

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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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 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.		Date: 11/25/2019 Time: 16:09	
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 HOSPITAL (15-0125) (Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019, 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) **DANIEL R. O'BRIEN**
 Chief Financial Officer or Administrator of Provider(s)

CFO
 Title

11/25/2019 16:09
 Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		257,686	99,195		-416	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		69,654	-123		-6	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		327,340	99,072		-422	200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2018	To: 06 / 30 / 2019	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

		1	2	3
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N	
22.01	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	
22.02	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	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N	

		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.	2,037	161		1,917	11,115	
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 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.	43	246		10	142	

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 OPPS 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
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
		1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	Y			60
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.	1	60.01
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63
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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.	Y			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N			76

Long Term Care Hospital PPS

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

TEFRA Providers

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

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

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	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)			107
108	If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			
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
		N	N	Respiratory
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		1	110
		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.			111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance	
118.01		1			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health care related taxes as defined in §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)	Y	15H054	140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: COMMUNITY FOUNDATION OF NW IN,	Contractor's Name: WPS	Contractor's Number: 00450	141
142	Street: 10100 DON POWERS DRIVE	P.O. Box:		142
143	City: MUNSTER	State: IN	ZIP Code: 46321	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07 / 01 / 2018	06 / 30 / 2019		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)	Y			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.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/16/2019	Y	10/16/2019	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.	Y		Y		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 relifed for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: CATHERINE	Last name: WOERNER	Title: DIRECTOR OF REIMBURSEMENT
42	Employer: COMMUNITY HOSPITAL		
43	Phone number: 12197031267	E-mail Address: CATHERINE.R.WOERNER@COMHS.ORG	

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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	339	123,735			35,430	1,205	75,017	1
2	HMO and other (see instructions)						15,820	12,872		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						1,077	398		4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		339	123,735			35,430	1,205	75,017	7
8	Intensive Care Unit	31	39	14,235			4,661	242	11,470	8
9	Coronary Care Unit	32								9
9.01	NEONATAL INTENSIVE CARE	32.01	32	11,680				362	4,153	9.01
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						228	3,504	13
14	Total (see instructions)		410	149,650			40,091	2,037	94,144	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	54	19,710			12,089	42	15,223	17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					35,637		57,650	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30							23	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		464							27
28	Observation Bed Days								12,536	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							321	723	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					7,796	271	17,965	1
2	HMO and other (see instructions)					2,427	2,048		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider						31		4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
9.01	NEONATAL INTENSIVE CARE								9.01
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		2,483.25			7,796	271	17,965	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF		72.70			1,100	4	1,369	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		53.07						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		2,609.02						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	177,448,919		177,448,919	5,426,755.00	32.70	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B		4,025,454		4,025,454	49,039.00	82.09	3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		7,856,786		7,856,786	43,442.00	180.86	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		12,806,586	184,285	12,990,871	418,676.00	31.03	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		2,663,982		2,663,982	26,729.00	99.67	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		665,020		665,020	4,822.33	137.90	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		20,198,142		20,198,142	596,105.00	33.88	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)		55,314,210		55,314,210			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		4,692,947		4,692,947			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B		1,067,950		1,067,950			21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		1,712,252		1,712,252			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related		5,059,319		5,059,319			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		614,953		614,953	21,609.00	28.46	26
27	Administrative & General		15,869,324		15,869,324	515,692.00	30.77	27
28	Administrative & General under contract (see instructions)		3,439,291		3,439,291	25,732.61	133.65	28
29	Maintenance & Repairs							29
30	Operation of Plant		5,145,496		5,145,496	189,288.00	27.18	30
31	Laundry & Linen Service		116,803		116,803	8,279.00	14.11	31
32	Housekeeping		3,417,066		3,417,066	218,809.00	15.62	32
33	Housekeeping under contract (see instructions)		1,200		1,200	10.33	116.17	33
34	Dietary		3,949,936	-1,269,860	2,680,076	142,349.00	18.83	34
35	Dietary under contract (see instructions)		400		400	2.92	136.99	35
36	Cafeteria			1,269,860	1,269,860	73,063.00	17.38	36
37	Maintenance of Personnel							37
38	Nursing Administration		3,398,739		3,398,739	74,334.00	45.72	38
39	Central Services and Supply							39
40	Pharmacy		4,369,275	-143,665	4,225,610	105,729.00	39.97	40
41	Medical Records & Medical Records Library		5,032		5,032	308.00	16.34	41
42	Social Service		792,861		792,861	26,056.00	30.43	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		169,007,570		169,007,570	5,360,019.86	31.53	1
2	Excluded area salaries (see instructions)		12,806,586	184,285	12,990,871	418,676.00	31.03	2
3	Subtotal salaries (line 1 minus line 2)		156,200,984	-184,285	156,016,699	4,941,343.86	31.57	3
4	Subtotal other wages & related costs (see instructions)		23,527,144		23,527,144	627,656.33	37.48	4
5	Subtotal wage-related costs (see instructions)		60,373,529		60,373,529		38.70%	5
6	Total (sum of lines 3 through 5)		240,101,657	-184,285	239,917,372	5,569,000.19	43.08	6
7	Total overhead cost (see instructions)		41,120,376	-143,665	40,976,711	1,401,261.86	29.24	7

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

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	5,693,306	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	21,153,248	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan	104,784	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)	20,429,228	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	1,557,900	10
11	Life Insurance (If employee is owner or beneficiary)	141,174	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	106,722	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	1,004,988	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	10,060,899	17
18	Medicare Taxes - Employers Portion Only	2,458,974	18
19	Unemployment Insurance	76,137	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	62,787,360	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 - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	2,663,982	62,787,360	1
2	Hospital	2,663,982	62,787,360	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA**HHA CCN: 15-7487****WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA

County: LAKE

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		3,177		1,380	4,557	1
2	Unduplicated Census Count (see instructions)		1,165.00		1,530.00	2,695.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

Enter the number of hours in your normal work week 40.00		Number of Employees (Full Time Equivalent)			
		Staff 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)	1.00		1.00	3
4	Director(s) and Assistant Director(s)	1.02		1.02	4
5	Other Administrative Personnel	23.55		23.55	5
6	Direct Nursing Service	13.75		13.75	6
7	Nursing Supervisor				7
8	Physical Therapy Service	4.60	0.31	4.91	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	7.15		7.15	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.01		0.01	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	2.26		2.26	16
17	Home Health Aide Supervisor				17
18	PRIVATE DUTY				18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

		Full Episodes				Total (columns 1 through 4)	
		Without Outliers 1	With Outliers 2	LUPA Episodes 3	PEP only Episodes 4		
21	Skilled Nursing Visits	12,131	3,620	263	326	16,340	21
22	Skilled Nursing Visit Charges	2,209,045	660,507	48,074	59,540	2,977,166	22
23	Physical Therapy Visits	9,119	1,340	81	233	10,773	23
24	Physical Therapy Visit Charges	1,948,831	285,650	17,578	50,037	2,302,096	24
25	Occupational Therapy Visits	3,801	704	19	127	4,651	25
26	Occupational Therapy Visit Charges	811,328	150,396	4,081	27,323	993,128	26
27	Speech Pathology Visits	454	190		47	691	27
28	Speech Pathology Visit Charges	96,836	40,410		10,183	147,429	28
29	Medical Social Service Visits	5				5	29
30	Medical Social Service Visit Charges	12,209				12,209	30
31	Home Health Aide Visits	2,240	849	3	85	3,177	31
32	Home Health Aide Visit Charges	304,010	115,192	406	11,578	431,186	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	27,750	6,703	366	818	35,637	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	5,382,259	1,252,155	70,139	158,661	6,863,214	35
36	Total Number of Episodes (standard/non-outlier)	1,407		143	34	1,584	36
37	Total Number of Outlier Episodes		163		10	173	37
38	Total Non-Routine Medical Supply Charges	369,545	189,292	10,378	4,839	574,054	38

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA**WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.226136	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	23,633,779	2
3	Did you receive DSH or supplemental payments from Medicaid?	N	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	221,944,843	6
7	Medicaid cost (line 1 times line 6)	50,189,719	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.	26,555,940	8

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

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

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

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)	1,036	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)	13,023	14
15	State or local indigent care program cost (line 1 times line 14)	2,945	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.	1,909	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)	26,557,849	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)	16,884,138	2,872,533	19,756,671	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,818,111	2,872,533	6,690,644	21
22	Payments received from patients for amounts previously written off as charity care	93,064		93,064	22
23	Cost of charity care (line 21 minus line 22)	3,725,047	2,872,533	6,597,580	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)	14,093,944	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,448,758	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,228,859	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	11,865,085	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,463,224	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	10,060,804	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	36,618,653	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				14,106,780	14,106,780	226,732	14,333,512	1
2	00200	Cap Rel Costs-Mvble Equip				10,118,385	10,118,385	1,913,153	12,031,538	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	614,953	-4,301,474	-3,686,521	25,696,556	22,010,035	-1,402	22,008,633	4
5	00500	Administrative & General	15,869,324	97,469,629	113,338,953	-10,924,369	102,414,584	-36,551,370	65,863,214	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	5,145,496	10,939,959	16,085,455	-1,376,929	14,708,526	-26,211	14,682,315	7
8	00800	Laundry & Linen Service	116,803	1,385,634	1,502,437	5,430	1,507,867		1,507,867	8
9	00900	Housekeeping	3,417,066	2,425,950	5,843,016	-1,144,691	4,698,325	-79,324	4,619,001	9
10	01000	Dietary	3,949,936	4,025,799	7,975,735	-4,029,917	3,945,818	-123	3,945,695	10
11	01100	Cafeteria				2,949,010	2,949,010	-2,165,334	783,676	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	3,398,739	1,862,610	5,261,349	-1,058,308	4,203,041	-102,610	4,100,431	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	4,369,275	17,875,023	22,244,298	-954,617	21,289,681	-5,805	21,283,876	15
16	01600	Medical Records & Library	5,032	126,807	131,839	4,819	136,658	5,498,147	5,634,805	16
17	01700	Social Service	792,861	277,143	1,070,004	-155,265	914,739		914,739	17
19	01900	Nonphysician Anesthetists								19
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	PARAMED ED PRGM-(SPECIFY)	203,250	46,691	249,941	122,963	372,904		372,904	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	36,181,202	18,315,709	54,496,911	-11,256,340	43,240,571	-5,112	43,235,459	30
31	03100	Intensive Care Unit	10,402,005	4,466,295	14,868,300	-1,969,839	12,898,461	-51,641	12,846,820	31
32.01	02060	NEONATAL INTENSIVE CARE	3,006,259	1,587,846	4,594,105	-897,719	3,696,386	-46,824	3,649,562	32.01
41	04100	Subprovider - IRF	4,166,053	3,069,138	7,235,191	-762,799	6,472,392		6,472,392	41
43	04300	Nursery				2,043,784	2,043,784		2,043,784	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	29,415,062	66,763,084	96,178,146	-42,929,787	53,248,359	-13,940,789	39,307,570	50
52	05200	Delivery Room & Labor Room	2,326,642	1,806,956	4,133,598	-912,032	3,221,566	-1,931	3,219,635	52
54	05400	Radiology-Diagnostic	8,803,191	13,597,380	22,400,571	-4,251,234	18,149,337	-102,526	18,046,811	54
60	06000	Laboratory	6,522,127	9,826,531	16,348,658	-1,666,920	14,681,738	-57,534	14,624,204	60
62	06200	Whole Blood & Packed Red Blood Cells	380,095	2,158,907	2,539,002	-80,674	2,458,328		2,458,328	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	3,750,052	1,885,478	5,635,530	-746,702	4,888,828	-11,585	4,877,243	65
66	06600	Physical Therapy	6,893,625	6,887,621	13,781,246	-1,209,069	12,572,177		12,572,177	66
70	07000	Electroencephalography	778,496	713,846	1,492,342	-205,742	1,286,600	-3,024	1,283,576	70
71	07100	Medical Supplies Charged to Patients				22,060,211	22,060,211		22,060,211	71
72	07200	Impl. Dev. Charged to Patients				32,334,534	32,334,534		32,334,534	72
73	07300	Drugs Charged to Patients								73
76	03140	CARDIOLOGY	8,573,992	22,946,261	31,520,253	-19,487,875	12,032,378	-499,137	11,533,241	76
76.97	07697	CARDIAC REHABILITATION	916,427	463,389	1,379,816	-205,701	1,174,115	-64,229	1,109,886	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	2,300,920	2,022,051	4,322,971	-516,982	3,805,989	-226,137	3,579,852	90
91	09100	Emergency	6,712,753	3,911,223	10,623,976	-1,260,343	9,363,633	-32,781	9,330,852	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	4,901,467	1,733,351	6,634,818	-617,501	6,017,317	65,282	6,082,599	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	173,913,103	294,288,837	468,201,940	821,117	469,023,057	-46,272,115	422,750,942	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
191	19100	Research	493,572	201,999	695,571	-64,492	631,079		631,079	191
192	19200	Physicians' Private Offices	1,601	1,926,903	1,928,504	-232,162	1,696,342	2,055	1,698,397	192
194	07950	ADVERTISING				678,246	678,246		678,246	194
194.01	07951	FITNESS POINTE	1,531,386	1,672,120	3,203,506	-703,338	2,500,168		2,500,168	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	313,532	171,182	484,714	-48,582	436,132		436,132	194.02
194.03	07953	RETAIL PHARMACY	816,998	10,508,166	11,325,164	-122,441	11,202,723		11,202,723	194.03
194.04	07954	HOSPICE								194.04
194.05	07955	RUSH RESIDENTS								194.05
194.06	07956	EINSTEIN BAGELS	134,098	250,066	384,164	-78,366	305,798		305,798	194.06
194.07	07957	NORTHWESTERN IMAGING	244,629	453,664	698,293	-249,982	448,311		448,311	194.07
200		TOTAL (sum of lines 118-199)	177,448,919	309,472,937	486,921,856		486,921,856	-46,270,060	440,651,796	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	OPERATING RM/CARDIOLOGY SUPPLIES	A	Medical Supplies Charged to P	71		21,217,275	1
2			Impl. Dev. Charged to Patient	72		32,334,534	2
3							3
4							4
5	NURSING UNITS ONLY	A	Medical Supplies Charged to P	71		842,936	5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					54,394,745	500
	Code Letter - A						
1	NURSING FLOAT SALARIES	B	Intensive Care Unit	31	74,532		1
2			NEONATAL INTENSIVE CARE	32.01	21,464		2
3			Delivery Room & Labor Room	52	18,381		3
4			Emergency	91	62,966		4
5			Subprovider - IRF	41	40,620		5
6			Nursery	43	11,145		6
500	Total reclassifications				229,108		500
	Code Letter - B						
1	CAFETERIA EXPENSE	D	Cafeteria	11	1,269,860	1,679,150	1
500	Total reclassifications				1,269,860	1,679,150	500
	Code Letter - D						
1	BUILDING INSURANCE	F	Cap Rel Costs-Bldg & Fixt	1		213,877	1
2			Cap Rel Costs-Mvble Equip	2		13,609	2
500	Total reclassifications					227,486	500
	Code Letter - F						
1	UTILITY RECLASS	G	Operation of Plant	7		1,057,736	1
2			Laboratory	60		9,783	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
500	Total reclassifications					1,067,519	500
	Code Letter - G						
1	ADVERTISING NON-REIMBURSABLE	H	ADVERTISING	194		678,246	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
500	Total reclassifications					678,246	500
	Code Letter - H						
1	BENEFITS RECLASS	I	Employee Benefits Department	4		20,996,611	1
2			Employee Benefits Department	4		4,767,944	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
500	Total reclassifications Code Letter - I					25,764,555
1	DEPRECIATION RECLASS	J	Cap Rel Costs-Bldg & Fixt	1		13,892,903
2	BUILDING	J	Medical Records & Library	16		1,758
3						
4						
5						
6						
7						
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11						
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29						
500	Total reclassifications Code Letter - J					13,894,661
1	RECLASS NURSERY	K	Nursery	43	1,374,825	657,814
500	Total reclassifications Code Letter - K				1,374,825	657,814
1	DEPRECIATION RECLASS EQUIPMENT	L	Cap Rel Costs-Mvble Equip	2		10,104,776
2						
3						
4						
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14						

