	285	41	76
76.97	CARDIAC REHABILITATION	0.420156			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.583082	244	142	90
91	Emergency	0.129218			91
92	Observation Beds (Non-Distinct Part)	0.445754			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		55,050	14,900	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		55,050		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	19,796,005			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	58,467,676			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,913,770			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	359.39			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0287			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1710			31
32	Sum of lines 30 and 31	0.1997			32
33	Allowable disproportionate share percentage (see instructions)	0.0573			33
34	Disproportionate share adjustment (see instructions)	1,121,128			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)	7,647,644,885		6,406,145,534	35
35.01	Factor 3 (see instructions)	0.000451725		0.000447984	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,454,632		2,869,851	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	870,757		2,148,468	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,019,225			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	84,317,804			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	84,317,804			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	6,647,308			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	27,548			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	92,306			58
59	Total (sum of amounts on lines 49 through 58)	91,084,966			59
60	Primary payer payments	74,657			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	91,010,309			61
62	Deductibles billed to program beneficiaries	7,193,928			62
63	Coinsurance billed to program beneficiaries	535,626			63
64	Allowable bad debts (see instructions)	1,045,073			64
65	Adjusted reimbursable bad debts (see instructions)	679,297			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	308,168			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	83,960,052			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (OTHER ADJUSTMENTS)				70
70.93	HVBP payment adjustment amount (see instructions)	277,570			70.93
70.94	HRR adjustment amount (see instructions)	-597,078			70.94
71	Amount due provider (see instructions)	83,640,544			71
71.01	Sequestration adjustment (see instructions)	1,672,811			71.01
72	Interim payments	81,235,421			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	732,312			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	752,352			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

HSP Bonus Payment Amount

Prior to 10/1 On or After 10/1

100	HSP bonus amount (see instructions)				100
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HVBP Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

HRR Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0125

**WORKSHEET E
PART B**

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	27,886			1
2	Medical and other services reimbursed under OPPS (see instructions)	52,670,906			2
3	PPS payments	49,773,839			3
4	Outlier payment (see instructions)	94,159			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	31,309			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	27,886			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	136,500			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	136,500			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	136,500			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	108,614			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	27,886			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	49,899,307			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	9,604,365			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	40,322,828			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	40,322,828			30
31	Primary payer payments	20,002			31
32	Subtotal (line 30 minus line 31)	40,302,826			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	1,492,236			34
35	Adjusted reimbursable bad debts (see instructions)	969,953			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	828,518			36
37	Subtotal (see instructions)	41,272,779			37
38	MSP-LCC reconciliation amount from PS&R	-3,024			38
39	Other adjustments (FDO LOSS)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	41,275,803			40
40.01	Sequestration adjustment (see instructions)	825,516			40.01
41	Interim payments	40,340,641			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	109,646			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E
PART B

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	7,864			2
3	PPS payments	7,055			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	61			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	7,116			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,443			26
27	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	5,673			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	5,673			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	5,673			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	5,673			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	5,673			40
40.01	Sequestration adjustment (see instructions)	113			40.01
41	Interim payments	5,500			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	60			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0125

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

		INPATIENT PART A		PART B	
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		80,542,690		39,460,977
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero		524,431		669,264
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01	01/22/2016	01/22/2016	210,400
		.02			3.01
		.03			3.02
	Program to	.04			3.03
	Provider	.05			3.04
		.06			3.05
		.07			3.06
		.08			3.07
		.09			3.08
		.10			3.09
		.50			3.10
		.51			3.50
		.52			3.51
	Provider to	.53			3.52
	Program	.54			3.53
		.55			3.54
		.56			3.55
		.57			3.56
		.58			3.57
		.59			3.58
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	168,300		210,400
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		81,235,421		40,340,641
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01			5.01
		.02			5.02
	Program to	.03			5.03
	Provider	.04			5.04
		.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		.52			5.52
	Provider to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	732,312		109,646
		.02			6.01
7	Total Medicare program liability (see instructions)		81,967,733		40,450,287
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)
					8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-T125

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		23,820,811		5,500
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
		.03			3.03
		.04			3.04
		.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
		.52			3.52
		.53			3.53
		.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		23,820,811		5,500
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
		.03			5.03
		.04			5.04
		.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		.52			5.52
		.53			5.53
		.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	56,747		60
		.02			6.02
7	Total Medicare program liability (see instructions)		23,877,558		5,560
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)	
					8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	17,289	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	46,505	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	5,919	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	88,884	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	1,482,049,691	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	24,249,704	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E-3
PART III

