

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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. ☒ Electronically filed cost report 2. ☐ Manually submitted cost report 3. [1] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 08/29/2018 Time: 15:12	
Contractor use only	5. ☐ 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. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ 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 ROSELAND COMMUNITY HOSPITAL (14-0068) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 04/01/2017 and ending 03/31/2018, 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				
		TITLE V	PART A	PART B	HIT	TITLE XIX
		1	2	3	4	5
1	HOSPITAL		-251,525	25,240		1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					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		-251,525	25,240		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: 45 W. 111TH STREET	P.O. Box:		1
2	City: CHICAGO	State: IL	ZIP Code: 60628-	County: COOK

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	ROSELAND COMMUNITY HOSPITAL	14-0068	16974	1	06 / 01 / 1966	N	P	O
4	Subprovider - IPF								4
5	Subprovider - IRF								5
6	Subprovider - (OTHER)								6
7	Swing Beds - SNF								7
8	Swing Beds - NF								8
9	Hospital-Based SNF								9
10	Hospital-Based NF								10
11	Hospital-Based OLTC								11
12	Hospital-Based HHA								12
13	Separately Certified ASC								13
14	Hospital-Based Hospice								14
15	Hospital-Based Health Clinic - RHC								15
16	Hospital-Based Health Clinic - FQHC								16
17	Hospital-Based (CMHC)								17
18	Renal Dialysis								18
19	Other								19

20	Cost Reporting Period (mm/dd/yyyy)	From: 04 / 01 / 2017	To: 03 / 31 / 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
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.	1	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.	1,102	1,700		32	5,614	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status is in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 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
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N
		1	2	3
	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		
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		
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		
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N		
		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)	N		
		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		
61.01	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)			
61.02	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)			
61.03	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)			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)			
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)			
61.06	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)			

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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 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.	N			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)				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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
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	N	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	N	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	N	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	N	98.06

		1	2	
Rural Providers		N		
105	Does this hospital qualify as a CAH?			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
	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.			
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
		Physical	Occupational	
		Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.			109

		1	2	
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.		N	110
		1	2	
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.			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.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	601,646			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.	N			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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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)	N		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:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	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	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	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.	Y			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)	04 / 01 / 2016	03 / 31 / 2017		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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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	2		
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	
		1	2	3	
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)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
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.	N			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		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
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		16
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	07/10/2017	Y	07/10/2017	17
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		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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

		Y/N	Date	
Home Office Costs		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: RAJ	Last name: SHAH	Title: MANAGER
42	Employer: STRATEGIC REIMBURSEMENT GROUP LLC		
43	Phone number: 630-530-7100 X 107	E-mail Address: RAJ.SHAH@SRGROUPLLC.COM	

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		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	124	45,260			2,011	5,078	11,147	1
2	HMO and other (see instructions)						1,305	2,144		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									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)		124	45,260			2,011	5,078	11,147	7
8	Intensive Care Unit	31	10	3,650			679	963	2,121	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						263	406	13
14	Total (see instructions)		134	48,910			2,690	6,304	13,674	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								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								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		134							27
28	Observation Bed Days							67	851	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							36	46	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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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)					478	1,505	2,796	1
2	HMO and other (see instructions)					183	540		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								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
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)		382.43			478	1,505	2,796	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								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)		382.43						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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1 Total salaries (see instructions)	200	22,982,841		22,982,841	795,458.00	28.89	1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetest Part B							3
4 Physician-Part A - Administrative							4
4.01 Physician-Part A - Teaching							4.01
5 Physician-Part B		581,790		581,790	3,189.00	182.44	5
6 Non-physician-Part B							6
7 Interns & residents (in an approved program)	21						7
7.01 Contracted interns & residents (in an approved program)							7.01
8 Home office and/or related organization personnel							8
9 SNF	44						9
10 Excluded area salaries (see instructions)		226,274		226,274	6,773.00	33.41	10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		449,136		449,136	6,265.00	71.69	11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative		153,323		153,323	1,439.00	106.55	13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries							14.01
14.02 Related organization salaries							14.02
15 Home office: Physician Part A - Administrative							15
16 Home office & Contract Physicians Part A - Teaching							16
WAGE-RELATED COSTS							
17 Wage-related costs (core)(see instructions)		3,361,701		3,361,701			17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		40,137		40,137			19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B							21
22 Physician Part A - Administrative							22
22.01 Physician Part A - Teaching							22.01
23 Physician Part B		61,011		61,011			23
24 Wage-related costs (RHC/FQHC)							24
25 Interns & residents (in an approved program)							25
25.50 Home office wage-related							25.50
25.51 Related organization wage-related							25.51
25.52 Home office: Physician Part A - Administrative - wage-related							25.52
25.53 Home office & Contract Physicians Part A - Teaching - wage-related							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department		975,218	-655,830	319,388	8,897.00	35.90	26
27 Administrative & General		4,971,537	655,830	5,627,367	176,514.00	31.88	27
28 Administrative & General under contract (see instructions)		423,376		423,376	2,104.00	201.22	28
29 Maintenance & Repairs							29
30 Operation of Plant		741,850		741,850	22,057.00	33.63	30
31 Laundry & Linen Service							31
32 Housekeeping		669,148		669,148	54,652.00	12.24	32
33 Housekeeping under contract (see instructions)							33
34 Dietary		596,815	-200,161	396,654	28,602.00	13.87	34
35 Dietary under contract (see instructions)							35
36 Cafeteria			200,161	200,161	14,130.00	14.17	36
37 Maintenance of Personnel							37
38 Nursing Administration		982,208		982,208	24,862.00	39.51	38
39 Central Services and Supply		138,397		138,397	5,997.00	23.08	39
40 Pharmacy		869,618		869,618	22,693.00	38.32	40
41 Medical Records & Medical Records Library		313,707		313,707	16,068.00	19.52	41
42 Social Service		171,724		171,724	5,616.00	30.58	42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	22,824,427		22,824,427	794,373.00	28.73	1
2	Excluded area salaries (see instructions)	226,274		226,274	6,773.00	33.41	2
3	Subtotal salaries (line 1 minus line 2)	22,598,153		22,598,153	787,600.00	28.69	3
4	Subtotal other wages & related costs (see instructions)	602,459		602,459	7,704.00	78.20	4
5	Subtotal wage-related costs (see instructions)	3,361,701		3,361,701		14.88%	5
6	Total (sum of lines 3 through 5)	26,562,313		26,562,313	795,304.00	33.40	6
7	Total overhead cost (see instructions)	10,853,598		10,853,598	382,192.00	28.40	7

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3****Part IV - Wage Related Cost****PART IV****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	189,506	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		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)		8.02
8.03	Health Insurance (Purchased)	2,005,312	8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	101,976	10
11	Life Insurance (If employee is owner or beneficiary)	32,371	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	85,080	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	248,335	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	1,743,302	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	-4,738	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)	4,401,144	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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	889,092	4,401,144	1
2	Hospital	889,092	4,401,144	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

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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)	0.372920	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	34,591,948	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	57,352,116	6
7	Medicaid cost (line 1 times line 6)	21,387,751	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.		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)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		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.		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 fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		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)	2,295,093	425,898	2,720,991	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	855,886	425,898	1,281,784	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)	855,886	425,898	1,281,784	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)	56,672,862	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	141,453	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	217,621	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	56,455,241	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	21,129,456	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	22,411,240	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	22,411,240	31

