

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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 type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 11/29/2018 Time: 07:54
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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 07/01/2017 and ending 06/30/2018, 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.

I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) _____
Chief Financial Officer or Administrator of Provider(s)

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		HIT	TITLE XIX		
		TITLE V	PART A				PART B
		1	2	3	4	5	
1	HOSPITAL		328,004	171,040			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		77,557	-84			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		405,561	170,956			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
4	Subprovider - IPF								
5	Subprovider - IRF	THE REHAB CENTER AT COMMUNITY	15-T125	23844	5	06 / 30 / 1996	N	P	P
6	Subprovider - (OTHER)								
7	Swing Beds - SNF								
8	Swing Beds - NF								
9	Hospital-Based SNF								
10	Hospital-Based NF								
11	Hospital-Based OLTC								
12	Hospital-Based HHA	COMMUNITY HOME HEALTH SERVICES	15-7487	23844		01 / 07 / 1997	N	P	N
13	Separately Certified ASC								
14	Hospital-Based Hospice								
15	Hospital-Based Health Clinic - RHC								
16	Hospital-Based Health Clinic - FQHC								
17	Hospital-Based (CMHC)								
18	Renal Dialysis								
19	Other								

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2017	To: 06 / 30 / 2018	20
21	Type of control (see instructions)	2		21

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)	Y	Y		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.	1,202	929		1,804	11,241	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.	42	187		4	140	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 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 OPSS 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)(i) or (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)(i) or (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
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
		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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	Y			60
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23	1	60.01
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 67. (see instructions)	N			63
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**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 is 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 is 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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? 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	Y	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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06

Rural Providers

		1	2			
105	Does this hospital qualify as a 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)			107		
108	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.	N		108		
109	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.	Physical	Occupational	Speech	Respiratory	109
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	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			1	2	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.			1	2	111

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-I, 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
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance	118.01
118.01		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 care related taxes as defined in §1983(w)(3) of the Act? 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 in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**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 the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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		Title V	Title XIX	
		Part A	Part B			
		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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

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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	
7	Are costs claimed for allied health programs? If yes, see instructions.	Y	
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N	
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N	
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N	
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	

		Y/N
Bad Debts		
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y
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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N

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

		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	10/09/2018	Y	10/09/2018
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.	Y		Y	
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 relifed 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
42	Employer: COMMUNITY HOSPITAL		
43	Phone number: 12198366789	E-mail Address: CBIEGEL@COMHS.ORG	

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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	339	123,735			34,879	812	73,077	1
2	HMO and other (see instructions)						14,559	13,715		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						1,110	331		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)		339	123,735			34,879	812	73,077	7
8	Intensive Care Unit	31	39	14,235			4,707	109	10,808	8
9	Coronary Care Unit	32								9
9.01	NEONATAL INTENSIVE CARE	32.01	32	11,680				101	4,435	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						154	3,765	13
14	Total (see instructions)		410	149,650			39,586	1,176	92,085	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	54	19,710			11,874	42	14,707	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					28,050	1,624	45,196	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30							6	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		464							27
28	Observation Bed Days								14,354	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							285	716	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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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)					7,762	195	17,965	1
2	HMO and other (see instructions)					2,319	2,280		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider						31		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)		2,301.41			7,762	195	17,965	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF		79.30			1,117	4	1,366	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		42.15						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)		2,422.86						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION

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

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassification 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	Total salaries (see instructions)	200	169,815,356		169,815,356	5,554,001.00	30.58
2	Non-physician anesthetist Part A						
3	Non-physician anesthetest Part B		3,435,967		3,435,967	38,819.00	88.51
4	Physician-Part A - Administrative						
4.01	Physician-Part A - Teaching						
5	Physician-Part B		7,682,902		7,682,902	43,549.00	176.42
6	Non-physician-Part B						
7	Interns & residents (in an approved program)	21					
7.01	Contracted interns & residents (in an approved program)						
8	Home office and/or related organization personnel						
9	SNF	44					
10	Excluded area salaries (see instructions)		11,054,165	170,870	11,225,035	401,393.00	27.97
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		2,304,744		2,304,744	23,191.00	99.38
12	Contract management and administrative services						
13	Contract labor: Physician-Part A - Administrative		774,656		774,656	5,078.00	152.55
14	Home office salaries & wage-related costs						
14.01	Home office salaries		18,640,738		18,640,738	590,878.00	31.55
14.02	Related organization salaries						
15	Home office: Physician Part A - Administrative						
16	Home office & Contract Physicians Part A - Teaching						
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		60,358,834		60,358,834		
18	Wage-related costs (other)(see instructions)						
19	Excluded areas		4,644,239		4,644,239		
20	Non-physician anesthetist Part A						
21	Non-physician anesthetist Part B		1,075,017		1,075,017		
22	Physician Part A - Administrative						
22.01	Physician Part A - Teaching						
23	Physician Part B		2,074,263		2,074,263		
24	Wage-related costs (RHC/FQHC)						
25	Interns & residents (in an approved program)						
25.50	Home office wage-related		4,497,738		4,497,738		
25.51	Related organization wage-related						
25.52	Home office: Physician Part A - Administrative - wage-related						
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		629,886		629,886	22,558.00	27.92
27	Administrative & General		15,331,209	-32,413	15,298,796	525,719.00	29.10
28	Administrative & General under contract (see instructions)		3,121,954		3,121,954	20,967.00	148.90
29	Maintenance & Repairs						
30	Operation of Plant		5,106,228		5,106,228	197,392.00	25.87
31	Laundry & Linen Service		92,870		92,870	7,370.00	12.60
32	Housekeeping		3,287,133		3,287,133	229,373.00	14.33
33	Housekeeping under contract (see instructions)						
34	Dietary		3,812,329	-1,374,159	2,438,170	142,937.00	17.06
35	Dietary under contract (see instructions)						
36	Cafeteria			1,374,159	1,374,159	80,560.00	17.06
37	Maintenance of Personnel						
38	Nursing Administration		2,367,771		2,367,771	57,583.00	41.12
39	Central Services and Supply			32,413	32,413	2,163.00	14.99
40	Pharmacy		4,010,925	-117,890	3,893,035	105,272.00	36.98
41	Medical Records & Medical Records Library		87,437		87,437	3,009.00	29.06
42	Social Service		719,316		719,316	25,251.00	28.49
43	Other General Service						

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		161,818,441		161,818,441	5,492,600.00	29.46
2	Excluded area salaries (see instructions)		11,054,165	170,870	11,225,035	401,393.00	27.97
3	Subtotal salaries (line 1 minus line 2)		150,764,276	-170,870	150,593,406	5,091,207.00	29.58
4	Subtotal other wages & related costs (see instructions)		21,720,138		21,720,138	619,147.00	35.08
5	Subtotal wage-related costs (see instructions)		64,856,572		64,856,572		43.07%
6	Total (sum of lines 3 through 5)		237,340,986	-170,870	237,170,116	5,710,354.00	41.53
7	Total overhead cost (see instructions)		38,567,058	-117,890	38,449,168	1,420,154.00	27.07

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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		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	9,875,636	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	24,486,581	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan	137,517	6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	18,810,013	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	1,532,518	10
11	Life Insurance (If employee is owner or beneficiary)	132,781	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	115,775	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	934,408	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	9,701,410	17
18	Medicare Taxes - Employers Portion Only	2,378,542	18
19	Unemployment Insurance	47,171	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		23
24	Total Wage Related cost (Sum of lines 1-23)	68,152,352	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	2,304,744	68,152,352	1
2	Hospital	2,304,744	68,152,352	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

KPMG LLP Compu-Max 2552-10

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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		2,292		1,292	3,584	1
2	Unduplicated Census Count (see instructions)		1,003.00		1,316.00	2,319.00	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)	1.05		1.05	3	
4	Director(s) and Assistant Director(s)				4	
5	Other Administrative Personnel		16.91	16.91	5	
6	Direct Nursing Service		11.50	11.50	6	
7	Nursing Supervisor		1.11	1.11	7	
8	Physical Therapy Service		8.51	0.75	9.26	8
9	Physical Therapy Supervisor				9	
10	Occupational Therapy Service		2.13	0.10	2.23	10
11	Occupational Therapy Supervisor				11	
12	Speech Pathology Service		0.19		0.19	12
13	Speech Pathology Supervisor				13	
14	Medical Social Service		0.01		0.01	14
15	Medical Social Service Supervisor				15	
16	Home Health Aide		2.01		2.01	16
17	Home Health Aide Supervisor				17	
18	PRIVATE DUTY				18	

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				Total (columns 1 through 4)	
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes		
		1	2	3	4		
21	Skilled Nursing Visits	10,320	2,623	293	199	13,435	21
22	Skilled Nursing Visit Charges	1,809,046	460,113	51,414	35,107	2,355,680	22
23	Physical Therapy Visits	7,441	900	78	112	8,531	23
24	Physical Therapy Visit Charges	1,526,967	184,613	15,846	23,076	1,750,502	24
25	Occupational Therapy Visits	2,905	492	18	48	3,463	25
26	Occupational Therapy Visit Charges	597,959	101,214	3,714	9,912	712,799	26
27	Speech Pathology Visits	216	91	4	8	319	27
28	Speech Pathology Visit Charges	44,055	18,216	803	1,584	64,658	28
29	Medical Social Service Visits	7	2	1		10	29
30	Medical Social Service Visit Charges	1,638	460	230		2,328	30
31	Home Health Aide Visits	1,682	569	5	36	2,292	31
32	Home Health Aide Visit Charges	220,178	74,973	653	4,752	300,556	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	22,571	4,677	399	403	28,050	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	4,199,843	839,589	72,660	74,431	5,186,523	35
36	Total Number of Episodes (standard/non-outlier)	1,149		144	23	1,316	36
37	Total Number of Outlier Episodes		113		5	118	37
38	Total Non-Routine Medical Supply Charges	245,702	84,592	10,122	4,757	345,173	38

KPMG LLP Compu-Max 2552-10

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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)		0.257986	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		20,113,677	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 and/or supplemental payments from Medicaid?			4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid			5
6	Medicaid charges		216,976,844	6
7	Medicaid cost (line 1 times line 6)		55,976,988	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.		35,863,311	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)		1,956	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		9,934	14
15	State or local indigent care program cost (line 1 times line 14)		2,563	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.		607	16

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to funding 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)		35,863,918	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	17,136,390	3,102,679	20,239,069	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,420,949	3,102,679	7,523,628	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	4,420,949	3,102,679	7,523,628	23

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?		N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit			25
26	Total bad debt expense for the entire hospital complex (see instructions)		16,711,381	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,260,552	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,939,310	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		14,772,071	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		4,489,746	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		12,013,374	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		47,877,292	31

KPMG LLP Compu-Max 2552-10

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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				13,332,290	13,332,290	303,524	13,635,814	1
2	00200	Cap Rel Costs-Mvble Equip				9,488,892	9,488,892	2,065,727	11,554,619	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	629,886	486,575	1,116,461	24,552,301	25,668,762	49,968,582	75,637,344	4
5	00500	Administrative & General	15,331,209	113,882,476	129,213,685	-10,463,256	118,750,429	-56,216,774	62,533,655	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	5,106,228	12,523,447	17,629,675	-1,490,172	16,139,503	-29,301	16,110,202	7
8	00800	Laundry & Linen Service	92,870	1,324,813	1,417,683	-20,358	1,397,325		1,397,325	8
9	00900	Housekeeping	3,287,133	2,261,039	5,548,172	-1,031,648	4,516,524	-78,172	4,438,352	9
10	01000	Dietary	3,812,329	4,217,526	8,029,855	-4,385,604	3,644,251	-72	3,644,179	10
11	01100	Cafeteria				3,280,111	3,280,111	-2,190,376	1,089,735	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	2,367,771	1,525,731	3,893,502	-645,490	3,248,012	-73,149	3,174,863	13
14	01400	Central Services & Supply					32,413		32,413	14
15	01500	Pharmacy	4,010,925	14,705,984	18,716,909	-953,535	17,763,374		17,763,374	15
16	01600	Medical Records & Library	87,437	192,311	279,748	-12,973	266,775	5,178,387	5,445,162	16
17	01700	Social Service	719,316	248,745	968,061	-142,336	825,725		825,725	17
19	01900	Nonphysician Anesthetists								19
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)	150,962	34,244	185,206	103,256	288,462		288,462	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	35,959,189	17,880,770	53,839,959	-11,317,696	42,522,263	-12,734	42,509,529	30
31	03100	Intensive Care Unit	9,447,713	4,193,849	13,641,562	-1,895,814	11,745,748	-35,269	11,710,479	31
32.01	02060	NEONATAL INTENSIVE CARE	3,009,207	1,635,618	4,644,825	-901,400	3,743,425	-51,217	3,692,208	32.01
41	04100	Subprovider - IRF	4,064,388	2,903,527	6,967,915	-759,083	6,208,832		6,208,832	41
43	04300	Nursery				2,108,088	2,108,088		2,108,088	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	28,246,886	57,931,155	86,178,041	-39,440,013	46,738,028	-14,665,802	32,072,226	50
52	05200	Delivery Room & Labor Room	2,358,515	1,549,726	3,908,241	-960,942	2,947,299		2,947,299	52
54	05400	Radiology-Diagnostic	8,641,307	13,158,708	21,800,015	-3,980,319	17,819,696	-130,238	17,689,458	54
60	06000	Laboratory	6,437,501	10,212,180	16,649,681	-1,625,889	15,023,792	-22,228	15,001,564	60
62	06200	Whole Blood & Packed Red Blood Cells	371,826	2,166,837	2,538,663	-86,387	2,452,276		2,452,276	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	3,611,318	1,859,605	5,470,923	-801,701	4,669,222	-11,533	4,657,689	65
66	06600	Physical Therapy	6,528,120	6,733,782	13,261,902	-1,360,732	11,901,170	-8,257	11,892,913	66
70	07000	Electroencephalography	771,391	676,315	1,447,706	-197,405	1,250,301	-2,769	1,247,532	70
71	07100	Medical Supplies Charged to Patients				18,136,186	18,136,186		18,136,186	71
72	07200	Impl. Dev. Charged to Patients				30,715,794	30,715,794		30,715,794	72
73	07300	Drugs Charged to Patients								73
76	03140	CARDIOLOGY	7,899,792	20,238,741	28,138,533	-16,643,015	11,495,518	-286,127	11,209,391	76
76.97	07697	CARDIAC REHABILITATION	808,015	412,275	1,220,290	-156,613	1,063,677	-62,404	1,001,273	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	2,795,471	1,848,836	4,644,307	-595,374	4,048,933	-27,541	4,021,392	90
91	09100	Emergency	6,429,836	3,740,605	10,170,441	-1,250,029	8,920,412	-13,784	8,906,628	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	3,654,638	1,329,584	4,984,222	-429,749	4,554,473		4,554,473	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	166,631,179	299,875,004	466,506,183	201,798	466,707,981	-16,401,527	450,306,454	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
191	19100	Research	464,238	222,282	686,520	-48,673	637,847		637,847	191
192	19200	Physicians' Private Offices		768,684	768,684	-27,092	741,592	1,064	742,656	192
194	07950	ADVERTISING				769,540	769,540		769,540	194
194.01	07951	FITNESS POINTE	1,508,376	1,626,990	3,135,366	-671,023	2,464,343		2,464,343	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	324,755	166,864	491,619	-32,164	459,455		459,455	194.02
194.03	07953	RETAIL PHARMACY	752,869	9,556,324	10,309,193	-109,989	10,199,204		10,199,204	194.03
194.04	07954	HOSPICE								194.04
194.05	07955	RUSH RESIDENTS								194.05
194.06	07956	EINSTEIN BAGELS	133,939	239,240	373,179	-82,397	290,782		290,782	194.06
200		TOTAL (sum of lines 118-199)	169,815,356	312,455,388	482,270,744		482,270,744	-16,400,463	465,870,281	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		17,329,499	1
2			Impl. Dev. Charged to Patient	72		30,715,794	2
3							3
4							4
5	NURSING UNITS ONLY	A	Medical Supplies Charged to P	71		806,687	5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					48,851,980	500
	Code Letter - A						
1	NURSING FLOAT SALARIES	B	Intensive Care Unit	31	88,783		1
2			NEONATAL INTENSIVE CARE	32.01	27,780		2
3			Delivery Room & Labor Room	52	23,474		3
4			Emergency	91	76,917		4
5			Subprovider - IRF	41	52,980		5
6			Nursery	43	14,859		6
500	Total reclassifications				284,793		500
	Code Letter - B						
1	STOREROOM SALARY RECLASS	C	Central Services & Supply	14	32,413		1
500	Total reclassifications				32,413		500
	Code Letter - C						
1	CAFETERIA EXPENSE	D	Cafeteria	11	1,374,159	1,905,952	1
500	Total reclassifications				1,374,159	1,905,952	500
	Code Letter - D						
1	BUILDING INSURANCE	F	Cap Rel Costs-Bldg & Fixt	1		244,420	1
2			Cap Rel Costs-Mvble Equip	2		6,503	2
500	Total reclassifications					250,923	500
	Code Letter - F						
1	UTILITY RECLASS	G	Operation of Plant	7		923,790	1
2			Laboratory	60		8,605	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					932,395	500
	Code Letter - G						
1	ADVERTISING NON-REIMBURSABLE	H	ADVERTISING	194		769,540	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
500	Total reclassifications					769,540	500
	Code Letter - H						
1	BENEFITS RECLASS	I	Employee Benefits Department	4		20,284,982	1
2			Employee Benefits Department	4		4,342,585	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11

