

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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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 Date: 05/29/2019 Time: 15:37 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.		
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 COMMUNITY FIRST MEDICAL CENTER (14-0251) (Provider Name(s) and Number(s)) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018, 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)

INTERIM CFO
Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-181,523	102,231			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		-181,523	102,231			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: 5645 WEST ADDISON ST.	P.O. Box:		1
2	City: CHICAGO	State: IL	ZIP Code: 60634	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	COMMUNITY FIRST MEDICAL CENTER	14-0251	16974	1	07 / 01 / 1966	N	P	O	3
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	CFMC SKILLED NURSING FACILITY	14-5548	16974		07 / 01 / 1985	N	P	N	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: 01 / 01 / 2018	To: 12 / 31 / 2018		20
21	Type of control (see instructions)	3			21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	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.	1,573	1,544			4,412		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 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)			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	45
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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
	Teaching Hospitals				
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	1.84			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	N	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

Rural Providers

		1	2	
105	Does this hospital qualify as a CAH?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
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.	Physical	Occupational Speech Respiratory	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
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	1	2	111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-L, chapter 22, section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118
118.01	List amounts of malpractice premiums and paid losses:	Premiums 1,380,419	Paid Losses	Self Insurance
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

Transplant Center Information

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

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

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	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				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N	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.	N			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	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.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		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.	Y		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.	N	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

		Y/N	
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	04/18/2019	Y	04/18/2019	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

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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 relined 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: DONALD	Last name: HOERL	Title: OWNER	41
42	Employer: SAME			42
43	Phone number: 7196483290	E-mail Address: DONHOERL@GMAIL.COM		43

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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	193	70,445			10,060	1,322	24,778	1
2	HMO and other (see instructions)						4,218	5,956		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)		193	70,445			10,060	1,322	24,778	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34	20	7,300			2,248	251	6,134	11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		213	77,745			12,308	1,573	30,912	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	66	24,090			9,704		14,153	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)		279							27
28	Observation Bed Days								4,822	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,393	230	5,656	1
2	HMO and other (see instructions)					742	1,069		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)	3.72	750.95			2,393	230	5,656	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		42.33						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)	3.72	793.28						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III****Part II - Wage Data**

		Wkst A Line No.	Amount Reported	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	52,021,973		52,021,973	1,650,014.00	31.53	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		3,282,782		3,282,782	26,731.00	122.81	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	2,812,396		2,812,396	88,052.00	31.94	9
10	Excluded area salaries (see instructions)		994,593		994,593	20,380.00	48.80	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		205,855		205,855	910.00	226.21	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)		9,044,879		9,044,879			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		766,428		766,428			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		483,501		483,501			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		432,828		432,828	10,082.00	42.93	26
27	Administrative & General		6,525,833		6,525,833	217,876.00	29.95	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		1,348,415		1,348,415	67,376.00	20.01	30
31	Laundry & Linen Service		79,495		79,495	5,236.00	15.18	31
32	Housekeeping		1,063,881		1,063,881	79,173.00	13.44	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		930,449	-250,105	680,344	42,960.00	15.84	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			250,105	250,105	15,793.00	15.84	36
37	Maintenance of Personnel							37
38	Nursing Administration		930,959		930,959	80,591.00	11.55	38
39	Central Services and Supply		637,671		637,671	31,713.00	20.11	39
40	Pharmacy		1,739,264		1,739,264	41,609.00	41.80	40
41	Medical Records & Medical Records Library		2,015,122		2,015,122	60,557.00	33.28	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		48,739,191		48,739,191	1,623,283.00	30.03	1
2	Excluded area salaries (see instructions)		3,806,989		3,806,989	108,432.00	35.11	2
3	Subtotal salaries (line 1 minus line 2)		44,932,202		44,932,202	1,514,851.00	29.66	3
4	Subtotal other wages & related costs (see instructions)		205,855		205,855	910.00	226.21	4
5	Subtotal wage-related costs (see instructions)		9,044,879		9,044,879		20.13%	5
6	Total (sum of lines 3 through 5)		54,182,936		54,182,936	1,515,761.00	35.75	6
7	Total overhead cost (see instructions)		15,703,917		15,703,917	652,966.00	24.05	7

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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3
PART IV****Part IV - Wage Related Cost****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		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)	4,617,331	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	226,198	10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	326,713	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	1,056,680	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	3,701,346	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	257,529	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	109,021	23
24	Total Wage Related cost (Sum of lines 1-23)	10,294,818	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3
PART V****Part V - Contract Labor and Benefit Cost****Hospital and Hospital-Based Component Identification:**

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

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA**WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N	/ /	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	356		356	12
13	RUB	4,258		4,258	13
14	RUA	2,640		2,640	14
15	RVC	128		128	15
16	RVB	932		932	16
17	RVA	942		942	17
18	RHC				18
19	RHB	73		73	19
20	RHA	126		126	20
21	RMC				21
22	RMB	27		27	22
23	RMA	33		33	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1	6		6	34
35	HB2				35
36	HB1	18		18	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1	3		3	42
43	LB2				43
44	LB1	1		1	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1	23		23	50
51	CB2				51
52	CB1	16		16	52
53	CA2				53
54	CA1	41		41	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA**WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1	15		15	74
75	PB2				75
76	PB1	2		2	76
77	PA2				77
78	PA1	64		64	78
199	AAA				199
200	TOTAL	9,704		9,704	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	14,964,204			207

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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)	0.159503	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	19,978,207	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	154,225,424	6
7	Medicaid cost (line 1 times line 6)	24,599,418	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.	4,621,211	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)	4,621,211	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)	25,939,392	399,034	26,338,426	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,137,411	399,034	4,536,445	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	4,137,411	399,034	4,536,445	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)	11,251,723	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	856,504	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,317,699	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	9,934,024	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,045,702	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	6,582,147	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,203,358	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				10,478,410	10,478,410	-4,589,236	5,889,174	1
2	00200	Cap Rel Costs-Mvble Equip				1,004,412	1,004,412		1,004,412	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	432,828	9,482,377	9,915,205		9,915,205	-483,500	9,431,705	4
5	00500	Administrative & General	6,525,833	30,546,947	37,072,780	-11,225,249	25,847,531	-6,723,804	19,123,727	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,348,415	2,086,569	3,434,984	-74	3,434,910	-220	3,434,690	7
8	00800	Laundry & Linen Service	79,495	541,526	621,021		621,021		621,021	8
9	00900	Housekeeping	1,063,881	461,870	1,525,751		1,525,751		1,525,751	9
10	01000	Dietary	930,449	954,938	1,885,387	-506,146	1,379,241		1,379,241	10
11	01100	Cafeteria				506,146	506,146	-291,762	214,384	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	930,959	23,876	954,835		954,835		954,835	13
14	01400	Central Services & Supply	637,671	8,371	646,042	-83,472	562,570		562,570	14
15	01500	Pharmacy	1,739,264	4,181,026	5,920,290	-4,157,235	1,763,055		1,763,055	15
16	01600	Medical Records & Library	2,015,122	325,152	2,340,274		2,340,274	-54,651	2,285,623	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd				52,056	52,056		52,056	21
22	02200	I&R Services-Other Prgm Costs Apprvd				208,226	208,226		208,226	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	9,785,499	824,126	10,609,625	-390,327	10,219,298	-1,289,296	8,930,002	30
34	03400	Surgical Intensive Care Unit	3,952,723	748,955	4,701,678	-298,150	4,403,528	-168,479	4,235,049	34
44	04400	Skilled Nursing Facility	2,812,396	180,316	2,992,712	-111,584	2,881,128		2,881,128	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,002,665	4,162,895	6,165,560	-2,921,425	3,244,135	-465,000	2,779,135	50
51	05100	Recovery Room	441,530	11,091	452,621	-4,508	448,113		448,113	51
53	05300	Anesthesiology	71,304	1,157,512	1,228,816	-51,236	1,177,580	-1,082,500	95,080	53
54	05400	Radiology-Diagnostic	1,458,468	363,438	1,821,906	-34,972	1,786,934	-4,020	1,782,914	54
56	05600	Radioisotope	194,833	215,730	410,563	-1,239	409,324		409,324	56
57	05700	CT Scan	628,577	296,012	924,589	-95,541	829,048		829,048	57
58	05800	MRI	190,464	124,864	315,328	-4,474	310,854		310,854	58
59	05900	Cardiac Catheterization	633,955	1,076,910	1,710,865	-995,921	714,944		714,944	59
60	06000	Laboratory	988,126	4,202,205	5,190,331	-8,043	5,182,288		5,182,288	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,035,510	484,055	1,519,565	-339,284	1,180,281	-58,463	1,121,818	65
66	06600	Physical Therapy	1,751,589	30,914	1,782,503	-4,765	1,777,738		1,777,738	66
67	06700	Occupational Therapy	704,371	525	704,896		704,896		704,896	67
68	06800	Speech Pathology	192,451	623	193,074		193,074		193,074	68
69	06900	Electrocardiology	485,753	37,817	523,570	-7,879	515,691	-2,490	513,201	69
70	07000	Electroencephalography	45,901	364	46,265		46,265		46,265	70
71	07100	Medical Supplies Charged to Patients		3,944	3,944	3,632,070	3,636,014		3,636,014	71
72	07200	Impl. Dev. Charged to Patients				1,712,296	1,712,296		1,712,296	72
73	07300	Drugs Charged to Patients				4,229,180	4,229,180	-38,464	4,190,716	73
74	07400	Renal Dialysis	321,050	24,498	345,548	-12,611	332,937		332,937	74
76.97	07697	CARDIAC REHABILITATION	157,824	6,507	164,331	-172	164,159	-279	163,880	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	1,001,811	36,429	1,038,240	-18,112	1,020,128	-115,511	904,617	90
91	09100	Emergency	6,466,663	4,671,868	11,138,531	-550,377	10,588,154	-5,658,139	4,930,015	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	51,027,380	67,274,250	118,301,630		118,301,630	-21,025,814	97,275,816	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		1,617	1,617		1,617		1,617	190
194	07950	ADDISON CENTRAL PHARMACY	246,725	1,364,352	1,611,077		1,611,077		1,611,077	194
194.01	07951	PHYSICIAN PRACTICES	747,868	245,495	993,363		993,363		993,363	194.01
200		TOTAL (sum of lines 118-199)	52,021,973	68,885,714	120,907,687		120,907,687	-21,025,814	99,881,873	200