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
500	Total reclassifications					10,104,776	500
	Code Letter - L						
1	RECLASS PRECEPTOR TIME	M	PARAMED ED PRGM-(SPECIFY)	23	143,665		1
500	Total reclassifications				143,665		500
	Code Letter - M						
1	LINEN RECLASS FOR OFFSITES SJ	N	Radiology-Diagnostic	54		6,575	1
2			Physical Therapy	66		2,630	2
3			CARDIOLOGY	76		1,315	3
4			Physicians' Private Offices	192		11,836	4
5							5
6	LINEN RECLASS CDC	N	Radiology-Diagnostic	54		16,721	6
7			CARDIOLOGY	76		7,166	7
8			Clinic	90		2,389	8
9							9
10	LINEN RECLASS SV	N	Radiology-Diagnostic	54		6,614	10
11			CARDIOLOGY	76		2,205	11
12			Physicians' Private Offices	192		2,205	12
13							13
14	RECLASS COSTS TO LAUNDRY	N	Laundry & Linen Service	8		47,763	14
15							15
16							16
17							17
500	Total reclassifications					107,419	500
	Code Letter - N						
1	RECLASS OFFSITE HOUSEK COSTS SJ	O	Administrative & General	5		45,178	1
2			Operation of Plant	7		14,591	2
3			Housekeeping	9		497	3
4			Medical Records & Library	16		4,437	4
5			Radiology-Diagnostic	54		18,800	5
6			Laboratory	60		4,224	6
7			Physical Therapy	66		20,343	7
8			CARDIOLOGY	76		2,126	8
9							9
10	RECLASS HOUSEKEEPING SV	O	Administrative & General	5		10,366	10
11			Operation of Plant	7		579	11
12			Radiology-Diagnostic	54		5,382	12
13			Laboratory	60		1,889	13
14			CARDIOLOGY	76		405	14
500	Total reclassifications					128,817	500
	Code Letter - O						
	GRAND TOTAL (Increases)				3,017,458	108,705,188	

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

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9		
1	OPERATING RM/CARDIOLOGY SUPPLIES	A	Operating Room	50		36,467,109		1
2			CARDIOLOGY	76		16,743,643		2
3			Radiology-Diagnostic	54		214,885		3
4			Clinic	90		126,172		4
5	NURSING UNITS ONLY	A	Adults & Pediatrics	30		441,142		5
6			Intensive Care Unit	31		184,896		6
7			NEONATAL INTENSIVE CARE	32.01		25,199		7
8			Subprovider - IRF	41		46,251		8
9			Delivery Room & Labor Room	52		45,973		9
10			Emergency	91		99,475		10
500	Total reclassifications					54,394,745		500
	Code letter - A							
1	NURSING FLOAT SALARIES	B	Adults & Pediatrics	30	229,108			1
2								2
3								3
4								4
5								5
6								6
500	Total reclassifications				229,108			500
	Code letter - B							
1	CAFETERIA EXPENSE	D	Dietary	10	1,269,860	1,679,150		1
500	Total reclassifications				1,269,860	1,679,150		500
	Code letter - D							
1	BUILDING INSURANCE	F	Administrative & General	5		213,877	12	1
2			Administrative & General	5		13,609	12	2
500	Total reclassifications					227,486		500
	Code letter - F							
1	UTILITY RECLASS	G	Administrative & General	5		626,698		1
2			Housekeeping	9		11,451		2
3			Delivery Room & Labor Room	52		244		3
4			Radiology-Diagnostic	54		573		4
5			Physical Therapy	66		42,435		5
6			CARDIOLOGY	76		145		6
7			Clinic	90		8,114		7
8			Emergency	91		677		8
9			Research	191		4,766		9
10			Physicians' Private Offices	192		79,737		10
11			FITNESS POINTE	194.01		275,955		11
12			NORTHWESTERN IMAGING	194.07		16,724		12
500	Total reclassifications					1,067,519		500
	Code letter - G							
1	ADVERTISING NON-REIMBURSABLE	H						1
2			Administrative & General	5		622,140		2
3			Dietary	10		3,496		3
4			Nursing Administration	13		6,980		4
5			Pharmacy	15		1,820		5
6			Adults & Pediatrics	30		20,244		6
7			NEONATAL INTENSIVE CARE	32.01		586		7
8			Delivery Room & Labor Room	52		759		8
9			Radiology-Diagnostic	54		4,898		9
10			Laboratory	60		534		10
11			Respiratory Therapy	65		400		11
12			Physical Therapy	66		57		12
13			Electroencephalography	70		3,499		13
14			CARDIOLOGY	76		9,952		14
15			Clinic	90		92		15
16			Home Health Agency	101		2,789		16
500	Total reclassifications					678,246		500
	Code letter - H							
1	BENEFITS RECLASS	I						1
2			Administrative & General	5		2,584,912		2
3			Operation of Plant	7		997,464		3
4			Laundry & Linen Service	8		42,333		4
5			Housekeeping	9		918,218		5
6			Dietary	10		954,505		6
7			Nursing Administration	13		385,680		7
8			Pharmacy	15		443,674		8
9			Medical Records & Library	16		1,085		9
10			Social Service	17		139,613		10

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RECLASSIFICATIONS
WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
11			PARAMED ED PRGM-(SPECIFY)	23		20,702		11
12			Adults & Pediatrics	30		5,169,247		12
13			Intensive Care Unit	31		1,308,402		13
14			NEONATAL INTENSIVE CARE	32.01		468,657		14
15			Subprovider - IRF	41		570,894		15
16			Operating Room	50		3,086,149		16
17			Delivery Room & Labor Room	52		437,793		17
18			Radiology-Diagnostic	54		1,326,919		18
19			Laboratory	60		1,119,362		19
20			Whole Blood & Packed Red Bloo	62		47,196		20
21			Respiratory Therapy	65		612,229		21
22			Physical Therapy	66		901,999		22
23			Electroencephalography	70		140,830		23
24			CARDIOLOGY	76		1,299,751		24
25			CARDIAC REHABILITATION	76.97		167,049		25
26			Clinic	90		343,470		26
27			Emergency	91		1,105,547		27
28			Home Health Agency	101		614,404		28
29			Research	191		59,726		29
30			FITNESS POINTE	194.01		270,964		30
31			FITNESS POINTE SPA/PRO SHOP/D	194.02		43,622		31
32			RETAIL PHARMACY	194.03		75,833		32
33			NORTHWESTERN IMAGING	194.07		47,375		33
34			EINSTEIN BAGELS	194.06		58,951		34
500	Total reclassifications					25,764,555		500
	Code letter - I							
1	DEPRECIATION RECLASS	J	Employee Benefits Department	4		64,914	9	1
2	BUILDING	J	Administrative & General	5		6,452,948		2
3			Operation of Plant	7		1,112,961		3
4			Housekeeping	9		7,424		4
5			Dietary	10		58,176		5
6			Nursing Administration	13		318,223		6
7			Pharmacy	15		44,492		7
8			Social Service	17		15,652		8
9			Adults & Pediatrics	30		2,844,743		9
10			Intensive Care Unit	31		245,362		10
11			NEONATAL INTENSIVE CARE	32.01		202,890		11
12			Subprovider - IRF	41		161,429		12
13			Operating Room	50		1,002,997		13
14			Delivery Room & Labor Room	52		341,237		14
15			Radiology-Diagnostic	54		239,489		15
16			Laboratory	60		108,170		16
17			Whole Blood & Packed Red Bloo	62		7,100		17
18			Respiratory Therapy	65		21,397		18
19			Physical Therapy	66		184,151		19
20			Electroencephalography	70		10,454		20
21			CARDIOLOGY	76		75,483		21
22			CARDIAC REHABILITATION	76.97		16,963		22
23			Clinic	90		29,989		23
24			Emergency	91		6,316		24
25			Physicians' Private Offices	192		164,979		25
26			FITNESS POINTE	194.01		128,589		26
27			FITNESS POINTE SPA/PRO SHOP/D	194.02		1,478		27
28			RETAIL PHARMACY	194.03		16,582		28
29			EINSTEIN BAGELS	194.06		10,073		29
500	Total reclassifications					13,894,661		500
	Code letter - J							
1	RECLASS NURSERY	K	Adults & Pediatrics	30	1,374,825	657,814		1
500	Total reclassifications				1,374,825	657,814		500
	Code letter - K							
1	DEPRECIATION RECLASS EQUIPMENT	L	Employee Benefits Department	4		3,085	9	1
2			Administrative & General	5		413,281		2
3			Operation of Plant	7		339,410		3
4			Housekeeping	9		24,960		4
5			Dietary	10		64,632		5
6			Nursing Administration	13		347,425		6
7			Pharmacy	15		320,966		7
8			Medical Records & Library	16		291		8
9			Adults & Pediatrics	30		519,217		9
10			Intensive Care Unit	31		305,711		10
11			NEONATAL INTENSIVE CARE	32.01		221,851		11
12			Subprovider - IRF	41		24,845		12

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RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9		
13			Operating Room	50		2,373,532		13
14			Delivery Room & Labor Room	52		104,407		14
15			Radiology-Diagnostic	54		2,518,562		15
16			Laboratory	60		454,750		16
17			Whole Blood & Packed Red Bloo	62		26,378		17
18			Respiratory Therapy	65		112,676		18
19			Physical Therapy	66		103,400		19
20			Electroencephalography	70		50,959		20
21			CARDIOLOGY	76		1,372,118		21
22			CARDIAC REHABILITATION	76.97		21,689		22
23			Clinic	90		10,979		23
24			Emergency	91		111,294		24
25			Home Health Agency	101		308		25
26			Physicians' Private Offices	192		1,487		26
27			FITNESS POINTE	194.01		27,830		27
28			FITNESS POINTE SPA/PRO SHOP/D	194.02		3,482		28
29			RETAIL PHARMACY	194.03		30,026		29
30			EINSTEIN BAGELS	194.06		9,342		30
31			NORTHWESTERN IMAGING	194.07		185,883		31
500	Total reclassifications					10,104,776		500
	Code letter - L							
1	RECLASS PRECEPTOR TIME	M	Pharmacy	15	143,665			1
500	Total reclassifications				143,665			500
	Code letter - M							
1	LINEN RECLASS FOR OFFSITES SJ	N	Administrative & General	5		22,356		1
2								2
3								3
4								4
5								5
6	LINEN RECLASS CDC	N	Housekeeping	9		26,276		6
7								7
8								8
9								9
10	LINEN RECLASS SV	N	Administrative & General	5		11,024		10
11								11
12								12
13								13
14	RECLASS COSTS TO LAUNDRY	N	Administrative & General	5		447		14
15			Housekeeping	9		46,663		15
16			Dietary	10		98		16
17			Clinic	90		555		17
500	Total reclassifications					107,419		500
	Code letter - N							
1	RECLASS OFFSITE HOUSEK COSTS SJ	O	Housekeeping	9		110,196		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10	RECLASS HOUSEKEEPING SV	O	Administrative & General	5		18,621		10
11								11
12								12
13								13
14								14
500	Total reclassifications					128,817		500
	Code letter - O							
	GRAND TOTAL (Decreases)				3,017,458	108,705,188		

(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	
		1	2	3	4	5	6	7	
1	Land	13,456,197	404,963		404,963	124,362	13,736,798		1
2	Land Improvements	1,266,082	171,043		171,043	180,087	1,257,038		2
3	Buildings and Fixtures	373,859,181	16,958,903		16,958,903	3,326,035	387,492,049		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	146,285,703	13,452,195		13,452,195	12,527,982	147,209,916		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	534,867,163	30,987,104		30,987,104	16,158,466	549,695,801		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	534,867,163	30,987,104		30,987,104	16,158,466	549,695,801		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	402,485,885		402,485,885	0.732197					1
2	Cap Rel Costs-Mvble Equ	147,209,916		147,209,916	0.267803					2
3	Total (sum of lines 1-2)	549,695,801		549,695,801	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	14,119,635			213,877			14,333,512	1
2	Cap Rel Costs-Mvble Equip	12,017,929			13,609			12,031,538	2
3	Total (sum of lines 1-2)	26,137,564			227,486			26,365,050	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. 5	
				COST CENTER	LINE#		
				3	4		
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-14,207,122				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-27,957,676				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35	A&G OTHER INCOME	B	-129,255	Administrative & General	5		35
36							36
36.02	OFFSET PHYSICIAN FEES	A	-48	Clinic	90		36.02
36.03	OFFSET LASER CLINIC FEES	A	-6,875	CARDIOLOGY	76		36.03
36.04	OFFSET ON CALL FEES	A	-544,000	Administrative & General	5		36.04
36.05	OFFSET NP SALARIES	A	-180,172	Clinic	90		36.05
37	OFFSET MAMMO FEES	A	-17,311	Radiology-Diagnostic	54		37
38	OFFSET OTHER INCOME PHARMACY	B	-4,500	Pharmacy	15		38
39							39
40	PHYSICIAN RENTAL-LAB	B	-32,577	Laboratory	60		40
41							41
42	VARIOUS EH&W OFFSETS	B	-1,402	Employee Benefits Department	4		42
42.04	OFFSET NURS ADMIN OTHER REVENUE	B	-557	Nursing Administration	13		42.04
42.05	OTHER INCOME ACUTE	B	-2,824	Adults & Pediatrics	30		42.05
43	OFFSET OTHER INCOME ICU	B	-63	Intensive Care Unit	31		43
43.02	OFFSET RESEARCH COSTS HEART CTR	A	-354,186	CARDIOLOGY	76		43.02
43.07	OTHER INCOME ER	B	-80	Emergency	91		43.07
43.08	OTHER INCOME CARDIOLOGY	B	-3,509	CARDIOLOGY	76		43.08
43.09	OFFSET OTHER INCOME HHA	B	-86	Home Health Agency	101		43.09
43.10	OFFSET RESEARCH RELATED COSTS NEUR	A	-102,053	Nursing Administration	13		43.10
44	OTHER INCOME	A	-123	Dietary	10		44
45	OFFSET NEONATOLOGY FEES	A	-8,020	NEONATAL INTENSIVE CARE	32.01		45
45.01	EMPLOYEE CAFETERIA REVENUE	B	-2,164,272	Cafeteria	11		45.01
45.03	OTHER INCOME DIETARY	B	-1,062	Cafeteria	11		45.03
45.04	TELEPHONE SERVICE	A	-86,200	Administrative & General	5		45.04
45.05	TELEPHONE SERVICE	A	-18,200	Administrative & General	5		45.05
45.06	TELEPHONE SERVICE	A	-8,083	Cap Rel Costs-Mvble Equip	2	9	45.06
45.08	TELEVISION SERVICE	A	-11,317	Operation of Plant	7		45.08
45.09	TELEVISION SERVICE	A	-30,885	Cap Rel Costs-Mvble Equip	2	9	45.09
45.21	PARETN ASSET DEP AJE	A	-2,672	Cap Rel Costs-Bldg & Fixt	1	9	45.21
45.29	OFFSET RELEASED TEMP REST OP IN	B	-90,121	Administrative & General	5		45.29