Check [] Hospital
Applicable [XX] Subprovider IRF
Box:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	24,137,615		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.018400		2
3	Inpatient Rehabilitation LIP payments (see instructions)	304,134		3
4	Outlier payments	189,564		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	45.461749		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	24,631,313		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	24,631,313		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	24,631,313		19
20	Deductibles	252,728		20
21	Subtotal (line 19 minus line 20)	24,378,585		21
22	Coinsurance	51,205		22
23	Subtotal (line 21 minus line 22)	24,327,380		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,958		24
25	Adjusted reimbursable bad debts (see instructions)	23,373		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,248		26
27	Subtotal (sum of lines 23 and 25)	24,350,753		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)	14,102		29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	24,364,855		32
32.01	Sequestration adjustment (see instructions)	487,297		32.01
33	Interim payments	23,820,811		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	56,747		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	156,894		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)			50
51	Outlier reconciliation adjustment amount (see instructions)			51
52	The rate used to calculate the Time Value of Money (see instructions)			52
53	Time Value of Money (see instructions)			53

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0125

WORKSHEET E-3
PART VII

Check [] Title V [XX] Hospital [] NF [XX] PPS
 Applicable [XX] Title XIX [] SUB (Other) [] ICF/IID [] TEFRA
 Boxes: [] SNF [] Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	8,797,896		8
9	4,826,273		9
10			10
11			11
12	13,624,169		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	13,624,169		16
17	13,624,169		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26	2,198		26
27	2,198		27
28			28
29	2,198		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	2,198		31
32			32
33			33
34			34
35			35
36	2,198		36
37			37
38	2,198		38
39			39
40	2,198		40
41			41
42	2,198		42
43			43

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E-3
PART VII

Check Title V Hospital NF PPS
 Applicable Title XIX Subprovider IRF ICF/IID TEFRA
 Boxes: SNF Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	107,790		8
9	55,050		9
10			10
11			11
12	162,840		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	162,840		16
17	162,840		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26	24		26
27	24		27
28			28
29	24		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	24		31
32			32
33			33
34			34
35			35
36	24		36
37			37
38	24		38
39			39
40	24		40
41			41
42	24		42
43			43

KPMG LLP Compu-Max 2552-10

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	2,276,774				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	114,239,729				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-54,205,581				6
7	Inventory	9,920,727				7
8	Prepaid expenses	3,250,770				8
9	Other current assets	1,153,861				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	76,636,280				11
FIXED ASSETS						
12	Land					12
13	Land improvements	14,376,371				13
14	Accumulated depreciation	-6,051,898				14
15	Buildings	359,716,421				15
16	Accumulated depreciation	-204,638,863				16
17	Leasehold improvements	1,286,570				17
18	Accumulated depreciation	-1,092,646				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	147,752,318				23
24	Accumulated depreciation	-109,667,203				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	3,931,450				29
30	Total fixed assets (sum of lines 12-29)	205,612,520				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,807,668				34
35	Total other assets (sum of lines 31-34)	4,807,668				35
36	Total assets (sum of lines 11, 30 and 35)	287,056,468				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	2,350,648				37
38	Salaries, wages and fees payable	19,775,894				38
39	Payroll taxes payable	6,666,619				39
40	Notes and loans payable (short term)	91,483				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	20,704,161				44
45	Total current liabilities (sum of lines 37 thru 44)	49,588,805				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	74,881,273				49
50	Total long term liabilities (sum of lines 46 thru 49)	74,881,273				50
51	Total liabilities (sum of lines 45 and 50)	124,470,078				51
CAPITAL ACCOUNTS						
52	General fund balance	162,586,390				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	162,586,390				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	287,056,468				60