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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	
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					24,627,567	500
	Code Letter - I						
1	DEPRECIATION RECLASS	J	Cap Rel Costs-Bldg & Fixt	1		13,087,870	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
30							30
500	Total reclassifications					13,087,870	500
	Code Letter - J						
1	RECLASS NURSERY	K	Nursery	43	1,429,727	663,502	1
500	Total reclassifications				1,429,727	663,502	500
	Code Letter - K						
1	DEPRECIATION RECLASS EQUIPMENT	L	Cap Rel Costs-Mvble Equip	2		9,482,389	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

KPMG LLP Compu-Max 2552-10

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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	
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
500	Total reclassifications Code Letter - L					9,482,389	500
1	RECLASS PRECEPTOR TIME	M	PARAMED ED PRGM-(SPECIFY)	23	117,890		1
500	Total reclassifications Code Letter - M				117,890		500
1	LINEN RECLASS FOR OFFSITES SJ	N	Radiology-Diagnostic	54		6,737	1
2			Physical Therapy	66		2,695	2
3			CARDIOLOGY	76		1,347	3
4			Physicians' Private Offices	192		12,126	4
5							5
6	LINEN RECLASS CDC	N	Radiology-Diagnostic	54		18,698	6
7			CARDIOLOGY	76		8,013	7
8			Clinic	90		2,672	8
9							9
10	LINEN RECLASS SV	N	Radiology-Diagnostic	54		6,425	10
11			CARDIOLOGY	76		2,142	11
12			Physicians' Private Offices	192		2,142	12
13							13
14	RECLASS COSTS TO LAUNDRY	N	Laundry & Linen Service	8		13,955	14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
500	Total reclassifications Code Letter - N					76,952	500
1	RECLASS OFFSITE HOUSEK COSTS SJ	O	Administrative & General	5		25,312	1
2			Operation of Plant	7		8,205	2
3			Housekeeping	9		279	3
4			Medical Records & Library	16		2,486	4
5			Radiology-Diagnostic	54		10,745	5
6			Laboratory	60		2,367	6
7			Physical Therapy	66		11,397	7
8			CARDIOLOGY	76		1,191	8
9			Physicians' Private Offices	192		45,381	9
10							10
11	RECLASS HOUSEKEEPING SV	O	Operation of Plant	7		329	11
12			Radiology-Diagnostic	54		3,282	12
13			Laboratory	60		1,073	13
14			CARDIOLOGY	76		230	14
15			Physicians' Private Offices	192		7,225	15
16							16
500	Total reclassifications Code Letter - O					119,502	500
	GRAND TOTAL (Increases)					3,238,982	100,768,572

(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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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9		
1	OPERATING RM/CARDIOLOGY SUPPLIES	A	Operating Room	50		33,434,508	1	
2			CARDIOLOGY	76		14,230,028	2	
3			Radiology-Diagnostic	54		242,831	3	
4			Clinic	90		137,925	4	
5	NURSING UNITS ONLY	A	Adults & Pediatrics	30		411,996	5	
6			Intensive Care Unit	31		153,781	6	
7			NEONATAL INTENSIVE CARE	32.01		27,588	7	
8			Subprovider - IRF	41		39,453	8	
9			Delivery Room & Labor Room	52		49,333	9	
10			Emergency	91		124,537	10	
500	Total reclassifications					48,851,980	500	
	Code letter - A							
1	NURSING FLOAT SALARIES	B	Adults & Pediatrics	30	284,793		1	
2							2	
3							3	
4							4	
5							5	
6							6	
500	Total reclassifications				284,793		500	
	Code letter - B							
1	STOREROOM SALARY RECLASS	C	Administrative & General	5	32,413		1	
500	Total reclassifications				32,413		500	
	Code letter - C							
1	CAFETERIA EXPENSE	D	Dietary	10	1,374,159	1,905,952	1	
500	Total reclassifications				1,374,159	1,905,952	500	
	Code letter - D							
1	BUILDING INSURANCE	F	Administrative & General	5		244,420	12 1	
2			Administrative & General	5		6,503	12 2	
500	Total reclassifications					250,923	500	
	Code letter - F							
1	UTILITY RECLASS	G	Administrative & General	5		530,504	1	
2			Housekeeping	9		12,069	2	
3			Dietary	10		756	3	
4			Operating Room	50		1,093	4	
5			Physical Therapy	66		52,590	5	
6			Clinic	90		6,279	6	
7			Home Health Agency	101		7,800	7	
8			Research	191		3,738	8	
9			Physicians' Private Offices	192		24,477	9	
10			FITNESS POINTE	194.01		293,089	10	
500	Total reclassifications					932,395	500	
	Code letter - G							
1	ADVERTISING NON-REIMBURSABLE	H	Employee Benefits Department	4		7,321	1	
2			Administrative & General	5		701,132	2	
3			Operation of Plant	7		114	3	
4			Nursing Administration	13		9,479	4	
5			Adults & Pediatrics	30		10,566	5	
6			NEONATAL INTENSIVE CARE	32.01		1,592	6	
7			Subprovider - IRF	41		1,146	7	
8			Operating Room	50		226	8	
9			Delivery Room & Labor Room	52		500	9	
10			Radiology-Diagnostic	54		12,216	10	
11			Respiratory Therapy	65		279	11	
12			CARDIOLOGY	76		20,737	12	
13			Clinic	90		3,396	13	
14			Research	191		836	14	
500	Total reclassifications					769,540	500	
	Code letter - H							
1	BENEFITS RECLASS	I					1	
2			Administrative & General	5		2,464,246	2	
3			Operation of Plant	7		950,009	3	
4			Laundry & Linen Service	8		34,313	4	
5			Housekeeping	9		848,617	5	
6			Dietary	10		982,089	6	
7			Nursing Administration	13		251,705	7	
8			Pharmacy	15		439,448	8	
9			Medical Records & Library	16		7,773	9	
10			Social Service	17		126,684	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	
11			PARAMED ED PRGM-(SPECIFY)	23		14,634	11	
12			Adults & Pediatrics	30		5,242,014	12	
13			Intensive Care Unit	31		1,271,607	13	
14			NEONATAL INTENSIVE CARE	32.01		468,352	14	
15			Subprovider - IRF	41		620,174	15	
16			Operating Room	50		2,768,373	16	
17			Delivery Room & Labor Room	52		443,483	17	
18			Radiology-Diagnostic	54		1,255,217	18	
19			Laboratory	60		1,094,355	19	
20			Whole Blood & Packed Red Bloo	62		51,083	20	
21			Respiratory Therapy	65		639,043	21	
22			Physical Therapy	66		905,871	22	
23			Electroencephalography	70		138,768	23	
24			CARDIOLOGY	76		1,171,266	24	
25			CARDIAC REHABILITATION	76.97		145,430	25	
26			Clinic	90		389,064	26	
27			Emergency	91		1,000,330	27	
28			Home Health Agency	101		421,641	28	
29			Research	191		44,066	29	
30			FITNESS POINTE	194.01		287,012	30	
31			FITNESS POINTE SPA/PRO SHOP/D	194.02		27,232	31	
32			RETAIL PHARMACY	194.03		62,237	32	
33			EINSTEIN BAGELS	194.06		61,431	33	
500	Total reclassifications					24,627,567	500	
	Code letter - I							
1	DEPRECIATION RECLASS	J	Employee Benefits Department	4		65,648	9 1	
2	BUILDING	J	Administrative & General	5		6,107,629	2	
3			Operation of Plant	7		1,164,444	3	
4			Housekeeping	9		7,424	4	
5			Dietary	10		58,176	5	
6			Nursing Administration	13		825	6	
7			Pharmacy	15		32,802	7	
8			Medical Records & Library	16		7,125	8	
9			Social Service	17		15,652	9	
10			Adults & Pediatrics	30		2,744,890	10	
11			Intensive Care Unit	31		254,445	11	
12			NEONATAL INTENSIVE CARE	32.01		202,831	12	
13			Subprovider - IRF	41		126,550	13	
14			Operating Room	50		971,643	14	
15			Delivery Room & Labor Room	52		369,777	15	
16			Radiology-Diagnostic	54		272,084	16	
17			Laboratory	60		92,944	17	
18			Whole Blood & Packed Red Bloo	62		7,100	18	
19			Respiratory Therapy	65		21,397	19	
20			Physical Therapy	66		266,724	20	
21			Electroencephalography	70		11,206	21	
22			CARDIOLOGY	76		70,879	22	
23			CARDIAC REHABILITATION	76.97		5,182	23	
24			Clinic	90		29,907	24	
25			Emergency	91		8,487	25	
26			Physicians' Private Offices	192		68,551	26	
27			FITNESS POINTE	194.01		75,358	27	
28			FITNESS POINTE SPA/PRO SHOP/D	194.02		1,486	28	
29			RETAIL PHARMACY	194.03		16,628	29	
30			EINSTEIN BAGELS	194.06		10,076	30	
500	Total reclassifications					13,087,870	500	
	Code letter - J							
1	RECLASS NURSERY	K	Adults & Pediatrics	30	1,429,727	663,502	1	
500	Total reclassifications				1,429,727	663,502	500	
	Code letter - K							
1	DEPRECIATION RECLASS EQUIPMENT	L	Employee Benefits Department	4		2,297	9 1	
2			Administrative & General	5		355,968	2	
3			Operation of Plant	7		307,854	3	
4			Housekeeping	9		20,864	4	
5			Dietary	10		62,426	5	
6			Nursing Administration	13		383,481	6	
7			Pharmacy	15		363,395	7	
8			Medical Records & Library	16		561	8	
9			Adults & Pediatrics	30		530,208	9	
10			Intensive Care Unit	31		304,764	10	
11			NEONATAL INTENSIVE CARE	32.01		228,817	11	
12			Subprovider - IRF	41		24,740	12	

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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	
13			Operating Room	50		2,264,170	13	
14			Delivery Room & Labor Room	52		121,323	14	
15			Radiology-Diagnostic	54		2,243,711	15	
16			Laboratory	60		450,612	16	
17			Whole Blood & Packed Red Bloo	62		28,204	17	
18			Respiratory Therapy	65		140,982	18	
19			Physical Therapy	66		149,639	19	
20			Electroencephalography	70		42,941	20	
21			CARDIOLOGY	76		1,163,028	21	
22			CARDIAC REHABILITATION	76.97		6,001	22	
23			Clinic	90		30,514	23	
24			Emergency	91		193,592	24	
25			Home Health Agency	101		308	25	
26			Research	191		27	26	
27			Physicians' Private Offices	192		938	27	
28			FITNESS POINTE	194.01		15,564	28	
29			FITNESS POINTE SPA/PRO SHOP/D	194.02		3,446	29	
30			RETAIL PHARMACY	194.03		31,124	30	
31			EINSTEIN BAGELS	194.06		10,890	31	
500	Total reclassifications Code letter - L					9,482,389	500	
1	RECLASS PRECEPTOR TIME	M	Pharmacy	15	117,890		1	
500	Total reclassifications Code letter - M				117,890		500	
1	LINEN RECLASS FOR OFFSITES SJ	N	Administrative & General	5		22,905	1	
2							2	
3							3	
4							4	
5							5	
6	LINEN RECLASS CDC	N	Housekeeping	9		29,383	6	
7							7	
8							8	
9							9	
10	LINEN RECLASS SV	N	Administrative & General	5		10,709	10	
11							11	
12							12	
13							13	
14	RECLASS COSTS TO LAUNDRY	N	Radiology-Diagnostic	54		147	14	
15			Operation of Plant	7		75	15	
16			Housekeeping	9		6,207	16	
17			Dietary	10		2,046	17	
18			Laboratory	60		23	18	
19			Research	191		6	19	
20			Electroencephalography	70		4,490	20	
21			Clinic	90		961	21	
500	Total reclassifications Code letter - N					76,952	500	
1	RECLASS OFFSITE HOUSEK COSTS SJ	O	Housekeeping	9		107,363	1	
2							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		12,139	11	
12							12	
13							13	
14							14	
15							15	
16							16	
500	Total reclassifications Code letter - O					119,502	500	
	GRAND TOTAL (Decreases)				3,238,982	100,768,572		