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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		5,253,735	5,253,735	-549,414	4,704,321	-4,355,596	348,725	1
2	00200	Cap Rel Costs-Mvble Equip				920,310	920,310		920,310	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	975,218	3,628,987	4,604,205	-655,830	3,948,375		3,948,375	4
5.01	00540	NONPATIENT TELEPHONES	66,382	24,234	90,616		90,616		90,616	5.01
5.02	00550	DATA PROCESSING	567,100	923,135	1,490,235		1,490,235		1,490,235	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	209,029	47,681	256,710		256,710		256,710	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	656,076	141,356	797,432		797,432		797,432	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	3,472,950	3,329,752	6,802,702	284,934	7,087,636	-554,082	6,533,554	5.05
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	741,850	1,843,351	2,585,201		2,585,201		2,585,201	7
8	00800	Laundry & Linen Service								8
9	00900	Housekeeping	669,148	511,532	1,180,680		1,180,680		1,180,680	9
10	01000	Dietary	596,815	561,746	1,158,561	-388,561	770,000	-3,331	766,669	10
11	01100	Cafeteria				388,561	388,561	-83,439	305,122	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	982,208	231,302	1,213,510		1,213,510		1,213,510	13
14	01400	Central Services & Supply	138,397	25,844	164,241		164,241		164,241	14
15	01500	Pharmacy	869,618	1,422,510	2,292,128	-1,270,942	1,021,186	-6,414	1,014,772	15
16	01600	Medical Records & Library	313,707	517,475	831,182		831,182		831,182	16
17	01700	Social Service	171,724		171,724		171,724		171,724	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	4,814,911	1,984,694	6,799,605	-451,946	6,347,659	-451,196	5,896,463	30
31	03100	Intensive Care Unit	1,223,070	351,431	1,574,501		1,574,501	-182,000	1,392,501	31
43	04300	Nursery	317,440	14,029	331,469		331,469		331,469	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	628,031	342,822	970,853		970,853	-222,945	747,908	50
52	05200	Delivery Room & Labor Room				451,946	451,946		451,946	52
53	05300	Anesthesiology		1,195,770	1,195,770		1,195,770	-1,177,000	18,770	53
54	05400	Radiology-Diagnostic	1,185,505	1,145,511	2,331,016		2,331,016		2,331,016	54
60	06000	Laboratory	904,268	1,062,725	1,966,993	-153,747	1,813,246		1,813,246	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.				153,747	153,747		153,747	63
66	06600	Physical Therapy	96,358	13,207	109,565		109,565		109,565	66
69.01	06901	CARDIOPULMONARY	892,527	675,493	1,568,020		1,568,020	-152,625	1,415,395	69.01
71	07100	Medical Supplies Charged to Patients								71
73	07300	Drugs Charged to Patients				1,270,942	1,270,942		1,270,942	73
74	07400	Renal Dialysis		179,006	179,006		179,006		179,006	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		6,500	6,500		6,500		6,500	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	Emergency	2,264,235	1,586,610	3,850,845		3,850,845	-1,105,346	2,745,499	91
92	09200	Observation Beds (Non-Distinct Part)								92
92.01	09201	23-HR OBSERVATION								92.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	22,756,567	27,020,438	49,777,005		49,777,005	-8,293,974	41,483,031	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	107,919	2,775	110,694		110,694		110,694	192
194	07950	FOUNDATION	118,355	47,740	166,095		166,095		166,095	194
200		TOTAL (sum of lines 118-199)	22,982,841	27,070,953	50,053,794		50,053,794	-8,293,974	41,759,820	200

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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	
1	OB DELIVERY	B	Delivery Room & Labor Room	52	260,611	191,335	1
500	Total reclassifications				260,611	191,335	500
	Code Letter - B						
1	PROPERTY INSURANCE RECLASS	C	Cap Rel Costs-Bldg & Fixt	1		364,474	1
2			Cap Rel Costs-Mvble Equip	2		6,422	2
500	Total reclassifications					370,896	500
	Code Letter - C						
1	CHARGEABLE MEDICAL SUPPLIES	D					1
500	Total reclassifications						500
	Code Letter - D						
1	DRUGS SOLD RECLASS	E	Drugs Charged to Patients	73		1,270,942	1
500	Total reclassifications					1,270,942	500
	Code Letter - E						
1	DIETARY-CAFETERIA	F	Cafeteria	11	200,161	188,400	1
500	Total reclassifications				200,161	188,400	500
	Code Letter - F						
1	BLOOD COST	H	Blood Storing, Processing & T	63		153,747	1
500	Total reclassifications					153,747	500
	Code Letter - H						
1	DEPRECIATION EXPENSE	J	Cap Rel Costs-Mvble Equip	2		913,888	1
500	Total reclassifications					913,888	500
	Code Letter - J						
1	ADMIN SALARY	K	OTHER ADMINISTRATIVE AND GENE	5.05	655,830		1
500	Total reclassifications				655,830		500
	Code Letter - K						
	GRAND TOTAL (Increases)				1,116,602	3,089,208	

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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	OB DELIVERY	B	Adults & Pediatrics	30	260,611	191,335		1
500	Total reclassifications				260,611	191,335		500
	Code letter - B							
1	PROPERTY INSURANCE RECLASS	C	OTHER ADMINISTRATIVE AND GENE	5.05		370,896	12	1
2							12	2
500	Total reclassifications					370,896		500
	Code letter - C							
1	CHARGEABLE MEDICAL SUPPLIES	D						1
500	Total reclassifications							500
	Code letter - D							
1	DRUGS SOLD RECLASS	E	Pharmacy	15		1,270,942		1
500	Total reclassifications					1,270,942		500
	Code letter - E							
1	DIETARY-CAFETERIA	F	Dietary	10	200,161	188,400		1
500	Total reclassifications				200,161	188,400		500
	Code letter - F							
1	BLOOD COST	H	Laboratory	60		153,747		1
500	Total reclassifications					153,747		500
	Code letter - H							
1	DEPRECIATION EXPENSE	J	Cap Rel Costs-Bldg & Fixt	1		913,888	9	1
500	Total reclassifications					913,888		500
	Code letter - J							
1	ADMIN SALARY	K	Employee Benefits Department	4	655,830			1
500	Total reclassifications				655,830			500
	Code letter - K							
	GRAND TOTAL (Decreases)				1,116,602	3,089,208		

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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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	934,453					934,453		1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements	7,338					7,338		4
5	Fixed Equipment								5
6	Movable Equipment	22,428,320	6,885		6,885		22,435,205		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	23,370,111	6,885		6,885		23,376,996		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	23,370,111	6,885		6,885		23,376,996		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	4,896,671		357,064				5,253,735	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	4,896,671		357,064				5,253,735	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	7,338		7,338	0.000327					1
2	Cap Rel Costs-Mvble Equip	22,435,205		22,435,205	0.999673					2
3	Total (sum of lines 1-2)	22,442,543		22,442,543	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	3,982,783	-64,660	357,064	-3,926,462			348,725	1
2	Cap Rel Costs-Mvble Equip	913,888			6,422			920,310	2
3	Total (sum of lines 1-2)	4,896,671	-64,660	357,064	-3,920,040			1,269,035	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.)

