

COMMUNITY HOSPITAL Provider CCN: 15-0125

## COMPU-MAX

In Lieu of Form CMS-2552-10 Period: From: 07/01/2013 To: 06/30/2014 Run Date: 12/01/2014 Run Time: 15:07 Version: 2014.10

# HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S PARTS I, II & III

PARTI-COST REPORT S PROVIDER USE ONL	.Y 1. [X] 2. [] 3. [] 4. [F]	MANUALLY SUBMI IF THIS IS AN RESUBMITTED TH MEDICARE UTILI	ZATION. ENTER 'F' FC	THE NUMBER OF T	PIMES THE PROV	
	] COST REPOR! 1 -AS SUBMITT! 2 -SETTLED WI' 3 -SETTLED WI' 4 -REOPENED 5 -AMENDED	ED 7. THOUT AUDIT 8.	DATE RECEIVED: CONTRACTOR NO: [] INITIAL REPORT FO PROVIDER CCN [] FINAL REPORT FOR PROVIDER CCN	11. R THIS 12.	CONTRACTOR'S	, COLUMN 1 15 4 BER OF TIMES

PART II - CERTIFICATION
MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MERE PROVIDED OR PROCURED THROUGH THE ACTION, FINE AND OR IMPRISONMENT UNDER FEDERAL LAW, FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE ACTION, FINE AND OR IMPRISONMENT DIAGRAMMENT DIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND OR IMPRISONMENT MAY RESULT.

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 12/01/2014 15:07 qKB3FoogKeJxGgAkXdr4oBNkGmW.y0 Z4XXH015kM8X75niO.eZCo1rvNnR7k jA.w1V3WkN0S9bbli

PI Encryption: 12/01/2014 15:07 pOSAiEyT8H0Osl:aUqO69dH0Kzr1Z0 YSAhM0L5lhDMykTakzVJwd3gcLA8wt at6k0OzirW05cTs7 (SIGNED) And Matrian
OFFICER OR ADMINISTRATOR OF PROVIDER(S)
TITLE

TITLE

DATE

PART III - SETTLEMENT SUMMARY

HOSPITAL SUBPROVIDER - IPF 2 SUBPROVIDER - IRF SUBPROVIDER (OTHER) SWING BED - SNF SWING BED - NF 6 SKILLED NURSING FACILITY NURSING FACILITY 8 HOME HEALTH AGENCY 0 HEALTH CLINIC - RHC HEALTH CLINIC - FQHC 10 11 OUTPATIENT REHABILITATION PROVIDER 17 TOTAL 200

TITLE XVIII TITLE XIX HIT PART B PART A TITLE V 428.569 -15.962 325,141 70,369 136 6 8 9 10 1.1 200 -428,569 -15.826 395,510

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 OMD 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.



## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

	Street: 901 MACARTHUR BOULEVARD	P.O. Box:	71	D.C. 1. 4(221	0		ζ.Ε.				1
ocnite	City: MUNSTER l and Hospital-Based Component Identification:	State: IN	ZI	P Code: 46321	C	ounty: LAI	KE .				2
ospita	and Hospital-Based Component Identification.							Pav	ment Syst	em	T
									T, O, or 1		+
	Component	Component Name		CCN Number	CBSA Number	Prov- ider	Date Certified	v	XVIII	XIX	
	0	1		2	3	Type 4	5	6	7	8	+-
	Hospital	COMMUNITY HOSPITA	L	15-0125	23844	1	10/03/1973	N	P	P	3
	Subprovider - IPF										4
	Subprovider - IRF	THE REHAB CENTER A COMMUNITY	Т	15-T125	23844	5	06/30/1996	N	P	P	5
	Subprovider - (OTHER)										6
	Swing Beds - SNF Swing Beds - NF										8
	Hospital-Based SNF										9
)	Hospital-Based NF										10
	Hospital-Based OLTC										11
	Hospital-Based HHA	COMMUNITY HOME HI SERVICES	EALTH	15-7487	23844		01/07/1997	N	P	N	12
	Separately Certified ASC										13
ŀ	Hospital-Based Hospice										14
	Hospital-Based Health Clinic - RHC										15
	Hospital-Based Health Clinic - FQHC										16
3	Hospital-Based (CMHC)										17
	Renal Dialysis										18
	Other										19
	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013		To: 06 / 30 / 2	2014						20
	Type of control (see instructions)	2		10.0073072	2014						21
natie	t PPS Information							Т	1	2	
	Does this facility qualify for and receive disproportion	ate share hospital payments	in accordance	ce 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)(Pic					,			Y	N	22
	Did this hospital receive interim uncompensated care					or 'N' for n	o for the portion	n of the			
2.01	cost reporting period occurring prior to October 1. En	ter in column 2 'Y' for yes or	'N' for no fo	or the portion of	the cost repor	rting period	l occurring on or	r after	N	N	22
	October 1. (see instructions)										
3	Which method is used to determine Medicaid days on discharge. Is the method of identifying the days in this 'Y' for yes or 'N' for no.								3	N	23
	1 Tot yes of 14 Tot No.		In-State Medicaio paid day	d eligib	aid S le Med	nt-of- tate dicaid d days	Out-of- State Medicaid eligible unpaid days	Medicaid HMO days	Me	Other edicaid days	
			1	2		3	4	5		6	
4	If this provider is an IPPS hospital, enter the in-state I, in-state Medicaid eligible unpaid days in col. 2, out days in col. 3, out-of-state Medicaid eligible unpaid days in col. 5, and IMO paid and eligible but unpaid days in col. 5, and IMO paid and eligible but unpaid days in col. 5, and IMO paid and eligible but unpaid days in col. 5, and IMO paid and eligible but unpaid days in col. 5, and IMO paid and eligible but unpaid days in col. 5, and IMO paid and eligible but unpaid days in col. 5, and IMO paid and Eligible but unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and Eligible unpaid days in col. 5, and IMO paid and IMO pai	of-state Medicaid paid ays in col. 4, Medicaid	5,2	231	381	792	249	7,4.	31		24
5	col. 6.  If this provider is an IRF, enter the in-state Medicaid I Medicaid eligible unpaid days in col. 2, out-of-state N of-state Medicaid eligible unpaid days in col. 4, Medic eligible but unpaid days in col. 5, and other Medicaid	ledicaid days in col. 3, out- caid HMO paid and	:	220	57		25		13		25
5	Enter your standard geographic classification (not wag '1' for urban and '2' for rural.	ge) status at the beginning of	f the cost rep	orting period. E	inter	1					26
r	Enter your standard geographic classification (not was column 1, '1' for urban or '2' for rural. If applicable, er					1					27
	column 2.  If this is a sole community hospital (SCH), enter the n	umber of periods SCH status	s in effect in	the cost reporti	ng						35
		tatus. Subscript line 36 for n	umber of per	riods in excess	of Begin	ning:		Ending:			36
	one and enter subsequent dates.  If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost										37
	reporting period.  Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of Beginning.  Ending:										
36	one and enter subsequent dates.  If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.  Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of										



## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see  Instructions)  Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see  Instructions)  St. 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)  Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTE count for primary care or 1500 of ACA). (see instructions)  Enter the baseline FTE count for primary care and year general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  Enter the unmber of unweighted primary care or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  Enter the unmber of unweighted primary care or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)  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)  Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)  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). Enter in column 1 the program surgery. (see instructions) and the program of the FTEs in line 61.05, specify each new 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 of specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, ent			V	XVIII	XIX	
shis facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR \$412.348(7) Tyes, complete Worksheet. L. Part III and 1-1. Parts I farrings III II.  It is this a new hospital under 42 CFR \$412.300 PPS capital? Enter "V" for yes or "N" for no.  N N N N N N N N N N N N N N N N N N N	rospec	tive Payment System (PPS)-Capital	1	2	3	
his fis facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR \$412.348(7) try see, complete Worksheet. L. Part II and 1-1, Parts I through III.  It is this a new hospital under 42 CFR \$412.300 PPS capital? Enter 'Y' for yes or 'N' for no.  N N N N N N N N N N N N N N N N N N N	5	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR \$412.3207	? N	Y	N	45
Self.2-38(I)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.  Is this an envelopatil under 42 CFR \$412.300 PFS explain Finetr ("Yor yes or "N for no.  N N N N N N N N N N N N N N N N N N N	,	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR	N.I.	NT.	N	46
Seaching Hospitals  Is this a hospital involved in training residents in approved GME programs? Enter Y' for yes or 'N' for no.  It is a hospital involved in training residents in approved GME programs? Enter Y' for yes or 'N' for no.  It is so 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 1. If column 2 is 'Y', complete Worksheet DA. If column 2 is 'N', complete Worksheet DA. If the 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet DA. If yes, complete Worksheet DA. If the 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet DA. If yes, complete Worksheet DA.	)	§412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	IN .	IN .	IN IN	46
eaching Hospitals  5 Is this a hospital involved in training residents in approved GME programs? Enter "Y for yes or "N for no.  6 Is this a hospital involved in training residents in approved GME programs? Enter "Y for yes or "N for no.  7 Il files 65 is ves, 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 2 is "Y don't residents start training in the first month of this cost reporting period felter "Y for yes or "N for no in column 2. If column 2 is "Y, complete Worksheet E-4. If column 2 is "N, complete Worksheet D-2 part III, if applicable.  8 If line 65 is ves, did this facility elect tost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2 148° If yes, complete Worksheet D-5.  9 Are costs claimed on line 100 of Worksheet D-5.  9 Are costs claimed on line 100 of Worksheet D-5. Part II, if applicable.  10 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under \$413.85 ? Enter "Y for yes or "N" for no is column 1.)/see instructions?  10 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1.)/see instructions?  11 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1.)/see instructions?  12 Did your hospital receive FTE slots under ACA section 5503 of ACA), (see instructions)  13 Enter the haspital PTE count of the many care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA), (see instructions)  14 Enter the number of unweighted primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  15 Enter the humber of write-glited primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  16 Enter the number of write-glited pri	7	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
If line 56 is yes, is this the intervence of the programs? Emer Y' for yes or N' for no.   N	8	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
1 If line 56 is we, is this it absopital involved in training residents in approved GME programs? Enter "Y for yes or "N for no.  If line 56 is ve, is this the first cost reporting period draing which residents in approved GME programs trained at this clinity? Enter "Y for yes or "N for no in column 1. If column 2 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 Worksheet F4. If we column 2 is "N, complete Worksheet D, Part III is I' applicable.  If line 56 is ves, did this facility elect tost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 21487 if yes, complete Worksheet D-5.  A re costs claimed on line 100 of Worksheet D-5.  A re costs claimed on line 100 of Worksheet D-5.  Part II. N  A rey out claiming amusing school and/or allied health costs for a program that meets the provider-operated criteria under 9413.85? Enter "Y rey seo "N" for no (see instructions)  Did your hospital receive FTE slots under ACA section 5503? Enter "Y' for yes or "N" for no in column 1.)(see			1			_
S Is this a hospital involved in training residents in approved GME programs? Enter Y' for yes or N' for no.  If lime 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this children or the program of the programs. The provided of the programs trained at this children or the program of the p	eachin	g Hospitals	1	2	3	
If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility. Fine Y' for yes or N' for on 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 Worksheet D-2. Part II. If applicable.    If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section N 21487 lives, complete Worksheet D-2. Part II. If applicable.   Are costs claimed on line 100 of Worksheet A? If 'yes, complete Worksheet D-2. Part II. In applicable.   Are costs claimed on line 100 of Worksheet A? If 'yes, complete Worksheet D-2. Part I. In applicable. In a Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria N and the Yorksheet D-2. Part II. In applicable of the Worksheet D-2. Part II. In applicable. In the Worksheet D-2. Part II. In applicable in the Worksheet D-2. Part II. In applicable. In the Worksheet D-2. Part II. In ap			N			56
2 1487 If yes, complete Worksheet D-5. 9 Are cost sclamide on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I. N Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under \$413.85? Enter 'Y' for yes or 'N' for no (see instructions)  Di your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see N IME Direct GW instructions)  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)  Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs of 503 of ACA), (see instructions)  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)  Enter the number of unweighted primary care or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)  Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care or general surgery FTE counts (fine 61.04 minus line 61.03). (see instructions)  Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care or general surgery. (see instructions)  Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CAP rovisions Affecting the Health Re	7	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 Worksheet E-4. If				57
Are you claiming aursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)  Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see Instructions)  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)  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)  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)  Enter the haseline FTE counts (for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)  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)  Enter the amount of Aca \$5503 award hat is being used for cap relef and/or FTEs that are nonprimary care or general surgery, (see instructions)  Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column	8		n N			58