(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	14,470,317	129,306		129,306	1,143,426	13,456,197		1
2	Land Improvements	1,286,570				20,488	1,266,082		2
3	Buildings and Fixtures	370,804,020	8,083,465		8,083,465	5,028,303	373,859,182		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	150,261,361	7,582,184		7,582,184	11,564,365	146,279,180		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	536,822,268	15,794,955		15,794,955	17,756,582	534,860,641		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	536,822,268	15,794,955		15,794,955	17,756,582	534,860,641		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		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 lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		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	388,581,460		388,581,460	0.726510					1
2	Cap Rel Costs-Mvble Equip	146,279,181		146,279,181	0.273490					2
3	Total (sum of lines 1-2)	534,860,641		534,860,641	1.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	13,391,394			244,420				13,635,814	1
2	Cap Rel Costs-Mvble Equip	11,548,116			6,503				11,554,619	2
3	Total (sum of lines 1-2)	24,939,510			250,923				25,190,433	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			Wkst. A-7 Ref.
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
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	-14,972,499				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-22,424,931				12
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						18
19	Nursing and allied health education (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		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35	A&G OTHER INCOME	B	-98,255	Administrative & General	5		35
36	OFFSET PROFESSIONAL FEES	A	-776	Laboratory	60		36
36.02	OFFSET PHYSICIAN FEES	A	-465	Clinic	90		36.02
36.03	OFFSET LASER CLINIC FEES	A	-7,970	CARDIOLOGY	76		36.03
37	OFFSET MAMMO FEES	A	-15,924	Radiology-Diagnostic	54		37
38	PHYSICIAN RENTAL/X RAY SALES-RA	B	8,388	Radiology-Diagnostic	54		38
39	OFFSET PT OTHER INCOME	B	-7,300	Physical Therapy	66		39
40	PHYSICIAN RENTAL-LAB	B	-35,250	Laboratory	60		40
41	REMOVE MEDICAID ASSESSMENT FEES	A	-25,952,616	Administrative & General	5		41
42	VARIOUS EH&W OFFSETS	B	-1,291	Employee Benefits Department	4		42
42.01	OTHER INCOME PLANT	B	-15,535	Operation of Plant	7		42.01
42.05	OTHER INCOME ACUTE	B	-2,993	Adults & Pediatrics	30		42.05
43	OFFSET OTHER INCOME ICU	B	-16	Intensive Care Unit	31		43
43.02	OFFSET RESEARCH COSTS HEART CTR	A	-238,438	CARDIOLOGY	76		43.02
43.05	OTHER INCOME PT	B	-957	Physical Therapy	66		43.05
43.06	OTHER INCOME CLINIC	B	-305	Clinic	90		43.06
43.07	OTHER INCOME ER	B	-16	Emergency	91		43.07
43.08	OTHER INCOME CARDIOLOGY	B	-2,658	CARDIOLOGY	76		43.08
44	OTHER INCOME	A	-72	Dietary	10		44
45	OFFSET NEONATOLOGY FEES	A	-13,300	NEONATAL INTENSIVE CARE	32.01		45
45.01	EMPLOYEE CAFETERIA REVENUE	B	-2,189,251	Cafeteria	11		45.01
45.03	OTHER INCOME DIETARY	B	-1,125	Cafeteria	11		45.03
45.04	TELEPHONE SERVICE	A	-118,062	Administrative & General	5		45.04
45.05	TELEPHONE SERVICE	A	-30,127	Employee Benefits Department	4		45.05
45.06	TELEPHONE SERVICE	A	-9,355	Cap Rel Costs-Mvble Equip	2	9	45.06
45.08	TELEVISION SERVICE	A	-11,317	Operation of Plant	7		45.08
45.09	TELEVISION SERVICE	A	-29,440	Cap Rel Costs-Mvble Equip	2	9	45.09
45.10	PENSION CONTRIBTN EXCESS OF EXP	A	50,000,000	Employee Benefits Department	4		45.10
45.19	CAPITALIZED INTEREST	A	795	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
45.29	OFFSET RELEASED TEMP REST OP IN	B	-28,110	Administrative & General	5		45.29

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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. 5
				COST CENTER	LINE#		
		1	2	3	4		
45.30	OFFSET RELEASED TEMP REST OP IN	B	-1,479	CARDIOLOGY	76		45.30
45.31	OFFSET RELEASED TEMP REST OP IN	B	-10,017	Respiratory Therapy	65		45.31
45.32	OFFSET RELEASED TEMP REST OP IN	B	-12,216	Radiology-Diagnostic	54		45.32
45.33	NON-PT CARE RELATED EXPENSES	A	-11,223	Administrative & General	5		45.33
45.34	OFFSET RELEASED TEMP REST OP INC	B	-1,000	Nursing Administration	13		45.34
45.35	OFFSET RELEASED TEMP REST OP INC	B	-6,192	Clinic	90		45.35
46	OFFSET SURGERY INCOME	B	-16	Operating Room	50		46
47	OFFSET CARDIAC REHAB CLASS INCO	B	-62,404	CARDIAC REHABILITATION	76.97		47
47.01	CLEANING SERVICES-SJ SV	A	-15,465	Administrative & General	5		47.01
47.03	CLEANING SERVICES-SJ SV	A	-78,608	Housekeeping	9		47.03
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-16,400,463				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.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	305,401		305,401	9	1
2	2	Cap Rel Costs-Mvble Equip	CFNI ALLOCATION	2,104,522		2,104,522	9	2
3	5	Administrative & General	CFNI ALLOCATION	29,401,990	48,495,706	-19,093,716		3
3.01	16	Medical Records & Library	CFNI ALLOCATION	5,161,454		5,161,454		3.01
3.02	5	Administrative & General	COMMUNICATIONS	1,238,466		1,238,466		3.02
3.03	5	Administrative & General	PATIENT ACCOUNTING	5,563,100		5,563,100		3.03
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	72,138		72,138		3.10
3.11	7	Operation of Plant	CDC LEASE DEPR	7,421		7,421		3.11
3.12	9	Housekeeping	CDC LEASE DEPR	436		436		3.12
3.13	54	Radiology-Diagnostic	CDC LEASE DEPR	30,085		30,085		3.13
3.14	60	Laboratory	CDC LEASE DEPR	2,799		2,799		3.14
3.15	76	CARDIOLOGY	CDC LEASE DEPR	2,260		2,260		3.15
3.16	90	Clinic	CDC LEASE DEPR	3,317		3,317		3.16
3.18	192	Physicians' Private Offices	CDC LEASE DEPR	1,064		1,064		3.18
3.21	5	Administrative & General	LEASE EXPENSE		74,140	-74,140		3.21
3.22	90	Clinic	800 MACARTHUR DEPR	20,990		20,990		3.22
3.23	90	Clinic	800 MACARTHUR A&G	29,502		29,502		3.23
3.24	5	Administrative & General	800 MACARTHUR DEPR	73,115		73,115		3.24
3.25	5	Administrative & General	800 MACARTHUR A&G	102,763		102,763		3.25
3.26	16	Medical Records & Library	800 MACARTHUR DEPR	7,039		7,039		3.26
3.27	16	Medical Records & Library	800 MACARTHUR A&G	9,894		9,894		3.27
3.28	60	Laboratory	800 MACARTHUR DEPR	13,526		13,526		3.28
3.29	60	Laboratory	800 MACARTHUR A&G	19,010		19,010		3.29
3.30	7	Operation of Plant	800 MACARTHUR DEPR	6,316		6,316		3.30
3.31	7	Operation of Plant	800 MACARTHUR A&G	8,877		8,877		3.31
3.33	5	Administrative & General	CCN COSTS		17,778,851	-17,778,851		3.33
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			44,185,485	66,610,416	-22,424,931		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.

KPMG LLP Compu-Max 2552-10

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

WORKSHEET A-8-1

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

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:

KPMG LLP Compu-Max 2552-10

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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	50	Operating Room	7,580		7,580	211,500	41	4,169	208	1
2	5	Administrative & Gen AGGREGATE	206,161		206,161	211,500	1,872	190,350	9,518	2
3	50	Operating Room CRNA ANESTHESIO	14,662,375	14,662,375						3
4	30	Adults & Pediatrics AGGREGATE	31,603		31,603	211,500	215	21,862	1,093	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE	55,000	30,000	25,000	211,500	168	17,083	854	5
6	54	Radiology-Diagnostic AGGREGATE	46,050		46,050	271,900	209	27,321	1,366	6
7	13	Nursing Administrati AGGREGATE	98,993		98,993	211,500	264	26,844	1,342	7
8	60	Laboratory	52,957		52,957	260,300	344	43,050	2,153	8
9	65	Respiratory Therapy AGGREGATE	25,920		25,920	211,500	240	24,404	1,220	9
10	70	Electroencephalogram	34,087		34,087	211,500	308	31,318	1,566	10
11	76	CARDIOLOGY AGGREGATE	64,233	700	63,533	211,500	296	30,098	1,505	11
12	90	Clinic AGGREGATE	136,771		136,771	211,500	804	81,753	4,088	12
13	91	Emergency AGGREGATE	46,001		46,001	211,500	317	32,233	1,612	13
14	31	Intensive Care Unit AGGREGATE	35,253	35,253						14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	15,502,984	14,728,328	774,656		5,078	530,485	26,525	200

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	50	Operating Room					4,169	3,411	3,411	1
2	5	Administrative & Gen AGGREGATE					190,350	15,811	15,811	2
3	50	Operating Room CRNA ANESTHESIO							14,662,375	3
4	30	Adults & Pediatrics AGGREGATE					21,862	9,741	9,741	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE					17,083	7,917	37,917	5
6	54	Radiology-Diagnostic AGGREGATE					27,321	18,729	18,729	6
7	13	Nursing Administrati AGGREGATE					26,844	72,149	72,149	7
8	60	Laboratory					43,050	9,907	9,907	8
9	65	Respiratory Therapy AGGREGATE					24,404	1,516	1,516	9
10	70	Electroencephalograp					31,318	2,769	2,769	10
11	76	CARDIOLOGY AGGREGATE					30,098	33,435	34,135	11
12	90	Clinic AGGREGATE					81,753	55,018	55,018	12
13	91	Emergency AGGREGATE					32,233	13,768	13,768	13
14	31	Intensive Care Unit AGGREGATE							35,253	14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					530,485	244,171	14,972,499	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	13,635,814	13,635,814					1
2	Cap Rel Costs-Mvble Equip	11,554,619		11,554,619				2
4	Employee Benefits Department	75,637,344	59,723	2,799	75,699,866			4
5	Administrative & General	62,533,655	1,146,903	433,759	6,845,247	70,959,564	70,959,564	5
6	Maintenance & Repairs							6
7	Operation of Plant	16,110,202	2,135,395	375,131	2,284,715	20,905,443	3,756,395	7
8	Laundry & Linen Service	1,397,325	23,523		41,553	1,462,401	262,772	8
9	Housekeeping	4,438,352	67,203	25,424	1,470,785	6,001,764	1,078,427	9
10	Dietary	3,644,179	173,175	76,068	1,090,927	4,984,349	895,613	10
11	Cafeteria	1,089,735	177,336		614,850	1,881,921	338,153	11
12	Maintenance of Personnel							12
13	Nursing Administration	3,174,863	37,432	467,285	1,059,428	4,739,008	851,529	13
14	Central Services & Supply	32,413			14,503	46,916	8,430	14
15	Pharmacy	17,763,374	72,295	442,810	1,741,888	20,020,367	3,597,360	15
16	Medical Records & Library	5,445,162	94,181	684	39,123	5,579,150	1,002,490	16
17	Social Service	825,725	16,012		321,849	1,163,586	209,079	17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	288,462	1,682		120,294	410,438	73,750	23
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	42,509,529	2,606,152	646,077	15,322,363	61,084,121	10,975,930	30
31	Intensive Care Unit	11,710,479	486,345	371,366	4,266,981	16,835,171	3,025,028	31
32.01	NEONATAL INTENSIVE CARE	3,692,208	133,220	278,822	1,358,860	5,463,110	981,639	32.01
41	Subprovider - IRF	6,208,832	373,388	30,147	1,842,263	8,454,630	1,519,170	41
43	Nursery	2,108,088	33,677		646,361	2,788,126	500,984	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	32,072,226	1,481,522	2,758,966	12,638,702	48,951,416	8,795,835	50
52	Delivery Room & Labor Room	2,947,299	244,795	147,836	1,065,790	4,405,720	791,642	52
54	Radiology-Diagnostic	17,689,458	656,441	2,734,040	3,866,440	24,946,379	4,482,490	54
60	Laboratory	15,001,564	263,150	549,086	2,880,376	18,694,176	3,359,063	60
62	Whole Blood & Packed Red Blood Cells	2,452,276	22,486	34,368	166,369	2,675,499	480,747	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,657,689	54,360	171,792	1,615,837	6,499,678	1,167,895	65
66	Physical Therapy	11,892,913	592,077	182,340	2,920,922	15,588,252	2,800,975	66
70	Electroencephalography	1,247,532	40,391	52,325	345,149	1,685,397	302,841	70
71	Medical Supplies Charged to Patients	18,136,186				18,136,186	3,258,801	71
72	Impl. Dev. Charged to Patients	30,715,794				30,715,794	5,519,167	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	11,209,391	438,354	1,417,190	3,534,659	16,599,594	2,982,698	76
76.97	CARDIAC REHABILITATION	1,001,273	52,813	7,312	361,536	1,422,934	255,680	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	Clinic	4,021,392	129,870	37,182	1,250,797	5,439,241	977,350	90
91	Emergency	8,906,628	364,541	235,899	2,911,362	12,418,430	2,231,406	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
101	Home Health Agency	4,554,473		375	1,635,220	6,190,068	1,112,262	101
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	450,306,454	11,978,442	11,479,083	74,275,149	447,148,829	67,595,601	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen		18,145			18,145	3,260	190
191	Research	637,847		33	207,717	845,597	151,941	191
192	Physicians' Private Offices	742,656	788,986	1,143		1,532,785	275,418	192
194	ADVERTISING	769,540				769,540	138,275	194
194.01	FITNESS POINTE	2,464,343	686,123	18,965	674,903	3,844,334	690,769	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	459,455	22,261	4,199	145,307	631,222	113,421	194.02
194.03	RETAIL PHARMACY	10,199,204	26,662	37,926	336,861	10,600,653	1,904,778	194.03
194.04	HOSPICE		106,092			106,092	19,063	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	290,782	9,103	13,270	59,929	373,084	67,038	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	465,870,281	13,635,814	11,554,619	75,699,866	465,870,281	70,959,564	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	24,661,838						7
8	Laundry & Linen Service	56,356	1,781,529					8
9	Housekeeping	161,005		7,241,196				9
10	Dietary	414,893	1,551	7,250	6,303,656			10
11	Cafeteria	424,862		33,460		2,678,396		11
12	Maintenance of Personnel							12
13	Nursing Administration	89,679		1,992		39,180	5,721,388	13
14	Central Services & Supply					1,472		14
15	Pharmacy	173,205		18,293		71,636		15
16	Medical Records & Library	225,638		76,082		2,052		16
17	Social Service	38,362		16,730		17,184		17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	4,031		428		5,761		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,243,800	795,973	2,256,358	4,922,453	827,541	2,499,458	30
31	Intensive Care Unit	1,165,185	99,975	385,776	440,720	188,099	568,122	31
32.01	NEONATAL INTENSIVE CARE	319,168	595	117,219		58,854	177,762	32.01
41	Subprovider - IRF	894,563	115,282	352,226	831,743	112,245	339,017	41
43	Nursery	80,683	18,954	40,998		31,480	95,081	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,549,426	303,621	1,508,278		410,806	1,240,760	50
52	Delivery Room & Labor Room	586,479	77,324	273,007	108,740	49,739	150,212	52
54	Radiology-Diagnostic	1,572,701	76,788	209,603		132,189		54
60	Laboratory	630,455		136,628		151,099		60
62	Whole Blood & Packed Red Blood Cells	53,872				7,728		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	130,237		16,730		76,151		65
66	Physical Therapy	1,418,497	15,391	88,769		70,829		66
70	Electroencephalography	96,769	5,633	11,651		7,459		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	1,050,206	108,643	416,557		160,455		76
76.97	CARDIAC REHABILITATION	126,530	914	24,059		10,460		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	311,143	12,415	38,210		52,343	158,783	90
91	Emergency	873,367	148,193	924,889		162,961	492,193	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			11,950				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,691,112	1,781,252	6,967,143	6,303,656	2,647,723	5,721,388	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	43,472						190
191	Research					9,469		191
192	Physicians' Private Offices	1,890,249	277	271,265				192
194	ADVERTISING							194
194.01	FITNESS POINTE	1,643,811						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	53,333						194.02
194.03	RETAIL PHARMACY	63,877		2,788		15,004		194.03
194.04	HOSPICE	254,176						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	21,808				6,200		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,661,838	1,781,529	7,241,196	6,303,656	2,678,396	5,721,388	202