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		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	-3,683,957				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-83,439	Cafeteria	11		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	B	-3,331	Dietary	10		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	AHA/IHA/MCHC NON-ALLOWABLE	A	-15,874	OTHER ADMINISTRATIVE AND GENERAL	5.05		33
34	LOBBYING EXPENSE	A	-45,000	OTHER ADMINISTRATIVE AND GENERAL	5.05		34
35							35
36							36
37							37
38							38
39							39
40							40
41	RCH SUITE RENTAL	B	-64,660	Cap Rel Costs-Bldg & Fixt	1	10	41
42	MISC INCOME	B	-204	OTHER ADMINISTRATIVE AND GENERAL	5.05		42
43	OUTPATIENT PHARMACY	B	-6,414	Pharmacy	15		43
44							44
45	INTEREST-TAX PENALTY	A	-375,064	Cap Rel Costs-Bldg & Fixt	1	12	45
45.04	MISC OTHER ADMIN REV	B	-100,159	OTHER ADMINISTRATIVE AND GENERAL	5.05		45.04
46	STATE TAX ASSESSMENT	A	-3,915,872	Cap Rel Costs-Bldg & Fixt	1	12	46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-8,293,974				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

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							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							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial Or non-financial) specify:

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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	5.05	OTHER ADMINISTRATIVE AGGREGATE	471,168	392,845	78,323	211,500	919	93,446	4,672	1
2	30	Adults & Pediatrics AGGREGATE	451,196	451,196						2
3	31	Intensive Care Unit AGGREGATE	182,000	182,000						3
4	50	Operating Room AGGREGATE	222,945	222,945						4
5										5
6	53	Anesthesiology AGGREGATE	1,177,000	1,177,000						6
7	69.01	CARDIOPULMONARY AGGREGATE	205,500	130,500	75,000	211,500	520	52,875	2,644	7
8	91	Emergency AGGREGATE	1,105,346	1,105,346						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
200		TOTAL	3,815,155	3,661,832	153,323		1,439	146,321	7,316	200

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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	5.05	OTHER ADMINISTRATIVE AGGREGATE					93,446		392,845	1
2	30	Adults & Pediatrics AGGREGATE							451,196	2
3	31	Intensive Care Unit AGGREGATE							182,000	3
4	50	Operating Room AGGREGATE							222,945	4
5										5
6	53	Anesthesiology AGGREGATE							1,177,000	6
7	69.01	CARDIOPULMONARY AGGREGATE					52,875	22,125	152,625	7
8	91	Emergency AGGREGATE							1,105,346	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
200		TOTAL					146,321	22,125	3,683,957	200