Are you claiming mrsing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)  Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see Instructions)  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)  Enter the current year total unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)  Enter the current year total unweighted primary care FTEs out (see instructions)  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)  Enter the number of unweighted primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  Enter the number of unweighted primary care or surgery allopathic and/or osteopathei FTEs in the current cost reporting period. (see instructions)  Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery. (see instructions)  Enter the amount of ACA §5503 award that is being used for cap relef and/or FTEs that are nonprimary care or general surgery. (see instructions)  Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  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)  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for e	)		N			59
Direct GN  Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see	)		N			60
Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1./(see			Y/N	IME	Direct GME	
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)  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)  Enter the baseline FTE count for primary care affect on 5503 of ACA). (see instructions)  Enter the baseline FTE count for primary care affect of see instructions)  Enter the the sale the baseline primary care affect or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)  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 (in 61.04 minus line 61.03). (see instructions)  Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name enter in column 2 the program code, enter in column 3 the IME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CAP rovisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE reside						61
submitted before March 23, 2010. (see instructions)  Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5:03 of ACA). (see instructions)  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)  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)  Enter the number of unweighted primary care/or surgery allopathic and/or osteopathei FTEs in the current cost reporting period. (see instructions)  Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs counts (line 61.04) minus line 61.03). (see instructions)  Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program Name  Program Name  Program Code  IME  Program Code  IME  Program Code  IME  Program Code  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 specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CAP rovisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital in this cost reporting period of HRSA THC pr						
primary care FTEs added under section 5503 of ACA), (see instructions)  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)  Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)  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)  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 center in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program Name  Program Name  Program Code  IME  FTE Count  FTE Count  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period of Which your hospital reserved HRSA PCRE funding (see instructions)  Enter the number of FTE residents that your hospital trained in this cost reporting period of HRSA THC program. (see instructions)  Enter the number of FTE residents that your hospital trained in this cost reporting period of HRSA THC program. (see instructions)	.01	submitted before March 23, 2010. (see instructions)				61.0
compliance with the 75% test. (see instructions)  Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)  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)  Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program neenter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Program Name  Program Code  IME  Direct GM  FTE Count  FTE Count  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period of which your hospital reserved HRSA PCRE funding (see instructions)  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)	.02	primary care FTEs added under section 5503 of ACA). (see instructions)				61.0
Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)  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 61.03). (see instructions)  Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reserved HRSA PCRE funding (see instructions)  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)	1.03					61.0
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)  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 nenter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Unweighted Program Name  Program Name  Program Code  IME  FTE Count  FTE Count  FTE Count  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 ode, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period of HRSA PCRE funding (see instructions)  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)  Enter the number of FTE residents in Non-Provider Settings  Hospitals that Claim Residents in Non-Provider Settings	1.04					61.0
Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program neenter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Program Name  Program Code  IME  Program Code  IME  Program Code  FTE Count  FTE Count  FTE Count  FTE Count  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reserved HRSA PCRE funding (see instructions)  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)  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)  Program Name  Program Name  Program Code  IME  Program Code  IME  Program Code  IME  Program Code  IME  Program Name  Program Code  IME  P	1.05					61.0
enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  Program Name Program Code IME FTE Count FTE Count FTE Count FTE Count 1 2 3 4  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions) 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)  Enter the number of FTE residents in Non-Provider Settings  Hospitals that Claim Residents in Non-Provider Settings	1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or				61.0
Program Name Program Code IME Program Code FTE Count FTE Count FTE Count FTE Count FTE Count Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reserved HRSA PCRE funding (see instructions)  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)  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)  Headening Hospitals that Claim Residents in Non-Provider Settings  Headening Hospitals that Claim Residents in Non-Provider Settings					the program name,	
Program Name Program Code IME FTE Count FTE Count  1 2 3 4  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reserved HRSA PCRE funding (see instructions)  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)  eaching Hospitals that Claim Residents in Non-Provider Settings		enter in column 2 the program code, enter in column 3 the live FTE unweighted count and enter in column 4 thect of			Unweighted	_
Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reserved HRSA PCRE funding (see instructions)  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)  Hospitals that Claim Residents in Non-Provider Settings		Program Name	Program Code	IME	Direct GME FTE Count	
Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.  CA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reserved HRSA PCRE funding (see instructions)  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)  eaching Hospitals that Claim Residents in Non-Provider Settings		1	2			1
Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)  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)  eaching Hospitals that Claim Residents in Non-Provider Settings  Heaven feeling trained residents in non-provider settings designed this cost reporting period? Enter IV/ for use or					n column 1 the	
Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)  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)  eaching Hospitals that Claim Residents in Non-Provider Settings  Heaven for facility trained residents in your provider settings designed to the contraction period? Enter IVI for use or IVI for us						
reseived HRSA PCRE funding (see instructions)  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)  eaching Hospitals that Claim Residents in Non-Provider Settings	CA Pr					
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)  eaching Hospitals that Claim Residents in Non-Provider Settings  Has your facility trained projections in your provider settings during this cost reporting period? Enter IV/ for use or IV/ for	2					62
eaching Hospitals that Claim Residents in Non-Provider Settings	2.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost				62.0
Has your facility trained recidents in non-provider cattings during this cost reporting period? Enter IV! for you or IV! for	achin		•			
no. If yes, complete lines 64-67. (see instructions)		Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for	N			63



## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Section	5504 of the ACA Base Year FTE Resid	dents in Nonprovider settings-This base year is your cost re	porting period that	Unweighted	TT	RATIO	
egins	on or after July 1, 2009 and before June	30, 2010.		FTEs	Unweighted FTEs	(col. 1/	
				Nonprovider	in Hospital	col. 1 +	
	Enter in column 1 if line 63 is ves or	r your facility trained residents in the base year period, the	number of unweighted	Site	-	col. 2))	
		butable to rotations occurring in all non-provider settings. E					
1		are resident FTEs that trained in your hospital. Enter in ool					64
	(column 1 divided by (column 1 + co		unini 5 the ratio of				
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
		f line 63 is yes, or your facility trained residents in the base					ı
		care FTE residents attributable to rotations occurring in all			number of unweighted	primary care	
	resident F1Es that trained in your hos	spital. Enter in column 5 the ratio of (column 3 divided by (	column 3 ÷ column 4)).			Datia	+
				Unweighted FTEs	Unweighted	Ratio (col. 3/	
		Program Name	Program Code	Nonprovider	FTEs	col. 3 +	
				Site	in Hospital	col. 4))	
		1	2	3	4	5	-
5		1	2	<u> </u>	7		65
	5504 of the ACA Current Year FTE Re	esidents in Nonprovider settings-Effective for cost reporting	g periods beginning on	Unweighted	TT 11.1	RATIO	1
	July 1, 2010		51	FTEs	Unweighted	(col. 1/	
	* *			Nonprovider	FTEs	col. 1 +	
				Site	in Hospital	col. 2))	
		weighted non-primary care resident FTEs attributable to rota					
6		in 2 the number of unweighted non-primary care resident F					66
	your hospital. Enter in column 3 the r	ratio of (column 1 divided by (column 1 + column 2)). (see	instructions)				
	F	F 4 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		0 11.1	ETE '1		
		program name. Enter in column 2 the program code. Enter					
		er settings. Enter in column 4 the number of unweighted prin	mary care resident FTEs	that trained in your h	ospital. Enter in colum	in 5 the ratio of	
	(column 3 divided by (column 3 ÷ co	lumn 4)). (see instructions)		I Immoi ahta d		Datia	_
				Unweighted FTEs	Unweighted	Ratio (col. 3/	
		Program Name	Program Code		FTEs		
			1 Togram Couc				
		2 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 Togram Code	Nonprovider	in Hospital	col. 3 +	
				Site	in Hospital	col. 4))	
7		1	2				67
67				Site	in Hospital	col. 4))	67
	nt Psychiatric Faciltiy PPS	1	2	Site	in Hospital	col. 4))	67
npatie			2	Site 3	in Hospital 4	col. 4)) 5	
npatie	Is this facility an Inpatient Psychiatric no.	1	2	Site 3	in Hospital 4	col. 4)) 5	67
npatie	Is this facility an Inpatient Psychiatric no. If line 70 yes:	t Facility (IPF), or does it contain an IPF subprovider? Ente	2 er 'Y' for yes or 'N' for	Site 3	in Hospital 4	col. 4)) 5	
npatie	Is this facility an Inpatient Psychiatric no.  If line 70 yes: Column 1: Did the facility have a teac	1	2 or 'Y' for yes or 'N' for	Site 3	in Hospital 4	col. 4)) 5	
npatie	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no.	c Facility (IPF), or does it contain an IPF subprovider? Ente	2 er 'Y' for yes or 'N' for ore November 15,	Site 3	in Hospital 4	col. 4)) 5	
npatier	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a tead 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid	c Facility (IPF), or does it contain an IPF subprovider? Enteching program in the most recent cost report filed on or beflents in a new teaching program in accordance with 42 CFR	2 er 'Y' for yes or 'N' for ore November 15,	Site 3	in Hospital 4	col. 4)) 5	
npatier	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for	c Facility (IPF), or does it contain an IPF subprovider? Enteching program in the most recent cost report filed on or befolents in a new teaching program in accordance with 42 CFR yes and 'N' for no.	2 or 'Y' for yes or 'N' for ore November 15,	Site 3	in Hospital 4	col. 4)) 5	70
npatier	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1.	c Facility (IPF), or does it contain an IPF subprovider? Enteching program in the most recent cost report filed on or before the in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2. or 3 respectively in column 3. If this cost reporting perior	2 er 'Y' for yes or 'N' for ore November 15,	Site 3	in Hospital 4	col. 4)) 5	70
npatier	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column	c Facility (IPF), or does it contain an IPF subprovider? Enteching program in the most recent cost report filed on or befolents in a new teaching program in accordance with 42 CFR yes and 'N' for no.	2 er 'Y' for yes or 'N' for ore November 15,	Site 3	in Hospital 4	col. 4)) 5	70
npatier	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1.	c Facility (IPF), or does it contain an IPF subprovider? Enteching program in the most recent cost report filed on or before the in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2. or 3 respectively in column 3. If this cost reporting perior	2 er 'Y' for yes or 'N' for ore November 15,	Site 3	in Hospital 4	col. 4)) 5	70
npatier	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.	c Facility (IPF), or does it contain an IPF subprovider? Enter thing program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new tea	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in	Site 3	in Hospital 4	col. 4)) 5	70
npatier  1	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.	c Facility (IPF), or does it contain an IPF subprovider? Enteching program in the most recent cost report filed on or before the in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2. or 3 respectively in column 3. If this cost reporting perior	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in	Site 3 1 N	in Hospital  4  2	col. 4)) 5	70