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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	RECLASS CAFETERIA COST	A	Cafeteria	11	250,105	256,041	1
500	Total reclassifications				250,105	256,041	500
	Code Letter - A						
1	RECLASS OTHER CAPITAL COSTS	B	Cap Rel Costs-Bldg & Fixt	1		129,176	1
2			Cap Rel Costs-Bldg & Fixt	1		4,987,609	2
500	Total reclassifications					5,116,785	500
	Code Letter - B						
1	CHARGEABLE MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		3,632,070	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
500	Total reclassifications					3,632,070	500
	Code Letter - C						
1	RECLASS IMPLANT COST	D	Impl. Dev. Charged to Patient	72		1,712,296	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	Total reclassifications					1,712,296	500
	Code Letter - D						
1	CHARGEABLE DRUG COST	E	Drugs Charged to Patients	73		4,229,180	1
2							2
3							3
4							4
500	Total reclassifications					4,229,180	500
	Code Letter - E						
1	DEPRECIATION AND INTEREST	F	Cap Rel Costs-Bldg & Fixt	1		5,361,625	1
2			Cap Rel Costs-Mvble Equip	2		590,839	2
500	Total reclassifications					5,952,464	500
	Code Letter - F						
1	GME COSTS	G	I&R Services-Salary & Fringes	21		52,056	1
2			I&R Services-Other Prgm Costs	22		208,226	2
500	Total reclassifications					260,282	500
	Code Letter - G						
1	EQUIPMENT RENTAL	H	Cap Rel Costs-Mvble Equip	2		413,573	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					413,573	500
	Code Letter - H						
	GRAND TOTAL (Increases)				250,105	21,572,691	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

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RECLASSIFICATIONS

WORKSHEET A-6

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	RECLASS CAFETERIA COST	A	Dietary	10	250,105	256,041		1
500	Total reclassifications				250,105	256,041		500
	Code letter - A							
1	RECLASS OTHER CAPITAL COSTS	B	Administrative & General	5		129,176	12	1
2			Administrative & General	5		4,987,609	11	2
500	Total reclassifications					5,116,785		500
	Code letter - B							
1	CHARGEABLE MEDICAL SUPPLIES	C	Pharmacy	15		96		1
2			Adults & Pediatrics	30		319,240		2
3			Surgical Intensive Care Unit	34		266,811		3
4			Skilled Nursing Facility	44		97,732		4
5			Operating Room	50		1,816,775		5
6			Recovery Room	51		4,508		6
7			Anesthesiology	53		51,236		7
8			Radiology-Diagnostic	54		34,255		8
9			Radioisotope	56		1,239		9
10			Cardiac Catheterization	59		278,771		10
11			MRI	58		4,474		11
12			Laboratory	60		8,043		12
13			Respiratory Therapy	65		321,376		13
14			Electrocardiology	69		7,879		14
15			Renal Dialysis	74		12,611		15
16			CARDIAC REHABILITATION	76.97		172		16
17			Clinic	90		17,777		17
18			Emergency	91		289,991		18
19			Physical Therapy	66		4,765		19
20			CT Scan	57		94,319		20
500	Total reclassifications					3,632,070		500
	Code letter - C							
1	RECLASS IMPLANT COST	D	Pharmacy	15		78		1
2			Operating Room	50		992,247		2
3			Surgical Intensive Care Unit	34		158		3
4			Skilled Nursing Facility	44		285		4
5			Radiology-Diagnostic	54		717		5
6			CT Scan	57		1,222		6
7			Cardiac Catheterization	59		717,150		7
8			Clinic	90		335		8
9			Emergency	91		104		9
500	Total reclassifications					1,712,296		500
	Code letter - D							
1	CHARGEABLE DRUG COST	E	Pharmacy	15		4,157,061		1
2			Adults & Pediatrics	30		48,044		2
3			Surgical Intensive Care Unit	34		19,342		3
4			Skilled Nursing Facility	44		4,733		4
500	Total reclassifications					4,229,180		500
	Code letter - E							
1	DEPRECIATION AND INTEREST	F	Administrative & General	5		5,952,464	9	1
2							9	2
500	Total reclassifications					5,952,464		500
	Code letter - F							
1	GME COSTS	G	Emergency	91		260,282		1
2								2
500	Total reclassifications					260,282		500
	Code letter - G							
1	EQUIPMENT RENTAL	H	Administrative & General	5		156,000	10	1
2			Operation of Plant	7		74		2
3			Central Services & Supply	14		83,472		3
4			Adults & Pediatrics	30		23,043		4
5			Surgical Intensive Care Unit	34		11,839		5
6			Skilled Nursing Facility	44		8,834		6
7			Operating Room	50		112,403		7
8			Respiratory Therapy	65		17,908		8
500	Total reclassifications					413,573		500
	Code letter - H							
	GRAND TOTAL (Decreases)				250,105	21,572,691		

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	2,492,380					2,492,380		1
2	Land Improvements								2
3	Buildings and Fixtures	18,469,570	143,070		143,070		18,612,640		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	8,793,454	129,003		129,003		8,922,457		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	29,755,404	272,073		272,073		30,027,477		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	29,755,404	272,073		272,073		30,027,477		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								1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	21,105,020		21,105,020	0.702857					1
2	Cap Rel Costs-Mvble Equip	8,922,457		8,922,457	0.297143					2
3	Total (sum of lines 1-2)	30,027,477		30,027,477	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	772,389		4,987,609	129,176			5,889,174	1
2	Cap Rel Costs-Mvble Equip	590,839	413,573					1,004,412	2
3	Total (sum of lines 1-2)	1,363,228	413,573	4,987,609	129,176			6,893,586	3

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

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-11,647	Administrative & General	5		7
8	Television and radio service (chapter 21)	A	-4,891	Administrative & General	5		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-5,549,163				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	-291,762	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	B	-38,464	Drugs Charged to Patients	73		17
18	Sale of medical records and abstracts	B	-3,558	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant	A	-196,096	Adults & Pediatrics	30		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	MISC INCOME	B	-4,020	Radiology-Diagnostic	54		33
34	MISC INCOME	B	-220	Operation of Plant	7		34
35	FITNESS CENTER	B	-56,536	Respiratory Therapy	65		35
36	MISC INCOME	B	-2,490	Electrocardiology	69		36
37	MISC INCOME	B	-279	CARDIAC REHABILITATION	76.97		37
38	MISC INCOME	B	-186,874	Administrative & General	5		38
39	MIDLEVEL SALARIES	A	-115,511	Clinic	90		39
40	MIDLEVEL SALARIES	A	-529,608	Emergency	91		40
41	HOSPITALISTS SALARIES	A	-850,920	Adults & Pediatrics	30		41
42	ER PHYSICIAN SALARIES	A	-1,590,647	Emergency	91		42
43	MEDICAID TAX ASSESSMENTS	A	-6,520,392	Administrative & General	5		43
44	PHYS AND MIDLEVEL BENEFITS	A	-483,500	Employee Benefits Department	4		44
45	REALESTATE TAX CREDITS	B	-4,589,236	Cap Rel Costs-Bldg & Fixt	1	9	45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-21,025,814				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

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

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
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			
	1	2	3	Name	Percentage of Ownership	Type of Business	
6				4	5	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:

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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	34	Surgical Intensive C VARIOUS	206,000	150,325	55,675	211,500	369	37,521	1,876	1
2	50	Operating Room DR A	465,000	465,000						2
3	53	Anesthesiology DR B	1,082,500	1,082,500						3
4	91	Emergency VARIOUS	3,552,469	3,446,578	105,891	171,400	177	14,585	729	4
5	65	Respiratory Therapy DR C	18,501		18,501	211,500	163	16,574	829	5
6	16	Medical Records & Li VARIOUS	71,531	45,743	25,788	211,500	201	20,438	1,022	6
7	30	Adults & Pediatrics HOSPITALISTS	242,280	242,280						7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	5,638,281	5,432,426	205,855		910	89,118	4,456	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	34	Surgical Intensive C VARIOUS					37,521	18,154	168,479	1
2	50	Operating Room DR A							465,000	2
3	53	Anesthesiology DR B							1,082,500	3
4	91	Emergency VARIOUS					14,585	91,306	3,537,884	4
5	65	Respiratory Therapy DR C					16,574	1,927	1,927	5
6	16	Medical Records & Li VARIOUS					20,438	5,350	51,093	6
7	30	Adults & Pediatrics HOSPITALISTS							242,280	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					89,118	116,737	5,549,163	200