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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 MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	348,725	348,725					1
2	Cap Rel Costs-Mvble Equip	920,310		920,310				2
4	Employee Benefits Department	3,948,375	2,714	2,274	3,953,363			4
5.01	NONPATIENT TELEPHONES	90,616			11,596	102,212		5.01
5.02	DATA PROCESSING	1,490,235	1,702	291,358	102,736	11,253	1,897,284	5.02
5.03	PURCHASING RECEIVING AND STORES	256,710	4,966	1,200	44,041	2,813	51,980	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	797,432		11,903	105,127	5,314	168,936	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	6,533,554	99,626	22,579	727,952	29,382	610,770	5.05
6	Maintenance & Repairs							6
7	Operation of Plant	2,585,201	6,134	6,263	123,780	4,063	25,990	7
8	Laundry & Linen Service							8
9	Housekeeping	1,180,680	3,031	5,992	105,124	625		9
10	Dietary	766,669	10,240	10,721	64,149	3,126	25,990	10
11	Cafeteria	305,122			28,957			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,213,510		6,994	218,958	1,250		13
14	Central Services & Supply	164,241	6,164	7,860	14,843		12,995	14
15	Pharmacy	1,014,772	1,761		84,900	2,813	51,980	15
16	Medical Records & Library	831,182	4,040	12,625	51,905	4,689	142,946	16
17	Social Service	171,724			10,590			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,896,463	90,852	235,379	760,746	8,440	350,868	30
31	Intensive Care Unit	1,392,501	7,168	23,237	206,658	625	12,995	31
43	Nursery	331,469	8,422	5,279	59,891			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	747,908	20,356	96,334	125,127	8,752	25,990	50
52	Delivery Room & Labor Room	451,946	10,613	10,053	122,364			52
53	Anesthesiology	18,770		15,783				53
54	Radiology-Diagnostic	2,331,016	11,084	112,884	208,633	5,001		54
60	Laboratory	1,813,246	8,448		158,528	6,564	220,917	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	153,747						63
66	Physical Therapy	109,565		7,788	20,168	2,813		66
69.01	CARDIOPULMONARY	1,415,395	2,847	18,644	160,341	3,438	103,961	69.01
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients	1,270,942		90				73
74	Renal Dialysis	179,006						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	6,500				313		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,745,499	38,399	15,070	400,314		90,966	91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	41,483,031	338,567	920,310	3,917,428	101,274	1,897,284	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		891			938		190
192	Physicians' Private Offices	110,694	9,267		20,602			192
194	FOUNDATION	166,095			15,333			194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	41,759,820	348,725	920,310	3,953,363	102,212	1,897,284	202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORE	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	HOUSE- KEEPING	
		5.03	5.04	4A	5.05	7	9	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES	361,710						5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE		1,088,712					5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL			8,023,863	8,023,863			5.05
6	Maintenance & Repairs							6
7	Operation of Plant			2,751,431	654,409	3,405,840		7
8	Laundry & Linen Service							8
9	Housekeeping			1,295,452	308,114	44,194	1,647,760	9
10	Dietary			880,895	209,515	149,304	28,446	10
11	Cafeteria			334,079	79,458		28,446	11
12	Maintenance of Personnel							12
13	Nursing Administration			1,440,712	342,663		14,237	13
14	Central Services & Supply			206,103	49,020	89,881	34,560	14
15	Pharmacy			1,156,226	275,000	25,680	14,237	15
16	Medical Records & Library			1,047,387	249,114	58,900	24,399	16
17	Social Service			182,314	43,362			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	100,972	303,895	7,747,615	1,842,720	1,324,696	1,045,507	30
31	Intensive Care Unit	14,352	43,199	1,700,735	404,508	104,513	24,399	31
43	Nursery	832	2,503	408,396	97,134	122,802	14,237	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,890	11,710	1,040,067	247,373	296,816	81,290	50
52	Delivery Room & Labor Room	2,821	8,491	606,288	144,201	154,753	21,342	52
53	Anesthesiology	2,507	7,546	44,606	10,609		3,057	53
54	Radiology-Diagnostic	29,118	87,644	2,785,380	662,483	161,621	54,883	54
60	Laboratory	28,710	86,417	2,322,830	552,469	123,176	38,607	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,990	5,989	161,726	38,465			63
66	Physical Therapy	647	1,947	142,928	33,994		10,161	66
69.01	CARDIOPULMONARY	36,451	109,718	1,850,795	440,199	41,506	17,673	69.01
71	Medical Supplies Charged to Patients	41,000	123,408	164,408	39,103			71
73	Drugs Charged to Patients	28,874	86,912	1,386,818	329,845		3,057	73
74	Renal Dialysis	2,420	7,283	188,709	44,883			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	4	13	6,830	1,624			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	67,122	202,037	3,559,407	846,580	559,889	162,610	91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	361,710	1,088,712	41,436,000	7,946,845	3,257,731	1,621,148	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			1,829	435	12,989		190
192	Physicians' Private Offices			140,563	33,432	135,120	26,612	192
194	FOUNDATION			181,428	43,151			194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	361,710	1,088,712	41,759,820	8,023,863	3,405,840	1,647,760	202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	1,268,160						10
11	Cafeteria		441,983					11
12	Maintenance of Personnel							12
13	Nursing Administration		22,393	1,820,005				13
14	Central Services & Supply		5,397		384,961			14
15	Pharmacy		20,444			1,491,587		15
16	Medical Records & Library		14,485				1,394,285	16
17	Social Service		5,060					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,158,291	155,349	1,073,485			389,227	30
31	Intensive Care Unit	109,869	24,605	170,023			55,322	31
43	Nursery		6,990	48,300			3,205	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		10,213	70,573			14,996	50
52	Delivery Room & Labor Room		8,264	57,106			10,873	52
53	Anesthesiology						9,664	53
54	Radiology-Diagnostic		35,904			147,414	112,239	54
60	Laboratory		35,024				110,668	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.						7,669	63
66	Physical Therapy		3,279				2,493	66
69.01	CARDIOPULMONARY		26,572				140,509	69.01
71	Medical Supplies Charged to Patients				384,961		158,040	71
73	Drugs Charged to Patients					1,344,173	111,302	73
74	Renal Dialysis						9,327	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY						16	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		57,960	400,518			258,735	91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,268,160	431,939	1,820,005	384,961	1,491,587	1,394,285	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		5,884					192
194	FOUNDATION		4,160					194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,268,160	441,983	1,820,005	384,961	1,491,587	1,394,285	202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		17	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
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
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	230,736						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	216,294	14,953,184		14,953,184			30
31	Intensive Care Unit	14,442	2,608,416		2,608,416			31
43	Nursery		701,064		701,064			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,761,328		1,761,328			50
52	Delivery Room & Labor Room		1,002,827		1,002,827			52
53	Anesthesiology		67,936		67,936			53
54	Radiology-Diagnostic		3,959,924		3,959,924			54
60	Laboratory		3,182,774		3,182,774			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		207,860		207,860			63
66	Physical Therapy		192,855		192,855			66
69.01	CARDIOPULMONARY		2,517,254		2,517,254			69.01
71	Medical Supplies Charged to Patients		746,512		746,512			71
73	Drugs Charged to Patients		3,175,195		3,175,195			73
74	Renal Dialysis		242,919		242,919			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		8,470		8,470			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		5,845,699		5,845,699			91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	230,736	41,174,217		41,174,217			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		15,253		15,253			190
192	Physicians' Private Offices		341,611		341,611			192
194	FOUNDATION		228,739		228,739			194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	230,736	41,759,820		41,759,820			202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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 MOVEABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		2,714	2,274	4,988	4,988		4
5.01	NONPATIENT TELEPHONES	22,400			22,400	15	22,415	5.01
5.02	DATA PROCESSING	146,801	1,702	291,358	439,861	130	2,468	5.02
5.03	PURCHASING RECEIVING AND STORES	12,373	4,966	1,200	18,539	56	617	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE			11,903	11,903	133	1,165	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	422,756	99,626	22,579	544,961	919	6,444	5.05
6	Maintenance & Repairs							6
7	Operation of Plant		6,134	6,263	12,397	156	891	7
8	Laundry & Linen Service							8
9	Housekeeping		3,031	5,992	9,023	133	137	9
10	Dietary		10,240	10,721	20,961	81	685	10
11	Cafeteria					37		11
12	Maintenance of Personnel							12
13	Nursing Administration			6,994	6,994	276	274	13
14	Central Services & Supply	1,800	6,164	7,860	15,824	19		14
15	Pharmacy	8,418	1,761		10,179	107	617	15
16	Medical Records & Library		4,040	12,625	16,665	66	1,028	16
17	Social Service					13		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		90,852	235,379	326,231	957	1,851	30
31	Intensive Care Unit	2,100	7,168	23,237	32,505	261	137	31
43	Nursery		8,422	5,279	13,701	76		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		20,356	96,334	116,690	158	1,919	50
52	Delivery Room & Labor Room		10,613	10,053	20,666	155		52
53	Anesthesiology	24,726		15,783	40,509			53
54	Radiology-Diagnostic	284,330	11,084	112,884	408,298	263	1,097	54
60	Laboratory		8,448		8,448	200	1,439	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
66	Physical Therapy	297		7,788	8,085	25	617	66
69.01	CARDIOPULMONARY	267,779	2,847	18,644	289,270	202	754	69.01
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients			90	90			73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY						69	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		38,399	15,070	53,469	505		91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,193,780	338,567	920,310	2,452,657	4,943	22,209	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		891		891		206	190
192	Physicians' Private Offices		9,267		9,267	26		192
194	FOUNDATION					19		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,193,780	348,725	920,310	2,462,815	4,988	22,415	202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DATA PROCE SSING	PURCHASING RECEIVING AND STORE	CASHIERING /ACCOUNTS RECEIVABLE	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	HOUSE- KEEPING	
		5.02	5.03	5.04	5.05	7	9	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING	442,459						5.02
5.03	PURCHASING RECEIVING AND STORES	12,122	31,334					5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	39,397		52,598				5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	142,435			694,759			5.05
6	Maintenance & Repairs							6
7	Operation of Plant	6,061			56,663	76,168		7
8	Laundry & Linen Service							8
9	Housekeeping				26,679	988	36,960	9
10	Dietary	6,061			18,141	3,339	638	10
11	Cafeteria				6,880		638	11
12	Maintenance of Personnel							12
13	Nursing Administration				29,670		319	13
14	Central Services & Supply	3,031			4,244	2,010	775	14
15	Pharmacy	12,122			23,811	574	319	15
16	Medical Records & Library	33,336			21,570	1,317	547	16
17	Social Service				3,755			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	81,825	8,707	14,708	159,555	29,628	23,453	30
31	Intensive Care Unit	3,031	1,245	2,086	35,025	2,337	547	31
43	Nursery		72	121	8,411	2,746	319	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,061	338	565	21,419	6,638	1,823	50
52	Delivery Room & Labor Room		245	410	12,486	3,461	479	52
53	Anesthesiology		218	364	919		69	53
54	Radiology-Diagnostic		2,527	4,231	57,362	3,614	1,231	54
60	Laboratory	51,519	2,491	4,172	47,836	2,755	866	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		173	289	3,331			63
66	Physical Therapy		56	94	2,943		228	66
69.01	CARDIOPULMONARY	24,244	3,163	5,297	38,115	928	396	69.01
71	Medical Supplies Charged to Patients		3,558	5,958	3,386			71
73	Drugs Charged to Patients		2,506	4,196	28,560		69	73
74	Renal Dialysis		210	352	3,886			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			1	141			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	21,214	5,825	9,754	73,302	12,521	3,647	91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	442,459	31,334	52,598	688,090	72,856	36,363	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				38	290		190
192	Physicians' Private Offices				2,895	3,022	597	192
194	FOUNDATION				3,736			194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	442,459	31,334	52,598	694,759	76,168	36,960	202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	49,906						10
11	Cafeteria		7,555					11
12	Maintenance of Personnel							12
13	Nursing Administration		383	37,916				13
14	Central Services & Supply		92		25,995			14
15	Pharmacy		349			48,078		15
16	Medical Records & Library		248				74,777	16
17	Social Service		86					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	45,582	2,655	22,364			20,905	30
31	Intensive Care Unit	4,324	421	3,542			2,965	31
43	Nursery		119	1,006			172	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		175	1,470			804	50
52	Delivery Room & Labor Room		141	1,190			583	52
53	Anesthesiology						518	53
54	Radiology-Diagnostic		614			4,752	6,016	54
60	Laboratory		599				5,932	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.						411	63
66	Physical Therapy		56				134	66
69.01	CARDIOPULMONARY		454				7,531	69.01
71	Medical Supplies Charged to Patients				25,995		8,471	71
73	Drugs Charged to Patients					43,326	5,966	73
74	Renal Dialysis						500	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY						1	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		991	8,344			13,868	91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	49,906	7,383	37,916	25,995	48,078	74,777	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		101					192
194	FOUNDATION		71					194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	49,906	7,555	37,916	25,995	48,078	74,777	202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		17	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
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
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	3,854						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,613	742,034		742,034			30
31	Intensive Care Unit	241	88,667		88,667			31
43	Nursery		26,743		26,743			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		158,060		158,060			50
52	Delivery Room & Labor Room		39,816		39,816			52
53	Anesthesiology		42,597		42,597			53
54	Radiology-Diagnostic		490,005		490,005			54
60	Laboratory		126,257		126,257			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		4,204		4,204			63
66	Physical Therapy		12,238		12,238			66
69.01	CARDIOPULMONARY		370,354		370,354			69.01
71	Medical Supplies Charged to Patients		47,368		47,368			71
73	Drugs Charged to Patients		84,713		84,713			73
74	Renal Dialysis		4,948		4,948			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		212		212			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		203,440		203,440			91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,854	2,441,656		2,441,656			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,425		1,425			190
192	Physicians' Private Offices		15,908		15,908			192
194	FOUNDATION		3,826		3,826			194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,854	2,462,815		2,462,815			202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NONPATIENT TELEPHONE S PHONES	DATA PROCE SSING MACH	PURCHASING RECEIVING AND STORE GROSS REVENUE	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	136,225						1
2	Cap Rel Costs-Mvble Equip		101,982					2
4	Employee Benefits Department	1,060	252	24,590,726				4
5.01	NONPATIENT TELEPHONES			72,127	327			5.01
5.02	DATA PROCESSING	665	32,286	639,042	36	146		5.02
5.03	PURCHASING RECEIVING AND STORES	1,940	133	273,947	9	4	124,556,527	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE		1,319	653,915	17	13		5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	38,918	2,502	4,528,021	94	47		5.05
6	Maintenance & Repairs							6
7	Operation of Plant	2,396	694	769,938	13	2		7
8	Laundry & Linen Service							8
9	Housekeeping	1,184	664	653,895	2			9
10	Dietary	4,000	1,188	399,019	10	2		10
11	Cafeteria			180,120				11
12	Maintenance of Personnel							12
13	Nursing Administration		775	1,361,965	4			13
14	Central Services & Supply	2,408	871	92,327		1		14
15	Pharmacy	688		528,095	9	4		15
16	Medical Records & Library	1,578	1,399	322,863	15	11		16
17	Social Service			65,871				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	35,490	26,083	4,731,943	27	27	34,770,965	30
31	Intensive Care Unit	2,800	2,575	1,285,460	2	1	4,942,147	31
43	Nursery	3,290	585	372,535			286,335	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,952	10,675	778,316	28	2	1,339,649	50
52	Delivery Room & Labor Room	4,146	1,114	761,130			971,359	52
53	Anesthesiology		1,749				863,279	53
54	Radiology-Diagnostic	4,330	12,509	1,297,746	16		10,026,725	54
60	Laboratory	3,300		986,081	21	17	9,886,387	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.						685,136	63
66	Physical Therapy		863	125,450	9		222,744	66
69.01	CARDIOPULMONARY	1,112	2,066	997,354	11	8	12,552,135	69.01
71	Medical Supplies Charged to Patients						14,118,296	71
73	Drugs Charged to Patients		10				9,943,004	73
74	Renal Dialysis						833,208	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY				1		1,440	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	15,000	1,670	2,490,041		7	23,113,718	91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	132,257	101,982	24,367,201	324	146	124,556,527	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	348			3			190
192	Physicians' Private Offices	3,620		128,152				192
194	FOUNDATION			95,373				194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	348,725	920,310	3,953,363	102,212	1,897,284	361,710	202
203	Unit Cost Multiplier (Wkst. B, Part I)	2.559919	9.024240	0.160766	312.574924	12,995.095890	0.002904	203
204	Cost to be allocated (Per Wkst. B, Part II)			4,988	22,415	442,459	31,334	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000203	68.547401	3,030.541096	0.000252	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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	HOUSE- KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	
		5.04	5A.05	5.05	7	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	124,556,527						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL		-8,023,863	33,735,957				5.05
6	Maintenance & Repairs							6
7	Operation of Plant			2,751,431	91,246			7
8	Laundry & Linen Service							8
9	Housekeeping			1,295,452	1,184	56,594		9
10	Dietary			880,895	4,000	977	36,728	10
11	Cafeteria			334,079		977		11
12	Maintenance of Personnel							12
13	Nursing Administration			1,440,712		489		13
14	Central Services & Supply			206,103	2,408	1,187		14
15	Pharmacy			1,156,226	688	489		15
16	Medical Records & Library			1,047,387	1,578	838		16
17	Social Service			182,314				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	34,770,965		7,747,615	35,490	35,909	33,546	30
31	Intensive Care Unit	4,942,147		1,700,735	2,800	838	3,182	31
43	Nursery	286,335		408,396	3,290	489		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,339,649		1,040,067	7,952	2,792		50
52	Delivery Room & Labor Room	971,359		606,288	4,146	733		52
53	Anesthesiology	863,279		44,606		105		53
54	Radiology-Diagnostic	10,026,725		2,785,380	4,330	1,885		54
60	Laboratory	9,886,387		2,322,830	3,300	1,326		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	685,136		161,726				63
66	Physical Therapy	222,744		142,928		349		66
69.01	CARDIOPULMONARY	12,552,135		1,850,795	1,112	607		69.01
71	Medical Supplies Charged to Patients	14,118,296		164,408				71
73	Drugs Charged to Patients	9,943,004		1,386,818		105		73
74	Renal Dialysis	833,208		188,709				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,440		6,830				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	23,113,718		3,559,407	15,000	5,585		91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	124,556,527	-8,023,863	33,412,137	87,278	55,680	36,728	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			1,829	348			190
192	Physicians' Private Offices			140,563	3,620	914		192
194	FOUNDATION			181,428				194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,088,712		8,023,863	3,405,840	1,647,760	1,268,160	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.008741		0.237843	37.325910	29.115454	34.528425	203
204	Cost to be allocated (Per Wkst. B, Part II)	52,598		694,759	76,168	36,960	49,906	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000422		0.020594	0.834754	0.653073	1.358800	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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAFETERIA MEALS SERVED	NURSING ADMINIS- TRATION DIRECT NRSING	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE ASSIGNED TIME	
		11	13	14	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	23,586						11
12	Maintenance of Personnel							12
13	Nursing Administration	1,195	14,055					13
14	Central Services & Supply	288		100				14
15	Pharmacy	1,091			1,360,891			15
16	Medical Records & Library	773				124,556,527		16
17	Social Service	270					42,164	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,290	8,290			34,770,965	39,525	30
31	Intensive Care Unit	1,313	1,313			4,942,147	2,639	31
43	Nursery	373	373			286,335		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	545	545			1,339,649		50
52	Delivery Room & Labor Room	441	441			971,359		52
53	Anesthesiology					863,279		53
54	Radiology-Diagnostic	1,916			134,497	10,026,725		54
60	Laboratory	1,869				9,886,387		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					685,136		63
66	Physical Therapy	175				222,744		66
69.01	CARDIOPULMONARY	1,418				12,552,135		69.01
71	Medical Supplies Charged to Patients			100		14,118,296		71
73	Drugs Charged to Patients				1,226,394	9,943,004		73
74	Renal Dialysis					833,208		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY					1,440		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	3,093	3,093			23,113,718		91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	23,050	14,055	100	1,360,891	124,556,527	42,164	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	314						192
194	FOUNDATION	222						194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	441,983	1,820,005	384,961	1,491,587	1,394,285	230,736	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.739210	129.491640	3,849.610000	1.096037	0.011194	5.472346	203
204	Cost to be allocated (Per Wkst. B, Part II)	7.555	37,916	25,995	48,078	74,777	3,854	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.320317	2.697688	259.950000	0.035328	0.000600	0.091405	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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
66	Physical Therapy							66
69.01	CARDIOPULMONARY							69.01
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	FOUNDATION							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							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