KPMG LLP Compu-Max 2552-10

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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	56,818						14
15	Pharmacy		23,880,861					15
16	Medical Records & Library			6,885,412				16
17	Social Service				1,444,941			17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)					494,408		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			537,948	984,620		91,128,202	30
31	Intensive Care Unit			94,313	144,024		22,946,413	31
32.01	NEONATAL INTENSIVE CARE			96,145	59,099		7,273,591	32.01
41	Subprovider - IRF			63,790	195,980		12,878,646	41
43	Nursery			22,696	50,171		3,629,173	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			1,093,752			65,853,894	50
52	Delivery Room & Labor Room			44,214			6,487,077	52
54	Radiology-Diagnostic			1,281,311			32,701,461	54
60	Laboratory			799,558			23,770,979	60
62	Whole Blood & Packed Red Blood Cells			41,185			3,259,031	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			133,525			8,024,216	65
66	Physical Therapy			219,093			20,201,806	66
70	Electroencephalography			63,373			2,173,123	70
71	Medical Supplies Charged to Patients	56,818		197,316			21,649,121	71
72	Impl. Dev. Charged to Patients			269,806			36,504,767	72
73	Drugs Charged to Patients		23,880,861	542,291		494,408	24,917,560	73
76	CARDIOLOGY			727,170			22,045,323	76
76.97	CARDIAC REHABILITATION			9,714			1,850,291	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			41,263			7,030,748	90
91	Emergency			578,270	11,047		17,840,756	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			28,679			7,342,959	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	56,818	23,880,861	6,885,412	1,444,941	494,408	439,509,137	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						64,877	190
191	Research						1,007,007	191
192	Physicians' Private Offices						3,969,994	192
194	ADVERTISING						907,815	194
194.01	FITNESS POINTE						6,178,914	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						797,976	194.02
194.03	RETAIL PHARMACY						12,587,100	194.03
194.04	HOSPICE						379,331	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS						468,130	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	56,818	23,880,861	6,885,412	1,444,941	494,408	465,870,281	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
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		91,128,202				30
31	Intensive Care Unit		22,946,413				31
32.01	NEONATAL INTENSIVE CARE		7,273,591				32.01
41	Subprovider - IRF		12,878,646				41
43	Nursery		3,629,173				43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		65,853,894				50
52	Delivery Room & Labor Room		6,487,077				52
54	Radiology-Diagnostic		32,701,461				54
60	Laboratory		23,770,979				60
62	Whole Blood & Packed Red Blood Cells		3,259,031				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		8,024,216				65
66	Physical Therapy		20,201,806				66
70	Electroencephalography		2,173,123				70
71	Medical Supplies Charged to Patients		21,649,121				71
72	Impl. Dev. Charged to Patients		36,504,767				72
73	Drugs Charged to Patients		24,917,560				73
76	CARDIOLOGY		22,045,323				76
76.97	CARDIAC REHABILITATION		1,850,291				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		7,030,748				90
91	Emergency		17,840,756				91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		7,342,959				101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)		439,509,137				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		64,877				190
191	Research		1,007,007				191
192	Physicians' Private Offices		3,969,994				192
194	ADVERTISING		907,815				194
194.01	FITNESS POINTE		6,178,914				194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		797,976				194.02
194.03	RETAIL PHARMACY		12,587,100				194.03
194.04	HOSPICE		379,331				194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS		468,130				194.06
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)		465,870,281				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		59,723	2,799	62,522	62,522		4
5	Administrative & General	377,069	1,146,903	433,759	1,957,731	5,661	1,963,392	5
6	Maintenance & Repairs							6
7	Operation of Plant	7,104	2,135,395	375,131	2,517,630	1,889	103,942	7
8	Laundry & Linen Service	22,736	23,523		46,259	34	7,271	8
9	Housekeeping	5,330	67,203	25,424	97,957	1,216	29,841	9
10	Dietary	32,128	173,175	76,068	281,371	902	24,782	10
11	Cafeteria		177,336		177,336	508	9,357	11
12	Maintenance of Personnel							12
13	Nursing Administration	5,489	37,432	467,285	510,206	876	23,562	13
14	Central Services & Supply					12	233	14
15	Pharmacy		72,295	442,810	515,105	1,440	99,541	15
16	Medical Records & Library		94,181	684	94,865	32	27,740	16
17	Social Service		16,012		16,012	266	5,785	17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)		1,682		1,682	99	2,041	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	213,425	2,606,152	646,077	3,465,654	12,598	303,610	30
31	Intensive Care Unit	15,133	486,345	371,366	872,844	3,529	83,704	31
32.01	NEONATAL INTENSIVE CARE	1,440	133,220	278,822	413,482	1,124	27,163	32.01
41	Subprovider - IRF	18,866	373,388	30,147	422,401	1,523	42,036	41
43	Nursery		33,677		33,677	534	13,863	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,943,625	1,481,522	2,758,966	6,184,113	10,451	243,386	50
52	Delivery Room & Labor Room		244,795	147,836	392,631	881	21,905	52
54	Radiology-Diagnostic	656,600	656,441	2,734,040	4,047,081	3,197	124,033	54
60	Laboratory	113,926	263,150	549,086	926,162	2,382	92,947	60
62	Whole Blood & Packed Red Blood Cells		22,486	34,368	56,854	138	13,303	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	76,551	54,360	171,792	302,703	1,336	32,316	65
66	Physical Therapy	203,334	592,077	182,340	977,751	2,415	77,505	66
70	Electroencephalography	218,111	40,391	52,325	310,827	285	8,380	70
71	Medical Supplies Charged to Patients						90,173	71
72	Impl. Dev. Charged to Patients						152,719	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	168,147	438,354	1,417,190	2,023,691	2,923	82,533	76
76.97	CARDIAC REHABILITATION		52,813	7,312	60,125	299	7,075	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	67,748	129,870	37,182	234,800	1,034	27,044	90
91	Emergency	704	364,541	235,899	601,144	2,407	61,744	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			375	375	1,352	30,777	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,147,466	11,978,442	11,479,083	27,604,991	61,343	1,870,311	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		18,145		18,145		90	190
191	Research	74		33	107	172	4,204	191
192	Physicians' Private Offices		788,986	1,143	790,129		7,621	192
194	ADVERTISING						3,826	194
194.01	FITNESS POINTE	388	686,123	18,965	705,476	558	19,114	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		22,261	4,199	26,460	120	3,138	194.02
194.03	RETAIL PHARMACY		26,662	37,926	64,588	279	52,706	194.03
194.04	HOSPICE		106,092		106,092		527	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	145	9,103	13,270	22,518	50	1,855	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,148,073	13,635,814	11,554,619	29,338,506	62,522	1,963,392	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	2,623,461						7
8	Laundry & Linen Service	5,995	59,559					8
9	Housekeeping	17,127		146,141				9
10	Dietary	44,135	52	146	351,388			10
11	Cafeteria	45,196		675		233,072		11
12	Maintenance of Personnel							12
13	Nursing Administration	9,540		40		3,409	547,633	13
14	Central Services & Supply					128		14
15	Pharmacy	18,425		369		6,234		15
16	Medical Records & Library	24,003		1,535		179		16
17	Social Service	4,081		338		1,495		17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	429		9		501		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	664,199	26,611	45,537	274,395	72,013	239,239	30
31	Intensive Care Unit	123,949	3,342	7,786	24,567	16,368	54,379	31
32.01	NEONATAL INTENSIVE CARE	33,952	20	2,366		5,121	17,015	32.01
41	Subprovider - IRF	95,161	3,854	7,109	46,364	9,767	32,450	41
43	Nursery	8,583	634	827		2,739	9,101	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	377,579	10,150	30,440		35,748	118,762	50
52	Delivery Room & Labor Room	62,388	2,585	5,510	6,062	4,328	14,378	52
54	Radiology-Diagnostic	167,300	2,567	4,230		11,503		54
60	Laboratory	67,066		2,757		13,149		60
62	Whole Blood & Packed Red Blood Cells	5,731				673		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,854		338		6,627		65
66	Physical Therapy	150,896	515	1,792		6,163		66
70	Electroencephalography	10,294	188	235		649		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	111,718	3,632	8,407		13,963		76
76.97	CARDIAC REHABILITATION	13,460	31	486		910		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	33,099	415	771		4,555	15,198	90
91	Emergency	92,906	4,954	18,666		14,181	47,111	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			241				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,201,066	59,550	140,610	351,388	230,403	547,633	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	4,624						190
191	Research					824		191
192	Physicians' Private Offices	201,080	9	5,475				192
194	ADVERTISING							194
194.01	FITNESS POINTE	174,864						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	5,673						194.02
194.03	RETAIL PHARMACY	6,795		56		1,306		194.03
194.04	HOSPICE	27,039						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	2,320				539		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,623,461	59,559	146,141	351,388	233,072	547,633	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	373						14
15	Pharmacy		641,114					15
16	Medical Records & Library			148,354				16
17	Social Service				27,977			17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)					4,761		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			11,579	19,064		5,134,499	30
31	Intensive Care Unit			2,030	2,789		1,195,287	31
32.01	NEONATAL INTENSIVE CARE			2,069	1,144		503,456	32.01
41	Subprovider - IRF			1,373	3,795		665,833	41
43	Nursery			489	971		71,418	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			23,542			7,034,171	50
52	Delivery Room & Labor Room			952			511,620	52
54	Radiology-Diagnostic			27,731			4,387,642	54
60	Laboratory			17,210			1,121,673	60
62	Whole Blood & Packed Red Blood Cells			886			77,585	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			2,874			360,048	65
66	Physical Therapy			4,716			1,221,753	66
70	Electroencephalography			1,364			332,222	70
71	Medical Supplies Charged to Patients	373		4,247			94,793	71
72	Impl. Dev. Charged to Patients			5,807			158,526	72
73	Drugs Charged to Patients		641,114	11,672			652,786	73
76	CARDIOLOGY			15,652			2,262,519	76
76.97	CARDIAC REHABILITATION			209			82,595	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			888			317,804	90
91	Emergency			12,447	214		855,774	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			617			33,362	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	373	641,114	148,354	27,977		27,075,366	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						22,859	190
191	Research						5,307	191
192	Physicians' Private Offices						1,004,314	192
194	ADVERTISING						3,826	194
194.01	FITNESS POINTE						900,012	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						35,391	194.02
194.03	RETAIL PHARMACY						125,730	194.03
194.04	HOSPICE						133,658	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS						27,282	194.06
200	Cross Foot Adjustments					4,761	4,761	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	373	641,114	148,354	27,977	4,761	29,338,506	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
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		5,134,499				30
31	Intensive Care Unit		1,195,287				31
32.01	NEONATAL INTENSIVE CARE		503,456				32.01
41	Subprovider - IRF		665,833				41
43	Nursery		71,418				43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		7,034,171				50
52	Delivery Room & Labor Room		511,620				52
54	Radiology-Diagnostic		4,387,642				54
60	Laboratory		1,121,673				60
62	Whole Blood & Packed Red Blood Cells		77,585				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		360,048				65
66	Physical Therapy		1,221,753				66
70	Electroencephalography		332,222				70
71	Medical Supplies Charged to Patients		94,793				71
72	Impl. Dev. Charged to Patients		158,526				72
73	Drugs Charged to Patients		652,786				73
76	CARDIOLOGY		2,262,519				76
76.97	CARDIAC REHABILITATION		82,595				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		317,804				90
91	Emergency		855,774				91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		33,362				101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)		27,075,366				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		22,859				190
191	Research		5,307				191
192	Physicians' Private Offices		1,004,314				192
194	ADVERTISING		3,826				194
194.01	FITNESS POINTE		900,012				194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		35,391				194.02
194.03	RETAIL PHARMACY		125,730				194.03
194.04	HOSPICE		133,658				194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS		27,282				194.06
200	Cross Foot Adjustments		4,761				200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)		29,338,506				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	907,792						1
2	Cap Rel Costs-Mvble Equip		9,482,389					2
4	Employee Benefits Department	3,976	2,297	169,185,470				4
5	Administrative & General	76,354	355,968	15,298,796	-70,959,564	394,910,717		5
6	Maintenance & Repairs							6
7	Operation of Plant	142,162	307,854	5,106,228		20,905,443	685,300	7
8	Laundry & Linen Service	1,566		92,870		1,462,401	1,566	8
9	Housekeeping	4,474	20,864	3,287,133		6,001,764	4,474	9
10	Dietary	11,529	62,426	2,438,170		4,984,349	11,529	10
11	Cafeteria	11,806		1,374,159		1,881,921	11,806	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,492	383,481	2,367,771		4,739,008	2,492	13
14	Central Services & Supply			32,413		46,916		14
15	Pharmacy	4,813	363,395	3,893,035		20,020,367	4,813	15
16	Medical Records & Library	6,270	561	87,437		5,579,150	6,270	16
17	Social Service	1,066		719,316		1,163,586	1,066	17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	112		268,852		410,438	112	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	173,502	530,208	34,244,669		61,084,121	173,502	30
31	Intensive Care Unit	32,378	304,764	9,536,496		16,835,171	32,378	31
32.01	NEONATAL INTENSIVE CARE	8,869	228,817	3,036,987		5,463,110	8,869	32.01
41	Subprovider - IRF	24,858	24,740	4,117,368		8,454,630	24,858	41
43	Nursery	2,242		1,444,586		2,788,126	2,242	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	98,631	2,264,170	28,246,886		48,951,416	98,631	50
52	Delivery Room & Labor Room	16,297	121,323	2,381,989		4,405,720	16,297	52
54	Radiology-Diagnostic	43,702	2,243,711	8,641,307		24,946,379	43,702	54
60	Laboratory	17,519	450,612	6,437,501		18,694,176	17,519	60
62	Whole Blood & Packed Red Blood Cells	1,497	28,204	371,826		2,675,499	1,497	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,619	140,982	3,611,318		6,499,678	3,619	65
66	Physical Therapy	39,417	149,639	6,528,120		15,588,252	39,417	66
70	Electroencephalography	2,689	42,941	771,391		1,685,397	2,689	70
71	Medical Supplies Charged to Patients					18,136,186		71
72	Impl. Dev. Charged to Patients					30,715,794		72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	29,183	1,163,028	7,899,792		16,599,594	29,183	76
76.97	CARDIAC REHABILITATION	3,516	6,001	808,015		1,422,934	3,516	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	8,646	30,514	2,795,471		5,439,241	8,646	90
91	Emergency	24,269	193,592	6,506,753		12,418,430	24,269	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		308	3,654,638		6,190,068		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	797,454	9,420,400	166,001,293	-70,959,564	376,189,265	574,962	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,208				18,145	1,208	190
191	Research		27	464,238		845,597		191
192	Physicians' Private Offices	52,526	938			1,532,785	52,526	192
194	ADVERTISING					769,540		194
194.01	FITNESS POINTE	45,678	15,564	1,508,376		3,844,334	45,678	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	1,482	3,446	324,755		631,222	1,482	194.02
194.03	RETAIL PHARMACY	1,775	31,124	752,869		10,600,653	1,775	194.03
194.04	HOSPICE	7,063				106,092	7,063	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	606	10,890	133,939		373,084	606	194.06
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	13,635,814	11,554,619	75,699,866		70,959,564	24,661,838	202
203	Unit Cost Multiplier (Wkst. B, Part I)	15.020857	1.218535	0.447437		0.179685	35.986923	203
204	Cost to be allocated (Per Wkst. B, Part II)			62,522		1,963,392	2,623,461	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000370		0.004972	3.828193	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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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	212,519						8
9	Housekeeping		727,150					9
10	Dietary	185	728	342,602				10
11	Cafeteria		3,360		189,226			11
12	Maintenance of Personnel							12
13	Nursing Administration		200		2,768	2,783,641		13
14	Central Services & Supply				104		100	14
15	Pharmacy		1,837		5,061			15
16	Medical Records & Library		7,640		145			16
17	Social Service		1,680		1,214			17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)		43		407			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	94,952	226,580	267,534	58,465	1,216,067		30
31	Intensive Care Unit	11,926	38,739	23,953	13,289	276,410		31
32.01	NEONATAL INTENSIVE CARE	71	11,771		4,158	86,487		32.01
41	Subprovider - IRF	13,752	35,370	45,205	7,930	164,943		41
43	Nursery	2,261	4,117		2,224	46,260		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	36,219	151,459		29,023	603,670		50
52	Delivery Room & Labor Room	9,224	27,415	5,910	3,514	73,083		52
54	Radiology-Diagnostic	9,160			9,339			54
60	Laboratory		13,720		10,675			60
62	Whole Blood & Packed Red Blood Cells				546			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,680		5,380			65
66	Physical Therapy	1,836	8,914		5,004			66
70	Electroencephalography	672	1,170		527			70
71	Medical Supplies Charged to Patients						100	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	12,960	41,830		11,336			76
76.97	CARDIAC REHABILITATION	109	2,416		739			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,481	3,837		3,698	77,253		90
91	Emergency	17,678	92,876		11,513	239,468		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)	212,486	699,630	342,602	187,059	2,783,641	100	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research				669			191
192	Physicians' Private Offices	33	27,240					192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY		280		1,060			194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS				438			194.06
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,781,529	7,241,196	6,303,656	2,678,396	5,721,388	56,818	202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.382916	9.958325	18.399356	14.154482	2.055361	568.180000	203
204	Cost to be allocated (Per Wkst. B, Part II)	59,559	146,141	351,388	233,072	547,633	373	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.280253	0.200978	1.025645	1.231712	0.196733	3.730000	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	PARAMED EDUCATION ASSIGNED TIME		
	COSTED REQ					
	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		1,703,615,948			16
17	Social Service			108,433		17
19	Nonphysician Anesthetists					19
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		133,089,633	73,889		30
31	Intensive Care Unit		23,333,297	10,808		31
32.01	NEONATAL INTENSIVE CARE		23,786,544	4,435		32.01
41	Subprovider - IRF		15,781,913	14,707		41
43	Nursery		5,614,993	3,765		43
ANCILLARY SERVICE COST CENTERS						
50	Operating Room		270,596,623			50
52	Delivery Room & Labor Room		10,938,686			52
54	Radiology-Diagnostic		317,148,275			54
60	Laboratory		197,812,447			60
62	Whole Blood & Packed Red Blood Cells		10,189,149			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		33,034,363			65
66	Physical Therapy		54,204,135			66
70	Electroencephalography		15,678,746			70
71	Medical Supplies Charged to Patients		48,816,329			71
72	Impl. Dev. Charged to Patients		66,750,624			72
73	Drugs Charged to Patients	10,000	134,163,989		100	73
76	CARDIOLOGY		179,903,602			76
76.97	CARDIAC REHABILITATION		2,403,313			76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	Clinic		10,208,578			90
91	Emergency		143,065,388	829		91
92	Observation Beds (Non-Distinct Part)					92
OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		7,095,321			101
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	10,000	1,703,615,948	108,433	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)	23,880,861	6,885,412	1,444,941	494,408	202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,388.086100	0.004042	13.325657	4,944.080000	203
204	Cost to be allocated (Per Wkst. B, Part II)	641,114	148,354	27,977	4,761	204
205	Unit Cost Multiplier (Wkst. B, Part II)	64.111400	0.000087	0.258012	47.610000	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)					206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)					207