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		195,482,732			1
2	Net income (loss) (from Worksheet G-3, line 29)		50,465,277			2
3	Total (sum of line 1 and line 2)		245,948,009			3
4	Additions (credit adjustments) (specify)					4
5	NET ASSETS TRANSFERRED TO AFFILITES					5
6	RESTRICTED CONTRIBUTIONS	86,979				6
7	NET ASSETS RELEASED FROM RESTRICTN	-43,129				7
8	OTHER					8
9						9
10	Total additions (sum of lines 4-9)		43,850			10
11	Subtotal (line 3 plus line 10)		245,991,859			11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS RELEASED FROM RESTRICTN					13
14	PENSION-RELATED ADJ-NOT NET COST	19,531,734				14
15	NET ASSETS TRANSFERRED TO AFFILIATE	63,872,735				15
16	OTHER	1,000				16
17						17
18	Total deductions (sum of lines 12-17)		83,405,469			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		162,586,390			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	NET ASSETS TRANSFERRED TO AFFILITES					5
6	RESTRICTED CONTRIBUTIONS					6
7	NET ASSETS RELEASED FROM RESTRICTN					7
8	OTHER					8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS RELEASED FROM RESTRICTN					13
14	PENSION-RELATED ADJ-NOT NET COST					14
15	NET ASSETS TRANSFERRED TO AFFILIATE					15
16	OTHER					16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	101,980,725		101,980,725	1
2	Subprovider IPF				2
3	Subprovider IRF	16,052,372		16,052,372	3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	118,033,097		118,033,097	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	21,931,731		21,931,731	11
12	Coronary Care Unit				12
12.01	NEONATAL INTENSIVE CARE	22,486,246		22,486,246	12.01
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	44,417,977		44,417,977	16
17	Total inpatient routine care services (sum of lines 10 and 16)	162,451,074		162,451,074	17
18	Ancillary services	536,422,760		536,422,760	18
19	Outpatient services		776,671,220	776,671,220	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		6,527,350	6,527,350	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		50,968,580	50,968,580	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	698,873,834	834,167,150	1,533,040,984	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		454,902,761	29
30	Add (specify)			30
31	BAD DEBTS			31
32	CHARITY CARE			32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		454,902,761	43

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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1,533,040,984	1
2	Less contractual allowances and discounts on patients' accounts	1,039,677,295	2
3	Net patient revenues (line 1 minus line 2)	493,363,689	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	454,902,761	4
5	Net income from service to patients (line 3 minus line 4)	38,460,928	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	252,750	6
7	Income from investments	224,938	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	2,325,105	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients	6,357,602	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	27,682	21
22	Rental of hospital space	1,973,179	22
23	Governmental appropriations	32,028	23
24	Other (OTHER REVENUE)	531,777	24
24.01	Other (REVENUE-CLASSES)	35,561	24.01
24.02	Other (ASSETS RELEASED FROM RESTRICTION)	40,209	24.02
24.03	Other (FITNESS REVENUE)	3,675,323	24.03
24.04	Other (SALE OF XRAY SCRAP)	2,231	24.04
24.05	Other (GAIN ON FIXED ASSETS)	3,100	24.05
25	Total other income (sum of lines 6-24)	15,481,485	25
26	Total (line 5 plus line 25)	53,942,413	26
27	Other expenses (PENSION SETTLEMENT)	3,477,136	27
28	Total other expenses (sum of line 27 and subscripts)	3,477,136	28
29	Net income (or loss) for the period (line 26 minus line 28)	50,465,277	29

KPMG LLP Compu-Max 2552-10

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	627,545	359,885	17,185	700	52,178	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,050,963					6
7	Physical Therapy				885,117		7
8	Occupational Therapy				209,337		8
9	Speech Pathology	25,328			420		9
10	Medical Social Services	737					10
11	Home Health Aide	83,450					11
12	Supplies (see instructions)					177,399	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing	337,677	37,899			9,292	17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	2,125,700	397,784	17,185	1,095,574	238,869	24

KPMG LLP Compu-Max 2552-10

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	1,057,493	-256,231	801,262	11,947	813,209	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,050,963		1,050,963		1,050,963	6
7	Physical Therapy	885,117		885,117		885,117	7
8	Occupational Therapy	209,337		209,337		209,337	8
9	Speech Pathology	25,748		25,748		25,748	9
10	Medical Social Services	737		737		737	10
11	Home Health Aide	83,450		83,450		83,450	11
12	Supplies (see instructions)	177,399		177,399		177,399	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing	384,868		384,868		384,868	17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	3,875,112	-256,231	3,618,881	11,947	3,630,828	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

KPMG LLP Compu-Max 2552-10

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H-1
PART I

		CAPITAL RELATED COSTS				
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	813,209				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,050,963				6
7	Physical Therapy	885,117				7
8	Occupational Therapy	209,337				8
9	Speech Pathology	25,748				9
10	Medical Social Services	737				10
11	Home Health Aide	83,450				11
12	Supplies (see instructions)	177,399				12
13	Drugs					13
14	DME					14
HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing	384,868				17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	3,630,828				24