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	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	14,953,184		14,953,184		14,953,184	30
31	Intensive Care Unit	2,608,416		2,608,416		2,608,416	31
43	Nursery	701,064		701,064		701,064	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,761,328		1,761,328		1,761,328	50
52	Delivery Room & Labor Room	1,002,827		1,002,827		1,002,827	52
53	Anesthesiology	67,936		67,936		67,936	53
54	Radiology-Diagnostic	3,959,924		3,959,924		3,959,924	54
60	Laboratory	3,182,774		3,182,774		3,182,774	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	207,860		207,860		207,860	63
66	Physical Therapy	192,855		192,855		192,855	66
69.01	CARDIOPULMONARY	2,517,254		2,517,254	22,125	2,539,379	69.01
71	Medical Supplies Charged to Patients	746,512		746,512		746,512	71
73	Drugs Charged to Patients	3,175,195		3,175,195		3,175,195	73
74	Renal Dialysis	242,919		242,919		242,919	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	8,470		8,470		8,470	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	5,845,699		5,845,699		5,845,699	91
92	Observation Beds (Non-Distinct Part)	1,060,610		1,060,610		1,060,610	92
92.01	23-HR OBSERVATION						92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	42,234,827		42,234,827	22,125	42,256,952	200
201	Less Observation Beds	1,060,610		1,060,610		1,060,610	201
202	Total (line 200 minus line 201)	41,174,217		41,174,217		41,196,342	202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	28,185,753		28,185,753				30
31	Intensive Care Unit	6,171,060		6,171,060				31
43	Nursery	327,762		327,762				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,480,520	655,163	2,135,683	0.824714	0.824714	0.824714	50
52	Delivery Room & Labor Room	909,622	71,591	981,213	1.022028	1.022028	1.022028	52
53	Anesthesiology	770,179	323,851	1,094,030	0.062097	0.062097	0.062097	53
54	Radiology-Diagnostic	1,915,181	7,197,381	9,112,562	0.434557	0.434557	0.434557	54
60	Laboratory	4,414,721	4,820,781	9,235,502	0.344624	0.344624	0.344624	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	358,418	249,840	608,258	0.341730	0.341730	0.341730	63
66	Physical Therapy	172,471	21,092	193,563	0.996342	0.996342	0.996342	66
69.01	CARDIOPULMONARY	13,660,522	4,468,564	18,129,086	0.138852	0.138852	0.140072	69.01
71	Medical Supplies Charged to Patients	552,606	203,513	756,119	0.987294	0.987294	0.987294	71
73	Drugs Charged to Patients	6,522,171	2,410,719	8,932,890	0.355450	0.355450	0.355450	73
74	Renal Dialysis	545,220	46,134	591,354	0.410784	0.410784	0.410784	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,034	84	1,118	7.576029	7.576029	7.576029	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	5,816,280	17,215,913	23,032,193	0.253806	0.253806	0.253806	91
92	Observation Beds (Non-Distinct Part)	145,958	776,188	922,146	1.150154	1.150154	1.150154	92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	71,949,478	38,460,814	110,410,292				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	71,949,478	38,460,814	110,410,292				202