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		CODE	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	91,128,202		91,128,202	9,741	91,137,943	30
31	Intensive Care Unit	22,946,413		22,946,413		22,946,413	31
32.01	NEONATAL INTENSIVE CARE	7,273,591		7,273,591	7,917	7,281,508	32.01
41	Subprovider - IRF	12,878,646		12,878,646		12,878,646	41
43	Nursery	3,629,173		3,629,173		3,629,173	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	65,853,894		65,853,894	3,411	65,857,305	50
52	Delivery Room & Labor Room	6,487,077		6,487,077		6,487,077	52
54	Radiology-Diagnostic	32,701,461		32,701,461	18,729	32,720,190	54
60	Laboratory	23,770,979		23,770,979	9,907	23,780,886	60
62	Whole Blood & Packed Red Blood Cells	3,259,031		3,259,031		3,259,031	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	8,024,216		8,024,216	1,516	8,025,732	65
66	Physical Therapy	20,201,806		20,201,806		20,201,806	66
70	Electroencephalography	2,173,123		2,173,123	2,769	2,175,892	70
71	Medical Supplies Charged to Patients	21,649,121		21,649,121		21,649,121	71
72	Impl. Dev. Charged to Patients	36,504,767		36,504,767		36,504,767	72
73	Drugs Charged to Patients	24,917,560		24,917,560		24,917,560	73
76	CARDIOLOGY	22,045,323		22,045,323	33,435	22,078,758	76
76.97	CARDIAC REHABILITATION	1,850,291		1,850,291		1,850,291	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	7,030,748		7,030,748	55,018	7,085,766	90
91	Emergency	17,840,756		17,840,756	13,768	17,854,524	91
92	Observation Beds (Non-Distinct Part)	14,962,610		14,962,610		14,962,610	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	7,342,959		7,342,959		7,342,959	101
200	Subtotal (sum of lines 30 thru 199)	454,471,747		454,471,747	156,211	454,627,958	200
201	Less Observation Beds	14,962,610		14,962,610		14,962,610	201
202	Total (line 200 minus line 201)	439,509,137		439,509,137		439,665,348	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				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	100,394,988		100,394,988				30
31	Intensive Care Unit	23,333,297		23,333,297				31
32.01	NEONATAL INTENSIVE CARE	23,786,544		23,786,544				32.01
41	Subprovider - IRF	15,781,913		15,781,913				41
43	Nursery	5,614,993		5,614,993				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	100,361,737	170,234,886	270,596,623	0.243366	0.243366	0.243378	50
52	Delivery Room & Labor Room	7,158,822	3,779,864	10,938,686	0.593040	0.593040	0.593040	52
54	Radiology-Diagnostic	68,265,742	248,882,533	317,148,275	0.103111	0.103111	0.103170	54
60	Laboratory	67,746,557	130,065,890	197,812,447	0.120169	0.120169	0.120219	60
62	Whole Blood & Packed Red Blood Cells	6,593,714	3,595,435	10,189,149	0.319853	0.319853	0.319853	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	29,886,280	3,148,083	33,034,363	0.242905	0.242905	0.242951	65
66	Physical Therapy	28,235,678	25,968,457	54,204,135	0.372699	0.372699	0.372699	66
70	Electroencephalography	1,587,673	14,091,073	15,678,746	0.138603	0.138603	0.138780	70
71	Medical Supplies Charged to Patients	22,561,130	26,255,199	48,816,329	0.443481	0.443481	0.443481	71
72	Impl. Dev. Charged to Patients	46,587,648	20,162,976	66,750,624	0.546883	0.546883	0.546883	72
73	Drugs Charged to Patients	87,250,929	46,913,060	134,163,989	0.185725	0.185725	0.185725	73
76	CARDIOLOGY	70,117,538	109,786,064	179,903,602	0.122540	0.122540	0.122725	76
76.97	CARDIAC REHABILITATION	410,734	1,992,579	2,403,313	0.769892	0.769892	0.769892	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	429,759	9,778,819	10,208,578	0.688710	0.688710	0.694099	90
91	Emergency	44,772,115	98,293,273	143,065,388	0.124704	0.124704	0.124800	91
92	Observation Beds (Non-Distinct Part)	5,578,913	27,115,732	32,694,645	0.457647	0.457647	0.457647	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		7,095,321	7,095,321				101
200	Subtotal (sum of lines 30 thru 199)	756,456,704	947,159,244	1,703,615,948				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	756,456,704	947,159,244	1,703,615,948				202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	91,128,202		91,128,202	9,741	91,137,943	30
31	Intensive Care Unit	22,946,413		22,946,413		22,946,413	31
32.01	NEONATAL INTENSIVE CARE	7,273,591		7,273,591	7,917	7,281,508	32.01
41	Subprovider - IRF	12,878,646		12,878,646		12,878,646	41
43	Nursery	3,629,173		3,629,173		3,629,173	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	65,853,894		65,853,894	3,411	65,857,305	50
52	Delivery Room & Labor Room	6,487,077		6,487,077		6,487,077	52
54	Radiology-Diagnostic	32,701,461		32,701,461	18,729	32,720,190	54
60	Laboratory	23,770,979		23,770,979	9,907	23,780,886	60
62	Whole Blood & Packed Red Blood Cells	3,259,031		3,259,031		3,259,031	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	8,024,216		8,024,216	1,516	8,025,732	65
66	Physical Therapy	20,201,806		20,201,806		20,201,806	66
70	Electroencephalography	2,173,123		2,173,123	2,769	2,175,892	70
71	Medical Supplies Charged to Patients	21,649,121		21,649,121		21,649,121	71
72	Impl. Dev. Charged to Patients	36,504,767		36,504,767		36,504,767	72
73	Drugs Charged to Patients	24,917,560		24,917,560		24,917,560	73
76	CARDIOLOGY	22,045,323		22,045,323	33,435	22,078,758	76
76.97	CARDIAC REHABILITATION	1,850,291		1,850,291		1,850,291	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	7,030,748		7,030,748	55,018	7,085,766	90
91	Emergency	17,840,756		17,840,756	13,768	17,854,524	91
92	Observation Beds (Non-Distinct Part)	14,962,610		14,962,610		14,962,610	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	7,342,959		7,342,959		7,342,959	101
200	Subtotal (sum of lines 30 thru 199)	454,471,747		454,471,747	156,211	454,627,958	200
201	Less Observation Beds	14,962,610		14,962,610		14,962,610	201
202	Total (line 200 minus line 201)	439,509,137		439,509,137	156,211	439,665,348	202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

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				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	100,394,988		100,394,988				30
31	Intensive Care Unit	23,333,297		23,333,297				31
32.01	NEONATAL INTENSIVE CARE	23,786,544		23,786,544				32.01
41	Subprovider - IRF	15,781,913		15,781,913				41
43	Nursery	5,614,993		5,614,993				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	100,361,737	170,234,886	270,596,623	0.243366	0.243366	0.243378	50
52	Delivery Room & Labor Room	7,158,822	3,779,864	10,938,686	0.593040	0.593040	0.593040	52
54	Radiology-Diagnostic	68,265,742	248,882,533	317,148,275	0.103111	0.103111	0.103170	54
60	Laboratory	67,746,557	130,065,890	197,812,447	0.120169	0.120169	0.120219	60
62	Whole Blood & Packed Red Blood Cells	6,593,714	3,595,435	10,189,149	0.319853	0.319853	0.319853	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	29,886,280	3,148,083	33,034,363	0.242905	0.242905	0.242951	65
66	Physical Therapy	28,235,678	25,968,457	54,204,135	0.372699	0.372699	0.372699	66
70	Electroencephalography	1,587,673	14,091,073	15,678,746	0.138603	0.138603	0.138780	70
71	Medical Supplies Charged to Patients	22,561,130	26,255,199	48,816,329	0.443481	0.443481	0.443481	71
72	Impl. Dev. Charged to Patients	46,587,648	20,162,976	66,750,624	0.546883	0.546883	0.546883	72
73	Drugs Charged to Patients	87,250,929	46,913,060	134,163,989	0.185725	0.185725	0.185725	73
76	CARDIOLOGY	70,117,538	109,786,064	179,903,602	0.122540	0.122540	0.122725	76
76.97	CARDIAC REHABILITATION	410,734	1,992,579	2,403,313	0.769892	0.769892	0.769892	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	429,759	9,778,819	10,208,578	0.688710	0.688710	0.694099	90
91	Emergency	44,772,115	98,293,273	143,065,388	0.124704	0.124704	0.124800	91
92	Observation Beds (Non-Distinct Part)	5,578,913	27,115,732	32,694,645	0.457647	0.457647	0.457647	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		7,095,321	7,095,321				101
200	Subtotal (sum of lines 30 thru 199)	756,456,704	947,159,244	1,703,615,948				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	756,456,704	947,159,244	1,703,615,948				202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