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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	5,889,174	5,889,174					1
2	Cap Rel Costs-Mvble Equip	1,004,412		1,004,412				2
4	Employee Benefits Department	9,431,705	62,672	10,689	9,505,066			4
5	Administrative & General	19,123,727	464,954	79,299	1,284,062	20,952,042	20,952,042	5
6	Maintenance & Repairs							6
7	Operation of Plant	3,434,690	681,978	116,313	265,322	4,498,303	1,194,079	7
8	Laundry & Linen Service	621,021			15,642	636,663	169,003	8
9	Housekeeping	1,525,751	141,181	24,079	209,336	1,900,347	504,449	9
10	Dietary	1,379,241	187,693	32,011	133,869	1,732,814	459,977	10
11	Cafeteria	214,384	184,099	31,398	49,212	479,093	127,176	11
12	Maintenance of Personnel							12
13	Nursing Administration	954,835	59,310	10,116	183,181	1,207,442	320,517	13
14	Central Services & Supply	562,570	179,694	30,647	125,472	898,383	238,477	14
15	Pharmacy	1,763,055	63,043	10,752	342,228	2,179,078	578,438	15
16	Medical Records & Library	2,285,623	174,384	29,742	396,507	2,886,256	766,160	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	52,056				52,056	13,818	21
22	I&R Services-Other Prgm Costs Apprvd	208,226				208,226	55,274	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,930,002	1,270,771	216,734	1,719,452	12,136,959	3,221,805	30
34	Surgical Intensive Care Unit	4,235,049	169,677	28,939	777,761	5,211,426	1,383,378	34
44	Skilled Nursing Facility	2,881,128	461,662	78,737	553,384	3,974,911	1,055,144	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,779,135	485,613	82,822	394,056	3,741,626	993,218	50
51	Recovery Room	448,113	32,554	5,552	86,878	573,097	152,129	51
53	Anesthesiology	95,080	14,260	2,432	14,030	125,802	33,394	53
54	Radiology-Diagnostic	1,782,914	233,184	39,770	286,977	2,342,845	621,911	54
56	Radioisotope	409,324	14,260	2,432	38,337	464,353	123,263	56
57	CT Scan	829,048	25,922	4,421	123,683	983,074	260,958	57
58	MRI	310,854	6,933	1,182	37,477	356,446	94,619	58
59	Cardiac Catheterization	714,944	101,092	17,241	124,741	958,018	254,307	59
60	Laboratory	5,182,288	223,516	38,121	194,430	5,638,355	1,496,707	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,121,818	47,091	8,032	203,753	1,380,694	366,507	65
66	Physical Therapy	1,777,738	112,824	19,242	344,653	2,254,457	598,448	66
67	Occupational Therapy	704,896	28,519	4,864	138,596	876,875	232,767	67
68	Speech Pathology	193,074	18,781	3,203	37,868	252,926	67,139	68
69	Electrocardiology	513,201	34,177	5,829	95,580	648,787	172,221	69
70	Electroencephalography	46,265			9,032	55,297	14,679	70
71	Medical Supplies Charged to Patients	3,636,014				3,636,014	965,184	71
72	Impl. Dev. Charged to Patients	1,712,296				1,712,296	454,531	72
73	Drugs Charged to Patients	4,190,716				4,190,716	1,112,430	73
74	Renal Dialysis	332,937	16,485	2,812	63,172	415,406	110,270	74
76.97	CARDIAC REHABILITATION	163,880	41,156	7,019	31,054	243,109	64,534	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	904,617	74,289	12,670	174,394	1,165,970	309,508	90
91	Emergency	4,930,015	244,128	41,637	855,225	6,071,005	1,611,554	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	97,275,816	5,855,902	998,737	9,309,364	97,041,167	20,197,973	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,617	33,272	5,675		40,564	10,768	190
194	ADDISON CENTRAL PHARMACY	1,611,077			48,547	1,659,624	440,549	194
194.01	PHYSICIAN PRACTICES	993,363			147,155	1,140,518	302,752	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	99,881,873	5,889,174	1,004,412	9,505,066	99,881,873	20,952,042	202

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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	5,692,382						7
8	Laundry & Linen Service		805,666					8
9	Housekeeping	171,737		2,576,533				9
10	Dietary	228,316		106,557	2,527,664			10
11	Cafeteria	223,944		104,517		934,730		11
12	Maintenance of Personnel							12
13	Nursing Administration	72,147		33,672		63,808	1,697,586	13
14	Central Services & Supply	218,585		102,016		25,112		14
15	Pharmacy	76,688		35,791		32,933		15
16	Medical Records & Library	212,126		99,001		47,934		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					6,126		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,545,807	321,051	721,442	1,489,582	214,544	624,289	30
34	Surgical Intensive Care Unit	206,401	81,799	96,329	308,709	71,383	276,563	34
44	Skilled Nursing Facility	561,581	90,802	262,095	729,373	69,703	143,922	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	590,716	64,719	275,692		42,550	115,448	50
51	Recovery Room	39,599		18,481		6,735	33,543	51
53	Anesthesiology	17,346		8,095		1,630		53
54	Radiology-Diagnostic	283,653	70,334	132,383		36,095		54
56	Radioisotope	17,346		8,095		3,343		56
57	CT Scan	31,533		14,717		14,491	6,437	57
58	MRI	8,433		3,936		2,816		58
59	Cardiac Catheterization	122,972	4,740	57,392		9,287	26,349	59
60	Laboratory	271,892		126,894		31,830		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	57,283		26,735		27,351		65
66	Physical Therapy	137,243	17,466	64,053		40,920		66
67	Occupational Therapy	34,692		16,191		15,479		67
68	Speech Pathology	22,846		10,662		3,458		68
69	Electrocardiology	41,573	4,617	19,403		11,691	13,933	69
70	Electroencephalography		123			1,383		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	20,053	1,929	9,359		3,820	19,002	74
76.97	CARDIAC REHABILITATION	50,063		23,365		2,997	14,942	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	90,367	4,157	42,175		25,145	34,851	90
91	Emergency	296,966	140,285	138,596		122,166	388,307	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,651,908	802,022	2,557,644	2,527,664	934,730	1,697,586	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	40,474	3,644	18,889				190
194	ADDISON CENTRAL PHARMACY							194
194.01	PHYSICIAN PRACTICES							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,692,382	805,666	2,576,533	2,527,664	934,730	1,697,586	202

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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	1,482,573						14
15	Pharmacy		2,902,928					15
16	Medical Records & Library			4,011,477				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				72,000			21
22	I&R Services-Other Prgm Costs Apprvd					263,500		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			541,353			20,816,832	30
34	Surgical Intensive Care Unit			147,911			7,783,899	34
44	Skilled Nursing Facility			99,856			6,987,387	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			173,908			5,997,877	50
51	Recovery Room			30,753			854,337	51
53	Anesthesiology			53,032			239,299	53
54	Radiology-Diagnostic			151,828			3,639,049	54
56	Radioisotope			40,291			656,691	56
57	CT Scan			326,725			1,637,935	57
58	MRI			46,838			513,088	58
59	Cardiac Catheterization			112,766			1,545,831	59
60	Laboratory			502,176			8,067,854	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			130,352			1,988,922	65
66	Physical Therapy			85,553			3,198,140	66
67	Occupational Therapy			38,238			1,214,242	67
68	Speech Pathology			7,116			364,147	68
69	Electrocardiology			134,500			1,046,725	69
70	Electroencephalography			1,814			73,296	70
71	Medical Supplies Charged to Patients	1,482,573		127,251			6,211,022	71
72	Impl. Dev. Charged to Patients			59,619			2,226,446	72
73	Drugs Charged to Patients		2,902,928	508,983			8,715,057	73
74	Renal Dialysis			16,833			596,672	74
76.97	CARDIAC REHABILITATION			1,469			400,479	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			81,864			1,754,037	90
91	Emergency			590,448	72,000	263,500	9,694,827	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,482,573	2,902,928	4,011,477	72,000	263,500	96,224,091	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						114,339	190
194	ADDISON CENTRAL PHARMACY						2,100,173	194
194.01	PHYSICIAN PRACTICES						1,443,270	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,482,573	2,902,928	4,011,477	72,000	263,500	99,881,873	202

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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		20,816,832				30
34	Surgical Intensive Care Unit		7,783,899				34
44	Skilled Nursing Facility		6,987,387				44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		5,997,877				50
51	Recovery Room		854,337				51
53	Anesthesiology		239,299				53
54	Radiology-Diagnostic		3,639,049				54
56	Radioisotope		656,691				56
57	CT Scan		1,637,935				57
58	MRI		513,088				58
59	Cardiac Catheterization		1,545,831				59
60	Laboratory		8,067,854				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		1,988,922				65
66	Physical Therapy		3,198,140				66
67	Occupational Therapy		1,214,242				67
68	Speech Pathology		364,147				68
69	Electrocardiology		1,046,725				69
70	Electroencephalography		73,296				70
71	Medical Supplies Charged to Patients		6,211,022				71
72	Impl. Dev. Charged to Patients		2,226,446				72
73	Drugs Charged to Patients		8,715,057				73
74	Renal Dialysis		596,672				74
76.97	CARDIAC REHABILITATION		400,479				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		1,754,037				90
91	Emergency	-335,500	9,359,327				91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	-335,500	95,888,591				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		114,339				190
194	ADDISON CENTRAL PHARMACY		2,100,173				194
194.01	PHYSICIAN PRACTICES		1,443,270				194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	-335,500	99,546,373				202