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**WORKSHEET D
PART I**

Check ☐ Title V
Applicable ☒ Title XVIII, Part A
Boxes: ☐ Title XIX

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	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)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	742,034		742,034	11,998	61.85	2,011	124,380	30
31	Intensive Care Unit	88,667		88,667	2,121	41.80	679	28,382	31
32	Coronary Care Unit								32
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	26,743		26,743	406	65.87			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	857,444		857,444	14,525		2,690	152,762	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0068

WORKSHEET D PART II

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

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	158,060	2,135,683	0.074009	256,569	18,988	50
52	Delivery Room & Labor Room	39,816	981,213	0.040578	19,157	777	52
53	Anesthesiology	42,597	1,094,030	0.038936	134,366	5,232	53
54	Radiology-Diagnostic	490,005	9,112,562	0.053772	531,367	28,573	54
60	Laboratory	126,257	9,235,502	0.013671	1,093,262	14,946	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,204	608,258	0.006912	64,108	443	63
66	Physical Therapy	12,238	193,563	0.063225	63,685	4,026	66
69.01	CARDIOPULMONARY	370,354	18,129,086	0.020429	4,703,210	96,082	69.01
71	Medical Supplies Charged to Pat	47,368	756,119	0.062646	123,566	7,741	71
73	Drugs Charged to Patients	84,713	8,932,890	0.009483	1,805,759	17,124	73
74	Renal Dialysis	4,948	591,354	0.008367	197,118	1,649	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	212	1,118	0.189624	60	11	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	203,440	23,032,193	0.008833	1,025,894	9,062	91
92	Observation Beds (Non-Distinct	52,632	922,146	0.057076	60,040	3,427	92
92.01	23-HR OBSERVATION						92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,636,844	75,725,717		10,078,161	208,081	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	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
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

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ 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)	11,998		2,011		30
31	Intensive Care Unit	2,121		679		31
32	Coronary Care Unit					32
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	406				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	14,525		2,690		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0068

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(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
53	Anesthesiology									53
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
63	Blood Storing, Processing & Tra									63
66	Physical Therapy									66
69.01	CARDIOPULMONARY									69.01
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
92.01	23-HR OBSERVATION									92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**
COMPONENT CCN: 14-0068
**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