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
45.30	OFFSET RELEASED TEMP REST OP IN	B	-103,047	CARDIOLOGY	76		45.30
45.31	OFFSET RELEASED TEMP REST OP IN	B	-9,964	Respiratory Therapy	65		45.31
45.32	OFFSET RELEASED TEMP REST OP IN	B	-19,000	Emergency	91		45.32
45.33	NON-PT CARE RELATED EXPENSES	A	-10,563	Administrative & General	5		45.33
45.35	OFFSET RELEASED TEMP REST OP INCOM	B	-4,898	Radiology-Diagnostic	54		45.35
45.36	OFFSET RELEASED TEMP REST OP INCOM	B	-1,305	Pharmacy	15		45.36
46	OFFSET SURGERY INCOME	B	-32	Operating Room	50		46
47	OFFSET CARDIAC REHAB CLASS INCO	B	-64,229	CARDIAC REHABILITATION	76.97		47
47.01	CLEANING SERVICES-SJ SV	A	-11,608	Administrative & General	5		47.01
47.03	CLEANING SERVICES-SJ SV	A	-80,163	Housekeeping	9		47.03
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-46,270,060				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
 A. Costs - if cost, including applicable overhead, can be determined
 B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	CFNI CORPORATE ALLOCATION	229,404		229,404	9	1
2	2	Cap Rel Costs-Mvble Equip	CFNI ALLOCATION	1,952,121		1,952,121	9	2
3	5	Administrative & General	CFNI ALLOCATION	31,378,934	50,638,644	-19,259,710		3
3.01	16	Medical Records & Library	CFNI ALLOCATION	5,499,150		5,499,150		3.01
3.02	5	Administrative & General	COMMUNICATIONS	1,398,009		1,398,009		3.02
3.03	5	Administrative & General	PATIENT ACCOUNTING	6,307,621		6,307,621		3.03
3.04	5	Administrative & General	CDC LEASE		80,107	-80,107		3.04
3.05	7	Operation of Plant	CDC LEASE		25,063	-25,063		3.05
3.06	54	Radiology-Diagnostic	CDC LEASE		121,842	-121,842		3.06
3.07	60	Laboratory	CDC LEASE		11,630	-11,630		3.07
3.08	90	Clinic	CDC LEASE		19,370	-19,370		3.08
3.09	76	CARDIOLOGY	CDC LEASE		3,707	-3,707		3.09
3.10	5	Administrative & General	CDC LEASE DEPR	8,088		8,088		3.10
3.11	7	Operation of Plant	CDC LEASE DEPR	10,160		10,160		3.11
3.12	9	Housekeeping	CDC LEASE DEPR	838		838		3.12
3.13	54	Radiology-Diagnostic	CDC LEASE DEPR	57,974		57,974		3.13
3.14	60	Laboratory	CDC LEASE DEPR	5,400		5,400		3.14
3.15	76	CARDIOLOGY	CDC LEASE DEPR	4,365		4,365		3.15
3.16	90	Clinic	CDC LEASE DEPR	6,396		6,396		3.16
3.18	192	Physicians' Private Offices	CDC LEASE DEPR	2,053		2,053		3.18
3.21	5	Administrative & General	LEASE EXPENSE		74,140	-74,140		3.21
3.22	5	Administrative & General	800 MACARTHUR DEPR	37,407		37,407		3.22
3.23	5	Administrative & General	800 MACARTHUR A&G	42,933		42,933		3.23
3.25	101	Home Health Agency	LEASE EXPENSE		96,710	-96,710		3.25
3.27	101	Home Health Agency	DEPRECIATION	68,422		68,422		3.27
3.28	101	Home Health Agency	ALL OTHER	93,656		93,656		3.28
3.33	5	Administrative & General	CCN COSTS		23,989,482	-23,989,482		3.33
3.35	5	Administrative & General	CDC A&G	7		7		3.35
3.36	7	Operation of Plant	CDC A&G	9		9		3.36
3.37	9	Housekeeping	CDC A&G	1		1		3.37
3.38	54	Radiology-Diagnostic	CDC A&G	54		54		3.38
3.39	60	Laboratory	CDC A&G	5		5		3.39
3.40	76	CARDIOLOGY	CDC A&G	4		4		3.40
3.41	90	Clinic	CDC A&G	6		6		3.41
3.42	192	Physicians' Private Offices	CDC A&G	2		2		3.42
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		47,103,019	75,060,695	-27,957,676		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	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		100.00	CFNI		PARENT	6
7							7
8							8
9							9
10							10

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

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

WORKSHEET A-8-1

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	

- 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	50	Operating Room	55,175		55,175	211,500	324	32,945	1,647	1
2	5	Administrative & Gen AGGREGATE	215,351	52,008	163,343	211,500	1,606	163,302	8,165	2
3	50	Operating Room CRNA ANESTHESIO	13,918,527	13,918,527						3
4	30	Adults & Pediatrics AGGREGATE	20,083		20,083	211,500	175	17,795	890	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE	57,717	30,000	27,717	211,500	186	18,913	946	5
6	54	Radiology-Diagnostic AGGREGATE	40,033		40,033	271,900	180	23,530	1,177	6
7	16	Medical Records & Li AGGREGATE	5,375		5,375	211,500	43	4,372	219	7
8	60	Laboratory	56,401		56,401	260,300	301	37,669	1,883	8
9	65	Respiratory Therapy AGGREGATE	27,957		27,957	211,500	259	26,336	1,317	9
10	70	Electroencephalogram	35,867		35,867	211,500	323	32,843	1,642	10
11	76	CARDIOLOGY AGGREGATE	61,060		61,060	211,500	284	28,878	1,444	11
12	90	Clinic AGGREGATE	97,009		97,009	211,500	630	64,060	3,203	12
13	91	Emergency AGGREGATE	45,833		45,833	211,500	316	32,132	1,607	13
14	31	Intensive Care Unit AGGREGATE	67,237	44,170	23,067	211,500	154	15,659	783	14
15	52	Delivery Room & Labo	6,100		6,100	211,500	41	4,169	208	15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	14,709,725	14,044,705	665,020		4,822	502,603	25,131	200

KPMG LLP Compu-Max 2552-10

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	50	Operating Room					32,945	22,230	22,230	1
2	5	Administrative & Gen AGGREGATE					163,302	41	52,049	2
3	50	Operating Room CRNA ANESTHESIO							13,918,527	3
4	30	Adults & Pediatrics AGGREGATE					17,795	2,288	2,288	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE					18,913	8,804	38,804	5
6	54	Radiology-Diagnostic AGGREGATE					23,530	16,503	16,503	6
7	16	Medical Records & Li AGGREGATE					4,372	1,003	1,003	7
8	60	Laboratory					37,669	18,732	18,732	8
9	65	Respiratory Therapy AGGREGATE					26,336	1,621	1,621	9
10	70	Electroencephalograp					32,843	3,024	3,024	10
11	76	CARDIOLOGY AGGREGATE					28,878	32,182	32,182	11
12	90	Clinic AGGREGATE					64,060	32,949	32,949	12
13	91	Emergency AGGREGATE					32,132	13,701	13,701	13
14	31	Intensive Care Unit AGGREGATE					15,659	7,408	51,578	14
15	52	Delivery Room & Labo					4,169	1,931	1,931	15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					502,603	162,417	14,207,122	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	14,333,512	14,333,512					1
2	Cap Rel Costs-Mvble Equip	12,031,538		12,031,538				2
4	Employee Benefits Department	22,008,633	62,512	3,673	22,074,818			4
5	Administrative & General	65,863,214	1,191,110	492,085	1,981,031	69,527,440	69,527,440	5
6	Maintenance & Repairs							6
7	Operation of Plant	14,682,315	2,221,297	404,128	642,333	17,950,073	3,362,821	7
8	Laundry & Linen Service	1,507,867	24,474		14,581	1,546,922	289,805	8
9	Housekeeping	4,619,001	59,574	29,719	426,566	5,134,860	961,980	9
10	Dietary	3,945,695	180,176	76,956	334,565	4,537,392	850,049	10
11	Cafeteria	783,676	184,505		158,522	1,126,703	211,080	11
12	Maintenance of Personnel							12
13	Nursing Administration	4,100,431	43,024	413,671	424,278	4,981,404	933,231	13
14	Central Services & Supply							14
15	Pharmacy	21,283,876	80,000	382,167	527,500	22,273,543	4,172,792	15
16	Medical Records & Library	5,634,805	86,173	346	628	5,721,952	1,071,968	16
17	Social Service	914,739	16,660		98,976	1,030,375	193,034	17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	372,904	3,563		43,307	419,774	78,642	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	43,235,459	2,676,448	618,220	4,316,343	50,846,470	9,525,619	30
31	Intensive Care Unit	12,846,820	506,006	364,003	1,307,828	15,024,657	2,814,764	31
32.01	NEONATAL INTENSIVE CARE	3,649,562	173,644	264,153	377,963	4,465,322	836,547	32.01
41	Subprovider - IRF	6,472,392	388,483	29,582	525,136	7,415,593	1,389,259	41
43	Nursery	2,043,784	35,038		173,016	2,251,838	421,866	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	39,307,570	1,543,023	2,826,112	3,672,000	47,348,705	8,870,448	50
52	Delivery Room & Labor Room	3,219,635	241,829	124,315	292,739	3,878,518	726,613	52
54	Radiology-Diagnostic	18,046,811	638,376	2,998,802	1,098,938	22,782,927	4,268,222	54
60	Laboratory	14,624,204	280,618	541,461	814,183	16,260,466	3,046,284	60
62	Whole Blood & Packed Red Blood Cells	2,458,328	23,395	31,408	47,449	2,560,580	479,707	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,877,243	56,558	134,161	468,134	5,536,096	1,037,149	65
66	Physical Therapy	12,572,177	616,012	123,116	860,559	14,171,864	2,655,000	66
70	Electroencephalography	1,283,576	42,024	60,676	97,183	1,483,459	277,916	70
71	Medical Supplies Charged to Patients	22,060,211				22,060,211	4,132,826	71
72	Impl. Dev. Charged to Patients	32,334,534				32,334,534	6,057,649	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	11,533,241	624,107	1,633,751	1,070,326	14,861,425	2,784,184	76
76.97	CARDIAC REHABILITATION	1,109,886	70,592	25,825	114,401	1,320,704	247,425	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	3,579,852	135,089	13,072	287,233	4,015,246	752,228	90
91	Emergency	9,330,852	378,700	132,515	845,840	10,687,907	2,002,305	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	6,082,599		367	611,870	6,694,836	1,254,231	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	422,750,942	12,583,010	11,724,284	21,633,428	420,251,796	65,705,644	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		18,879			18,879	3,537	190
191	Research	631,079			61,615	692,694	129,771	191
192	Physicians' Private Offices	1,698,397	837,993	1,771	200	2,538,361	475,544	192
194	ADVERTISING	678,246				678,246	127,065	194
194.01	FITNESS POINTE	2,500,168	722,877	33,137	191,169	3,447,351	645,837	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	436,132	23,161	4,146	39,139	502,578	94,154	194.02
194.03	RETAIL PHARMACY	11,202,723	27,740	35,751	101,989	11,368,203	2,129,753	194.03
194.04	HOSPICE		110,381			110,381	20,679	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	305,798	9,471	11,122	16,740	343,131	64,283	194.06
194.07	NORTHWESTERN IMAGING	448,311		221,327	30,538	700,176	131,173	194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	440,651,796	14,333,512	12,031,538	22,074,818	440,651,796	69,527,440	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	21,312,894						7
8	Laundry & Linen Service	48,036	1,884,763					8
9	Housekeeping	116,930		6,213,770				9
10	Dietary	353,644	2,501	5,416	5,749,002			10
11	Cafeteria	362,141		14,173		1,714,097		11
12	Maintenance of Personnel							12
13	Nursing Administration	84,446		2,953		31,470	6,033,504	13
14	Central Services & Supply							14
15	Pharmacy	157,022		15,185		44,758		15
16	Medical Records & Library	169,138		38,004		132		16
17	Social Service	32,699		8,942		11,033		17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	6,994		675		4,517		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,253,248	833,573	2,139,821	4,453,586	501,086	2,675,629	30
31	Intensive Care Unit	993,172	121,263	393,945	427,322	117,446	627,144	31
32.01	NEONATAL INTENSIVE CARE	340,822	825	118,222		33,821	180,610	32.01
41	Subprovider - IRF	762,501	144,582	294,501	773,637	64,015	341,800	41
43	Nursery	68,772	17,800	13,152		17,567	93,789	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,028,595	321,069	1,197,561		259,204	1,384,063	50
52	Delivery Room & Labor Room	474,654	70,907	229,730	94,457	11,738	62,685	52
54	Radiology-Diagnostic	1,252,983	94,009	218,847		111,784		54
60	Laboratory	550,788		113,380		101,975		60
62	Whole Blood & Packed Red Blood Cells	45,919				4,623		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	111,010		13,160		45,251		65
66	Physical Therapy	1,209,088	17,366	75,351		81,027		66
70	Electroencephalography	82,483	8,070	21,394		11,341		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	1,224,978	109,216	307,012		104,705		76
76.97	CARDIAC REHABILITATION	138,556	1,326	20,432		11,156		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	265,149	17,016	31,762		25,835	137,955	90
91	Emergency	743,299	125,240	779,024		99,228	529,829	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	17,877,067	1,884,763	6,052,642	5,749,002	1,693,712	6,033,504	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	37,055						190
191	Research					6,983		191
192	Physicians' Private Offices	1,644,786		158,766				192
194	ADVERTISING							194
194.01	FITNESS POINTE	1,418,839						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	45,459						194.02
194.03	RETAIL PHARMACY	54,447		2,362		9,554		194.03
194.04	HOSPICE	216,652						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	18,589				3,848		194.06
194.07	NORTHWESTERN IMAGING							194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,312,894	1,884,763	6,213,770	5,749,002	1,714,097	6,033,504	202