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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		62,672	10,689	73,361	73,361		4
5	Administrative & General		464,954	79,299	544,253	9,913	554,166	5
6	Maintenance & Repairs							6
7	Operation of Plant		681,978	116,313	798,291	2,048	31,583	7
8	Laundry & Linen Service					121	4,470	8
9	Housekeeping		141,181	24,079	165,260	1,616	13,342	9
10	Dietary		187,693	32,011	219,704	1,033	12,166	10
11	Cafeteria		184,099	31,398	215,497	380	3,364	11
12	Maintenance of Personnel							12
13	Nursing Administration		59,310	10,116	69,426	1,414	8,477	13
14	Central Services & Supply		179,694	30,647	210,341	969	6,308	14
15	Pharmacy		63,043	10,752	73,795	2,642	15,299	15
16	Medical Records & Library		174,384	29,742	204,126	3,061	20,264	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd						365	21
22	I&R Services-Other Prgm Costs Apprvd						1,462	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,270,771	216,734	1,487,505	13,257	85,213	30
34	Surgical Intensive Care Unit		169,677	28,939	198,616	6,004	36,589	34
44	Skilled Nursing Facility		461,662	78,737	540,399	4,272	27,908	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		485,613	82,822	568,435	3,042	26,270	50
51	Recovery Room		32,554	5,552	38,106	671	4,024	51
53	Anesthesiology		14,260	2,432	16,692	108	883	53
54	Radiology-Diagnostic		233,184	39,770	272,954	2,215	16,449	54
56	Radioisotope		14,260	2,432	16,692	296	3,260	56
57	CT Scan		25,922	4,421	30,343	955	6,902	57
58	MRI		6,933	1,182	8,115	289	2,503	58
59	Cardiac Catheterization		101,092	17,241	118,333	963	6,726	59
60	Laboratory		223,516	38,121	261,637	1,501	39,587	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		47,091	8,032	55,123	1,573	9,694	65
66	Physical Therapy		112,824	19,242	132,066	2,661	15,829	66
67	Occupational Therapy		28,519	4,864	33,383	1,070	6,157	67
68	Speech Pathology		18,781	3,203	21,984	292	1,776	68
69	Electrocardiology		34,177	5,829	40,006	738	4,555	69
70	Electroencephalography					70	388	70
71	Medical Supplies Charged to Patients						25,528	71
72	Impl. Dev. Charged to Patients						12,022	72
73	Drugs Charged to Patients						29,423	73
74	Renal Dialysis		16,485	2,812	19,297	488	2,917	74
76.97	CARDIAC REHABILITATION		41,156	7,019	48,175	240	1,707	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		74,289	12,670	86,959	1,346	8,186	90
91	Emergency		244,128	41,637	285,765	6,602	42,625	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		5,855,902	998,737	6,854,639	71,850	534,221	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		33,272	5,675	38,947		285	190
194	ADDISON CENTRAL PHARMACY					375	11,652	194
194.01	PHYSICIAN PRACTICES					1,136	8,008	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		5,889,174	1,004,412	6,893,586	73,361	554,166	202

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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	831,922						7
8	Laundry & Linen Service		4,591					8
9	Housekeeping	25,099		205,317				9
10	Dietary	33,368		8,491	274,762			10
11	Cafeteria	32,729		8,329		260,299		11
12	Maintenance of Personnel							12
13	Nursing Administration	10,544		2,683		17,769	110,313	13
14	Central Services & Supply	31,945		8,129		6,993		14
15	Pharmacy	11,208		2,852		9,171		15
16	Medical Records & Library	31,002		7,889		13,349		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					1,706		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	225,912	1,829	57,491	161,921	59,745	40,568	30
34	Surgical Intensive Care Unit	30,165	466	7,676	33,557	19,878	17,972	34
44	Skilled Nursing Facility	82,073	517	20,886	79,284	19,411	9,352	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	86,331	369	21,969		11,849	7,502	50
51	Recovery Room	5,787		1,473		1,875	2,180	51
53	Anesthesiology	2,535		645		454		53
54	Radiology-Diagnostic	41,455	401	10,549		10,052		54
56	Radioisotope	2,535		645		931		56
57	CT Scan	4,608		1,173		4,035	418	57
58	MRI	1,232		314		784		58
59	Cardiac Catheterization	17,972	27	4,573		2,586	1,712	59
60	Laboratory	39,736		10,112		8,864		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,372		2,130		7,617		65
66	Physical Therapy	20,058	100	5,104		11,395		66
67	Occupational Therapy	5,070		1,290		4,310		67
68	Speech Pathology	3,339		850		963		68
69	Electrocardiology	6,076	26	1,546		3,256	905	69
70	Electroencephalography		1			385		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	2,931	11	746		1,064	1,235	74
76.97	CARDIAC REHABILITATION	7,317		1,862		835	971	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	13,207	24	3,361		7,002	2,265	90
91	Emergency	43,401	799	11,044		34,020	25,233	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	826,007	4,570	203,812	274,762	260,299	110,313	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,915	21	1,505				190
194	ADDISON CENTRAL PHARMACY							194
194.01	PHYSICIAN PRACTICES							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	831,922	4,591	205,317	274,762	260,299	110,313	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	264,685						14
15	Pharmacy		114,967					15
16	Medical Records & Library			279,691				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				2,071			21
22	I&R Services-Other Prgm Costs Apprvd					1,462		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			37,724			2,171,165	30
34	Surgical Intensive Care Unit			10,307			361,230	34
44	Skilled Nursing Facility			6,958			791,060	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			12,119			737,886	50
51	Recovery Room			2,143			56,259	51
53	Anesthesiology			3,695			25,012	53
54	Radiology-Diagnostic			10,580			364,655	54
56	Radioisotope			2,808			27,167	56
57	CT Scan			22,767			71,201	57
58	MRI			3,264			16,501	58
59	Cardiac Catheterization			7,858			160,750	59
60	Laboratory			34,994			396,431	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			9,083			93,592	65
66	Physical Therapy			5,962			193,175	66
67	Occupational Therapy			2,665			53,945	67
68	Speech Pathology			496			29,700	68
69	Electrocardiology			9,372			66,480	69
70	Electroencephalography			126			970	70
71	Medical Supplies Charged to Patients	264,685		8,867			299,080	71
72	Impl. Dev. Charged to Patients			4,154			16,176	72
73	Drugs Charged to Patients		114,967	35,468			179,858	73
74	Renal Dialysis			1,173			29,862	74
76.97	CARDIAC REHABILITATION			102			61,209	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			5,705			128,055	90
91	Emergency			41,301			490,790	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	264,685	114,967	279,691			6,822,209	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						46,673	190
194	ADDISON CENTRAL PHARMACY						12,027	194
194.01	PHYSICIAN PRACTICES						9,144	194.01
200	Cross Foot Adjustments				2,071	1,462	3,533	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	264,685	114,967	279,691	2,071	1,462	6,893,586	202

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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,171,165					30
34	Surgical Intensive Care Unit		361,230					34
44	Skilled Nursing Facility		791,060					44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		737,886					50
51	Recovery Room		56,259					51
53	Anesthesiology		25,012					53
54	Radiology-Diagnostic		364,655					54
56	Radioisotope		27,167					56
57	CT Scan		71,201					57
58	MRI		16,501					58
59	Cardiac Catheterization		160,750					59
60	Laboratory		396,431					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		93,592					65
66	Physical Therapy		193,175					66
67	Occupational Therapy		53,945					67
68	Speech Pathology		29,700					68
69	Electrocardiology		66,480					69
70	Electroencephalography		970					70
71	Medical Supplies Charged to Patients		299,080					71
72	Impl. Dev. Charged to Patients		16,176					72
73	Drugs Charged to Patients		179,858					73
74	Renal Dialysis		29,862					74
76.97	CARDIAC REHABILITATION		61,209					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		128,055					90
91	Emergency		490,790					91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		6,822,209					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		46,673					190
194	ADDISON CENTRAL PHARMACY		12,027					194
194.01	PHYSICIAN PRACTICES		9,144					194.01
200	Cross Foot Adjustments		3,533					200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		6,893,586					202

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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	253,994						1
2	Cap Rel Costs-Mvble Equip		253,994					2
4	Employee Benefits Department	2,703	2,703	48,306,363				4
5	Administrative & General	20,053	20,053	6,525,833	-20,952,042	78,929,831		5
6	Maintenance & Repairs							6
7	Operation of Plant	29,413	29,413	1,348,415		4,498,303	201,825	7
8	Laundry & Linen Service			79,495		636,663		8
9	Housekeeping	6,089	6,089	1,063,881		1,900,347	6,089	9
10	Dietary	8,095	8,095	680,344		1,732,814	8,095	10
11	Cafeteria	7,940	7,940	250,105		479,093	7,940	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,558	2,558	930,959		1,207,442	2,558	13
14	Central Services & Supply	7,750	7,750	637,671		898,383	7,750	14
15	Pharmacy	2,719	2,719	1,739,264		2,179,078	2,719	15
16	Medical Records & Library	7,521	7,521	2,015,122		2,886,256	7,521	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					52,056		21
22	I&R Services-Other Prgm Costs Apprvd					208,226		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	54,807	54,807	8,738,483		12,136,959	54,807	30
34	Surgical Intensive Care Unit	7,318	7,318	3,952,723		5,211,426	7,318	34
44	Skilled Nursing Facility	19,911	19,911	2,812,396		3,974,911	19,911	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	20,944	20,944	2,002,665		3,741,626	20,944	50
51	Recovery Room	1,404	1,404	441,530		573,097	1,404	51
53	Anesthesiology	615	615	71,304		125,802	615	53
54	Radiology-Diagnostic	10,057	10,057	1,458,468		2,342,845	10,057	54
56	Radioisotope	615	615	194,833		464,353	615	56
57	CT Scan	1,118	1,118	628,577		983,074	1,118	57
58	MRI	299	299	190,464		356,446	299	58
59	Cardiac Catheterization	4,360	4,360	633,955		958,018	4,360	59
60	Laboratory	9,640	9,640	988,126		5,638,355	9,640	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,031	2,031	1,035,510		1,380,694	2,031	65
66	Physical Therapy	4,866	4,866	1,751,589		2,254,457	4,866	66
67	Occupational Therapy	1,230	1,230	704,371		876,875	1,230	67
68	Speech Pathology	810	810	192,451		252,926	810	68
69	Electrocardiology	1,474	1,474	485,753		648,787	1,474	69
70	Electroencephalography			45,901		55,297		70
71	Medical Supplies Charged to Patients					3,636,014		71
72	Impl. Dev. Charged to Patients					1,712,296		72
73	Drugs Charged to Patients					4,190,716		73
74	Renal Dialysis	711	711	321,050		415,406	711	74
76.97	CARDIAC REHABILITATION	1,775	1,775	157,824		243,109	1,775	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	3,204	3,204	886,300		1,165,970	3,204	90
91	Emergency	10,529	10,529	4,346,408		6,071,005	10,529	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	252,559	252,559	47,311,770	-20,952,042	76,089,125	200,390	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,435	1,435			40,564	1,435	190
194	ADDISON CENTRAL PHARMACY			246,725		1,659,624		194
194.01	PHYSICIAN PRACTICES			747,868		1,140,518		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	5,889,174	1,004,412	9,505,066		20,952,042	5,692,382	202
203	Unit Cost Multiplier (Wkst. B, Part I)	23.186272	3.954471	0.196766		0.265451	28.204544	203
204	Cost to be allocated (Per Wkst. B, Part II)			73,361		554,166	831,922	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001519		0.007021	4.121997	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS- TRATION DIRECT NRSNG HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	1,153,033						8
9	Housekeeping		195,736					9
10	Dietary		8,095	177,144				10
11	Cafeteria		7,940		56,765			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,558		3,875	430,689		13
14	Central Services & Supply		7,750		1,525		100	14
15	Pharmacy		2,719		2,000			15
16	Medical Records & Library		7,521		2,911			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				372			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	459,474	54,807	104,393	13,029	158,386		30
34	Surgical Intensive Care Unit	117,067	7,318	21,635	4,335	70,166		34
44	Skilled Nursing Facility	129,952	19,911	51,116	4,233	36,514		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	92,623	20,944		2,584	29,290		50
51	Recovery Room		1,404		409	8,510		51
53	Anesthesiology		615		99			53
54	Radiology-Diagnostic	100,659	10,057		2,192			54
56	Radioisotope		615		203			56
57	CT Scan		1,118		880	1,633		57
58	MRI		299		171			58
59	Cardiac Catheterization	6,783	4,360		564	6,685		59
60	Laboratory		9,640		1,933			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,031		1,661			65
66	Physical Therapy	24,997	4,866		2,485			66
67	Occupational Therapy		1,230		940			67
68	Speech Pathology		810		210			68
69	Electrocardiology	6,608	1,474		710	3,535		69
70	Electroencephalography	176			84			70
71	Medical Supplies Charged to Patients						100	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	2,760	711		232	4,821		74
76.97	CARDIAC REHABILITATION		1,775		182	3,791		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	5,949	3,204		1,527	8,842		90
91	Emergency	200,770	10,529		7,419	98,516		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,147,818	194,301	177,144	56,765	430,689	100	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,215	1,435					190
194	ADDISON CENTRAL PHARMACY							194
194.01	PHYSICIAN PRACTICES							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	805,666	2,576,533	2,527,664	934,730	1,697,586	1,482,573	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.698736	13.163307	14.268979	16.466661	3.941559	14,825.730000	203
204	Cost to be allocated (Per Wkst. B, Part II)	4,591	205,317	274,762	260,299	110,313	264,685	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.003982	1.048949	1.551066	4.585554	0.256131	2,646.850000	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME			
		15	16	21	22			