		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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,135,683			256,569		73,814		50
52	Delivery Room & Labor Room	981,213			19,157		438		52
53	Anesthesiology	1,094,030			134,366		46,216		53
54	Radiology-Diagnostic	9,112,562			531,367		631,783		54
60	Laboratory	9,235,502			1,093,262		459,699		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	608,258			64,108		21,632		63
66	Physical Therapy	193,563			63,685		2,573		66
69.01	CARDIOPULMONARY	18,129,086			4,703,210		505,420		69.01
71	Medical Supplies Charged to Pat	756,119			123,566		23,408		71
73	Drugs Charged to Patients	8,932,890			1,805,759		260,106		73
74	Renal Dialysis	591,354			197,118		2,796		74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,118			60				76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	23,032,193			1,025,894		1,655,208		91
92	Observation Beds (Non-Distinct	922,146			60,040		150,670		92
92.01	23-HR OBSERVATION								92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	75,725,717			10,078,161		3,833,763		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0068

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	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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	0.824714	73,814			60,875			50
52	Delivery Room & Labor Room	1.022028	438			448			52
53	Anesthesiology	0.062097	46,216			2,870			53
54	Radiology-Diagnostic	0.434557	631,783			274,546			54
60	Laboratory	0.344624	459,699			158,423			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.341730	21,632			7,392			63
66	Physical Therapy	0.996342	2,573			2,564			66
69.01	CARDIOPULMONARY	0.138852	505,420			70,179			69.01
71	Medical Supplies Charged to Pat	0.987294	23,408			23,111			71
73	Drugs Charged to Patients	0.355450	260,106			92,455			73
74	Renal Dialysis	0.410784	2,796			1,149			74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	7.576029							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.253806	1,655,208			420,102			91
92	Observation Beds (Non-Distinct	1.150154	150,670			173,294			92
92.01	23-HR OBSERVATION								92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		3,833,763			1,287,408			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		3,833,763			1,287,408			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**WORKSHEET D
PART I**

Check ☐ Title V
Applicable ☐ Title XVIII, Part A
Boxes: ☒ Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	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)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	742,034		742,034	11,998	61.85	5,078	314,074	30
31	Intensive Care Unit	88,667		88,667	2,121	41.80	963	40,253	31
32	Coronary Care Unit								32
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	26,743		26,743	406	65.87	263	17,324	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	857,444		857,444	14,525		6,304	371,651	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0068

WORKSHEET D
PART II

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	158,060	2,135,683	0.074009			50
52	Delivery Room & Labor Room	39,816	981,213	0.040578			52
53	Anesthesiology	42,597	1,094,030	0.038936			53
54	Radiology-Diagnostic	490,005	9,112,562	0.053772			54
60	Laboratory	126,257	9,235,502	0.013671			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,204	608,258	0.006912			63
66	Physical Therapy	12,238	193,563	0.063225			66
69.01	CARDIOPULMONARY	370,354	18,129,086	0.020429			69.01
71	Medical Supplies Charged to Pat	47,368	756,119	0.062646			71
73	Drugs Charged to Patients	84,713	8,932,890	0.009483			73
74	Renal Dialysis	4,948	591,354	0.008367			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	212	1,118	0.189624			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	203,440	23,032,193	0.008833			91
92	Observation Beds (Non-Distinct	52,632	922,146	0.057076			92
92.01	23-HR OBSERVATION						92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,636,844	75,725,717				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	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
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

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ 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)	11,998		5,078		30
31	Intensive Care Unit	2,121		963		31
32	Coronary Care Unit					32
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	406		263		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	14,525		6,304		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0068

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(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
53	Anesthesiology									53
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
63	Blood Storing, Processing & Tra									63
66	Physical Therapy									66
69.01	CARDIOPULMONARY									69.01
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
92.01	23-HR OBSERVATION									92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0068

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,135,683							50
52	Delivery Room & Labor Room	981,213							52
53	Anesthesiology	1,094,030							53
54	Radiology-Diagnostic	9,112,562							54
60	Laboratory	9,235,502							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	608,258							63
66	Physical Therapy	193,563							66
69.01	CARDIOPULMONARY	18,129,086							69.01
71	Medical Supplies Charged to Pat	756,119							71
73	Drugs Charged to Patients	8,932,890							73
74	Renal Dialysis	591,354							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,118							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	23,032,193							91
92	Observation Beds (Non-Distinct	922,146							92
92.01	23-HR OBSERVATION								92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	75,725,717							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0068

WORKSHEET D PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.824714							50
52	Delivery Room & Labor Room	1.022028							52
53	Anesthesiology	0.062097							53
54	Radiology-Diagnostic	0.434557							54
60	Laboratory	0.344624							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.341730							63
66	Physical Therapy	0.996342							66
69.01	CARDIOPULMONARY	0.138852							69.01
71	Medical Supplies Charged to Pat	0.987294							71
73	Drugs Charged to Patients	0.355450							73
74	Renal Dialysis	0.410784							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY	7.576029							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.253806							91
92	Observation Beds (Non-Distinct	1.150154							92
92.01	23-HR OBSERVATION								92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0068****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)	11,998	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,998	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	11,147	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)	2,011	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)	14,953,184	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)	14,953,184	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		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)	14,953,184	37

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0068****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

1

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,246.31	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,506,329	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)					2,506,329	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	2,608,416	2,121	1,229.80	679	835,034	43
44	Coronary Care Unit						44
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)	2,766,054	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	6,107,417	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	152,762	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	208,081	51
52	Total Program excludable cost (sum of lines 50 and 51)	360,843	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	5,746,574	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

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0068

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					851	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,246.31	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,060,610	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	742,034	14,953,184	0.049624	1,060,610	52,632	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0068****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)	11,998	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,998	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	11,147	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)	5,078	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)	406	15
16	Nursery days (title V or XIX only)	263	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)	14,953,184	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)	14,953,184	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		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)	14,953,184	37

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0068****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS****1**

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,246.31	38
39	Program general inpatient routine service cost (line 9 x line 38)					6,328,762	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)					6,328,762	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)	701,064	406	1,726.76	263	454,138	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	2,608,416	2,121	1,229.80	963	1,184,297	43
44	Coronary Care Unit						44
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)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	7,967,197	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	371,651	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	371,651	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		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

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0068

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					851	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,246.31	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,060,610	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	742,034	14,953,184	0.049624	1,060,610	52,632	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0068

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		5,287,653		30
31	Intensive Care Unit		1,948,770		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.824714	256,569	211,596	50
52	Delivery Room & Labor Room	1.022028	19,157	19,579	52
53	Anesthesiology	0.062097	134,366	8,344	53
54	Radiology-Diagnostic	0.434557	531,367	230,909	54
60	Laboratory	0.344624	1,093,262	376,764	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.341730	64,108	21,908	63
66	Physical Therapy	0.996342	63,685	63,452	66
69.01	CARDIOPULMONARY	0.140072	4,703,210	658,788	69.01
71	Medical Supplies Charged to Patients	0.987294	123,566	121,996	71
73	Drugs Charged to Patients	0.355450	1,805,759	641,857	73
74	Renal Dialysis	0.410784	197,118	80,973	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	7.576029	60	455	76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.253806	1,025,894	260,378	91
92	Observation Beds (Non-Distinct Part)	1.150154	60,040	69,055	92
92.01	23-HR OBSERVATION				92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		10,078,161	2,766,054	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		10,078,161		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0068