COST CENTER DESCRIPTIONS		Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
ANCILLARY SERVICE COST CENTERS						
50	Operating Room	65,853,894	7,034,171	58,819,723		50
52	Delivery Room & Labor Room	6,487,077	511,620	5,975,457		52
54	Radiology-Diagnostic	32,701,461	4,387,642	28,313,819		54
60	Laboratory	23,770,979	1,121,673	22,649,306		60
62	Whole Blood & Packed Red Blood Cells	3,259,031	77,585	3,181,446		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	8,024,216	360,048	7,664,168		65
66	Physical Therapy	20,201,806	1,221,753	18,980,053		66
70	Electroencephalography	2,173,123	332,222	1,840,901		70
71	Medical Supplies Charged to Patients	21,649,121	94,793	21,554,328		71
72	Impl. Dev. Charged to Patients	36,504,767	158,526	36,346,241		72
73	Drugs Charged to Patients	24,917,560	652,786	24,264,774		73
76	CARDIOLOGY	22,045,323	2,262,519	19,782,804		76
76.97	CARDIAC REHABILITATION	1,850,291	82,595	1,767,696		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	Clinic	7,030,748	317,804	6,712,944		90
91	Emergency	17,840,756	855,774	16,984,982		91
92	Observation Beds (Non-Distinct Part)	14,962,610	842,964	14,119,646		92
OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	7,342,959	33,362	7,309,597		101
200	Subtotal	316,615,722	20,347,837	296,267,885		200
201	Less Observation Beds	14,962,610	842,964	14,119,646		201
202	Total	301,653,112	19,504,873	282,148,239		202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		65,853,894	270,596,623	0.243366	50
52	Delivery Room & Labor Room		6,487,077	10,938,686	0.593040	52
54	Radiology-Diagnostic		32,701,461	317,148,275	0.103111	54
60	Laboratory		23,770,979	197,812,447	0.120169	60
62	Whole Blood & Packed Red Blood Cells		3,259,031	10,189,149	0.319853	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		8,024,216	33,034,363	0.242905	65
66	Physical Therapy		20,201,806	54,204,135	0.372699	66
70	Electroencephalography		2,173,123	15,678,746	0.138603	70
71	Medical Supplies Charged to Patients		21,649,121	48,816,329	0.443481	71
72	Impl. Dev. Charged to Patients		36,504,767	66,750,624	0.546883	72
73	Drugs Charged to Patients		24,917,560	134,163,989	0.185725	73
76	CARDIOLOGY		22,045,323	179,903,602	0.122540	76
76.97	CARDIAC REHABILITATION		1,850,291	2,403,313	0.769892	76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic		7,030,748	10,208,578	0.688710	90
91	Emergency		17,840,756	143,065,388	0.124704	91
92	Observation Beds (Non-Distinct Part)		14,962,610	32,694,645	0.457647	92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		7,342,959	7,095,321	1.034902	101
200	Subtotal		316,615,722	1,534,704,213		200
201	Less Observation Beds		14,962,610	32,694,645		201
202	Total		301,653,112	1,502,009,568		202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)	5,134,499		5,134,499	87,431	58.73	34,879	2,048,444	30
31	Intensive Care Unit	1,195,287		1,195,287	10,808	110.59	4,707	520,547	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	503,456		503,456	4,435	113.52			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	665,833		665,833	14,707	45.27	11,874	537,536	41
42	Subprovider I								42
43	Nursery	71,418		71,418	3,765	18.97			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,570,493		7,570,493	121,146		51,460	3,106,527	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	7,034,171	270,596,623	0.025995	42,092,495	1,094,194	50
52	Delivery Room & Labor Room	511,620	10,938,686	0.046772	16,412	768	52
54	Radiology-Diagnostic	4,387,642	317,148,275	0.013835	30,772,572	425,739	54
60	Laboratory	1,121,673	197,812,447	0.005670	30,370,305	172,200	60
62	Whole Blood & Packed Red Blood	77,585	10,189,149	0.007614	2,617,786	19,932	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	360,048	33,034,363	0.010899	14,633,608	159,492	65
66	Physical Therapy	1,221,753	54,204,135	0.022540	7,092,497	159,865	66
70	Electroencephalography	332,222	15,678,746	0.021189	780,674	16,542	70
71	Medical Supplies Charged to Pat	94,793	48,816,329	0.001942	10,656,776	20,695	71
72	Impl. Dev. Charged to Patients	158,526	66,750,624	0.002375	24,898,505	59,134	72
73	Drugs Charged to Patients	652,786	134,163,989	0.004866	37,259,358	181,304	73
76	CARDIOLOGY	2,262,519	179,903,602	0.012576	34,685,397	436,204	76
76.97	CARDIAC REHABILITATION	82,595	2,403,313	0.034367	171,960	5,910	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	317,804	10,208,578	0.031131	99,083	3,085	90
91	Emergency	855,774	143,065,388	0.005982	21,509,855	128,672	91
92	Observation Beds (Non-Distinct	842,964	32,694,645	0.025783			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	20,314,475	1,527,608,892		257,657,283	2,883,736	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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

		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	87,431		34,879		30
31	Intensive Care Unit	10,808		4,707		31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE	4,435				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	14,707		11,874		41
42	Subprovider I					42
43	Nursery	3,765				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	121,146		51,460		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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	2A	2	3A	3	4	5	6
	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					494,408		494,408	494,408
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)					494,408		494,408	494,408

(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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	270,596,623			42,092,495		45,838,675		50
52	Delivery Room & Labor Room	10,938,686			16,412				52
54	Radiology-Diagnostic	317,148,275			30,772,572		78,992,792		54
60	Laboratory	197,812,447			30,370,305		15,249,419		60
62	Whole Blood & Packed Red Blood	10,189,149			2,617,786		883,415		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,034,363			14,633,608		1,150,497		65
66	Physical Therapy	54,204,135			7,092,497		500,197		66
70	Electroencephalography	15,678,746			780,674		4,169,270		70
71	Medical Supplies Charged to Pat	48,816,329			10,656,776		10,141,284		71
72	Impl. Dev. Charged to Patients	66,750,624			24,898,505		7,599,988		72
73	Drugs Charged to Patients	134,163,989	0.003685	0.003685	37,259,358	137,301	19,935,761	73,463	73
76	CARDIOLOGY	179,903,602			34,685,397		50,229,305		76
76.97	CARDIAC REHABILITATION	2,403,313			171,960		1,030,845		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	10,208,578			99,083		4,875,037		90
91	Emergency	143,065,388			21,509,855		16,727,711		91
92	Observation Beds (Non-Distinct	32,694,645					6,856,503		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,527,608,892			257,657,283	137,301	264,180,699	73,463	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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.)
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.243366	45,838,675			11,155,575		50
52	Delivery Room & Labor Room	0.593040						52
54	Radiology-Diagnostic	0.103111	78,992,792			8,145,026		54
60	Laboratory	0.120169	15,249,419			1,832,507		60
62	Whole Blood & Packed Red Blood	0.319853	883,415			282,563		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.242905	1,150,497			279,461		65
66	Physical Therapy	0.372699	500,197			186,423		66
70	Electroencephalography	0.138603	4,169,270			577,873		70
71	Medical Supplies Charged to Pat	0.443481	10,141,284			4,497,467		71
72	Impl. Dev. Charged to Patients	0.546883	7,599,988			4,156,304		72
73	Drugs Charged to Patients	0.185725	19,935,761		119,768	3,702,569	22,244	73
76	CARDIOLOGY	0.122540	50,229,305			6,155,099		76
76.97	CARDIAC REHABILITATION	0.769892	1,030,845			793,639		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	0.688710	4,875,037			3,357,487		90
91	Emergency	0.124704	16,727,711			2,086,012		91
92	Observation Beds (Non-Distinct)	0.457647	6,856,503			3,137,858		92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)		264,180,699		119,768	50,345,863	22,244	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)		264,180,699		119,768	50,345,863	22,244	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	7,034,171	270,596,623	0.025995	251,853	6,547	50
52	Delivery Room & Labor Room	511,620	10,938,686	0.046772			52
54	Radiology-Diagnostic	4,387,642	317,148,275	0.013835	1,352,437	18,711	54
60	Laboratory	1,121,673	197,812,447	0.005670	2,326,984	13,194	60
62	Whole Blood & Packed Red Blood	77,585	10,189,149	0.007614	171,818	1,308	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	360,048	33,034,363	0.010899	1,413,486	15,406	65
66	Physical Therapy	1,221,753	54,204,135	0.022540	11,747,079	264,779	66
70	Electroencephalography	332,222	15,678,746	0.021189	75,196	1,593	70
71	Medical Supplies Charged to Pat	94,793	48,816,329	0.001942	1,132,142	2,199	71
72	Impl. Dev. Charged to Patients	158,526	66,750,624	0.002375	35,442	84	72
73	Drugs Charged to Patients	652,786	134,163,989	0.004866	5,272,832	25,658	73
76	CARDIOLOGY	2,262,519	179,903,602	0.012576	708,263	8,907	76
76.97	CARDIAC REHABILITATION	82,595	2,403,313	0.034367			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	317,804	10,208,578	0.031131	15,901	495	90
91	Emergency	855,774	143,065,388	0.005982	5,790	35	91
92	Observation Beds (Non-Distinct		32,694,645				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	19,471,511	1,527,608,892		24,509,223	358,916	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	2A	2	3A	3	4	5	6
	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					494,408		494,408	494,408
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)					494,408		494,408	494,408

(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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	270,596,623			251,853				50
52	Delivery Room & Labor Room	10,938,686							52
54	Radiology-Diagnostic	317,148,275			1,352,437				54
60	Laboratory	197,812,447			2,326,984				60
62	Whole Blood & Packed Red Blood	10,189,149			171,818				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,034,363			1,413,486				65
66	Physical Therapy	54,204,135			11,747,079				66
70	Electroencephalography	15,678,746			75,196				70
71	Medical Supplies Charged to Pat	48,816,329			1,132,142				71
72	Impl. Dev. Charged to Patients	66,750,624			35,442				72
73	Drugs Charged to Patients	134,163,989	0.003685	0.003685	5,272,832	19,430			73
76	CARDIOLOGY	179,903,602			708,263				76
76.97	CARDIAC REHABILITATION	2,403,313							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	10,208,578			15,901				90
91	Emergency	143,065,388			5,790				91
92	Observation Beds (Non-Distinct	32,694,645					2,994		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,527,608,892			24,509,223	19,430	2,994		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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	0.243366							50
52	Delivery Room & Labor Room	0.593040							52
54	Radiology-Diagnostic	0.103111							54
60	Laboratory	0.120169							60
62	Whole Blood & Packed Red Blood	0.319853							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.242905							65
66	Physical Therapy	0.372699							66
70	Electroencephalography	0.138603							70
71	Medical Supplies Charged to Pat	0.443481							71
72	Impl. Dev. Charged to Patients	0.546883							72
73	Drugs Charged to Patients	0.185725			6,077			1,129	73
76	CARDIOLOGY	0.122540							76
76.97	CARDIAC REHABILITATION	0.769892							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.688710							90
91	Emergency	0.124704							91
92	Observation Beds (Non-Distinct)	0.457647	2,994			1,370			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		2,994		6,077	1,370		1,129	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		2,994		6,077	1,370		1,129	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)	5,134,499		5,134,499	87,431	58.73	812	47,689	30
31	Intensive Care Unit	1,195,287		1,195,287	10,808	110.59	109	12,054	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	503,456		503,456	4,435	113.52	101	11,466	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	665,833		665,833	14,707	45.27	42	1,901	41
42	Subprovider I								42
43	Nursery	71,418		71,418	3,765	18.97	154	2,921	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,570,493		7,570,493	121,146		1,218	76,031	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	7,034,171	270,596,623	0.025995	1,057,595	27,492	50
52	Delivery Room & Labor Room	511,620	10,938,686	0.046772	120,772	5,649	52
54	Radiology-Diagnostic	4,387,642	317,148,275	0.013835	547,295	7,572	54
60	Laboratory	1,121,673	197,812,447	0.005670	727,505	4,125	60
62	Whole Blood & Packed Red Blood	77,585	10,189,149	0.007614	54,636	416	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	360,048	33,034,363	0.010899	178,946	1,950	65
66	Physical Therapy	1,221,753	54,204,135	0.022540	105,736	2,383	66
70	Electroencephalography	332,222	15,678,746	0.021189	20,201	428	70
71	Medical Supplies Charged to Pat	94,793	48,816,329	0.001942	252,775	491	71
72	Impl. Dev. Charged to Patients	158,526	66,750,624	0.002375	136,808	325	72
73	Drugs Charged to Patients	652,786	134,163,989	0.004866	1,199,341	5,836	73
76	CARDIOLOGY	2,262,519	179,903,602	0.012576	228,123	2,869	76
76.97	CARDIAC REHABILITATION	82,595	2,403,313	0.034367	4,592	158	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	317,804	10,208,578	0.031131	60,703	1,890	90
91	Emergency	855,774	143,065,388	0.005982	234,426	1,402	91
92	Observation Beds (Non-Distinct	842,964	32,694,645	0.025783			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	20,314,475	1,527,608,892		4,929,454	62,986	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	Nursing School Post-Stepdown Adjustments 1A	Nursing School 1	Allied Health Post-Stepdown Adjustments 2A	Allied Health Cost 2	All Other Medical Education Cost 3	Swing-Bed Adjustment Amount (see instructions) 4	Total Costs (sum of cols. 1 through 3 minus col 4.) 5	
	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check [] Title V [XX] PPS
Applicable [] Title XVIII, Part A [] TEFRA
Boxes: [XX] 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)
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	87,431		812	30
31	Intensive Care Unit	10,808		109	31
32	Coronary Care Unit				32
32.01	NEONATAL INTENSIVE CARE	4,435		101	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	14,707		42	41
42	Subprovider I				42
43	Nursery	3,765		154	43
44	Skilled Nursing Facility				44
45	Nursing Facility				45
200	Total (lines 30-199)	121,146		1,218	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	2A	2	3A	3	4	5	6
	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					494,408		494,408	494,408
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)					494,408		494,408	494,408