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	
		15	16	17	23	24	25	
	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	26,663,300						15
16	Medical Records & Library		7,001,194					16
17	Social Service			1,276,083				17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)				510,602			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		550,266	866,264		77,645,562		30
31	Intensive Care Unit		101,971	130,973		20,752,657		31
32.01	NEONATAL INTENSIVE CARE		92,898	47,422		6,116,489		32.01
41	Subprovider - IRF		67,219	173,828		11,426,935		41
43	Nursery		21,266	40,011		2,946,061		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,172,838			63,582,483		50
52	Delivery Room & Labor Room		42,355			5,591,657		52
54	Radiology-Diagnostic		1,277,255			30,006,027		54
60	Laboratory		783,280			20,856,173		60
62	Whole Blood & Packed Red Blood Cells		43,679			3,134,508		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		131,043			6,873,709		65
66	Physical Therapy		207,257			18,416,953		66
70	Electroencephalography		57,037			1,941,700		70
71	Medical Supplies Charged to Patients		184,932			26,377,969		71
72	Impl. Dev. Charged to Patients		293,476			38,685,659		72
73	Drugs Charged to Patients	26,663,300	569,709		510,602	27,743,611		73
76	CARDIOLOGY		740,410			20,131,930		76
76.97	CARDIAC REHABILITATION		10,880			1,750,479		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		45,666			5,290,857		90
91	Emergency		570,065	17,585		15,554,482		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		37,692			7,986,759		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	26,663,300	7,001,194	1,276,083	510,602	412,812,660		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					59,471		190
191	Research					829,448		191
192	Physicians' Private Offices					4,817,457		192
194	ADVERTISING					805,311		194
194.01	FITNESS POINTE					5,512,027		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY					642,191		194.02
194.03	RETAIL PHARMACY					13,564,319		194.03
194.04	HOSPICE					347,712		194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS					429,851		194.06
194.07	NORTHWESTERN IMAGING					831,349		194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	26,663,300	7,001,194	1,276,083	510,602	440,651,796		202

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

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	77,645,562						30
31	Intensive Care Unit	20,752,657						31
32.01	NEONATAL INTENSIVE CARE	6,116,489						32.01
41	Subprovider - IRF	11,426,935						41
43	Nursery	2,946,061						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	63,582,483						50
52	Delivery Room & Labor Room	5,591,657						52
54	Radiology-Diagnostic	30,006,027						54
60	Laboratory	20,856,173						60
62	Whole Blood & Packed Red Blood Cells	3,134,508						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,873,709						65
66	Physical Therapy	18,416,953						66
70	Electroencephalography	1,941,700						70
71	Medical Supplies Charged to Patients	26,377,969						71
72	Impl. Dev. Charged to Patients	38,685,659						72
73	Drugs Charged to Patients	27,743,611						73
76	CARDIOLOGY	20,131,930						76
76.97	CARDIAC REHABILITATION	1,750,479						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	5,290,857						90
91	Emergency	15,554,482						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	7,986,759						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	412,812,660						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	59,471						190
191	Research	829,448						191
192	Physicians' Private Offices	4,817,457						192
194	ADVERTISING	805,311						194
194.01	FITNESS POINTE	5,512,027						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	642,191						194.02
194.03	RETAIL PHARMACY	13,564,319						194.03
194.04	HOSPICE	347,712						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	429,851						194.06
194.07	NORTHWESTERN IMAGING	831,349						194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	440,651,796						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		62,512	3,673	66,185	66,185		4
5	Administrative & General	383,455	1,191,110	492,085	2,066,650	5,935	2,072,585	5
6	Maintenance & Repairs							6
7	Operation of Plant	20,450	2,221,297	404,128	2,645,875	1,924	100,251	7
8	Laundry & Linen Service	21,282	24,474		45,756	44	8,640	8
9	Housekeeping	838	59,574	29,719	90,131	1,278	28,678	9
10	Dietary	9,907	180,176	76,956	267,039	1,002	25,341	10
11	Cafeteria		184,505		184,505	475	6,293	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,889	43,024	413,671	458,584	1,271	27,821	13
14	Central Services & Supply							14
15	Pharmacy	12,820	80,000	382,167	474,987	1,580	124,398	15
16	Medical Records & Library		86,173	346	86,519	2	31,957	16
17	Social Service		16,660		16,660	297	5,755	17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)		3,563		3,563	130	2,344	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	153,228	2,676,448	618,220	3,447,896	12,982	283,833	30
31	Intensive Care Unit	11,408	506,006	364,003	881,417	3,918	83,913	31
32.01	NEONATAL INTENSIVE CARE		173,644	264,153	437,797	1,132	24,939	32.01
41	Subprovider - IRF	33,488	388,483	29,582	451,553	1,573	41,416	41
43	Nursery		35,038		35,038	518	12,577	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,778,707	1,543,023	2,826,112	6,147,842	11,001	264,443	50
52	Delivery Room & Labor Room		241,829	124,315	366,144	877	21,662	52
54	Radiology-Diagnostic	793,987	638,376	2,998,802	4,431,165	3,292	127,243	54
60	Laboratory	99,612	280,618	541,461	921,691	2,439	90,815	60
62	Whole Blood & Packed Red Blood Cells		23,395	31,408	54,803	142	14,301	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	95,560	56,558	134,161	286,279	1,403	30,919	65
66	Physical Therapy	208,370	616,012	123,116	947,498	2,578	79,150	66
70	Electroencephalography	216,441	42,024	60,676	319,141	291	8,285	70
71	Medical Supplies Charged to Patients						123,206	71
72	Impl. Dev. Charged to Patients						180,588	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	95,075	624,107	1,633,751	2,352,933	3,207	83,001	76
76.97	CARDIAC REHABILITATION	90,251	70,592	25,825	186,668	343	7,376	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	124,541	135,089	13,072	272,702	861	22,425	90
91	Emergency	751	378,700	132,515	511,966	2,534	59,692	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	68,422		367	68,789	1,833	37,391	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,220,482	12,583,010	11,724,284	28,527,776	64,862	1,958,653	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		18,879		18,879		105	190
191	Research					185	3,869	191
192	Physicians' Private Offices	2,103	837,993	1,771	841,867	1	14,177	192
194	ADVERTISING						3,788	194
194.01	FITNESS POINTE	13,292	722,877	33,137	769,306	573	19,253	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		23,161	4,146	27,307	117	2,807	194.02
194.03	RETAIL PHARMACY		27,740	35,751	63,491	306	63,491	194.03
194.04	HOSPICE		110,381		110,381		616	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS		9,471	11,122	20,593	50	1,916	194.06
194.07	NORTHWESTERN IMAGING	43,331		221,327	264,658	91	3,910	194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,279,208	14,333,512	12,031,538	30,644,258	66,185	2,072,585	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	2,748,050						7
8	Laundry & Linen Service	6,194	60,634					8
9	Housekeeping	15,077		135,164				9
10	Dietary	45,598	80	118	339,178			10
11	Cafeteria	46,694		308		238,275		11
12	Maintenance of Personnel							12
13	Nursing Administration	10,888		64		4,375	503,003	13
14	Central Services & Supply							14
15	Pharmacy	20,246		330		6,222		15
16	Medical Records & Library	21,808		827		18		16
17	Social Service	4,216		195		1,534		17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	902		15		628		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	677,345	26,816	46,547	262,751	69,654	223,063	30
31	Intensive Care Unit	128,058	3,901	8,569	25,211	16,326	52,284	31
32.01	NEONATAL INTENSIVE CARE	43,945	27	2,572		4,701	15,057	32.01
41	Subprovider - IRF	98,316	4,651	6,406	45,643	8,899	28,495	41
43	Nursery	8,867	573	286		2,442	7,819	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	390,502	10,329	26,050		36,032	115,387	50
52	Delivery Room & Labor Room	61,201	2,281	4,997	5,573	1,632	5,226	52
54	Radiology-Diagnostic	161,558	3,024	4,760		15,539		54
60	Laboratory	71,018		2,466		14,175		60
62	Whole Blood & Packed Red Blood Cells	5,921				643		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	14,313		286		6,290		65
66	Physical Therapy	155,898	559	1,639		11,263		66
70	Electroencephalography	10,635	260	465		1,577		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	157,947	3,514	6,678		14,555		76
76.97	CARDIAC REHABILITATION	17,865	43	444		1,551		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	34,188	547	691		3,591	11,501	90
91	Emergency	95,840	4,029	16,946		13,794	44,171	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,305,040	60,634	131,659	339,178	235,441	503,003	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	4,778						190
191	Research					971		191
192	Physicians' Private Offices	212,076		3,454				192
194	ADVERTISING							194
194.01	FITNESS POINTE	182,943						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	5,861						194.02
194.03	RETAIL PHARMACY	7,020		51		1,328		194.03
194.04	HOSPICE	27,935						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	2,397				535		194.06
194.07	NORTHWESTERN IMAGING							194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,748,050	60,634	135,164	339,178	238,275	503,003	202

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	
		15	16	17	23	24	25	
	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	627,763						15
16	Medical Records & Library		141,131					16
17	Social Service			28,657				17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)				7,582			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		11,048	19,453		5,081,388		30
31	Intensive Care Unit		2,047	2,941		1,208,585		31
32.01	NEONATAL INTENSIVE CARE		1,865	1,065		533,100		32.01
41	Subprovider - IRF		1,350	3,904		692,206		41
43	Nursery		427	899		69,446		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		23,549			7,025,135		50
52	Delivery Room & Labor Room		850			470,443		52
54	Radiology-Diagnostic		26,206			4,772,787		54
60	Laboratory		15,727			1,118,331		60
62	Whole Blood & Packed Red Blood Cells		877			76,687		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,631			342,121		65
66	Physical Therapy		4,161			1,202,746		66
70	Electroencephalography		1,145			341,799		70
71	Medical Supplies Charged to Patients		3,713			126,919		71
72	Impl. Dev. Charged to Patients		5,892			186,480		72
73	Drugs Charged to Patients	627,763	11,439			639,202		73
76	CARDIOLOGY		14,866			2,636,701		76
76.97	CARDIAC REHABILITATION		218			214,508		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		917			347,423		90
91	Emergency		11,446	395		760,813		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		757			108,770		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	627,763	141,131	28,657		27,955,590		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					23,762		190
191	Research					5,025		191
192	Physicians' Private Offices					1,071,575		192
194	ADVERTISING					3,788		194
194.01	FITNESS POINTE					972,075		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY					36,092		194.02
194.03	RETAIL PHARMACY					135,687		194.03
194.04	HOSPICE					138,932		194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS					25,491		194.06
194.07	NORTHWESTERN IMAGING					268,659		194.07
200	Cross Foot Adjustments				7,582	7,582		200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	627,763	141,131	28,657	7,582	30,644,258		202

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

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,081,388						30
31	Intensive Care Unit	1,208,585						31
32.01	NEONATAL INTENSIVE CARE	533,100						32.01
41	Subprovider - IRF	692,206						41
43	Nursery	69,446						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,025,135						50
52	Delivery Room & Labor Room	470,443						52
54	Radiology-Diagnostic	4,772,787						54
60	Laboratory	1,118,331						60
62	Whole Blood & Packed Red Blood Cells	76,687						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	342,121						65
66	Physical Therapy	1,202,746						66
70	Electroencephalography	341,799						70
71	Medical Supplies Charged to Patients	126,919						71
72	Impl. Dev. Charged to Patients	186,480						72
73	Drugs Charged to Patients	639,202						73
76	CARDIOLOGY	2,636,701						76
76.97	CARDIAC REHABILITATION	214,508						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	347,423						90
91	Emergency	760,813						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	108,770						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	27,955,590						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	23,762						190
191	Research	5,025						191
192	Physicians' Private Offices	1,071,575						192
194	ADVERTISING	3,788						194
194.01	FITNESS POINTE	972,075						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	36,092						194.02
194.03	RETAIL PHARMACY	135,687						194.03
194.04	HOSPICE	138,932						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	25,491						194.06
194.07	NORTHWESTERN IMAGING	268,659						194.07
200	Cross Foot Adjustments	7,582						200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	30,644,258						202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGs & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	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	917,164						1
2	Cap Rel Costs-Mvble Equip		10,104,775					2
4	Employee Benefits Department	4,000	3,085	176,833,966				4
5	Administrative & General	76,216	413,281	15,869,324	-69,527,440	371,124,356		5
6	Maintenance & Repairs							6
7	Operation of Plant	142,135	339,410	5,145,496		17,950,073	694,813	7
8	Laundry & Linen Service	1,566		116,803		1,546,922	1,566	8
9	Housekeeping	3,812	24,960	3,417,066		5,134,860	3,812	9
10	Dietary	11,529	64,632	2,680,076		4,537,392	11,529	10
11	Cafeteria	11,806		1,269,860		1,126,703	11,806	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,753	347,425	3,398,739		4,981,404	2,753	13
14	Central Services & Supply							14
15	Pharmacy	5,119	320,966	4,225,610		22,273,543	5,119	15
16	Medical Records & Library	5,514	291	5,032		5,721,952	5,514	16
17	Social Service	1,066		792,861		1,030,375	1,066	17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	228		346,915		419,774	228	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	171,259	519,217	34,577,269		50,846,470	171,259	30
31	Intensive Care Unit	32,378	305,711	10,476,537		15,024,657	32,378	31
32.01	NEONATAL INTENSIVE CARE	11,111	221,851	3,027,723		4,465,322	11,111	32.01
41	Subprovider - IRF	24,858	24,845	4,206,673		7,415,593	24,858	41
43	Nursery	2,242		1,385,970		2,251,838	2,242	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	98,734	2,373,532	29,415,062		47,348,705	98,734	50
52	Delivery Room & Labor Room	15,474	104,407	2,345,023		3,878,518	15,474	52
54	Radiology-Diagnostic	40,848	2,518,562	8,803,191		22,782,927	40,848	54
60	Laboratory	17,956	454,750	6,522,127		16,260,466	17,956	60
62	Whole Blood & Packed Red Blood Cells	1,497	26,378	380,095		2,560,580	1,497	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,619	112,676	3,750,052		5,536,096	3,619	65
66	Physical Therapy	39,417	103,400	6,893,625		14,171,864	39,417	66
70	Electroencephalography	2,689	50,959	778,496		1,483,459	2,689	70
71	Medical Supplies Charged to Patients					22,060,211		71
72	Impl. Dev. Charged to Patients					32,334,534		72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	39,935	1,372,118	8,573,992		14,861,425	39,935	76
76.97	CARDIAC REHABILITATION	4,517	21,689	916,427		1,320,704	4,517	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	8,644	10,979	2,300,920		4,015,246	8,644	90
91	Emergency	24,232	111,294	6,775,719		10,687,907	24,232	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		308	4,901,467		6,694,836		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	805,154	9,846,726	173,298,150	-69,527,440	350,724,356	582,803	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,208				18,879	1,208	190
191	Research			493,572		692,694		191
192	Physicians' Private Offices	53,621	1,487	1,601		2,538,361	53,621	192
194	ADVERTISING					678,246		194
194.01	FITNESS POINTE	46,255	27,830	1,531,386		3,447,351	46,255	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	1,482	3,482	313,532		502,578	1,482	194.02
194.03	RETAIL PHARMACY	1,775	30,026	816,998		11,368,203	1,775	194.03
194.04	HOSPICE	7,063				110,381	7,063	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	606	9,341	134,098		343,131	606	194.06
194.07	NORTHWESTERN IMAGING		185,883	244,629		700,176		194.07
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	14,333,512	12,031,538	22,074,818		69,527,440	21,312,894	202
203	Unit Cost Multiplier (Wkst. B, Part I)	15.628080	1.190678	0.124834		0.187343	30.674288	203
204	Cost to be allocated (Per Wkst. B, Part II)			66,185		2,072,585	2,748,050	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000374		0.005585	3.955093	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE POUNDS	HOUSE- KEEPING TIME SPENT	DIETARY PATIENT ME ALS	CAFETERIA FTES	NURSING ADMINIS- TRATION NURSING HO URS	PHARMACY COSTED REQ	
		8	9	10	11	13	15	
	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	226,070						8
9	Housekeeping		736,576					9
10	Dietary	300	642	340,227				10
11	Cafeteria		1,680		194,665			11
12	Maintenance of Personnel							12
13	Nursing Administration		350		3,574	2,669,129		13
14	Central Services & Supply							14
15	Pharmacy		1,800		5,083		10,000	15
16	Medical Records & Library		4,505		15			16
17	Social Service		1,060		1,253			17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)		80		513			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	99,984	253,653	263,564	56,907	1,183,657		30
31	Intensive Care Unit	14,545	46,698	25,289	13,338	277,439		31
32.01	NEONATAL INTENSIVE CARE	99	14,014		3,841	79,899		32.01
41	Subprovider - IRF	17,342	34,910	45,784	7,270	151,207		41
43	Nursery	2,135	1,559		1,995	41,491		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	38,511	141,958		29,437	612,288		50
52	Delivery Room & Labor Room	8,505	27,232	5,590	1,333	27,731		52
54	Radiology-Diagnostic	11,276	25,942		12,695			54
60	Laboratory		13,440		11,581			60
62	Whole Blood & Packed Red Blood Cells				525			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,560		5,139			65
66	Physical Therapy	2,083	8,932		9,202			66
70	Electroencephalography	968	2,536		1,288			70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients						10,000	73
76	CARDIOLOGY	13,100	36,393		11,891			76
76.97	CARDIAC REHABILITATION	159	2,422		1,267			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,041	3,765		2,934	61,029		90
91	Emergency	15,022	92,345		11,269	234,388		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	226,070	717,476	340,227	192,350	2,669,129	10,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research				793			191
192	Physicians' Private Offices		18,820					192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY		280		1,085			194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS				437			194.06
194.07	NORTHWESTERN IMAGING							194.07
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,884,763	6,213,770	5,749,002	1,714,097	6,033,504	26,663,300	202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.337077	8.436020	16.897548	8.805368	2.260477	2,666.330000	203
204	Cost to be allocated (Per Wkst. B, Part II)	60,634	135,164	339,178	238,275	503,003	627,763	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.268209	0.183503	0.996917	1.224026	0.188452	62.776300	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	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	PARAMED EDUCATION ASSIGNED TIME				
		16	17	23				