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	100						15
16	Medical Records & Library		601,169,837					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			100				21
22	I&R Services-Other Prgm Costs Apprvd				100			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		81,125,934					30
34	Surgical Intensive Care Unit		22,165,544					34
44	Skilled Nursing Facility		14,964,204					44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		26,061,406					50
51	Recovery Room		4,608,626					51
53	Anesthesiology		7,947,213					53
54	Radiology-Diagnostic		22,752,595					54
56	Radioisotope		6,037,857					56
57	CT Scan		48,962,289					57
58	MRI		7,019,091					58
59	Cardiac Catheterization		16,898,846					59
60	Laboratory		75,254,849					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		19,534,299					65
66	Physical Therapy		12,820,816					66
67	Occupational Therapy		5,730,321					67
68	Speech Pathology		1,066,329					68
69	Electrocardiology		20,155,853					69
70	Electroencephalography		271,900					70
71	Medical Supplies Charged to Patients		19,069,577					71
72	Impl. Dev. Charged to Patients		8,934,297					72
73	Drugs Charged to Patients	100	76,274,958					73
74	Renal Dialysis		2,522,626					74
76.97	CARDIAC REHABILITATION		220,162					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		12,267,970					90
91	Emergency		88,502,275	100	100			91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	601,169,837	100	100			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	ADDISON CENTRAL PHARMACY							194
194.01	PHYSICIAN PRACTICES							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,902,928	4,011,477	72,000	263,500			202
203	Unit Cost Multiplier (Wkst. B, Part I)	29,029.280000	0.006673	720.000000	2,635.000000			203
204	Cost to be allocated (Per Wkst. B, Part II)	114,967	279,691	2,071	1,462			204
205	Unit Cost Multiplier (Wkst. B, Part II)	1,149.670000	0.000465	20.710000	14.620000			205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

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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	20,816,832		20,816,832		20,816,832	30
34	Surgical Intensive Care Unit	7,783,899		7,783,899	18,154	7,802,053	34
44	Skilled Nursing Facility	6,987,387		6,987,387		6,987,387	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,997,877		5,997,877		5,997,877	50
51	Recovery Room	854,337		854,337		854,337	51
53	Anesthesiology	239,299		239,299		239,299	53
54	Radiology-Diagnostic	3,639,049		3,639,049		3,639,049	54
56	Radioisotope	656,691		656,691		656,691	56
57	CT Scan	1,637,935		1,637,935		1,637,935	57
58	MRI	513,088		513,088		513,088	58
59	Cardiac Catheterization	1,545,831		1,545,831		1,545,831	59
60	Laboratory	8,067,854		8,067,854		8,067,854	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,988,922		1,988,922	1,927	1,990,849	65
66	Physical Therapy	3,198,140		3,198,140		3,198,140	66
67	Occupational Therapy	1,214,242		1,214,242		1,214,242	67
68	Speech Pathology	364,147		364,147		364,147	68
69	Electrocardiology	1,046,725		1,046,725		1,046,725	69
70	Electroencephalography	73,296		73,296		73,296	70
71	Medical Supplies Charged to Patients	6,211,022		6,211,022		6,211,022	71
72	Impl. Dev. Charged to Patients	2,226,446		2,226,446		2,226,446	72
73	Drugs Charged to Patients	8,715,057		8,715,057		8,715,057	73
74	Renal Dialysis	596,672		596,672		596,672	74
76.97	CARDIAC REHABILITATION	400,479		400,479		400,479	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,754,037		1,754,037		1,754,037	90
91	Emergency	9,359,327		9,359,327	91,306	9,450,633	91
92	Observation Beds (Non-Distinct Part)	3,391,168		3,391,168		3,391,168	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	99,279,759		99,279,759	111,387	99,391,146	200
201	Less Observation Beds	3,391,168		3,391,168		3,391,168	201
202	Total (line 200 minus line 201)	95,888,591		95,888,591		95,999,978	202

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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	67,146,693		67,146,693				30
34	Surgical Intensive Care Unit	22,165,544		22,165,544				34
44	Skilled Nursing Facility	14,964,204		14,964,204				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	13,830,492	12,230,914	26,061,406	0.230144	0.230144	0.230144	50
51	Recovery Room	2,292,044	2,316,582	4,608,626	0.185378	0.185378	0.185378	51
53	Anesthesiology	3,499,632	4,447,581	7,947,213	0.030111	0.030111	0.030111	53
54	Radiology-Diagnostic	8,168,309	14,584,286	22,752,595	0.159940	0.159940	0.159940	54
56	Radioisotope	2,142,550	3,895,307	6,037,857	0.108762	0.108762	0.108762	56
57	CT Scan	17,498,919	31,463,370	48,962,289	0.033453	0.033453	0.033453	57
58	MRI	2,837,821	4,181,270	7,019,091	0.073099	0.073099	0.073099	58
59	Cardiac Catheterization	11,206,899	5,691,947	16,898,846	0.091476	0.091476	0.091476	59
60	Laboratory	46,830,179	28,424,670	75,254,849	0.107207	0.107207	0.107207	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,354,380	1,179,919	19,534,299	0.101817	0.101817	0.101916	65
66	Physical Therapy	10,032,052	2,788,764	12,820,816	0.249449	0.249449	0.249449	66
67	Occupational Therapy	5,148,415	581,906	5,730,321	0.211898	0.211898	0.211898	67
68	Speech Pathology	988,328	78,001	1,066,329	0.341496	0.341496	0.341496	68
69	Electrocardiology	10,410,374	9,745,479	20,155,853	0.051932	0.051932	0.051932	69
70	Electroencephalography	185,572	86,328	271,900	0.269570	0.269570	0.269570	70
71	Medical Supplies Charged to Patients	14,126,241	4,943,336	19,069,577	0.325703	0.325703	0.325703	71
72	Impl. Dev. Charged to Patients	6,121,080	2,813,217	8,934,297	0.249202	0.249202	0.249202	72
73	Drugs Charged to Patients	62,461,692	13,813,266	76,274,958	0.114258	0.114258	0.114258	73
74	Renal Dialysis	2,237,274	285,352	2,522,626	0.236528	0.236528	0.236528	74
76.97	CARDIAC REHABILITATION	96,547	123,615	220,162	1.819020	1.819020	1.819020	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,806,255	9,461,715	12,267,970	0.142977	0.142977	0.142977	90
91	Emergency	20,773,142	67,729,133	88,502,275	0.105752	0.105752	0.106784	91
92	Observation Beds (Non-Distinct Part)	1,950,196	12,029,045	13,979,241	0.242586	0.242586	0.242586	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	368,274,834	232,895,003	601,169,837				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	368,274,834	232,895,003	601,169,837				202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part 1 col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	20,816,832		20,816,832		20,816,832	30
34	Surgical Intensive Care Unit	7,783,899		7,783,899		7,783,899	34
44	Skilled Nursing Facility	6,987,387		6,987,387		6,987,387	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,997,877		5,997,877		5,997,877	50
51	Recovery Room	854,337		854,337		854,337	51
53	Anesthesiology	239,299		239,299		239,299	53
54	Radiology-Diagnostic	3,639,049		3,639,049		3,639,049	54
56	Radioisotope	656,691		656,691		656,691	56
57	CT Scan	1,637,935		1,637,935		1,637,935	57
58	MRI	513,088		513,088		513,088	58
59	Cardiac Catheterization	1,545,831		1,545,831		1,545,831	59
60	Laboratory	8,067,854		8,067,854		8,067,854	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,988,922		1,988,922		1,988,922	65
66	Physical Therapy	3,198,140		3,198,140		3,198,140	66
67	Occupational Therapy	1,214,242		1,214,242		1,214,242	67
68	Speech Pathology	364,147		364,147		364,147	68
69	Electrocardiology	1,046,725		1,046,725		1,046,725	69
70	Electroencephalography	73,296		73,296		73,296	70
71	Medical Supplies Charged to Patients	6,211,022		6,211,022		6,211,022	71
72	Impl. Dev. Charged to Patients	2,226,446		2,226,446		2,226,446	72
73	Drugs Charged to Patients	8,715,057		8,715,057		8,715,057	73
74	Renal Dialysis	596,672		596,672		596,672	74
76.97	CARDIAC REHABILITATION	400,479		400,479		400,479	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,754,037		1,754,037		1,754,037	90
91	Emergency	9,694,827		9,694,827		9,694,827	91
92	Observation Beds (Non-Distinct Part)	3,391,168		3,391,168		3,391,168	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	99,615,259		99,615,259		99,615,259	200
201	Less Observation Beds	3,391,168		3,391,168		3,391,168	201
202	Total (line 200 minus line 201)	96,224,091		96,224,091		96,224,091	202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
34	Surgical Intensive Care Unit							34
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
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							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V [XX] PPS
Applicable [XX] Title XVIII, Part A [] TEFRA
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)	2,171,165		2,171,165	29,600	73.35	10,060	737,901	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit	361,230		361,230	6,134	58.89	2,248	132,385	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	791,060		791,060	14,153	55.89	9,704	542,357	44
45	Nursing Facility								45
200	Total (lines 30-199)	3,323,455		3,323,455	49,887		22,012	1,412,643	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0251