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.824714			50
52	Delivery Room & Labor Room	1.022028			52
53	Anesthesiology	0.062097			53
54	Radiology-Diagnostic	0.434557			54
60	Laboratory	0.344624			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.341730			63
66	Physical Therapy	0.996342			66
69.01	CARDIOPULMONARY	0.138852			69.01
71	Medical Supplies Charged to Patients	0.987294			71
73	Drugs Charged to Patients	0.355450			73
74	Renal Dialysis	0.410784			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	7.576029			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.253806			91
92	Observation Beds (Non-Distinct Part)	1.150154			92
92.01	23-HR OBSERVATION				92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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)	2,596,321			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	865,440			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)	121,543			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	1,517,777			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	131.67			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)	0.1864			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.6157			31
32	Sum of lines 30 and 31	0.8021			32
33	Allowable disproportionate share percentage (see instructions)	0.5539			33
34	Disproportionate share adjustment (see instructions)	479,368			34
		Prior to October 1 (1.00)	(1.01)	On or after October 1 (2.00)	
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000412502	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,994,753		2,791,275	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,000,109		1,391,813	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,391,922			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	6,454,594			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)	6,454,594			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	334,382			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				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)				58
59	Total (sum of amounts on lines 49 through 58)	6,788,976			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	6,788,976			61
62	Deductibles billed to program beneficiaries	377,710			62
63	Coinsurance billed to program beneficiaries	55,739			63
64	Allowable bad debts (see instructions)	177,999			64
65	Adjusted reimbursable bad debts (see instructions)	115,699			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	174,079			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,471,226			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-8,769			70.93
70.94	HRR adjustment amount (see instructions)	-35,711			70.94
71	Amount due provider (see instructions)	6,426,746			71
71.01	Sequestration adjustment (see instructions)	128,535			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	6,549,736			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-251,525			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	315,257			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)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-0068****WORKSHEET E
PART B**Check applicable box: ☒ **Hospital** ☐ **IPF** ☐ **IRF** ☐ **SUB (Other)** ☐ **SNF****PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	1,287,408			2
3	OPPS payments	902,411			3
4	Outlier payment (see instructions)	3,478			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)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	905,889			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	192,561			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)	713,328			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)	713,328			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	713,328			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)	39,622			34
35	Adjusted reimbursable bad debts (see instructions)	25,754			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,622			36
37	Subtotal (see instructions)	739,082			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	739,082			40
40.01	Sequestration adjustment (see instructions)	14,782			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	699,060			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	25,240			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

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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WORKSHEET E-1
PART I

		INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
DESCRIPTION		1	2	3	4	
1	Total interim payments paid to provider		6,381,629		699,060	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 .02 .03 .04 .05 .06 .07 .08 .09 .10 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99	03/29/2018 168,107			3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.10 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		168,107			
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)		6,549,736		699,060	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 .02 .03 .04 .05 .06 .07 .08 .09 .10 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99				5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.10 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					
6	Determined net settlement amount (balance due) based on the cost report (1)	.01 .02			25,240	6.01 6.02
7	Total Medicare program liability (see instructions)		6,298,211		724,300	7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

Page: 63

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0068

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	Inpatient hospital/SNF/NF services	7,967,197		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	7,967,197		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	7,967,197		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a charge basis			13
14	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)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	7,967,197		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	7,967,197		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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)

	Assets (Omit Cents)	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT ASSETS						
1	Cash on hand and in banks	3,289,385				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	132,837,932				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-130,512,420				6
7	Inventory	371,089				7
8	Prepaid expenses	8,767				8
9	Other current assets	14,855,222				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	20,849,975				11
FIXED ASSETS						
12	Land	934,453				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	7,338				17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	19,517,521				23
24	Accumulated depreciation	-14,269,152				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	6,190,160				30
OTHER ASSETS						
31	Investments	404,563				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	358,115				34
35	Total other assets (sum of lines 31-34)	762,678				35
36	Total assets (sum of lines 11, 30 and 35)	27,802,813				36
	Liabilities and Fund Balances (Omit Cents)	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT LIABILITIES						
37	Accounts payable	7,316,600				37
38	Salaries, wages and fees payable	1,387,035				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	143,072				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	2,966,893				44
45	Total current liabilities (sum of lines 37 thru 44)	11,813,600				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	13,418,350				49
50	Total long term liabilities (sum of lines 46 thru 49)	13,418,350				50
51	Total liabilities (sum of lines 45 and 50)	25,231,950				51
CAPITAL ACCOUNTS						
52	General fund balance	2,570,863				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)	2,570,863				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	27,802,813				60

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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		8,372,347			1
2	Net income (loss) (from Worksheet G-3, line 29)		-5,801,484			2
3	Total (sum of line 1 and line 2)		2,570,863			3
4	Additions (credit adjustments) (specify)					4
5	NET EQUITY ADJ					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		2,570,863			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						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)		2,570,863			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	NET EQUITY ADJ					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						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

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	28,513,515		28,513,515	1
2	Subprovider IPF				2
3	Subprovider IRF				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)	28,513,515		28,513,515	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	6,171,060		6,171,060	11
12	Coronary Care Unit				12
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)	6,171,060		6,171,060	16
17	Total inpatient routine care services (sum of lines 10 and 16)	34,684,575		34,684,575	17
18	Ancillary services	37,264,903		37,264,903	18
19	Outpatient services		38,460,814	38,460,814	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	71,949,478	38,460,814	110,410,292	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		50,053,794	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38	INTEREST EXPENSE PUBLIC AID ASSESSM	-4,290,936		38
39	OTHER VARIANCE	-44,563		39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-4,335,499	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		45,718,295	43

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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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)	110,410,292	1
2	Less contractual allowances and discounts on patients' accounts	71,139,065	2
3	Net patient revenues (line 1 minus line 2)	39,271,227	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	45,718,295	4
5	Net income from service to patients (line 3 minus line 4)	-6,447,068	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		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		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		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		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (GAIN/LOSS - ACE OWNERSHIP)		24
24.01	Other (2016 MEDICARE TENTATIVE CR SETTLEME)		24.01
24.02	Other (ACA RETRO PYMT)		24.02
24.03	Other (HIT INCENTIVE PYMT)		24.03
24.04	Other (GRANT INCOME)		24.04
24.05	Other (OTHER MISC INCIOME)	645,584	24.05
25	Total other income (sum of lines 6-24)	645,584	25
26	Total (line 5 plus line 25)	-5,801,484	26
29	Net income (or loss) for the period (line 26 minus line 28)	-5,801,484	29

KPMG LLP Compu-Max 2552-10

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/29/2018 Run Time: 15:12 Version: 2018.04 (06/21/2018)
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CALCULATION OF CAPITAL PAYMENT**COMPONENT CCN: 14-0068****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	281,021	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	3,817	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)	36.48	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)	0.1864	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.6157	8
9	Sum of lines 7 and 8	0.8021	9
10	Allowable disproportionate share percentage (see instructions)	0.1763	10
11	Disproportionate share adjustment (see instructions)	49,544	11
12	Total prospective capital payments (see instructions)	334,382	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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1 PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
66	Physical Therapy							66
69.01	CARDIOPULMONARY							69.01
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
92.01	23-HR OBSERVATION							92.01
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202