(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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	270,596,623			1,057,595				50
52	Delivery Room & Labor Room	10,938,686			120,772				52
54	Radiology-Diagnostic	317,148,275			547,295				54
60	Laboratory	197,812,447			727,505				60
62	Whole Blood & Packed Red Blood	10,189,149			54,636				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,034,363			178,946				65
66	Physical Therapy	54,204,135			105,736				66
70	Electroencephalography	15,678,746			20,201				70
71	Medical Supplies Charged to Pat	48,816,329			252,775				71
72	Impl. Dev. Charged to Patients	66,750,624			136,808				72
73	Drugs Charged to Patients	134,163,989	0.003685	0.003685	1,199,341	4,420			73
76	CARDIOLOGY	179,903,602			228,123				76
76.97	CARDIAC REHABILITATION	2,403,313			4,592				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	10,208,578			60,703				90
91	Emergency	143,065,388			234,426				91
92	Observation Beds (Non-Distinct	32,694,645							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,527,608,892			4,929,454	4,420			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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	0.243366							50
52	Delivery Room & Labor Room	0.593040							52
54	Radiology-Diagnostic	0.103111							54
60	Laboratory	0.120169							60
62	Whole Blood & Packed Red Blood	0.319853							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.242905							65
66	Physical Therapy	0.372699							66
70	Electroencephalography	0.138603							70
71	Medical Supplies Charged to Pat	0.443481							71
72	Impl. Dev. Charged to Patients	0.546883							72
73	Drugs Charged to Patients	0.185725							73
76	CARDIOLOGY	0.122540							76
76.97	CARDIAC REHABILITATION	0.769892							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.688710							90
91	Emergency	0.124704							91
92	Observation Beds (Non-Distinct	0.457647							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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	7,034,171	270,596,623	0.025995	1,719	45	50
52	Delivery Room & Labor Room	511,620	10,938,686	0.046772			52
54	Radiology-Diagnostic	4,387,642	317,148,275	0.013835	3,574	49	54
60	Laboratory	1,121,673	197,812,447	0.005670	4,794	27	60
62	Whole Blood & Packed Red Blood	77,585	10,189,149	0.007614			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	360,048	33,034,363	0.010899	15,210	166	65
66	Physical Therapy	1,221,753	54,204,135	0.022540	44,102	994	66
70	Electroencephalography	332,222	15,678,746	0.021189	882	19	70
71	Medical Supplies Charged to Pat	94,793	48,816,329	0.001942	9,912	19	71
72	Impl. Dev. Charged to Patients	158,526	66,750,624	0.002375			72
73	Drugs Charged to Patients	652,786	134,163,989	0.004866	29,315	143	73
76	CARDIOLOGY	2,262,519	179,903,602	0.012576	1,173	15	76
76.97	CARDIAC REHABILITATION	82,595	2,403,313	0.034367			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	317,804	10,208,578	0.031131			90
91	Emergency	855,774	143,065,388	0.005982			91
92	Observation Beds (Non-Distinct		32,694,645				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	19,471,511	1,527,608,892		110,681	1,477	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	2A	2	3A	3	4	5	6
	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					494,408		494,408	494,408
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)					494,408		494,408	494,408

(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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	270,596,623			1,719				50
52	Delivery Room & Labor Room	10,938,686							52
54	Radiology-Diagnostic	317,148,275			3,574				54
60	Laboratory	197,812,447			4,794				60
62	Whole Blood & Packed Red Blood	10,189,149							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,034,363			15,210				65
66	Physical Therapy	54,204,135			44,102				66
70	Electroencephalography	15,678,746			882				70
71	Medical Supplies Charged to Pat	48,816,329			9,912				71
72	Impl. Dev. Charged to Patients	66,750,624							72
73	Drugs Charged to Patients	134,163,989	0.003685	0.003685	29,315	108			73
76	CARDIOLOGY	179,903,602			1,173				76
76.97	CARDIAC REHABILITATION	2,403,313							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	10,208,578							90
91	Emergency	143,065,388							91
92	Observation Beds (Non-Distinct)	32,694,645							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,527,608,892			110,681	108			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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	0.243366							50
52	Delivery Room & Labor Room	0.593040							52
54	Radiology-Diagnostic	0.103111							54
60	Laboratory	0.120169							60
62	Whole Blood & Packed Red Blood	0.319853							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.242905							65
66	Physical Therapy	0.372699							66
70	Electroencephalography	0.138603							70
71	Medical Supplies Charged to Pat	0.443481							71
72	Impl. Dev. Charged to Patients	0.546883							72
73	Drugs Charged to Patients	0.185725							73
76	CARDIOLOGY	0.122540							76
76.97	CARDIAC REHABILITATION	0.769892							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.688710							90
91	Emergency	0.124704							91
92	Observation Beds (Non-Distinct)	0.457647							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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

**WORKSHEET D-1
PART I**

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [XX] 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)	87,431	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	87,431	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)	47,859	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)	34,879	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)	91,137,943	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)	91,137,943	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)	1.509510	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)	841.24	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)	91,137,943	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART II

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [XX] PPS
 Applicable [XX] 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)						1,042.40	38
39	Program general inpatient routine service cost (line 9 x line 38)						36,357,870	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)						36,357,870	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	22,946,413	10,808	2,123.10	4,707	9,993,432	43	
44	Coronary Care Unit						44	
44.01	NEONATAL INTENSIVE CARE	7,281,508	4,435	1,641.83			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)						56,629,280	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						102,980,582	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						2,568,991	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						3,021,037	51
52	Total Program excludable cost (sum of lines 50 and 51)						5,590,028	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						97,390,554	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

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)					14,354	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,042.40	88
89	Observation bed cost (line 87 x line 88) (see instructions)					14,962,610	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	5,134,499	91,137,943	0.056338	14,962,610	842,964	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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 [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
Boxes: [] Title XIX - I/P [XX] IRF [] NF [] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,707	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,707	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)	13,183	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)	11,874	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)	12,878,646	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)	12,878,646	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)	2.364070	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)	364.20	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	59.92	34
35	Average per diem private room cost differential (line 34 x line 31)	141.66	35
36	Private room cost differential adjustment (line 3 x line 35)	215,890	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,662,756	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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

38	Adjusted general inpatient routine service cost per diem (see instructions)	875.68	38
39	Program general inpatient routine service cost (line 9 x line 38)	10,397,824	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)	10,397,824	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	6,866,945	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	17,264,769	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	537,536	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	378,346	51
52	Total Program excludable cost (sum of lines 50 and 51)	915,882	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	16,348,887	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

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [XX] 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)	87,431	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	87,431	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)	47,859	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)	812	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)	3,765	15
16	Nursery days (title V or XIX only)	154	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)	91,137,943	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)	91,137,943	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)	1.509510	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)	841.24	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)	91,137,943	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)					1,042.40	38	
39	Program general inpatient routine service cost (line 9 x line 38)					846,429	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)					846,429	41	
42	Nursery (Titles V and XIX only)	3,629,173	3,765	963.92	154	148,444	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	22,946,413	10,808	2,123.10	109	231,418	43	
44	Coronary Care Unit						44	
44.01	NEONATAL INTENSIVE CARE	7,281,508	4,435	1,641.83	101	165,825	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)					1,088,691	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,480,807	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					74,130	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					67,406	51
52	Total Program excludable cost (sum of lines 50 and 51)					141,536	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					2,339,271	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

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)					14,354	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)	14,707	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,707	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)	13,183	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)	42	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)	12,878,646	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)	12,878,646	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)	2.364070	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)	364.20	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	59.92	34
35	Average per diem private room cost differential (line 34 x line 31)	141.66	35
36	Private room cost differential adjustment (line 3 x line 35)	215,890	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,662,756	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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

38	Adjusted general inpatient routine service cost per diem (see instructions)	875.68	38
39	Program general inpatient routine service cost (line 9 x line 38)	36,779	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)	36,779	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	31,602	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	68,381	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,901	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,585	51
52	Total Program excludable cost (sum of lines 50 and 51)	3,486	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	64,895	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

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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		51,135,881		30
31	Intensive Care Unit		11,717,552		31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.243378	42,092,495	10,244,387	50
52	Delivery Room & Labor Room	0.593040	16,412	9,733	52
54	Radiology-Diagnostic	0.103170	30,772,572	3,174,806	54
60	Laboratory	0.120219	30,370,305	3,651,088	60
62	Whole Blood & Packed Red Blood Cells	0.319853	2,617,786	837,307	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.242951	14,633,608	3,555,250	65
66	Physical Therapy	0.372699	7,092,497	2,643,367	66
70	Electroencephalography	0.138780	780,674	108,342	70
71	Medical Supplies Charged to Patients	0.443481	10,656,776	4,726,078	71
72	Impl. Dev. Charged to Patients	0.546883	24,898,505	13,616,569	72
73	Drugs Charged to Patients	0.185725	37,259,358	6,919,994	73
76	CARDIOLOGY	0.122725	34,685,397	4,256,765	76
76.97	CARDIAC REHABILITATION	0.769892	171,960	132,391	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.694099	99,083	68,773	90
91	Emergency	0.124800	21,509,855	2,684,430	91
92	Observation Beds (Non-Distinct Part)	0.457647			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		257,657,283	56,629,280	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		257,657,283		202

(A) Worksheet A line numbers

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COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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		13,189,155		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.243378	251,853	61,295	50
52	Delivery Room & Labor Room	0.593040			52
54	Radiology-Diagnostic	0.103170	1,352,437	139,531	54
60	Laboratory	0.120219	2,326,984	279,748	60
62	Whole Blood & Packed Red Blood Cells	0.319853	171,818	54,957	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.242951	1,413,486	343,408	65
66	Physical Therapy	0.372699	11,747,079	4,378,125	66
70	Electroencephalography	0.138780	75,196	10,436	70
71	Medical Supplies Charged to Patients	0.443481	1,132,142	502,083	71
72	Impl. Dev. Charged to Patients	0.546883	35,442	19,383	72
73	Drugs Charged to Patients	0.185725	5,272,832	979,297	73
76	CARDIOLOGY	0.122725	708,263	86,922	76
76.97	CARDIAC REHABILITATION	0.769892			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.694099	15,901	11,037	90
91	Emergency	0.124800	5,790	723	91
92	Observation Beds (Non-Distinct Part)	0.457647			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		24,509,223	6,866,945	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		24,509,223		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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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		1,277,617		30
31	Intensive Care Unit		198,680		31
32.01	NEONATAL INTENSIVE CARE		497,937		32.01
41	Subprovider - IRF				41
43	Nursery		74,266		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.243378	1,057,595	257,395	50
52	Delivery Room & Labor Room	0.593040	120,772	71,623	52
54	Radiology-Diagnostic	0.103170	547,295	56,464	54
60	Laboratory	0.120219	727,505	87,460	60
62	Whole Blood & Packed Red Blood Cells	0.319853	54,636	17,475	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.242951	178,946	43,475	65
66	Physical Therapy	0.372699	105,736	39,408	66
70	Electroencephalography	0.138780	20,201	2,803	70
71	Medical Supplies Charged to Patients	0.443481	252,775	112,101	71
72	Impl. Dev. Charged to Patients	0.546883	136,808	74,818	72
73	Drugs Charged to Patients	0.185725	1,199,341	222,748	73
76	CARDIOLOGY	0.122725	228,123	27,996	76
76.97	CARDIAC REHABILITATION	0.769892	4,592	3,535	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.694099	60,703	42,134	90
91	Emergency	0.124800	234,426	29,256	91
92	Observation Beds (Non-Distinct Part)	0.457647			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,929,454	1,088,691	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,929,454		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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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		43,996		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.243378	1,719	418	50
52	Delivery Room & Labor Room	0.593040			52
54	Radiology-Diagnostic	0.103170	3,574	369	54
60	Laboratory	0.120219	4,794	576	60
62	Whole Blood & Packed Red Blood Cells	0.319853			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.242951	15,210	3,695	65
66	Physical Therapy	0.372699	44,102	16,437	66
70	Electroencephalography	0.138780	882	122	70
71	Medical Supplies Charged to Patients	0.443481	9,912	4,396	71
72	Impl. Dev. Charged to Patients	0.546883			72
73	Drugs Charged to Patients	0.185725	29,315	5,445	73
76	CARDIOLOGY	0.122725	1,173	144	76
76.97	CARDIAC REHABILITATION	0.769892			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.694099			90
91	Emergency	0.124800			91
92	Observation Beds (Non-Distinct Part)	0.457647			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		110,681	31,602	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		110,681		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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)	18,746,952			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	57,079,194			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)	1,236,769			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)	370.66			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)	0.0303			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1635			31
32	Sum of lines 30 and 31	0.1938			32
33	Allowable disproportionate share percentage (see instructions)	0.0535			33
34	Disproportionate share adjustment (see instructions)	1,014,175			34
		Prior to		On or after	
		October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000399674	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,640,250		2,704,472	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	665,488		2,022,796	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,688,284			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 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

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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)	80,765,374			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)	80,765,374			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	6,467,851			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	6,214			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)	137,301			58
59	Total (sum of amounts on lines 49 through 58)	87,376,740			59
60	Primary payer payments	54,041			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	87,322,699			61
62	Deductibles billed to program beneficiaries	7,019,548			62
63	Coinsurance billed to program beneficiaries	393,035			63
64	Allowable bad debts (see instructions)	726,227			64
65	Adjusted reimbursable bad debts (see instructions)	472,048			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	107,513			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	80,382,164			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)	3,795			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)	141,606			70.93
70.94	HRR adjustment amount (see instructions)	-420,502			70.94
71	Amount due provider (see instructions)	80,099,473			71
71.01	Sequestration adjustment (see instructions)	1,601,989			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	78,169,480			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	328,004			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,046,474			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
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.000000000	0.000000000		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