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,825,505,029						16
17	Social Service		111,753					17
19	Nonphysician Anesthetists							19
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)			100				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	143,485,227	75,863					30
31	Intensive Care Unit	26,589,532	11,470					31
32.01	NEONATAL INTENSIVE CARE	24,223,748	4,153					32.01
41	Subprovider - IRF	17,527,665	15,223					41
43	Nursery	5,545,290	3,504					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	305,824,842						50
52	Delivery Room & Labor Room	11,044,373						52
54	Radiology-Diagnostic	332,952,468						54
60	Laboratory	204,245,120						60
62	Whole Blood & Packed Red Blood Cells	11,389,494						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	34,170,249						65
66	Physical Therapy	54,043,574						66
70	Electroencephalography	14,872,748						70
71	Medical Supplies Charged to Patients	48,222,226						71
72	Impl. Dev. Charged to Patients	76,525,661						72
73	Drugs Charged to Patients	148,555,224		100				73
76	CARDIOLOGY	193,066,437						76
76.97	CARDIAC REHABILITATION	2,837,007						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	11,907,579						90
91	Emergency	148,648,078	1,540					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	9,828,487						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,825,505,029	111,753	100				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY							194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS							194.06
194.07	NORTHWESTERN IMAGING							194.07
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	7,001,194	1,276,083	510,602				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.003835	11.418781	5,106.020000				203
204	Cost to be allocated (Per Wkst. B, Part II)	141,131	28,657	7,582				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000077	0.256432	75.820000				205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	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	77,645,562		77,645,562	2,288	77,647,850	30
31	Intensive Care Unit	20,752,657		20,752,657	7,408	20,760,065	31
32.01	NEONATAL INTENSIVE CARE	6,116,489		6,116,489	8,804	6,125,293	32.01
41	Subprovider - IRF	11,426,935		11,426,935		11,426,935	41
43	Nursery	2,946,061		2,946,061		2,946,061	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	63,582,483		63,582,483	22,230	63,604,713	50
52	Delivery Room & Labor Room	5,591,657		5,591,657	1,931	5,593,588	52
54	Radiology-Diagnostic	30,006,027		30,006,027	16,503	30,022,530	54
60	Laboratory	20,856,173		20,856,173	18,732	20,874,905	60
62	Whole Blood & Packed Red Blood Cells	3,134,508		3,134,508		3,134,508	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	6,873,709		6,873,709	1,621	6,875,330	65
66	Physical Therapy	18,416,953		18,416,953		18,416,953	66
70	Electroencephalography	1,941,700		1,941,700	3,024	1,944,724	70
71	Medical Supplies Charged to Patients	26,377,969		26,377,969		26,377,969	71
72	Impl. Dev. Charged to Patients	38,685,659		38,685,659		38,685,659	72
73	Drugs Charged to Patients	27,743,611		27,743,611		27,743,611	73
76	CARDIOLOGY	20,131,930		20,131,930	32,182	20,164,112	76
76.97	CARDIAC REHABILITATION	1,750,479		1,750,479		1,750,479	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	5,290,857		5,290,857	32,949	5,323,806	90
91	Emergency	15,554,482		15,554,482	13,701	15,568,183	91
92	Observation Beds (Non-Distinct Part)	11,117,802		11,117,802		11,117,802	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	7,986,759		7,986,759		7,986,759	101
200	Subtotal (sum of lines 30 thru 199)	423,930,462		423,930,462	161,373	424,091,835	200
201	Less Observation Beds	11,117,802		11,117,802		11,117,802	201
202	Total (line 200 minus line 201)	412,812,660		412,812,660		412,974,033	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	111,255,714		111,255,714				30
31	Intensive Care Unit	26,589,532		26,589,532				31
32.01	NEONATAL INTENSIVE CARE	24,223,748		24,223,748				32.01
41	Subprovider - IRF	17,527,665		17,527,665				41
43	Nursery	5,545,290		5,545,290				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	110,145,495	195,679,347	305,824,842	0.207905	0.207905	0.207978	50
52	Delivery Room & Labor Room	7,514,330	3,530,043	11,044,373	0.506290	0.506290	0.506465	52
54	Radiology-Diagnostic	72,284,555	260,667,913	332,952,468	0.090121	0.090121	0.090171	54
60	Laboratory	68,320,737	135,924,383	204,245,120	0.102113	0.102113	0.102205	60
62	Whole Blood & Packed Red Blood Cells	7,160,155	4,229,339	11,389,494	0.275210	0.275210	0.275210	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	31,085,278	3,084,971	34,170,249	0.201161	0.201161	0.201208	65
66	Physical Therapy	29,040,261	25,003,313	54,043,574	0.340780	0.340780	0.340780	66
70	Electroencephalography	1,780,013	13,092,735	14,872,748	0.130554	0.130554	0.130758	70
71	Medical Supplies Charged to Patients	23,565,349	24,656,877	48,222,226	0.547009	0.547009	0.547009	71
72	Impl. Dev. Charged to Patients	48,392,531	28,133,130	76,525,661	0.505525	0.505525	0.505525	72
73	Drugs Charged to Patients	91,630,945	56,924,279	148,555,224	0.186756	0.186756	0.186756	73
76	CARDIOLOGY	74,367,171	118,699,266	193,066,437	0.104275	0.104275	0.104441	76
76.97	CARDIAC REHABILITATION	428,468	2,408,539	2,837,007	0.617016	0.617016	0.617016	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	640,933	11,266,646	11,907,579	0.444327	0.444327	0.447094	90
91	Emergency	49,194,396	99,453,682	148,648,078	0.104640	0.104640	0.104732	91
92	Observation Beds (Non-Distinct Part)	4,131,434	28,098,079	32,229,513	0.344957	0.344957	0.344957	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		9,828,487	9,828,487				101
200	Subtotal (sum of lines 30 thru 199)	804,824,000	1,020,681,029	1,825,505,029				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	804,824,000	1,020,681,029	1,825,505,029				202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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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 (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	77,645,562		77,645,562	2,288	77,647,850	30
31	Intensive Care Unit	20,752,657		20,752,657	7,408	20,760,065	31
32.01	NEONATAL INTENSIVE CARE	6,116,489		6,116,489	8,804	6,125,293	32.01
41	Subprovider - IRF	11,426,935		11,426,935		11,426,935	41
43	Nursery	2,946,061		2,946,061		2,946,061	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	63,582,483		63,582,483	22,230	63,604,713	50
52	Delivery Room & Labor Room	5,591,657		5,591,657	1,931	5,593,588	52
54	Radiology-Diagnostic	30,006,027		30,006,027	16,503	30,022,530	54
60	Laboratory	20,856,173		20,856,173	18,732	20,874,905	60
62	Whole Blood & Packed Red Blood Cells	3,134,508		3,134,508		3,134,508	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	6,873,709		6,873,709	1,621	6,875,330	65
66	Physical Therapy	18,416,953		18,416,953		18,416,953	66
70	Electroencephalography	1,941,700		1,941,700	3,024	1,944,724	70
71	Medical Supplies Charged to Patients	26,377,969		26,377,969		26,377,969	71
72	Impl. Dev. Charged to Patients	38,685,659		38,685,659		38,685,659	72
73	Drugs Charged to Patients	27,743,611		27,743,611		27,743,611	73
76	CARDIOLOGY	20,131,930		20,131,930	32,182	20,164,112	76
76.97	CARDIAC REHABILITATION	1,750,479		1,750,479		1,750,479	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	5,290,857		5,290,857	32,949	5,323,806	90
91	Emergency	15,554,482		15,554,482	13,701	15,568,183	91
92	Observation Beds (Non-Distinct Part)	11,117,802		11,117,802		11,117,802	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	7,986,759		7,986,759		7,986,759	101
200	Subtotal (sum of lines 30 thru 199)	423,930,462		423,930,462	161,373	424,091,835	200
201	Less Observation Beds	11,117,802		11,117,802		11,117,802	201
202	Total (line 200 minus line 201)	412,812,660		412,812,660	161,373	412,974,033	202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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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**

		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	111,255,714		111,255,714				30
31	Intensive Care Unit	26,589,532		26,589,532				31
32.01	NEONATAL INTENSIVE CARE	24,223,748		24,223,748				32.01
41	Subprovider - IRF	17,527,665		17,527,665				41
43	Nursery	5,545,290		5,545,290				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	110,145,495	195,679,347	305,824,842	0.207905	0.207905	0.207978	50
52	Delivery Room & Labor Room	7,514,330	3,530,043	11,044,373	0.506290	0.506290	0.506465	52
54	Radiology-Diagnostic	72,284,555	260,667,913	332,952,468	0.090121	0.090121	0.090171	54
60	Laboratory	68,320,737	135,924,383	204,245,120	0.102113	0.102113	0.102205	60
62	Whole Blood & Packed Red Blood Cells	7,160,155	4,229,339	11,389,494	0.275210	0.275210	0.275210	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	31,085,278	3,084,971	34,170,249	0.201161	0.201161	0.201208	65
66	Physical Therapy	29,040,261	25,003,313	54,043,574	0.340780	0.340780	0.340780	66
70	Electroencephalography	1,780,013	13,092,735	14,872,748	0.130554	0.130554	0.130758	70
71	Medical Supplies Charged to Patients	23,565,349	24,656,877	48,222,226	0.547009	0.547009	0.547009	71
72	Impl. Dev. Charged to Patients	48,392,531	28,133,130	76,525,661	0.505525	0.505525	0.505525	72
73	Drugs Charged to Patients	91,630,945	56,924,279	148,555,224	0.186756	0.186756	0.186756	73
76	CARDIOLOGY	74,367,171	118,699,266	193,066,437	0.104275	0.104275	0.104441	76
76.97	CARDIAC REHABILITATION	428,468	2,408,539	2,837,007	0.617016	0.617016	0.617016	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	640,933	11,266,646	11,907,579	0.444327	0.444327	0.447094	90
91	Emergency	49,194,396	99,453,682	148,648,078	0.104640	0.104640	0.104732	91
92	Observation Beds (Non-Distinct Part)	4,131,434	28,098,079	32,229,513	0.344957	0.344957	0.344957	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		9,828,487	9,828,487				101
200	Subtotal (sum of lines 30 thru 199)	804,824,000	1,020,681,029	1,825,505,029				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	804,824,000	1,020,681,029	1,825,505,029				202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	63,582,483	7,025,135	56,557,348		50
52	Delivery Room & Labor Room	5,591,657	470,443	5,121,214		52
54	Radiology-Diagnostic	30,006,027	4,772,787	25,233,240		54
60	Laboratory	20,856,173	1,118,331	19,737,842		60
62	Whole Blood & Packed Red Blood Cells	3,134,508	76,687	3,057,821		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	6,873,709	342,121	6,531,588		65
66	Physical Therapy	18,416,953	1,202,746	17,214,207		66
70	Electroencephalography	1,941,700	341,799	1,599,901		70
71	Medical Supplies Charged to Patients	26,377,969	126,919	26,251,050		71
72	Impl. Dev. Charged to Patients	38,685,659	186,480	38,499,179		72
73	Drugs Charged to Patients	27,743,611	639,202	27,104,409		73
76	CARDIOLOGY	20,131,930	2,636,701	17,495,229		76
76.97	CARDIAC REHABILITATION	1,750,479	214,508	1,535,971		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	5,290,857	347,423	4,943,434		90
91	Emergency	15,554,482	760,813	14,793,669		91
92	Observation Beds (Non-Distinct Part)	11,117,802	727,560	10,390,242		92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	7,986,759	108,770	7,877,989		101
200	Subtotal	305,042,758	21,098,425	283,944,333		200
201	Less Observation Beds	11,117,802	727,560	10,390,242		201
202	Total	293,924,956	20,370,865	273,554,091		202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		63,582,483	305,824,842	0.207905	50
52	Delivery Room & Labor Room		5,591,657	11,044,373	0.506290	52
54	Radiology-Diagnostic		30,006,027	332,952,468	0.090121	54
60	Laboratory		20,856,173	204,245,120	0.102113	60
62	Whole Blood & Packed Red Blood Cells		3,134,508	11,389,494	0.275210	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		6,873,709	34,170,249	0.201161	65
66	Physical Therapy		18,416,953	54,043,574	0.340780	66
70	Electroencephalography		1,941,700	14,872,748	0.130554	70
71	Medical Supplies Charged to Patients		26,377,969	48,222,226	0.547009	71
72	Impl. Dev. Charged to Patients		38,685,659	76,525,661	0.505525	72
73	Drugs Charged to Patients		27,743,611	148,555,224	0.186756	73
76	CARDIOLOGY		20,131,930	193,066,437	0.104275	76
76.97	CARDIAC REHABILITATION		1,750,479	2,837,007	0.617016	76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic		5,290,857	11,907,579	0.444327	90
91	Emergency		15,554,482	148,648,078	0.104640	91
92	Observation Beds (Non-Distinct Part)		11,117,802	32,229,513	0.344957	92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		7,986,759	9,828,487	0.812613	101
200	Subtotal		305,042,758	1,640,363,080		200
201	Less Observation Beds		11,117,802	32,229,513		201
202	Total		293,924,956	1,608,133,567		202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