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H-1
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		813,209	813,209		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		1,050,963	313,375	1,364,338	6
7	Physical Therapy		885,117	255,380	1,140,497	7
8	Occupational Therapy		209,337	61,125	270,462	8
9	Speech Pathology		25,748	4,138	29,886	9
10	Medical Social Services		737	323	1,060	10
11	Home Health Aide		83,450	31,787	115,237	11
12	Supplies (see instructions)		177,399	51,751	229,150	12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing		384,868	95,330	480,198	17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		3,630,828		3,630,828	24

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
GENERAL SERVICE COST CENTERS								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-813,209	10,875,359	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care					3,139,882	4,190,845	6
7	Physical Therapy					2,530,202	3,415,319	7
8	Occupational Therapy					608,121	817,458	8
9	Speech Pathology					29,595	55,343	9
10	Medical Social Services					3,588	4,325	10
11	Home Health Aide					341,646	425,096	11
12	Supplies (see instructions)					514,684	692,083	12
13	Drugs							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing					890,022	1,274,890	17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					7,244,531	10,875,359	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						813,209	25
26	Unit Cost Multiplier						0.074775	26

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General		43,098	423	585,188	628,709	117,722	1
2	Skilled Nursing Care	1,364,338				1,364,338	255,466	2
3	Physical Therapy	1,140,497				1,140,497	213,551	3
4	Occupational Therapy	270,462				270,462	50,642	4
5	Speech Pathology	29,886				29,886	5,596	5
6	Medical Social Services	1,060				1,060	198	6
7	Home Health Aide	115,237				115,237	21,577	7
8	Supplies	229,150				229,150	42,907	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing	480,198				480,198	89,914	13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	3,630,828	43,098	423	585,188	4,259,537	797,573	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General		129,276		10,845			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		129,276		10,845			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SOCIAL SERVICE 17	
1	Administrative and General					32,467		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)					32,467		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						919,019	1
2	Skilled Nursing Care						1,619,804	2
3	Physical Therapy						1,354,048	3
4	Occupational Therapy						321,104	4
5	Speech Pathology						35,482	5
6	Medical Social Services						1,258	6
7	Home Health Aide						136,814	7
8	Supplies						272,057	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing						570,112	13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)						5,229,698	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PtII) 27	TOTAL HHA COSTS 28		
1	Administrative and General		919,019				1
2	Skilled Nursing Care		1,619,804	345,335	1,965,139		2
3	Physical Therapy		1,354,048	288,678	1,642,726		3
4	Occupational Therapy		321,104	68,458	389,562		4
5	Speech Pathology		35,482	7,565	43,047		5
6	Medical Social Services		1,258	268	1,526		6
7	Home Health Aide		136,814	29,168	165,982		7
8	Supplies		272,057	58,001	330,058		8
9	Drugs						9
10	DME						10
11	Home Dialysis Aide Services						11
12	Respiratory Therapy						12
13	Private Duty Nursing		570,112	121,546	691,658		13
14	Clinic						14
15	Health Promotion Activities						15
16	Day Care Program						16
17	Home Delivered Meals Program						17
18	Homemaker Service						18
19	All Others						19
20	Totals (sum of lines 1-19)(2)		5,229,698	919,019	5,229,698		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.213196			21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

**WORKSHEET H-2
PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	Administrative and General	3,575	308	2,125,700		628,709		1
2	Skilled Nursing Care					1,364,338		2
3	Physical Therapy					1,140,497		3
4	Occupational Therapy					270,462		4
5	Speech Pathology					29,886		5
6	Medical Social Services					1,060		6
7	Home Health Aide					115,237		7
8	Supplies					229,150		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing					480,198		13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	3,575	308	2,125,700		4,259,537		20
21	Total cost to be allocated	43,098	423	585,188		797,573		21
22	Unit Cost Multiplier	12.055385		0.275292		0.187244		22
22	Unit Cost Multiplier		1.373377					22

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

**WORKSHEET H-2
PART II**

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY + LINEN SERVICE POUNDS	HOUSE- KEEPING TIME SPENT	DIETARY PATIENT ME ALS	CAFETERIA FTES	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	Administrative and General	3,575		1,200				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	3,575		1,200				20
21	Total cost to be allocated	129,276		10,845				21
22	Unit Cost Multiplier	36.161119		9.037500				22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY COSTED REQ	PHARMACY COSTED REQ	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General				6,527,350			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)				6,527,350			20
21	Total cost to be allocated				32,467			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				0.004974			22

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COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME			
		20	21	22	23			
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7487