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	737,886	26,061,406	0.028313	4,833,474	136,850	50
51	Recovery Room	56,259	4,608,626	0.012207	775,604	9,468	51
53	Anesthesiology	25,012	7,947,213	0.003147	1,542,866	4,855	53
54	Radiology-Diagnostic	364,655	22,752,595	0.016027	3,675,191	58,902	54
56	Radioisotope	27,167	6,037,857	0.004499	934,861	4,206	56
57	CT Scan	71,201	48,962,289	0.001454	7,059,497	10,265	57
58	MRI	16,501	7,019,091	0.002351	1,116,097	2,624	58
59	Cardiac Catheterization	160,750	16,898,846	0.009512	3,759,084	35,756	59
60	Laboratory	396,431	75,254,849	0.005268	18,001,699	94,833	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	93,592	19,534,299	0.004791	7,118,009	34,102	65
66	Physical Therapy	193,175	12,820,816	0.015067	1,009,997	15,218	66
67	Occupational Therapy	53,945	5,730,321	0.009414	393,221	3,702	67
68	Speech Pathology	29,700	1,066,329	0.027853	363,681	10,130	68
69	Electrocardiology	66,480	20,155,853	0.003298	4,612,560	15,212	69
70	Electroencephalography	970	271,900	0.003567	94,556	337	70
71	Medical Supplies Charged to Pat	299,080	19,069,577	0.015684	5,456,823	85,585	71
72	Impl. Dev. Charged to Patients	16,176	8,934,297	0.001811	2,747,960	4,977	72
73	Drugs Charged to Patients	179,858	76,274,958	0.002358	21,991,320	51,856	73
74	Renal Dialysis	29,862	2,522,626	0.011838	1,088,472	12,885	74
76.97	CARDIAC REHABILITATION	61,209	220,162	0.278018	33,920	9,430	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	128,055	12,267,970	0.010438	1,035,041	10,804	90
91	Emergency	490,790	88,502,275	0.005546	8,531,284	47,315	91
92	Observation Beds (Non-Distinct	353,695	13,979,241	0.025301	882,197	22,320	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,852,449	496,893,396		97,057,414	681,632	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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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)	29,600		10,060		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit	6,134		2,248		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	14,153		9,704		44
45	Nursing Facility					45
200	Total (lines 30-199)	49,887		22,012		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0251

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

		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
51	Recovery Room									51
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
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									
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0251

**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	26,061,406			4,833,474		3,307,122		50
51	Recovery Room	4,608,626			775,604		491,784		51
53	Anesthesiology	7,947,213			1,542,866		1,241,669		53
54	Radiology-Diagnostic	22,752,595			3,675,191		3,004,126		54
56	Radioisotope	6,037,857			934,861		1,367,433		56
57	CT Scan	48,962,289			7,059,497		6,423,777		57
58	MRI	7,019,091			1,116,097		1,477,906		58
59	Cardiac Catheterization	16,898,846			3,759,084		2,272,860		59
60	Laboratory	75,254,849			18,001,699		4,838,306		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,534,299			7,118,009		227,422		65
66	Physical Therapy	12,820,816			1,009,997		61,385		66
67	Occupational Therapy	5,730,321			393,221		21,398		67
68	Speech Pathology	1,066,329			363,681		12,832		68
69	Electrocardiology	20,155,853			4,612,560		2,498,065		69
70	Electroencephalography	271,900			94,556		34,222		70
71	Medical Supplies Charged to Pat	19,069,577			5,456,823		1,376,515		71
72	Impl. Dev. Charged to Patients	8,934,297			2,747,960		1,368,824		72
73	Drugs Charged to Patients	76,274,958			21,991,320		3,612,197		73
74	Renal Dialysis	2,522,626			1,088,472		170,380		74
76.97	CARDIAC REHABILITATION	220,162			33,920		44,631		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	12,267,970			1,035,041		3,025,965		90
91	Emergency	88,502,275			8,531,284		9,304,577		91
92	Observation Beds (Non-Distinct	13,979,241			882,197		3,554,701		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	496,893,396			97,057,414		49,738,097		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0251

WORKSHEET D PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.230144	3,307,122			761,114			50
51	Recovery Room	0.185378	491,784			91,166			51
53	Anesthesiology	0.030111	1,241,669			37,388			53
54	Radiology-Diagnostic	0.159940	3,004,126			480,480			54
56	Radioisotope	0.108762	1,367,433			148,725			56
57	CT Scan	0.033453	6,423,777			214,895			57
58	MRI	0.073099	1,477,906			108,033			58
59	Cardiac Catheterization	0.091476	2,272,860			207,912			59
60	Laboratory	0.107207	4,838,306			518,700			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.101817	227,422			23,155			65
66	Physical Therapy	0.249449	61,385			15,312			66
67	Occupational Therapy	0.211898	21,398			4,534			67
68	Speech Pathology	0.341496	12,832			4,382			68
69	Electrocardiology	0.051932	2,498,065			129,730			69
70	Electroencephalography	0.269570	34,222			9,225			70
71	Medical Supplies Charged to Pat	0.325703	1,376,515			448,335			71
72	Impl. Dev. Charged to Patients	0.249202	1,368,824	19,840		341,114	4,944		72
73	Drugs Charged to Patients	0.114258	3,612,197		31,758	412,722		3,629	73
74	Renal Dialysis	0.236528	170,380			40,300			74
76.97	CARDIAC REHABILITATION	1.819020	44,631			81,185			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.142977	3,025,965			432,643			90
91	Emergency	0.105752	9,304,577			983,978			91
92	Observation Beds (Non-Distinct	0.242586	3,554,701			862,321			92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		49,738,097	19,840	31,758	6,357,349	4,944	3,629	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		49,738,097	19,840	31,758	6,357,349	4,944	3,629	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5548

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
51	Recovery Room									51
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
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									
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5548

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	26,061,406			35,171				50
51	Recovery Room	4,608,626							51
53	Anesthesiology	7,947,213			1,412				53
54	Radiology-Diagnostic	22,752,595			238,089				54
56	Radioisotope	6,037,857			14,998				56
57	CT Scan	48,962,289			4,395				57
58	MRI	7,019,091			2,660				58
59	Cardiac Catheterization	16,898,846			1,194				59
60	Laboratory	75,254,849			2,520,112				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,534,299			1,456,473				65
66	Physical Therapy	12,820,816			5,472,363				66
67	Occupational Therapy	5,730,321			3,069,226				67
68	Speech Pathology	1,066,329			215,769				68
69	Electrocardiology	20,155,853			48,644				69
70	Electroencephalography	271,900			614				70
71	Medical Supplies Charged to Pat	19,069,577			861,939				71
72	Impl. Dev. Charged to Patients	8,934,297							72
73	Drugs Charged to Patients	76,274,958			5,978,007				73
74	Renal Dialysis	2,522,626							74
76.97	CARDIAC REHABILITATION	220,162			6,148				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	12,267,970			1,558				90
91	Emergency	88,502,275			1,680				91
92	Observation Beds (Non-Distinct	13,979,241							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	496,893,396			19,930,452				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5548

WORKSHEET D PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [XX] Title XVIII, Part B [] IPF [XX] 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	1	2	3	4	5	6	7	
50	Operating Room	0.230144							50
51	Recovery Room	0.185378							51
53	Anesthesiology	0.030111							53
54	Radiology-Diagnostic	0.159940							54
56	Radioisotope	0.108762							56
57	CT Scan	0.033453							57
58	MRI	0.073099							58
59	Cardiac Catheterization	0.091476							59
60	Laboratory	0.107207							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.101817							65
66	Physical Therapy	0.249449							66
67	Occupational Therapy	0.211898							67
68	Speech Pathology	0.341496							68
69	Electrocardiology	0.051932							69
70	Electroencephalography	0.269570							70
71	Medical Supplies Charged to Pat	0.325703							71
72	Impl. Dev. Charged to Patients	0.249202							72
73	Drugs Charged to Patients	0.114258							73
74	Renal Dialysis	0.236528							74
76.97	CARDIAC REHABILITATION	1.819020							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.142977							90
91	Emergency	0.105752							91
92	Observation Beds (Non-Distinct	0.242586							92
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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V
Applicable [] Title XVIII, Part A
Boxes: [XX] 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)	2,171,165		2,171,165	29,600	73.35	1,322	96,969	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit	361,230		361,230	6,134	58.89	251	14,781	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	791,060		791,060	14,153	55.89			44
45	Nursing Facility								45
200	Total (lines 30-199)	3,323,455		3,323,455	49,887		1,573	111,750	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0251