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

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	5,081,388		5,081,388	87,553	58.04	35,430	2,056,357	30
31	Intensive Care Unit	1,208,585		1,208,585	11,470	105.37	4,661	491,130	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	533,100		533,100	4,153	128.37			32.01
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF	692,206		692,206	15,223	45.47	12,089	549,687	41
42	Subprovider I								42
43	Nursery	69,446		69,446	3,504	19.82			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,584,725		7,584,725	121,903		52,180	3,097,174	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0125

WORKSHEET D PART II

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

		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	7,025,135	305,824,842	0.022971	46,316,452	1,063,935	50
52	Delivery Room & Labor Room	470,443	11,044,373	0.042596	13,194	562	52
54	Radiology-Diagnostic	4,772,787	332,952,468	0.014335	32,626,365	467,699	54
60	Laboratory	1,118,331	204,245,120	0.005475	30,431,588	166,613	60
62	Whole Blood & Packed Red Blood	76,687	11,389,494	0.006733	2,920,630	19,665	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	342,121	34,170,249	0.010012	14,085,870	141,028	65
66	Physical Therapy	1,202,746	54,043,574	0.022255	7,039,922	156,673	66
70	Electroencephalography	341,799	14,872,748	0.022982	845,372	19,428	70
71	Medical Supplies Charged to Pat	126,919	48,222,226	0.002632	11,545,949	30,389	71
72	Impl. Dev. Charged to Patients	186,480	76,525,661	0.002437	24,757,761	60,335	72
73	Drugs Charged to Patients	639,202	148,555,224	0.004303	37,115,211	159,707	73
76	CARDIOLOGY	2,636,701	193,066,437	0.013657	37,776,893	515,919	76
76.97	CARDIAC REHABILITATION	214,508	2,837,007	0.075611	176,078	13,313	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	347,423	11,907,579	0.029177	180,410	5,264	90
91	Emergency	760,813	148,648,078	0.005118	23,900,706	122,324	91
92	Observation Beds (Non-Distinct	727,560	32,229,513	0.022574			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	20,989,655	1,630,534,593		269,732,401	2,942,854	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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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
32.01	NEONATAL INTENSIVE CARE								32.01
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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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)	87,553		35,430		30
31	Intensive Care Unit	11,470		4,661		31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE	4,153				32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	15,223		12,089		41
42	Subprovider I					42
43	Nursery	3,504				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	121,903		52,180		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

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
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
60	Laboratory									60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients					510,602		510,602	510,602	73
76	CARDIOLOGY									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					510,602		510,602	510,602	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	305,824,842			46,316,452		53,800,059		50
52	Delivery Room & Labor Room	11,044,373			13,194				52
54	Radiology-Diagnostic	332,952,468			32,626,365		82,593,720		54
60	Laboratory	204,245,120			30,431,588		15,189,989		60
62	Whole Blood & Packed Red Blood	11,389,494			2,920,630		1,155,623		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	34,170,249			14,085,870		1,140,449		65
66	Physical Therapy	54,043,574			7,039,922		477,848		66
70	Electroencephalography	14,872,748			845,372		3,740,250		70
71	Medical Supplies Charged to Pat	48,222,226			11,545,949		10,630,532		71
72	Impl. Dev. Charged to Patients	76,525,661			24,757,761		11,460,090		72
73	Drugs Charged to Patients	148,555,224	0.003437	0.003437	37,115,211	127,565	22,686,274	77,973	73
76	CARDIOLOGY	193,066,437			37,776,893		55,575,792		76
76.97	CARDIAC REHABILITATION	2,837,007			176,078		1,137,970		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	11,907,579			180,410		6,709,826		90
91	Emergency	148,648,078			23,900,706		16,238,301		91
92	Observation Beds (Non-Distinct	32,229,513					6,863,300		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,630,534,593			269,732,401	127,565	289,400,023	77,973	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☒ Title XVIII, Part B

☐ Title XIX - O/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

			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	0.207905	53,800,059			11,185,301			50
52	Delivery Room & Labor Room	0.506290							52
54	Radiology-Diagnostic	0.090121	82,593,720			7,443,429			54
60	Laboratory	0.102113	15,189,989			1,551,095			60
62	Whole Blood & Packed Red Blood	0.275210	1,155,623			318,039			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.201161	1,140,449			229,414			65
66	Physical Therapy	0.340780	477,848			162,841			66
70	Electroencephalography	0.130554	3,740,250			488,305			70
71	Medical Supplies Charged to Pat	0.547009	10,630,532			5,814,997			71
72	Impl. Dev. Charged to Patients	0.505525	11,460,090			5,793,362			72
73	Drugs Charged to Patients	0.186756	22,686,274		106,476	4,236,798		19,885	73
76	CARDIOLOGY	0.104275	55,575,792			5,795,166			76
76.97	CARDIAC REHABILITATION	0.617016	1,137,970			702,146			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.444327	6,709,826			2,981,357			90
91	Emergency	0.104640	16,238,301			1,699,176			91
92	Observation Beds (Non-Distinct	0.344957	6,863,300			2,367,543			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		289,400,023		106,476	50,768,969		19,885	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		289,400,023		106,476	50,768,969		19,885	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T125

WORKSHEET D PART II

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

		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	7,025,135	305,824,842	0.022971	203,065	4,665	50
52	Delivery Room & Labor Room	470,443	11,044,373	0.042596			52
54	Radiology-Diagnostic	4,772,787	332,952,468	0.014335	1,340,733	19,219	54
60	Laboratory	1,118,331	204,245,120	0.005475	2,125,262	11,636	60
62	Whole Blood & Packed Red Blood	76,687	11,389,494	0.006733	192,348	1,295	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	342,121	34,170,249	0.010012	1,226,102	12,276	65
66	Physical Therapy	1,202,746	54,043,574	0.022255	11,661,852	259,535	66
70	Electroencephalography	341,799	14,872,748	0.022982	24,760	569	70
71	Medical Supplies Charged to Pat	126,919	48,222,226	0.002632	972,120	2,559	71
72	Impl. Dev. Charged to Patients	186,480	76,525,661	0.002437	31,704	77	72
73	Drugs Charged to Patients	639,202	148,555,224	0.004303	5,242,295	22,558	73
76	CARDIOLOGY	2,636,701	193,066,437	0.013657	575,706	7,862	76
76.97	CARDIAC REHABILITATION	214,508	2,837,007	0.075611			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	347,423	11,907,579	0.029177	15,218	444	90
91	Emergency	760,813	148,648,078	0.005118	2,597	13	91
92	Observation Beds (Non-Distinct		32,229,513				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	20,262,095	1,630,534,593		23,613,762	342,708	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T125

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
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
60	Laboratory									60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients					510,602		510,602	510,602	73
76	CARDIOLOGY									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					510,602		510,602	510,602	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART IV

Check [] Title V [] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
Boxes: [] Title XIX [XX] 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	305,824,842			203,065				50
52	Delivery Room & Labor Room	11,044,373							52
54	Radiology-Diagnostic	332,952,468			1,340,733		5,331		54
60	Laboratory	204,245,120			2,125,262				60
62	Whole Blood & Packed Red Blood	11,389,494			192,348				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	34,170,249			1,226,102				65
66	Physical Therapy	54,043,574			11,661,852				66
70	Electroencephalography	14,872,748			24,760				70
71	Medical Supplies Charged to Pat	48,222,226			972,120		104		71
72	Impl. Dev. Charged to Patients	76,525,661			31,704				72
73	Drugs Charged to Patients	148,555,224	0.003437	0.003437	5,242,295	18,018	2,321	8	73
76	CARDIOLOGY	193,066,437			575,706				76
76.97	CARDIAC REHABILITATION	2,837,007							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	11,907,579			15,218				90
91	Emergency	148,648,078			2,597				91
92	Observation Beds (Non-Distinct	32,229,513					22,257		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,630,534,593			23,613,762	18,018	30,013	8	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☒ Title XVIII, Part B

☐ Title XIX - O/P

☐ Hospital

☐ IPF

☒ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

			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	0.207905							50
52	Delivery Room & Labor Room	0.506290							52
54	Radiology-Diagnostic	0.090121	5,331			480			54
60	Laboratory	0.102113							60
62	Whole Blood & Packed Red Blood	0.275210							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.201161							65
66	Physical Therapy	0.340780							66
70	Electroencephalography	0.130554							70
71	Medical Supplies Charged to Pat	0.547009	104			57			71
72	Impl. Dev. Charged to Patients	0.505525							72
73	Drugs Charged to Patients	0.186756	2,321		10,087	433		1,884	73
76	CARDIOLOGY	0.104275							76
76.97	CARDIAC REHABILITATION	0.617016							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.444327							90
91	Emergency	0.104640							91
92	Observation Beds (Non-Distinct	0.344957	22,257			7,678			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		30,013		10,087	8,648		1,884	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		30,013		10,087	8,648		1,884	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

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

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	5,081,388		5,081,388	87,553	58.04	1,205	69,938	30
31	Intensive Care Unit	1,208,585		1,208,585	11,470	105.37	242	25,500	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	533,100		533,100	4,153	128.37	362	46,470	32.01
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF	692,206		692,206	15,223	45.47	42	1,910	41
42	Subprovider I								42
43	Nursery	69,446		69,446	3,504	19.82	228	4,519	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,584,725		7,584,725	121,903		2,079	148,337	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART II

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)

☒ PPS
☐ TEFRA

		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	7,025,135	305,824,842	0.022971	1,183,318	27,182	50
52	Delivery Room & Labor Room	470,443	11,044,373	0.042596	182,586	7,777	52
54	Radiology-Diagnostic	4,772,787	332,952,468	0.014335	620,672	8,897	54
60	Laboratory	1,118,331	204,245,120	0.005475	879,688	4,816	60
62	Whole Blood & Packed Red Blood	76,687	11,389,494	0.006733	52,285	352	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	342,121	34,170,249	0.010012	236,846	2,371	65
66	Physical Therapy	1,202,746	54,043,574	0.022255	187,193	4,166	66
70	Electroencephalography	341,799	14,872,748	0.022982	18,601	427	70
71	Medical Supplies Charged to Pat	126,919	48,222,226	0.002632	353,811	931	71
72	Impl. Dev. Charged to Patients	186,480	76,525,661	0.002437	504,477	1,229	72
73	Drugs Charged to Patients	639,202	148,555,224	0.004303	1,125,773	4,844	73
76	CARDIOLOGY	2,636,701	193,066,437	0.013657	284,187	3,881	76
76.97	CARDIAC REHABILITATION	214,508	2,837,007	0.075611	4,129	312	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	347,423	11,907,579	0.029177	7,826	228	90
91	Emergency	760,813	148,648,078	0.005118	296,330	1,517	91
92	Observation Beds (Non-Distinct	727,560	32,229,513	0.022574			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	20,989,655	1,630,534,593		5,937,722	68,930	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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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
32.01	NEONATAL INTENSIVE CARE								32.01
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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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)	87,553		1,205		30
31	Intensive Care Unit	11,470		242		31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE	4,153		362		32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	15,223		42		41
42	Subprovider I					42
43	Nursery	3,504		228		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	121,903		2,079		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

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
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
60	Laboratory									60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients					510,602		510,602	510,602	73
76	CARDIOLOGY									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					510,602		510,602	510,602	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

WORKSHEET D PART IV

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

		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	305,824,842			1,183,318				50
52	Delivery Room & Labor Room	11,044,373			182,586				52
54	Radiology-Diagnostic	332,952,468			620,672				54
60	Laboratory	204,245,120			879,688				60
62	Whole Blood & Packed Red Blood	11,389,494			52,285				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	34,170,249			236,846				65
66	Physical Therapy	54,043,574			187,193				66
70	Electroencephalography	14,872,748			18,601				70
71	Medical Supplies Charged to Pat	48,222,226			353,811				71
72	Impl. Dev. Charged to Patients	76,525,661			504,477				72
73	Drugs Charged to Patients	148,555,224	0.003437	0.003437	1,125,773	3,869			73
76	CARDIOLOGY	193,066,437			284,187				76
76.97	CARDIAC REHABILITATION	2,837,007			4,129				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	11,907,579			7,826				90
91	Emergency	148,648,078			296,330				91
92	Observation Beds (Non-Distinct	32,229,513							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,630,534,593			5,937,722	3,869			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P
☐ Title XVIII, Part B
☒ Title XIX - O/P

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ Swing Bed SNF
☐ Swing Bed 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	0.207905							50
52	Delivery Room & Labor Room	0.506290							52
54	Radiology-Diagnostic	0.090121							54
60	Laboratory	0.102113							60
62	Whole Blood & Packed Red Blood	0.275210							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.201161							65
66	Physical Therapy	0.340780							66
70	Electroencephalography	0.130554							70
71	Medical Supplies Charged to Pat	0.547009							71
72	Impl. Dev. Charged to Patients	0.505525							72
73	Drugs Charged to Patients	0.186756							73
76	CARDIOLOGY	0.104275							76
76.97	CARDIAC REHABILITATION	0.617016							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.444327							90
91	Emergency	0.104640							91
92	Observation Beds (Non-Distinct	0.344957							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 15-T125****WORKSHEET D
PART II**

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

		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	7,025,135	305,824,842	0.022971	8,845	203	50
52	Delivery Room & Labor Room	470,443	11,044,373	0.042596			52
54	Radiology-Diagnostic	4,772,787	332,952,468	0.014335	179	3	54
60	Laboratory	1,118,331	204,245,120	0.005475	6,225	34	60
62	Whole Blood & Packed Red Blood	76,687	11,389,494	0.006733			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	342,121	34,170,249	0.010012			65
66	Physical Therapy	1,202,746	54,043,574	0.022255	36,772	818	66
70	Electroencephalography	341,799	14,872,748	0.022982			70
71	Medical Supplies Charged to Pat	126,919	48,222,226	0.002632	3,758	10	71
72	Impl. Dev. Charged to Patients	186,480	76,525,661	0.002437			72
73	Drugs Charged to Patients	639,202	148,555,224	0.004303	17,964	77	73
76	CARDIOLOGY	2,636,701	193,066,437	0.013657			76
76.97	CARDIAC REHABILITATION	214,508	2,837,007	0.075611			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	347,423	11,907,579	0.029177			90
91	Emergency	760,813	148,648,078	0.005118			91
92	Observation Beds (Non-Distinct		32,229,513				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	20,262,095	1,630,534,593		73,743	1,145	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T125

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
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
60	Laboratory									60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients					510,602		510,602	510,602	73
76	CARDIOLOGY									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					510,602		510,602	510,602	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☐ Hospital
☐ IPF
☒ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	305,824,842			8,845				50
52	Delivery Room & Labor Room	11,044,373							52
54	Radiology-Diagnostic	332,952,468			179				54
60	Laboratory	204,245,120			6,225				60
62	Whole Blood & Packed Red Blood	11,389,494							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	34,170,249							65
66	Physical Therapy	54,043,574			36,772				66
70	Electroencephalography	14,872,748							70
71	Medical Supplies Charged to Pat	48,222,226			3,758				71
72	Impl. Dev. Charged to Patients	76,525,661							72
73	Drugs Charged to Patients	148,555,224	0.003437	0.003437	17,964	62			73
76	CARDIOLOGY	193,066,437							76
76.97	CARDIAC REHABILITATION	2,837,007							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	11,907,579							90
91	Emergency	148,648,078							91
92	Observation Beds (Non-Distinct	32,229,513							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,630,534,593			73,743	62			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P
☐ Title XVIII, Part B
☒ Title XIX - O/P