**WORKSHEET H-3
PARTS I & II**

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation							
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
		1	2	3	4	5	
1	Skilled Nursing Care	2	1,965,139		1,965,139	19,828	99.11
2	Physical Therapy	3	1,642,726		1,642,726	14,447	113.71
3	Occupational Therapy	4	389,562		389,562	3,373	115.49
4	Speech Pathology	5	43,047		43,047	422	102.01
5	Medical Social Services	6	1,526		1,526	13	117.38
6	Home Health Aide	7	165,982		165,982	4,482	37.03
7	Total (sum of lines 1-6)		4,207,982		4,207,982	42,565	

Limitation Cost Computation				Program Visits	
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1	2	3	4
8	Skilled Nursing Care	23844		16,013	
9	Physical Therapy	23844		11,685	
10	Occupational Therapy	23844		2,938	
11	Speech Pathology	23844		291	
12	Medical Social Services	23844		10	
13	Home Health Aide	23844		4,200	
14	Total (sum of lines 8-13)			35,137	

Supplies and Drugs Cost Computations							
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
		1	2	3	4	5	
15	Cost of Medical Supplies	8	330,058		330,058	423,024	0.780235
16	Cost of Drugs	9					

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated
		1	2	3	4	
1	Physical Therapy	66	0.337444			col. 2, line 2
2	Occupational Therapy	67				col. 2, line 3
3	Speech Pathology	68				col. 2, line 4
4	Medical Supplies Charged to Pat	71	0.418063			col. 2, line 15
5	Drugs Charged to Patients	73	0.206300			col. 2, line 16

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/30/2016 Run Time: 13:29 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7487

WORKSHEET H-3
PARTS I & II

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
		Part B			Part B			Total Program Cost (sum of cols 9-10)	
Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6	7	8	9	10	11	12		
1 Skilled Nursing Care		16,013			1,587,048		1,587,048	1	
2 Physical Therapy		11,685			1,328,701		1,328,701	2	
3 Occupational Therapy		2,938			339,310		339,310	3	
4 Speech Pathology		291			29,685		29,685	4	
5 Medical Social Services		10			1,174		1,174	5	
6 Home Health Aide		4,200			155,526		155,526	6	
7 Total (sum of lines 1-6)		35,137			3,441,444		3,441,444	7	

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services				
		Part B			Part B			Total Program Cost (sum of cols 9-10)	
Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6	7	8	9	10	11	12		
15 Cost of Medical Supplies			280,559			218,902		218,902	15
16 Cost of Drugs									16

KPMG LLP Compu-Max 2552-10

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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 15-7487

**WORKSHEET H-4
PARTS I & II**

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	Description	Part A 1	Part B		
			Not Subject to Deductibles & Coinsurance 2	Subject to Deductibles & Coinsurance 3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts		1,706		9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)		-1,706	10
11	Total PPS Reimbursement - Full Episodes without Outliers		4,673,061	11
12	Total PPS Reimbursement - Full Episodes with Outliers		305,145	12
13	Total PPS Reimbursement - LUPA Episodes		68,354	13
14	Total PPS Reimbursement - PEP Episodes		52,843	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		54,917	15
16	Total PPS Outlier Reimbursement - PSP Episodes		4,384	16
17	Total Other Payments		14,638	17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		5,171,636	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		5,171,636	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		5,171,636	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		5,171,636	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		5,171,636	31
31.01	Sequestration adjustment (see instructions)		103,434	31.01
32	Interim payments (see instructions)		5,068,202	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM HHA CCN: 15-7487
BENEFICIARIES

WORKSHEET H-5

	DESCRIPTION	Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1	2	3	4	
1	Total interim payments paid to provider				5,068,202	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				5,068,202	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				5,068,202	7
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0125

WORKSHEET L

Check Title V Hospital PPS
 Applicable Title XVIII, Part A SUB (Other) Cost Method
 Boxes: Title XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	6,272,730	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	116,142	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	244.53	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0287	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1710	8
9	Sum of lines 7 and 8	0.1997	9
10	Allowable disproportionate share percentage (see instructions)	0.0412	10
11	Disproportionate share adjustment (see instructions)	258,436	11
12	Total prospective capital payments (see instructions)	6,647,308	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0125

WORKSHEET L

Check Title V Hospital PPS
 Applicable Title XVIII, Part A SUB (Other) Cost Method
 Boxes: Title XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
32.01	NEONATAL INTENSIVE CARE							32.01
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY							194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS							194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202