WORKSHEET D PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other)
Applicable ☐ Title XVIII, Part A ☐ IPF
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	737,886	26,061,406	0.028313			50
51	Recovery Room	56,259	4,608,626	0.012207			51
53	Anesthesiology	25,012	7,947,213	0.003147			53
54	Radiology-Diagnostic	364,655	22,752,595	0.016027			54
56	Radioisotope	27,167	6,037,857	0.004499			56
57	CT Scan	71,201	48,962,289	0.001454			57
58	MRI	16,501	7,019,091	0.002351			58
59	Cardiac Catheterization	160,750	16,898,846	0.009512			59
60	Laboratory	396,431	75,254,849	0.005268			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	93,592	19,534,299	0.004791			65
66	Physical Therapy	193,175	12,820,816	0.015067			66
67	Occupational Therapy	53,945	5,730,321	0.009414			67
68	Speech Pathology	29,700	1,066,329	0.027853			68
69	Electrocardiology	66,480	20,155,853	0.003298			69
70	Electroencephalography	970	271,900	0.003567			70
71	Medical Supplies Charged to Pat	299,080	19,069,577	0.015684			71
72	Impl. Dev. Charged to Patients	16,176	8,934,297	0.001811			72
73	Drugs Charged to Patients	179,858	76,274,958	0.002358			73
74	Renal Dialysis	29,862	2,522,626	0.011838			74
76.97	CARDIAC REHABILITATION	61,209	220,162	0.278018			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	128,055	12,267,970	0.010438			90
91	Emergency	490,790	88,502,275	0.005546			91
92	Observation Beds (Non-Distinct	353,695	13,979,241	0.025301			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,852,449	496,893,396				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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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)	29,600		1,322		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit	6,134		251		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	14,153				44
45	Nursing Facility					45
200	Total (lines 30-199)	49,887		1,573		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0251

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

		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
51	Recovery Room									51
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
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									
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0251

**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								50
51	Recovery Room								51
53	Anesthesiology								53
54	Radiology-Diagnostic								54
56	Radioisotope								56
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
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								
90	Clinic								90
91	Emergency								91
92	Observation Beds (Non-Distinct								92
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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0251

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								50
51	Recovery Room								51
53	Anesthesiology								53
54	Radiology-Diagnostic								54
56	Radioisotope								56
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
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								
90	Clinic								90
91	Emergency								91
92	Observation Beds (Non-Distinct								92
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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0251****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)	29,600	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,600	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)	24,778	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)	10,060	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)	20,816,832	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)	20,816,832	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)	20,816,832	37

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0251****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)						703.27 38
39	Program general inpatient routine service cost (line 9 x line 38)						7,074,896 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)						7,074,896 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						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit	7,802,053	6,134	1,271.94	2,248	2,859,321	46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					12,600,510	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					22,534,727	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					870,286	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					681,632	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,551,918	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					20,982,809	53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

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)					4,822	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					703.27	88
89	Observation bed cost (line 87 x line 88) (see instructions)					3,391,168	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	2,171,165	20,816,832	0.104299	3,391,168	353,695	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-5548****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,153	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,153	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)	14,153	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)	9,704	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)	6,987,387	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)	6,987,387	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)	6,987,387	37

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-5548****WORKSHEET D-1
PARTS III & IV**

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

PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	6,987,387	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	493.70	71
72	Program routine service cost (line 9 x line 71)	4,790,865	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	4,790,865	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	4,790,865	83
84	Program inpatient ancillary services (see instructions)	3,534,080	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	8,324,945	86

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0251****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)	29,600	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,600	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)	24,778	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)	1,322	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)	20,816,832	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)	20,816,832	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)	20,816,832	37

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0251****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)						703.27 38
39	Program general inpatient routine service cost (line 9 x line 38)						929,723 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)						929,723 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						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit	7,783,899	6,134	1,268.98	251	318,514	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)					1,248,237	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					111,750	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)					111,750	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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

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)					4,822	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					703.27	88
89	Observation bed cost (line 87 x line 88) (see instructions)					3,391,168	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	2,171,165	20,816,832	0.104299	3,391,168	353,695	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/29/2019 Run Time: 15:37 Version: 2018.12 (03/07/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0251

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		29,387,646		30
34	Surgical Intensive Care Unit		8,857,120		34
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.230144	4,833,474	1,112,395	50
51	Recovery Room	0.185378	775,604	143,780	51
53	Anesthesiology	0.030111	1,542,866	46,457	53
54	Radiology-Diagnostic	0.159940	3,675,191	587,810	54
56	Radioisotope	0.108762	934,861	101,677	56
57	CT Scan	0.033453	7,059,497	236,161	57
58	MRI	0.073099	1,116,097	81,586	58
59	Cardiac Catheterization	0.091476	3,759,084	343,866	59
60	Laboratory	0.107207	18,001,699	1,929,908	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.101916	7,118,009	725,439	65
66	Physical Therapy	0.249449	1,009,997	251,943	66
67	Occupational Therapy	0.211898	393,221	83,323	67
68	Speech Pathology	0.341496	363,681	124,196	68
69	Electrocardiology	0.051932	4,612,560	239,539	69
70	Electroencephalography	0.269570	94,556	25,489	70
71	Medical Supplies Charged to Patients	0.325703	5,456,823	1,777,304	71
72	Impl. Dev. Charged to Patients	0.249202	2,747,960	684,797	72
73	Drugs Charged to Patients	0.114258	21,991,320	2,512,684	73
74	Renal Dialysis	0.236528	1,088,472	257,454	74
76.97	CARDIAC REHABILITATION	1.819020	33,920	61,701	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.142977	1,035,041	147,987	90
91	Emergency	0.106784	8,531,284	911,005	91
92	Observation Beds (Non-Distinct Part)	0.242586	882,197	214,009	92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		97,057,414	12,600,510	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		97,057,414		202

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-5548

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
34	Surgical Intensive Care Unit				34
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.230144	35,171	8,094	50
51	Recovery Room	0.185378			51
53	Anesthesiology	0.030111	1,412	43	53
54	Radiology-Diagnostic	0.159940	238,089	38,080	54
56	Radioisotope	0.108762	14,998	1,631	56
57	CT Scan	0.033453	4,395	147	57
58	MRI	0.073099	2,660	194	58
59	Cardiac Catheterization	0.091476	1,194	109	59
60	Laboratory	0.107207	2,520,112	270,174	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.101916	1,456,473	148,438	65
66	Physical Therapy	0.249449	5,472,363	1,365,075	66
67	Occupational Therapy	0.211898	3,069,226	650,363	67
68	Speech Pathology	0.341496	215,769	73,684	68
69	Electrocardiology	0.051932	48,644	2,526	69
70	Electroencephalography	0.269570	614	166	70
71	Medical Supplies Charged to Patients	0.325703	861,939	280,736	71
72	Impl. Dev. Charged to Patients	0.249202			72
73	Drugs Charged to Patients	0.114258	5,978,007	683,035	73
74	Renal Dialysis	0.236528			74
76.97	CARDIAC REHABILITATION	1.819020	6,148	11,183	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.142977	1,558	223	90
91	Emergency	0.106784	1,680	179	91
92	Observation Beds (Non-Distinct Part)	0.242586			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		19,930,452	3,534,080	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		19,930,452		202

(A) Worksheet A line numbers

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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)	21,065,523			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				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)	156,218			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
2.03	Outlier payment for discharges occurring prior to October 1 (see instructions)				2.03
2.04	Outlier payment for discharges occurring on or after October 1 (see instructions)				2.04
3	Managed care simulated payments	6,670,771			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	199.79			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)	1.56			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.	0.11			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).	1.50			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)	2.95			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	3.72			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	2.95			12
13	Total allowable FTE count for the prior year	1.96			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	1.84			14
15	Sum of lines 12 through 14 divided by 3	2.25			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	2.25			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.011262			19
20	Prior year resident to bed ratio (see instructions)	0.010589			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.010589			21
22	IME payment adjustment (see instructions)	121,569			22
22.01	IME payment adjustment - Managed Care (see instructions)	38,497			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)	0.77			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)	121,569			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	38,497			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0795			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2436			31
32	Sum of lines 30 and 31	0.3231			32
33	Allowable disproportionate share percentage (see instructions)	0.1587			33
34	Disproportionate share adjustment (see instructions)	835,775			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		8,272,872,447	35
35.01	Factor 3 (see instructions)	0.000186707		0.000191038	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,263,389		1,580,433	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	944,945		398,356	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,343,301			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

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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)	23,522,386			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)	23,560,883			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,848,303			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)	68,618			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)	25,477,804			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	25,477,804			61
62	Deductibles billed to program beneficiaries	2,195,540			62
63	Coinsurance billed to program beneficiaries	101,164			63
64	Allowable bad debts (see instructions)	785,016			64
65	Adjusted reimbursable bad debts (see instructions)	510,260			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	437,928			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	23,691,360			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)	-9,585			70.93
70.94	HRR adjustment amount (see instructions)	-73,865			70.94
71	Amount due provider (see instructions)	23,607,910			71
71.01	Sequestration adjustment (see instructions)	472,158			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	23,317,275			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-181,523			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,570,496			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