☐ Hospital
☐ IPF
☒ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ Swing Bed SNF
☐ Swing Bed 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	0.207905							50
52	Delivery Room & Labor Room	0.506290							52
54	Radiology-Diagnostic	0.090121							54
60	Laboratory	0.102113							60
62	Whole Blood & Packed Red Blood	0.275210							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.201161							65
66	Physical Therapy	0.340780							66
70	Electroencephalography	0.130554							70
71	Medical Supplies Charged to Pat	0.547009							71
72	Impl. Dev. Charged to Patients	0.505525							72
73	Drugs Charged to Patients	0.186756							73
76	CARDIOLOGY	0.104275							76
76.97	CARDIAC REHABILITATION	0.617016							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.444327							90
91	Emergency	0.104640							91
92	Observation Beds (Non-Distinct	0.344957							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-0125****WORKSHEET D-1
PART I**

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

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

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	87,553	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	87,553	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	26,919	3
4	Semi-private room days (excluding swing-bed private room days)	48,098	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)	35,430	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)	77,647,850	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)	77,647,850	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	111,255,714	28
29	Private room charges (excluding swing-bed charges)	30,512,608	29
30	Semi-private room charges (excluding swing-bed charges)	80,743,106	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.697922	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,133.50	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,678.72	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)	77,647,850	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-0125****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						886.87 38
39	Program general inpatient routine service cost (line 9 x line 38)						31,421,804 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)						31,421,804 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	20,760,065	11,470	1,809.94	4,661	8,436,130	43
44	Coronary Care Unit						44
44.01	NEONATAL INTENSIVE CARE	6,125,293	4,153	1,474.91			44.01
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						54,240,099 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						94,098,033 49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						2,547,487 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						3,070,419 51
52	Total Program excludable cost (sum of lines 50 and 51)						5,617,906 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						88,480,127 53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

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)					12,536	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					886.87	88
89	Observation bed cost (line 87 x line 88) (see instructions)					11,117,802	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	5,081,388	77,647,850	0.065441	11,117,802	727,560	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-T125****WORKSHEET D-1
PART I**

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

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

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,223	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,223	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	2,039	3
4	Semi-private room days (excluding swing-bed private room days)	13,184	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)	12,089	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)	1,551	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)	11,426,935	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)	11,426,935	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	17,215,200	28
29	Private room charges (excluding swing-bed charges)	2,307,312	29
30	Semi-private room charges (excluding swing-bed charges)	14,907,888	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.663770	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,131.59	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,130.76	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.83	34
35	Average per diem private room cost differential (line 34 x line 31)	0.55	35
36	Private room cost differential adjustment (line 3 x line 35)	1,121	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,425,814	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-T125****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	750.64	38
39	Program general inpatient routine service cost (line 9 x line 38)	9,074,487	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)	9,074,487	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	6,251,360	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	15,325,847	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	549,687	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	360,726	51
52	Total Program excludable cost (sum of lines 50 and 51)	910,413	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	14,415,434	53
TARGET AMOUNT AND LIMIT COMPUTATION			
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
PROGRAM INPATIENT ROUTINE SWING BED COST			
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-0125****WORKSHEET D-1
PART I**

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

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

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	87,553	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	87,553	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	26,919	3
4	Semi-private room days (excluding swing-bed private room days)	48,098	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)	1,205	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	3,504	15
16	Nursery days (title V or XIX only)	228	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)	77,647,850	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)	77,647,850	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	111,255,714	28
29	Private room charges (excluding swing-bed charges)	30,512,608	29
30	Semi-private room charges (excluding swing-bed charges)	80,743,106	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.697922	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,133.50	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,678.72	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)	77,647,850	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-0125****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						886.87 38
39	Program general inpatient routine service cost (line 9 x line 38)						1,068,678 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)						1,068,678 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)	2,946,061	3,504	840.77	228	191,696	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	20,760,065	11,470	1,809.94	242	438,005	43
44	Coronary Care Unit						44
44.01	NEONATAL INTENSIVE CARE	6,125,293	4,153	1,474.91	362	533,917	44.01
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						1,338,293 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						3,570,589 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						146,427 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						72,799 51
52	Total Program excludable cost (sum of lines 50 and 51)						219,226 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						3,351,363 53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

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)					12,536	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-T125****WORKSHEET D-1
PART I**

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

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

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,223	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,223	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	2,039	3
4	Semi-private room days (excluding swing-bed private room days)	13,184	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	42	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	11,426,935	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)	11,426,935	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	17,215,200	28
29	Private room charges (excluding swing-bed charges)	2,307,312	29
30	Semi-private room charges (excluding swing-bed charges)	14,907,888	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.663770	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,131.59	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,130.76	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.83	34
35	Average per diem private room cost differential (line 34 x line 31)	0.55	35
36	Private room cost differential adjustment (line 3 x line 35)	1,121	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,425,814	37

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COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-T125****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	750.64	38
39	Program general inpatient routine service cost (line 9 x line 38)	31,527	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)	31,527	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	20,434	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	51,961	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,910	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,207	51
52	Total Program excludable cost (sum of lines 50 and 51)	3,117	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	48,844	53
TARGET AMOUNT AND LIMIT COMPUTATION			
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
PROGRAM INPATIENT ROUTINE SWING BED COST			
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

KPMG LLP Compu-Max 2552-10

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0125

WORKSHEET D-3

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

		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		55,083,908		30
31	Intensive Care Unit		12,280,167		31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.207978	46,316,452	9,632,803	50
52	Delivery Room & Labor Room	0.506465	13,194	6,682	52
54	Radiology-Diagnostic	0.090171	32,626,365	2,941,952	54
60	Laboratory	0.102205	30,431,588	3,110,260	60
62	Whole Blood & Packed Red Blood Cells	0.275210	2,920,630	803,787	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.201208	14,085,870	2,834,190	65
66	Physical Therapy	0.340780	7,039,922	2,399,065	66
70	Electroencephalography	0.130758	845,372	110,539	70
71	Medical Supplies Charged to Patients	0.547009	11,545,949	6,315,738	71
72	Impl. Dev. Charged to Patients	0.505525	24,757,761	12,515,667	72
73	Drugs Charged to Patients	0.186756	37,115,211	6,931,488	73
76	CARDIOLOGY	0.104441	37,776,893	3,945,456	76
76.97	CARDIAC REHABILITATION	0.617016	176,078	108,643	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.447094	180,410	80,660	90
91	Emergency	0.104732	23,900,706	2,503,169	91
92	Observation Beds (Non-Distinct Part)	0.344957			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		269,732,401	54,240,099	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		269,732,401		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T125

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF		14,495,521		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.207978	203,065	42,233	50
52	Delivery Room & Labor Room	0.506465			52
54	Radiology-Diagnostic	0.090171	1,340,733	120,895	54
60	Laboratory	0.102205	2,125,262	217,212	60
62	Whole Blood & Packed Red Blood Cells	0.275210	192,348	52,936	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.201208	1,226,102	246,702	65
66	Physical Therapy	0.340780	11,661,852	3,974,126	66
70	Electroencephalography	0.130758	24,760	3,238	70
71	Medical Supplies Charged to Patients	0.547009	972,120	531,758	71
72	Impl. Dev. Charged to Patients	0.505525	31,704	16,027	72
73	Drugs Charged to Patients	0.186756	5,242,295	979,030	73
76	CARDIOLOGY	0.104441	575,706	60,127	76
76.97	CARDIAC REHABILITATION	0.617016			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.447094	15,218	6,804	90
91	Emergency	0.104732	2,597	272	91
92	Observation Beds (Non-Distinct Part)	0.344957			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		23,613,762	6,251,360	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		23,613,762		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0125

WORKSHEET D-3

Check
Applicable
Boxes:

☐ Title V

☐ Title XVIII, Part A

☒ Title XIX

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ 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		1,458,353		30
31	Intensive Care Unit		208,235		31
32.01	NEONATAL INTENSIVE CARE		1,665,610		32.01
41	Subprovider - IRF				41
43	Nursery		330,360		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.207978	1,183,318	246,104	50
52	Delivery Room & Labor Room	0.506465	182,586	92,473	52
54	Radiology-Diagnostic	0.090171	620,672	55,967	54
60	Laboratory	0.102205	879,688	89,909	60
62	Whole Blood & Packed Red Blood Cells	0.275210	52,285	14,389	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.201208	236,846	47,655	65
66	Physical Therapy	0.340780	187,193	63,792	66
70	Electroencephalography	0.130758	18,601	2,432	70
71	Medical Supplies Charged to Patients	0.547009	353,811	193,538	71
72	Impl. Dev. Charged to Patients	0.505525	504,477	255,026	72
73	Drugs Charged to Patients	0.186756	1,125,773	210,245	73
76	CARDIOLOGY	0.104441	284,187	29,681	76
76.97	CARDIAC REHABILITATION	0.617016	4,129	2,548	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.447094	7,826	3,499	90
91	Emergency	0.104732	296,330	31,035	91
92	Observation Beds (Non-Distinct Part)	0.344957			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,937,722	1,338,293	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,937,722		202

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T125

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF		48,060		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.207978	8,845	1,840	50
52	Delivery Room & Labor Room	0.506465			52
54	Radiology-Diagnostic	0.090171	179	16	54
60	Laboratory	0.102205	6,225	636	60
62	Whole Blood & Packed Red Blood Cells	0.275210			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.201208			65
66	Physical Therapy	0.340780	36,772	12,531	66
70	Electroencephalography	0.130758			70
71	Medical Supplies Charged to Patients	0.547009	3,758	2,056	71
72	Impl. Dev. Charged to Patients	0.505525			72
73	Drugs Charged to Patients	0.186756	17,964	3,355	73
76	CARDIOLOGY	0.104441			76
76.97	CARDIAC REHABILITATION	0.617016			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.447094			90
91	Emergency	0.104732			91
92	Observation Beds (Non-Distinct Part)	0.344957			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		73,743	20,434	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		73,743		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	18,393,763			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	57,754,681			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)	2,051,000			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				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	375.59			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0312			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1605			31
32	Sum of lines 30 and 31	0.1917			32
33	Allowable disproportionate share percentage (see instructions)	0.0521			33
34	Disproportionate share adjustment (see instructions)	991,834			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)	6,766,695,164		8,272,872,447	35
35.01	Factor 3 (see instructions)	0.000399674		0.000396589	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,704,472		3,280,933	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	681,676		2,453,957	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,135,633			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)	82,326,911			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)	82,326,911			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	6,513,342			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment	24,745			53
54	Special add-on payments for new technologies	2,960			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)	127,565			58
59	Total (sum of amounts on lines 49 through 58)	88,995,523			59
60	Primary payer payments	26,871			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	88,968,652			61
62	Deductibles billed to program beneficiaries	7,035,228			62
63	Coinsurance billed to program beneficiaries	521,728			63
64	Allowable bad debts (see instructions)	880,296			64
65	Adjusted reimbursable bad debts (see instructions)	572,192			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	156,824			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	81,983,888			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (OTHER ADJUSTMENTS)				70
70.93	HVBP payment adjustment amount (see instructions)	45,137			70.93
70.94	HRR adjustment amount (see instructions)	-671,391			70.94
71	Amount due provider (see instructions)	81,357,634			71
71.01	Sequestration adjustment (see instructions)	1,627,153			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	79,472,795			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	257,686			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,026,473			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1		
100	HSP bonus amount (see instructions)				100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 15-0125****WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	19,885			1
2	Medical and other services reimbursed under OPPS (see instructions)	50,690,996			2
3	OPPS payments	50,029,002			3
4	Outlier payment (see instructions)	42,412			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	77,973			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	19,885			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	106,476			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)	106,476			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)	106,476			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	86,591			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)	19,885			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)	50,149,387			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	9,032,865			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)	41,136,407			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)	41,136,407			30
31	Primary payer payments	12,995			31
32	Subtotal (line 30 minus line 31)	41,123,412			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	1,320,775			34
35	Adjusted reimbursable bad debts (see instructions)	858,504			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	543,205			36
37	Subtotal (see instructions)	41,981,916			37
38	MSP-LCC reconciliation amount from PS&R	-274			38
39	Other adjustments (FDO LOSS)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	41,982,190			40
40.01	Sequestration adjustment (see instructions)	839,644			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	41,043,351			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	99,195			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 15-T125****WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	1,884			1
2	Medical and other services reimbursed under OPPS (see instructions)	8,640			2
3	OPPS payments	7,108			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	8			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	1,884			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	10,087			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)	10,087			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)	10,087			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	8,203			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	1,884			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)	7,116			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,136			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)	7,864			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)	7,864			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	7,864			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)	7,864			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	7,864			40
40.01	Sequestration adjustment (see instructions)	157			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	7,830			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-123			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 15-0125****WORKSHEET E-1
PART I**

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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			78,873,974		40,220,717
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			536,021		727,334
3	List separately each retroactive lump sum adjustment	.01	01/30/2019	62,800	01/30/2019	95,300
	amount based on subsequent revision of the interim	.02				
	rate for the cost reporting period. Also show date of	Program				
	each payment. If none, write 'NONE' or enter a zero. (1)	to				
		Provider				
		.05				
		.06				
		.07				
		.08				
		.09				
		.10				
		.50				
		.51				
		Provider				
		to				
		Program				
		.54				
		.55				
		.56				
		.57				
		.58				
		.59				
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		62,800		95,300
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)			79,472,795		41,043,351
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment	.01				
	after desk review. Also show date of each payment.	.02				
	If none, write 'NONE' or enter a zero. (1)	Program				
		to				
		Provider				
		.05				
		.06				
		.07				
		.08				
		.09				
		.10				
		.50				
		.51				
		Provider				
		to				
		Program				
		.54				
		.55				
		.56				
		.57				
		.58				
		.59				
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				
6	Determined net settlement amount (balance due)	.01		257,686		99,195
	based on the cost report (1)	.02				
7	Total Medicare program liability (see instructions)			79,730,481		41,142,546
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
COMPONENT CCN: 15-T125
**WORKSHEET E-1
PART I**

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

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1			1	2	3	4
1	Total interim payments paid to provider			20,338,960		7,830
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			20,338,960		7,830
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		69,654		6.01
		.02				-123
7	Total Medicare program liability (see instructions)			20,408,614		7,707
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

**WORKSHEET E-3
PART III**

Check ☐ Hospital
Applicable ☒ Subprovider IRF
Box:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	20,386,781		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.020800		2
3	Inpatient Rehabilitation LIP payments (see instructions)	318,034		3
4	Outlier payments	267,913		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	41.706849		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	20,972,728		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	20,972,728		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	20,972,728		19
20	Deductibles	86,480		20
21	Subtotal (line 19 minus line 20)	20,886,248		21
22	Coinsurance	97,212		22
23	Subtotal (line 21 minus line 22)	20,789,036		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,788		24
25	Adjusted reimbursable bad debts (see instructions)	18,062		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,756		26
27	Subtotal (sum of lines 23 and 25)	20,807,098		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)	18,018		29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	20,825,116		32
32.01	Sequestration adjustment (see instructions)	416,502		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	20,338,960		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	69,654		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			36