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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)	22,244			1
2	Medical and other services reimbursed under OPPS (see instructions)	50,272,400			2
3	OPPS payments	44,969,885			3
4	Outlier payment (see instructions)	92,670			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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	73,463			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	22,244			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	119,768			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)	119,768			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)	119,768			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	97,524			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 (see instructions)	22,244			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, 4.01, 8 and 9)	45,136,018			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	8,404,682			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)	36,753,580			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)	36,753,580			30
31	Primary payer payments	19,481			31
32	Subtotal (line 30 minus line 31)	36,734,099			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)	1,174,830			34
35	Adjusted reimbursable bad debts (see instructions)	763,640			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	553,606			36
37	Subtotal (see instructions)	37,497,739			37
38	MSP-LCC reconciliation amount from PS&R	-1,113			38
39	Other adjustments (FDO LOSS)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	37,498,852			40
40.01	Sequestration adjustment (see instructions)	749,977			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	36,577,835			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	171,040			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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)	1,129			1
2	Medical and other services reimbursed under OPPS (see instructions)	1,370			2
3	OPPS payments	893			3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	1,129			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	6,077			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)	6,077			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)	6,077			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	4,948			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 (see instructions)	1,129			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, 4.01, 8 and 9)	893			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				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)	2,022			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)	2,022			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,022			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)	2,022			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)	2,022			40
40.01	Sequestration adjustment (see instructions)	40			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,066			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-84			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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	Total interim payments paid to provider		77,681,403		35,923,136	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		488,077		654,699	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. E or Wkst. E-3, line and column as appropriate)		78,169,480		36,577,835	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	Determined net settlement amount (balance due) based on the cost report (1)	.01	328,004		171,040	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		78,497,484		36,748,875	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.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		19,677,503		2,066
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
	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. E or Wkst. E-3, line and column as appropriate)		19,677,503		2,066
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	Determined net settlement amount (balance due) based on the cost report (1)	.01	77,557		6.01
		.02			-84
7	Total Medicare program liability (see instructions)		19,755,060		1,982
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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)	19,766,633		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.024200		2
3	Inpatient Rehabilitation LIP payments (see instructions)	306,383		3
4	Outlier payments	236,239		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)	40,293,151		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	20,309,255		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)	20,309,255		17
18	Primary payer payments	13,432		18
19	Subtotal (line 17 less line 18)	20,295,823		19
20	Deductibles	102,004		20
21	Subtotal (line 19 minus line 20)	20,193,819		21
22	Coinsurance	79,889		22
23	Subtotal (line 21 minus line 22)	20,113,930		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	38,253		24
25	Adjusted reimbursable bad debts (see instructions)	24,864		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,327		26
27	Subtotal (sum of lines 23 and 25)	20,138,794		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)	19,430		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)	20,158,224		32
32.01	Sequestration adjustment (see instructions)	403,164		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	19,677,503		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	77,557		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	175,654		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

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0125

WORKSHEET E-3
PART VII

Check Title V Hospital NF PPS
 Applicable 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	2,048,500		8
9	4,929,454		9
10			10
11			11
12	6,977,954		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	6,977,954		16
17	6,977,954		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26	4,420		26
27	4,420		27
28			28
29	4,420		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	4,420		31
32			32
33			33
34			34
35			35
36	4,420		36
37	-4,420		37
38			38
39			39
40			40
41			41
42			42
43			43

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	115,760				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	135,103,730				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-67,938,995				6
7	Inventory	13,937,236				7
8	Prepaid expenses	6,178,676				8
9	Other current assets	754,187				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	88,150,594				11
FIXED ASSETS						
12	Land					12
13	Land improvements	13,456,196				13
14	Accumulated depreciation	-5,710,123				14
15	Buildings	373,859,298				15
16	Accumulated depreciation	-226,286,423				16
17	Leasehold improvements	1,266,081				17
18	Accumulated depreciation	-1,195,561				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	147,284,978				23
24	Accumulated depreciation	-108,353,551				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	17,989,531				29
30	Total fixed assets (sum of lines 12-29)	212,310,426				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	22,309,482				34
35	Total other assets (sum of lines 31-34)	22,309,482				35
36	Total assets (sum of lines 11, 30 and 35)	322,770,502				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	2,737,140				37
38	Salaries, wages and fees payable	18,659,229				38
39	Payroll taxes payable	3,681,866				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	5,329,844				44
45	Total current liabilities (sum of lines 37 thru 44)	30,408,079				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	12,428,877				49
50	Total long term liabilities (sum of lines 46 thru 49)	12,428,877				50
51	Total liabilities (sum of lines 45 and 50)	42,836,956				51
CAPITAL ACCOUNTS						
52	General fund balance	279,933,546				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)	279,933,546				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	322,770,502				60

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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		205,912,256			1
2	Net income (loss) (from Worksheet G-3, line 29)		65,023,466			2
3	Total (sum of line 1 and line 2)		270,935,722			3
4	Additions (credit adjustments) (specify)					4
5	PENSION RELATED CHANGES	6,237,000				5
6	RESTRICTED CONTRIBUTIONS	110,000				6
7	NET ASSETS RELEASED FROM RESTRICTN	15,000				7
8	OTHER	10,824				8
9	TRANSFERS	2,699,000				9
10	Total additions (sum of lines 4-9)		9,071,824			10
11	Subtotal (line 3 plus line 10)		280,007,546			11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS RELEASED FROM RESTRICTN	74,000				13
14	PENSION-RELATED ADJ-NOT NET COST					14
15	NET ASSETS TRANSFERRD TO AFFILIATE					15
16	OTHER					16
17						17
18	Total deductions (sum of lines 12-17)		74,000			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		279,933,546			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	PENSION RELATED CHANGES					5
6	RESTRICTED CONTRIBUTIONS					6
7	NET ASSETS RELEASED FROM RESTRICTN					7
8	OTHER					8
9	TRANSFERS					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 TRANSFERRD 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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

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

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	113,198,998		113,198,998	1
2	Subprovider IPF				2
3	Subprovider IRF	15,966,550		15,966,550	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)	129,165,548		129,165,548	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	24,017,933		24,017,933	11
12	Coronary Care Unit				12
12.01	NEONATAL INTENSIVE CARE	23,872,206		23,872,206	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)	47,890,139		47,890,139	16
17	Total inpatient routine care services (sum of lines 10 and 16)	177,055,687		177,055,687	17
18	Ancillary services	579,401,692		579,401,692	18
19	Outpatient services		941,036,045	941,036,045	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		7,095,321	7,095,321	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIAN REVENUES	32,597,365	25,469,517	58,066,882	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	789,054,744	973,600,883	1,762,655,627	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		482,270,744	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)		482,270,744	43

KPMG LLP Compu-Max 2552-10

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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)	1,762,655,627	1
2	Less contractual allowances and discounts on patients' accounts	1,232,466,967	2
3	Net patient revenues (line 1 minus line 2)	530,188,660	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	482,270,744	4
5	Net income from service to patients (line 3 minus line 4)	47,917,916	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	252,560	6
7	Income from investments	384,525	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	2,595,109	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	10,717,308	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	24,701	21
22	Rental of hospitial space	1,145,959	22
23	Governmental appropriations	2,000	23
24	Other (OTHER REVENUE)	129,564	24
24.01	Other (REVENUE-CLASSES)	67,475	24.01
24.02	Other (ASSETS RELEASED FROM RESTRICTION)	59,014	24.02
24.03	Other (FITNESS REVENUE)	3,655,915	24.03
24.04	Other (SALE OF XRAY SCRAP)	7,641	24.04
24.05	Other (GAIN ON FIXED ASSETS)	81,403	24.05
25	Total other income (sum of lines 6-24)	19,123,174	25
26	Total (line 5 plus line 25)	67,041,090	26
27.01	Other expenses (OTHER EXPENSE)	2,017,624	27.01
28	Total other expenses (sum of line 27 and subscripts)	2,017,624	28
29	Net income (or loss) for the period (line 26 minus line 28)	65,023,466	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	1,026,360	760,776	89,330		120,778	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,282,380					6
7	Physical Therapy	982,819			115,471		7
8	Occupational Therapy	247,942			15,137		8
9	Speech Pathology	38,283					9
10	Medical Social Services	1,228					10
11	Home Health Aide	75,626					11
12	Supplies (see instructions)					228,092	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						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)	3,654,638	760,776	89,330	130,608	348,870	24

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	1,997,244	-429,749	1,567,495		1,567,495	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,282,380		1,282,380		1,282,380	6
7	Physical Therapy	1,098,290		1,098,290		1,098,290	7
8	Occupational Therapy	263,079		263,079		263,079	8
9	Speech Pathology	38,283		38,283		38,283	9
10	Medical Social Services	1,228		1,228		1,228	10
11	Home Health Aide	75,626		75,626		75,626	11
12	Supplies (see instructions)	228,092		228,092		228,092	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						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)	4,984,222	-429,749	4,554,473		4,554,473	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**

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			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	1,567,495				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,282,380				6
7	Physical Therapy	1,098,290				7
8	Occupational Therapy	263,079				8
9	Speech Pathology	38,283				9
10	Medical Social Services	1,228				10
11	Home Health Aide	75,626				11
12	Supplies (see instructions)	228,092				12
13	Drugs					13
14	DME					14
HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					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)	4,554,473				24

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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		1,567,495	1,567,495		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		1,282,380	677,585	1,959,965	6
7	Physical Therapy		1,098,290	570,246	1,668,536	7
8	Occupational Therapy		263,079	130,514	393,593	8
9	Speech Pathology		38,283	9,891	48,174	9
10	Medical Social Services		1,228	727	1,955	10
11	Home Health Aide		75,626	65,464	141,090	11
12	Supplies (see instructions)		228,092	113,068	341,160	12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					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)		4,554,473		4,554,473	24

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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					-1,567,495	39,900,452	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care					15,965,422	17,247,802	6
7	Physical Therapy					13,417,322	14,515,612	7
8	Occupational Therapy					3,059,163	3,322,242	8
9	Speech Pathology					213,480	251,763	9
10	Medical Social Services					17,277	18,505	10
11	Home Health Aide					1,590,765	1,666,391	11
12	Supplies (see instructions)					2,650,045	2,878,137	12
13	Drugs							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							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)					35,345,979	39,900,452	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						1,567,495	25
26	Unit Cost Multiplier						0.039285	26

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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			375	1,635,220	1,635,595	293,892	1
2	Skilled Nursing Care	1,959,965				1,959,965	352,176	2
3	Physical Therapy	1,668,536				1,668,536	299,811	3
4	Occupational Therapy	393,593				393,593	70,723	4
5	Speech Pathology	48,174				48,174	8,656	5
6	Medical Social Services	1,955				1,955	351	6
7	Home Health Aide	141,090				141,090	25,352	7
8	Supplies	341,160				341,160	61,301	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)	4,554,473		375	1,635,220	6,190,068	1,112,262	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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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				11,950			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)				11,950			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

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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					28,679		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)					28,679		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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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.	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP- DOWN ADJS	
		19	21	22	23	24	25	
1	Administrative and General					1,970,116		1
2	Skilled Nursing Care					2,312,141		2
3	Physical Therapy					1,968,347		3
4	Occupational Therapy					464,316		4
5	Speech Pathology					56,830		5
6	Medical Social Services					2,306		6
7	Home Health Aide					166,442		7
8	Supplies					402,461		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)					7,342,959		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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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)	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PIII) 27	TOTAL HHA COSTS 28			
1	Administrative and General	1,970,116					1
2	Skilled Nursing Care	2,312,141	847,819	3,159,960			2
3	Physical Therapy	1,968,347	721,753	2,690,100			3
4	Occupational Therapy	464,316	170,255	634,571			4
5	Speech Pathology	56,830	20,838	77,668			5
6	Medical Social Services	2,306	846	3,152			6
7	Home Health Aide	166,442	61,031	227,473			7
8	Supplies	402,461	147,574	550,035			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)	7,342,959	1,970,116	7,342,959			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.		0.366680				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

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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		308	3,654,638		1,635,595		1
2	Skilled Nursing Care					1,959,965		2
3	Physical Therapy					1,668,536		3
4	Occupational Therapy					393,593		4
5	Speech Pathology					48,174		5
6	Medical Social Services					1,955		6
7	Home Health Aide					141,090		7
8	Supplies					341,160		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)		308	3,654,638		6,190,068		20
21	Total cost to be allocated		375	1,635,220		1,112,262		21
22	Unit Cost Multiplier			0.447437		0.179685		22
22	Unit Cost Multiplier		1.217532					22

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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			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)			1,200				20
21	Total cost to be allocated			11,950				21
22	Unit Cost Multiplier			9.958333				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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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 ADMINIS- TRATION NURSING HO URS	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				7,095,321			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)				7,095,321			20
21	Total cost to be allocated				28,679			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				0.004042			22

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME			
		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: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	3,159,960		3,159,960	22,282	141.82	1
2	Physical Therapy	3	2,690,100		2,690,100	13,555	198.46	2
3	Occupational Therapy	4	634,571		634,571	5,279	120.21	3
4	Speech Pathology	5	77,668		77,668	483	160.80	4
5	Medical Social Services	6	3,152		3,152	13	242.46	5
6	Home Health Aide	7	227,473		227,473	3,584	63.47	6
7	Total (sum of lines 1-6)		6,792,924		6,792,924	45,196		7

Limitation Cost Computation						
				Program Visits		
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	23844		13,435		8
9	Physical Therapy	23844		8,531		9
10	Occupational Therapy	23844		3,463		10
11	Speech Pathology	23844		319		11
12	Medical Social Services	23844		10		12
13	Home Health Aide	23844		2,292		13
14	Total (sum of lines 8-13)			28,050		14

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	550,035		550,035	374,026	1.470580	15
16	Cost of Drugs	9						16

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	0.372699			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.443481			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.185725			col. 2, line 16	5

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		13,435			1,905,352		1,905,352	1
2	Physical Therapy		8,531			1,693,062		1,693,062	2
3	Occupational Therapy		3,463			416,287		416,287	3
4	Speech Pathology		319			51,295		51,295	4
5	Medical Social Services		10			2,425		2,425	5
6	Home Health Aide		2,292			145,473		145,473	6
7	Total (sum of lines 1-6)		28,050			4,213,894		4,213,894	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services				
		Part B			Part B				
	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		
15	Cost of Medical Supplies			345,173			507,605		15
16	Cost of Drugs								16

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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 B		
		Part A	Not Subject to Deductibles & Coinsurance	
		1	2	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		6,837	9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)		-6,837	10
11	Total PPS Reimbursement - Full Episodes without Outliers		3,690,065	11
12	Total PPS Reimbursement - Full Episodes with Outliers		414,823	12
13	Total PPS Reimbursement - LUPA Episodes		65,678	13
14	Total PPS Reimbursement - PEP Episodes		24,975	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		10,794	15
16	Total PPS Outlier Reimbursement - PSP Episodes		3,005	16
17	Total Other Payments		110,434	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)		4,312,937	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		4,312,937	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		4,312,937	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)		4,312,937	29
30	Other adjustments (see instructions) (specify)		7,902	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		4,320,839	31
31.01	Sequestration adjustment (see instructions)		86,406	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		4,234,433	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES HHA CCN: 15-7487

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				4,234,433	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)				4,234,433	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)				4,234,433	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	6,167,275	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	53,885	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)	243.93	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)	0.0303	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1635	8
9	Sum of lines 7 and 8	0.1938	9
10	Allowable disproportionate share percentage (see instructions)	0.0400	10
11	Disproportionate share adjustment (see instructions)	246,691	11
12	Total prospective capital payments (see instructions)	6,467,851	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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/29/2018 Run Time: 07:54 Version: 2018.04 (09/26/2018)
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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	EXTRAORDINARY 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
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