npatier  1	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no.	c Facility (IPF), or does it contain an IPF subprovider? Enter thing program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new tea	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in	Site 3	in Hospital  4  2	col. 4)) 5	70
npatier	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a tead 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitat for no.  If line 75 yes:	c Facility (IPF), or does it contain an IPF subprovider? Enterching program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teattion Facility (IRF), or does it contain an IRF subprovider? I	2 er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in enter 'Y' for yes or 'N'	Site 3 1 N	in Hospital  4  2	col. 4)) 5	70
npatier  1	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a tead 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no. If line 75 yes: Column 1: Did the facility have a tead	c Facility (IPF), or does it contain an IPF subprovider? Enter thing program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teath the statement of the subsequent academic years of the new teath the statement of the subsequent academic years of the new teath the statement of the subsequent academic years of the new teath the statement of the subsequent academic years of the new teath the statement of the subsequent academic years of the new teath the years of the year	2 er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in enter 'Y' for yes or 'N'	Site 3 1 N	in Hospital  4  2	col. 4)) 5	70
npatier  1	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no. If line 75 yes: Column 1: Did the facility have a teat November 15, 2004? Enter 'Y' for yes	c Facility (IPF), or does it contain an IPF subprovider? Enter thing program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teather than the sort of the subsequent academic years of the new teather than the sort in the most recent cost reporting period endies or 'N' for no.	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in Enter 'Y' for yes or 'N'	Site 3 1 N	in Hospital  4  2	col. 4)) 5	70
npatier	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no.  If line 75 yes: Column 1: Did the facility have a teat November 15, 2004? Enter 'Y' for yes Column 2: Did this facility train resid	c Facility (IPF), or does it contain an IPF subprovider? Enter ching program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teath tion Facility (IRF), or does it contain an IRF subprovider? If the ching program in the most recent cost reporting period end is or 'N' for no. It is not a new teaching program in accordance with 42 CFR	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in Enter 'Y' for yes or 'N'	1 N	in Hospital  4  2	col. 4)) 5	70 71 75
npatier 0	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no.  If line 75 yes: Column 1: Did the facility have a teat November 15, 2004? Enter 'Y' for yes Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for	c Facility (IPF), or does it contain an IPF subprovider? Enterching program in the most recent cost report filed on or befolents in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teaching program in the most recent cost reporting period ending program in the most recent cost reporting period ending program in the most recent cost reporting period ending a new teaching program in accordance with 42 CFR yes and 'N' for no.	2 er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in Enter 'Y' for yes or 'N' ng on or before	Site 3 1 N	in Hospital  4  2	col. 4)) 5	70
npatier 0 1 1 1 npatier 5	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a tead 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  At Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no.  If line 75 yes: Column 1: Did the facility have a tead November 15, 2004? Enter 'Y' for yes Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1,	c Facility (IPF), or does it contain an IPF subprovider? Enter thing program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teath the strong program in the most recent cost reporting period ending program in the most recent cost reporting period ending or 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period ending program in the most recent cost reporting period ending or 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 2, or 3 respectively in column 3. If this cost reporting period 2, or 3 respectively in column 3. If this cost reporting period 2, or 3 respectively in column 3. If this cost reporting period 2.	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in enter 'Y' for yes or 'N' ng on or before d covers the beginning	1 N	in Hospital  4  2	col. 4)) 5	70 71 75
npatier 0 1 1 1 npatier 5	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no. If line 75 yes: Column 1: Did the facility have a teat November 15, 2004? Enter 'Y' for yes Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column	c Facility (IPF), or does it contain an IPF subprovider? Enterching program in the most recent cost report filed on or befolents in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teaching program in the most recent cost reporting period ending program in the most recent cost reporting period ending program in the most recent cost reporting period ending a new teaching program in accordance with 42 CFR yes and 'N' for no.	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in enter 'Y' for yes or 'N' ng on or before d covers the beginning	1 N	in Hospital  4  2	col. 4)) 5	70 71 75