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0125

WORKSHEET E-3
PART VII

Check ☐ Title V ☒ Hospital ☐ NF ☒ PPS
 Applicable ☒ Title XIX ☐ SUB (Other) ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☐ Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	3,662,558		8
9	Ancillary service charges	5,937,722		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)	9,600,280		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge 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)	9,600,280		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	9,600,280		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			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	3,869		26
27	Subtotal (sum of lines 22 through 26)	3,869		27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	3,869		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	3,869		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)	3,869		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	-4,285		37
38	Subtotal (line 36 ± line 37)	-416		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)	-416		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	-416		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

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	48,060		8
9	Ancillary service charges	73,743		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)	121,803		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge 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)	121,803		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	121,803		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			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	62		26
27	Subtotal (sum of lines 22 through 26)	62		27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	62		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	62		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)	62		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	-68		37
38	Subtotal (line 36 ± line 37)	-6		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)	-6		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	-6		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	10,076				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	140,350,563				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-72,560,993				6
7	Inventory	12,177,265				7
8	Prepaid expenses	2,120,503				8
9	Other current assets	8,396,223				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	90,493,637				11
	FIXED ASSETS					
12	Land					12
13	Land improvements	13,736,798				13
14	Accumulated depreciation	-5,911,827				14
15	Buildings	387,494,956				15
16	Accumulated depreciation	-237,619,407				16
17	Leasehold improvements	1,257,038				17
18	Accumulated depreciation	-1,085,280				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	148,545,795				23
24	Accumulated depreciation	-106,272,153				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	33,057,383				29
30	Total fixed assets (sum of lines 12-29)	233,203,303				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	15,979,321				34
35	Total other assets (sum of lines 31-34)	15,979,321				35
36	Total assets (sum of lines 11, 30 and 35)	339,676,261				36
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	2,198,626				37
38	Salaries, wages and fees payable	19,354,010				38
39	Payroll taxes payable	3,733,631				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	16,708,230				44
45	Total current liabilities (sum of lines 37 thru 44)	41,994,497				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	16,507,569				49
50	Total long term liabilities (sum of lines 46 thru 49)	16,507,569				50
51	Total liabilities (sum of lines 45 and 50)	58,502,066				51
	CAPITAL ACCOUNTS					
52	General fund balance	281,174,195				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)	281,174,195				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	339,676,261				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		279,933,546			1
2	Net income (loss) (from Worksheet G-3, line 29)		996,384			2
3	Total (sum of line 1 and line 2)		280,929,930			3
4	Additions (credit adjustments) (specify)					4
5	PENSION RELATED CHANGES	38,374,000				5
6	RESTRICTED CONTRIBUTIONS	131,000				6
7	ROUNDING	265				7
8	OTHER	32,000				8
9	INVESTMENT INCOME	5,000				9
10	Total additions (sum of lines 4-9)		38,542,265			10
11	Subtotal (line 3 plus line 10)		319,472,195			11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS RELEASED FROM RESTRCTN	221,000				13
14	PENSION-RELATED ADJ-NOT NET COST	38,077,000				14
15	NET ASSETS TRANSFERRD TO AFFILIATE					15
16	ROUNDING					16
17						17
18	Total deductions (sum of lines 12-17)		38,298,000			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		281,174,195			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	PENSION RELATED CHANGES					5
6	RESTRICTED CONTRIBUTIONS					6
7	ROUNDING					7
8	OTHER					8
9	INVESTMENT INCOME					9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS RELEASED FROM RESTRCTN					13
14	PENSION-RELATED ADJ-NOT NET COST					14
15	NET ASSETS TRANSFERRD TO AFFILIATE					15
16	ROUNDING					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	116,801,004		116,801,004	1
2	Subprovider IPF				2
3	Subprovider IRF	17,527,665		17,527,665	3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	134,328,669		134,328,669	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	26,589,532		26,589,532	11
12	Coronary Care Unit				12
12.01	NEONATAL INTENSIVE CARE	24,223,748		24,223,748	12.01
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	50,813,280		50,813,280	16
17	Total inpatient routine care services (sum of lines 10 and 16)	185,141,949		185,141,949	17
18	Ancillary services	619,682,052		619,682,052	18
19	Outpatient services		1,011,512,959	1,011,512,959	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		9,828,486	9,828,486	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIAN REVENUES	26,683,602	35,114,533	61,798,135	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	831,507,603	1,056,455,978	1,887,963,581	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		486,921,856	29
30	Add (specify)			30
31	BAD DEBTS			31
32	CHARITY CARE			32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		486,921,856	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1,887,963,581	1
2	Less contractual allowances and discounts on patients' accounts	1,370,987,098	2
3	Net patient revenues (line 1 minus line 2)	516,976,483	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	486,921,856	4
5	Net income from service to patients (line 3 minus line 4)	30,054,627	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	252,000	6
7	Income from investments	303,557	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	2,594,205	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	11,656,302	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	775	21
22	Rental of hosptial space	1,171,797	22
23	Governmental appropriations	5,000	23
24	Other (OTHER REVENUE)	332,615	24
24.01	Other (REVENUE-CLASSES)	64,891	24.01
24.02	Other (ASSETS RELEASED FROM RESTRICTION)	231,645	24.02
24.03	Other (FITNESS REVENUE)	3,562,099	24.03
24.04	Other (SALE OF XRAY SCRAP)		24.04
24.05	Other (GAIN ON FIXED ASSETS)	805,140	24.05
25	Total other income (sum of lines 6-24)	20,980,026	25
26	Total (line 5 plus line 25)	51,034,653	26
27	Other expenses (PENSION SETTLEMENT)	50,038,269	27
27.01	Other expenses (OTHER EXPENSE)		27.01
28	Total other expenses (sum of line 27 and subscripts)	50,038,269	28
29	Net income (or loss) for the period (line 26 minus line 28)	996,384	29

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**HHA CCN: 15-7487****WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	1,352,336	1,111,948	129,157		160,102	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,561,777					6
7	Physical Therapy	1,386,960			45,730		7
8	Occupational Therapy	432,512					8
9	Speech Pathology	70,448					9
10	Medical Social Services	903					10
11	Home Health Aide	96,531					11
12	Supplies (see instructions)					286,414	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	4,901,467	1,111,948	129,157	45,730	446,516	24

KPMG LLP Compu-Max 2552-10

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS
HHA CCN: 15-7487
WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	2,753,543	-617,501	2,136,042	65,282	2,201,324	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,561,777		1,561,777		1,561,777	6
7	Physical Therapy	1,432,690	-69,025	1,363,665		1,363,665	7
8	Occupational Therapy	432,512	60,741	493,253		493,253	8
9	Speech Pathology	70,448	8,284	78,732		78,732	9
10	Medical Social Services	903		903		903	10
11	Home Health Aide	96,531		96,531		96,531	11
12	Supplies (see instructions)	286,414		286,414		286,414	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	6,634,818	-617,501	6,017,317	65,282	6,082,599	24

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

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**HHA CCN: 15-7487****WORKSHEET H-1
PART I**

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	2,201,324				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	1,561,777				6
7	Physical Therapy	1,363,665				7
8	Occupational Therapy	493,253				8
9	Speech Pathology	78,732				9
10	Medical Social Services	903				10
11	Home Health Aide	96,531				11
12	Supplies (see instructions)	286,414				12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	6,082,599				24

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**HHA CCN: 15-7487****WORKSHEET H-1
PART I**

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		2,201,324	2,201,324		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		1,561,777	948,667	2,510,444	6
7	Physical Therapy		1,363,665	799,182	2,162,847	7
8	Occupational Therapy		493,253	187,534	680,787	8
9	Speech Pathology		78,732	14,839	93,571	9
10	Medical Social Services		903	1,001	1,904	10
11	Home Health Aide		96,531	91,485	188,016	11
12	Supplies (see instructions)		286,414	158,616	445,030	12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		6,082,599		6,082,599	24

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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT- ATION (Mileage)	RECONCIL- IATION	ADMINI- STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-2,201,324	80,695,201	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care					33,213,224	34,775,001	6
7	Physical Therapy					27,932,934	29,296,599	7
8	Occupational Therapy					6,381,405	6,874,658	8
9	Speech Pathology					465,243	543,975	9
10	Medical Social Services					35,782	36,685	10
11	Home Health Aide					3,257,156	3,353,687	11
12	Supplies (see instructions)					5,528,182	5,814,596	12
13	Drugs							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					74,612,602	80,695,201	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						2,201,324	25
26	Unit Cost Multiplier						0.027279	26

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COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**HHA CCN: 15-7487****WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General			367	611,870	612,237	114,698	1
2	Skilled Nursing Care	2,510,444				2,510,444	470,315	2
3	Physical Therapy	2,162,847				2,162,847	405,194	3
4	Occupational Therapy	680,787				680,787	127,541	4
5	Speech Pathology	93,571				93,571	17,530	5
6	Medical Social Services	1,904				1,904	357	6
7	Home Health Aide	188,016				188,016	35,223	7
8	Supplies	445,030				445,030	83,373	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	6,082,599		367	611,870	6,694,836	1,254,231	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

WORKSHEET H-2
PART I

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

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General					37,692		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)					37,692		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP- DOWN ADJS	
		19	21	22	23	24	25	
1	Administrative and General					764,627		1
2	Skilled Nursing Care					2,980,759		2
3	Physical Therapy					2,568,041		3
4	Occupational Therapy					808,328		4
5	Speech Pathology					111,101		5
6	Medical Social Services					2,261		6
7	Home Health Aide					223,239		7
8	Supplies					528,403		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)					7,986,759		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see Ptil) 27	TOTAL HHA COSTS 28				
1	Administrative and General	764,627						1
2	Skilled Nursing Care	2,980,759	315,580	3,296,339				2
3	Physical Therapy	2,568,041	271,886	2,839,927				3
4	Occupational Therapy	808,328	85,580	893,908				4
5	Speech Pathology	111,101	11,763	122,864				5
6	Medical Social Services	2,261	239	2,500				6
7	Home Health Aide	223,239	23,635	246,874				7
8	Supplies	528,403	55,944	584,347				8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	7,986,759	764,627	7,986,759				20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.105873					21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS**HHA CCN: 15-7487****WORKSHEET H-2
PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM. COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	Administrative and General		308	4,901,467		612,237		1
2	Skilled Nursing Care					2,510,444		2
3	Physical Therapy					2,162,847		3
4	Occupational Therapy					680,787		4
5	Speech Pathology					93,571		5
6	Medical Social Services					1,904		6
7	Home Health Aide					188,016		7
8	Supplies					445,030		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		308	4,901,467		6,694,836		20
21	Total cost to be allocated		367	611,870		1,254,231		21
22	Unit Cost Multiplier			0.124834		0.187343		22
22	Unit Cost Multiplier		1.191558					22

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS**HHA CCN: 15-7487****WORKSHEET H-2
PART II**

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS**HHA CCN: 15-7487****WORKSHEET H-2
PART II**

	HHA COST CENTER	NURSING ADMINIS- TRATION NURSING HO URS	CENTRAL SERVICES & SUPPLY COSTED REQ	PHARMACY COSTED REQ	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General				9,828,487			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)				9,828,487			20
21	Total cost to be allocated				37,692			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				0.003835			22

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

**WORKSHEET H-2
PART II**

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF PATIENT SERVICE COSTS**HHA CCN: 15-7487****WORKSHEET H-3
PARTS I & II**Check applicable box: ☐ Title V ☒ Title XVIII ☐ Title XIX**PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST**

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	3,296,339		3,296,339	26,154	126.04	1
2	Physical Therapy	3	2,839,927		2,839,927	18,016	157.63	2
3	Occupational Therapy	4	893,908		893,908	7,846	113.93	3
4	Speech Pathology	5	122,864		122,864	1,070	114.83	4
5	Medical Social Services	6	2,500		2,500	7	357.14	5
6	Home Health Aide	7	246,874		246,874	4,557	54.17	6
7	Total (sum of lines 1-6)		7,402,412		7,402,412	57,650		7

Limitation Cost Computation						
			Program Visits			
			PART B			
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	23844		16,340		8
9	Physical Therapy	23844		10,773		9
10	Occupational Therapy	23844		4,651		10
11	Speech Pathology	23844		691		11
12	Medical Social Services	23844		5		12
13	Home Health Aide	23844		3,177		13
14	Total (sum of lines 8-13)			35,637		14

Supplies and Drugs Cost Computations								
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8	584,347		584,347	599,539	0.974661	15
16	Cost of Drugs	9						16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.340780			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.547009			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.186756			col. 2, line 16	5

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7487

WORKSHEET H-3
PARTS I & II

Check applicable box: ☐ Title V ☒ Title XVIII ☐ Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
		Part B			Part B			Total Program Cost (sum of cols 9-10)	
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		16,340			2,059,494		2,059,494	1
2	Physical Therapy		10,773			1,698,148		1,698,148	2
3	Occupational Therapy		4,651			529,888		529,888	3
4	Speech Pathology		691			79,348		79,348	4
5	Medical Social Services		5			1,786		1,786	5
6	Home Health Aide		3,177			172,098		172,098	6
7	Total (sum of lines 1-6)		35,637			4,540,762		4,540,762	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services				
		Part B			Part B				
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6	7	8	9	10	11		
15	Cost of Medical Supplies		574,054			559,508			15
16	Cost of Drugs								16

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT**HHA CCN: 15-7487****WORKSHEET H-4
PARTS I & II**Check applicable box: ☐ Title V ☒ Title XVIII ☐ Title XIX**PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES**

	Description	Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts		496		9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)		-496	10
11	Total PPS Reimbursement - Full Episodes without Outliers		4,705,336	11
12	Total PPS Reimbursement - Full Episodes with Outliers		606,341	12
13	Total PPS Reimbursement - LUPA Episodes		63,980	13
14	Total PPS Reimbursement - PEP Episodes		49,652	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		21,875	15
16	Total PPS Outlier Reimbursement - PSP Episodes		4,095	16
17	Total Other Payments		134,415	17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		5,585,198	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		5,585,198	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		5,585,198	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		5,585,198	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		5,585,198	31
31.01	Sequestration adjustment (see instructions)		111,704	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		5,473,494	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES HHA CCN: 15-7487

WORKSHEET H-5

	DESCRIPTION		Part A		Part B		
			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
			1	2	3	4	
1	Total interim payments paid to provider					5,473,494	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.						2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
		.01					3.01
		.02					3.02
		Program .03					3.03
		To .04					3.04
		Provider .05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50					3.50
		.51					3.51
		Provider .52					3.52
		To .53					3.53
		Program .54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)					5,473,494	4
	TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
		.01					5.01
		.02					5.02
		Program .03					5.03
		To .04					5.04
		Provider .05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
		.51					5.51
		Provider .52					5.52
		To .53					5.53
		Program .54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99					5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01					6.01
		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					5,473,494	7
8	Name of Contractor		Contractor Number		NPR Date: Month, Day, Year		8

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF CAPITAL PAYMENT**COMPONENT CCN: 15-0125****WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	6,197,404	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	70,521	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)	250.31	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0312	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1605	8
9	Sum of lines 7 and 8	0.1917	9
10	Allowable disproportionate share percentage (see instructions)	0.0396	10
11	Disproportionate share adjustment (see instructions)	245,417	11
12	Total prospective capital payments (see instructions)	6,513,342	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF CAPITAL PAYMENT**COMPONENT CCN: 15-0125****WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 16:09 Version: 2018.12 (10/24/2019)
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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
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
32.01	NEONATAL INTENSIVE CARE							32.01
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY							194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS							194.06
194.07	NORTHWESTERN IMAGING							194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202