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-0251****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)	8,573			1
2	Medical and other services reimbursed under OPPS (see instructions)	6,357,349			2
3	OPPS payments	6,810,402			3
4	Outlier payment (see instructions)	48,515			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)	8,573			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	51,598			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)	51,598			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)	51,598			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	43,025			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)	8,573			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)	6,858,917			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	3,968			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,407,314			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,456,208			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	13,303			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	5,469,511			30
31	Primary payer payments	4,197			31
32	Subtotal (line 30 minus line 31)	5,465,314			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)	532,683			34
35	Adjusted reimbursable bad debts (see instructions)	346,244			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	369,081			36
37	Subtotal (see instructions)	5,811,558			37
38	MSP-LCC reconciliation amount from PS&R	343			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	5,811,215			40
40.01	Sequestration adjustment (see instructions)	116,224			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	5,592,760			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	102,231			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

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-5548****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)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				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)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				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)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				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)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0251

WORKSHEET E-1 PART I

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

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider			23,255,010		5,670,993
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		08/13/2018	62,265		
		.01				3.01
		.02				3.02
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50	08/13/2018		78,233	3.50
		.51				3.51
		.52				3.52
		.53				3.53
		.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		62,265		-78,233
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			23,317,275		5,592,760
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
		.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.52				5.52
		.53				5.53
		.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01				6.01
		.02				6.02
7	Total Medicare program liability (see instructions)					7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-5548

WORKSHEET E-1
PART I

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

			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			5,116,798			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		.01				3.01
	amount based on subsequent revision of the interim		.02				3.02
	rate for the cost reporting period. Also show date of	Program	.03				3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04				3.04
		Provider	.05				3.05
			.06				3.06
			.07				3.07
			.08				3.08
			.09				3.09
			.10				3.10
			.50				3.50
			.51				3.51
		Provider	.52				3.52
		to	.53				3.53
		Program	.54				3.54
			.55				3.55
			.56				3.56
			.57				3.57
			.58				3.58
			.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			5,116,798			4
	TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment		.01				5.01
	after desk review. Also show date of each payment.		.02				5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03				5.03
		to	.04				5.04
		Provider	.05				5.05
			.06				5.06
			.07				5.07
			.08				5.08
			.09				5.09
			.10				5.10
			.50				5.50
			.51				5.51
		Provider	.52				5.52
		to	.53				5.53
		Program	.54				5.54
			.55				5.55
			.56				5.56
			.57				5.57
			.58				5.58
			.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99				5.99
6	Determined net settlement amount (balance due)		.01				6.01
	based on the cost report (1)		.02				6.02
7	Total Medicare program liability (see instructions)						7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)		8

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E-3
PART VI****PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES**

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	5,487,810	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	5,487,810	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	266,588	7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	5,221,222	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	5,221,222	15
15.01	Sequestration adjustment (see instructions)	104,424	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	5,116,798	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0251

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	1,248,237		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	1,248,237		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	1,248,237		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 cahрге 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)	1,248,237		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)	1,248,237		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

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**WORKSHEET E-4**

Check [] Title V
Applicable [XX] Title XVIII
Box: [] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			1.56
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			0.13
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			1.25
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			2.68
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.72
7	Enter the lesser of line 5 or line 6			2.68
		Primary Care 1	Other 2	Total 3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	3.08	3.08
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	2.22	2.22
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			
11	Total weighted FTE count	0.00		
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	1.48	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	1.14	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	1.61	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
15.01	Unweighted adjustment for residents in initial years of new programs			
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure			
17	Adjusted rolling average FTE count	0.00	1.61	
18	Per resident amount	0.00	98,737.46	
19	Approved amount for resident costs		158,967	158,967
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			1.04
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			158,967
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	12,308	4,218	
27	Total inpatient days (see instructions)	30,912	30,912	
28	Ratio of inpatient days to total inpatient days	0.398163	0.136452	
29	Program direct GME amount	63,295	21,691	
30	Reduction for direct GME payments for Medicare Advantage		3,065	
31	Net Program direct GME amount			81,921
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			2,522,626
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			
35	Medicare outpatient ESRD charges (see instructions)			
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			
	Part A Reasonable Cost			
37	Reasonable cost (see instructions)			32,813,402
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			
39	Cost of physicians' services in a teaching hospital (see instructions)			
40	Primary payer payments (see instructions)			
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			32,813,402
	Part B Reasonable Cost			
42	Reasonable cost (see instructions)			6,365,922
43	Primary payer payments (see instructions)			4,197
44	Total Part B reasonable cost (line 42 minus line 43)			6,361,725
45	Total reasonable cost (sum of lines 41 and 44)			39,175,127
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.837608
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.162392
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	Total program GME payment (line 31)			81,921
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			68,618
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			13,303

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**WORKSHEET E-4**

Check [] Title V
Applicable [] Title XVIII
Box: [XX] Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			
11	Total weighted FTE count	0.00	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
15.01	Unweighted adjustment for residents in initial years of new programs			
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure			
17	Adjusted rolling average FTE count	0.00	0.00	
18	Per resident amount	0.00	0.00	
19	Approved amount for resident costs			
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	1,573	5,956	
27	Total inpatient days (see instructions)	30,912	30,912	
28	Ratio of inpatient days to total inpatient days	0.050886	0.192676	
29	Program direct GME amount			
30	Reduction for direct GME payments for Medicare Advantage			
31	Net Program direct GME amount			
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			
35	Medicare outpatient ESRD charges (see instructions)			
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			
	Part A Reasonable Cost			
37	Reasonable cost (see instructions)			
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			
39	Cost of physicians' services in a teaching hospital (see instructions)			
40	Primary payer payments (see instructions)			
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			
	Part B Reasonable Cost			
42	Reasonable cost (see instructions)			
43	Primary payer payments (see instructions)			
44	Total Part B reasonable cost (line 42 minus line 43)			
45	Total reasonable cost (sum of lines 41 and 44)			
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	Total program GME payment (line 31)			
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			

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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	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	-330,566				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	176,199,174				4
5	Other receivables	-309,360				5
6	Allowances for uncollectible notes and accounts receivable	-115,100,865				6
7	Inventory	4,136,668				7
8	Prepaid expenses	299,994				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	64,895,045				11

	FIXED ASSETS					
12	Land	2,492,384				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	16,280,177				15
16	Accumulated depreciation	-1,543,228				16
17	Leasehold improvements	16,506,007				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	11,254,949				23
24	Accumulated depreciation	-3,385,694				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)	41,604,595				30

	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	5,568,916				34
35	Total other assets (sum of lines 31-34)	5,568,916				35
36	Total assets (sum of lines 11, 30 and 35)	112,068,556				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	27,680,689				37
38	Salaries, wages and fees payable	3,459,830				38
39	Payroll taxes payable	928,469				39
40	Notes and loans payable (short term)	3,262,993				40
41	Deferred income	7,721,125				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	16,780,680				44
45	Total current liabilities (sum of lines 37 thru 44)	59,833,786				45

	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	34,128,914				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	34,128,914				50
51	Total liabilities (sum of lines 45 and 50)	93,962,700				51

	CAPITAL ACCOUNTS					
52	General fund balance	18,105,856				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)	18,105,856				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	112,068,556				60

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STATEMENT OF CHANGES IN FUND BALANCES**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		18,990,935		1
2	Net income (loss) (from Worksheet G-3, line 29)		-885,073		2
3	Total (sum of line 1 and line 2)		18,105,862		3
4	Additions (credit adjustments) (specify)				4
5					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)		18,105,862		11
12	Deductions (debit adjustments) (specify)				12
13	ROUNDING	6			13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		6		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,105,856		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					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	ROUNDING				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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	67,146,693		67,146,693	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	14,964,204		14,964,204	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	82,110,897		82,110,897	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit	22,165,544		22,165,544	14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	22,165,544		22,165,544	16
17	Total inpatient routine care services (sum of lines 10 and 16)	104,276,441		104,276,441	17
18	Ancillary services	238,468,800	143,675,110	382,143,910	18
19	Outpatient services	25,529,593	89,219,893	114,749,486	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 PATIENT REVENUES		2,263	2,263	27
27.01	PROFESSIONAL COMPONENT		32,661,588	32,661,588	27.01
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	368,274,834	265,558,854	633,833,688	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		120,907,687	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				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		120,907,687	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	633,833,688	1
2	Less contractual allowances and discounts on patients' accounts	520,604,888	2
3	Net patient revenues (line 1 minus line 2)	113,228,800	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	120,907,687	4
5	Net income from service to patients (line 3 minus line 4)	-7,678,887	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	291,762	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	38,466	17
18	Revenue from sale of medical records and abstracts	3,558	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen	8,232	20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (FITNESS CENTER)	56,536	24
24.01	Other (RETAIL PAHARMACY)	1,006,588	24.01
24.02	Other (POB RENT)	605,596	24.02
24.03	Other (REAL ESTATE TAX CREDITS)	4,589,236	24.03
24.04	Other (RADIOLOGY MISC REV)	4,020	24.04
24.05	Other (CARDIOLOGY MISC REV)	2,769	24.05
24.06	Other (ADMIN MISC REV)	187,051	24.06
25	Total other income (sum of lines 6-24)	6,793,814	25
26	Total (line 5 plus line 25)	-885,073	26
29	Net income (or loss) for the period (line 26 minus line 28)	-885,073	29

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CALCULATION OF CAPITAL PAYMENT**COMPONENT CCN: 14-0251****WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,715,229	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	4,261	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)	84.69	3
4	Number of interns & residents (see instructions)	2.25	4
5	Indirect medical education percentage (see instructions)	0.75	5
6	Indirect medical education adjustment (see instructions)	12,864	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0795	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.2436	8
9	Sum of lines 7 and 8	0.3231	9
10	Allowable disproportionate share percentage (see instructions)	0.0676	10
11	Disproportionate share adjustment (see instructions)	115,949	11
12	Total prospective capital payments (see instructions)	1,848,303	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1 PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
34	Surgical Intensive Care Unit							34
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
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							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
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
194	ADDISON CENTRAL PHARMACY							194
194.01	PHYSICIAN PRACTICES							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202