npatier	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a tead 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  At Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no.  If line 75 yes: Column 1: Did the facility have a tead November 15, 2004? Enter 'Y' for yes Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1,	c Facility (IPF), or does it contain an IPF subprovider? Enter thing program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teath the strong program in the most recent cost reporting period ending program in the most recent cost reporting period ending or 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period ending program in the most recent cost reporting period ending or 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 2, or 3 respectively in column 3. If this cost reporting period 2, or 3 respectively in column 3. If this cost reporting period 2, or 3 respectively in column 3. If this cost reporting period 2.	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in enter 'Y' for yes or 'N' ng on or before d covers the beginning	1 N	in Hospital  4  2	col. 4)) 5	70 71 75
npatier 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no. If line 75 yes: Column 1: Did the facility have a teat November 15, 2004? Enter 'Y' for yes Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.	c Facility (IPF), or does it contain an IPF subprovider? Enter thing program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teath the strong program in the most recent cost reporting period ending program in the most recent cost reporting period ending or 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period ending program in the most recent cost reporting period ending or 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 2, or 3 respectively in column 3. If this cost reporting period 2, or 3 respectively in column 3. If this cost reporting period 2, or 3 respectively in column 3. If this cost reporting period 2.	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in enter 'Y' for yes or 'N' ng on or before d covers the beginning	1 N	in Hospital  4  2	col. 4)) 5	70 71 75
npatier  1  npatier  5	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a tead 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitat for no.  If line 75 yes: Column 1: Did the facility have a tead November 15, 2004? Enter 'Y' for Column 2: Did this facility train resid §412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.	c Facility (IPF), or does it contain an IPF subprovider? Enterching program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teath tion Facility (IRF), or does it contain an IRF subprovider? If the sort in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period ending the sort in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teaching program in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teaching program in the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academi	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in enter 'Y' for yes or 'N' ng on or before d covers the beginning	1 N	in Hospital  4  2  2	col. 4)) 5	70 71 75
npatier 0 npatier 5 5	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation no. If line 75 yes: Column 1: Did the facility have a teat November 15, 2004? Enter 'Y' for yes Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  Erm Care Hospital PPS Is this a Long Term Care Hospital (L. Providers	c Facility (IPF), or does it contain an IPF subprovider? Enter thing program in the most recent cost report filed on or befolents in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teaching program in the most recent cost reporting period end is or 'N' for no.  lents in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teaching the following program in the sor treporting period 3, or if the 5th or subsequent academic years of the new teaching the following program in the subsequent academic years of the new teaching the following program in the 5th or subsequent academic years of the new teaching the following program in the file of the following program in the following program in the following program in accordance with 42 CFR yes and 'N' for no.	er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in enter 'Y' for yes or 'N' ng on or before d covers the beginning	1 N	in Hospital  4  2	col. 4)) 5	70 71 75 76
npatier 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Is this facility an Inpatient Psychiatrino.  If line 70 yes: Column 1: Did the facility have a teat 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  It Rehabilitation Facility PPS Is this facility an Inpatient Rehabilita for no. If line 75 yes: Column 1: Did the facility have a teat November 15, 2004? Enter 'Y' for yes Column 2: Did this facility train resid \$412.424(d)(1)(iii)(D)? Enter 'Y' for Column 3: If column 2 is Y, enter 1, of the fourth year, enter 4 in column existence, enter 5.  Is this a Long Term Care Hospital (L. Providers) Is this a new hospital under 42 CFR §	c Facility (IPF), or does it contain an IPF subprovider? Enterching program in the most recent cost report filed on or before the single and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teath tion Facility (IRF), or does it contain an IRF subprovider? If the sort in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period ending the sort in a new teaching program in accordance with 42 CFR yes and 'N' for no.  2, or 3 respectively in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teaching program in column 3. If this cost reporting period 3, or if the 5th or subsequent academic years of the new teaching program in the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academic years of the new teaching program in the subsequent academi	2 er 'Y' for yes or 'N' for ore November 15, d covers the beginning ching program in Enter 'Y' for yes or 'N' ng on or before d covers the beginning ching program in	Site 3  I N	in Hospital  4  2	col. 4)) 5	70 71 75 76



## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

				V	XIX	
Γitle V a	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	or no in applicable c	olumn.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in par applicable column.	t? Enter 'Y' for yes,	or 'N' for no in the	N	N	91
2	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes	s or 'N' for no in the	appilcable column.		N	92
13	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes			N	N	93
4	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable col		T	N	N	94
)5	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable	column.		N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Pr	oviders			1	2	+
.05	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
.06	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpat	ient services? (see in	nstructions)			106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R train no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 a If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an app the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.	ning programs? Ente	r 'Y' for yes and 'N' for ld be cost reimbursed.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §41:	2.113(c). Enter 'Y' fo	or ves or 'N' for no	N		108
	is any a ratal mospital quantying for an exception to the oral arrive senedate. See 12 or 12 yr.	Physical	Occupational	Speech	Respiratory	100
	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by	111,010	N	N	N	
09	outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109
Aiscella	neous Cost Reporting Information					
	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the	e method used (A			1	
15	B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term		N			115
16	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	i nospitai or 76		N		116
17	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			Y		117
18	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-	made Enter 2 if the	nolicy is occurrence	1		118
10	is the marpraetice insurance a claims-made of occurrence poncy? Enter 1 if the poncy is claims	-made. Enter 2 if the	policy is occurrence.	1	Self	110
			Premiums	Paid Losses	Insurance	
18.01	List amounts of malpractice premiums and paid losses:		1			118.01
18.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrati supporting schedule listing cost centers and amounts contained therein.	ive and General cost	center? If yes, submit	N		118.02
20	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §312 instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds	that qualifies for th	e Outpatient Hold	N	N	120
	Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in col					
21	Did this facility incur and report costs for high cost implantable devices charged to patients? E	nter 'Y' for yes or 'N	for no.	Y		121
	ant Center Information					
25	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification of the second of th			N		125
26	If this is a Medicare certified kidney transplant center enter the certification date in column 1 a column 2.	and termination date	, if applicable in			126
27	If this is a Medicare certified heart transplant center enter the certification date in column 1 an 2.	d termination date,	f applicable in column			127
28	If this is a Medicare certified liver transplant center enter the certification date in column 1 and 2	d termination date, i	f applicable in column			128
29	If this is a Medicare certified lung transplant center enter the certification date in column 1 and	l termination date, is	f applicable in column 2.			129
30	If this is a Medicare cetified pancreas transplant center enter the certification date in column column 2.	and termination da	te, if applicable in			130
31	If this is a Medicare certified intestinal transplant center enter the certification date in column column 2.	1 and termination da	nte, if applicable in			131
32	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and	I termination date, if	applicable in column 2.			132
	If this is a Medicare certified other transplant center enter the certification date in column 1 an					133
33	2.					133



## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

All Pro	• 1							
	viders					1	2	
	Are there any related organization or home office costs as d	afined in CMS Pub 15 1 Ch	anter 102 E	nter 'V' for yes o	r 'N' for no in	1	2	
40	column 1. If yes, and home office costs are claimed, enter in					Y	158054	140
	column 1. 11 yes, and nome office costs are claimed, enter it	r column 2 the nome office c	mann manno	ci (see instruction	13)			
thic f	acility is part of a chain organization, enter on lines 141 through	h 143 the name and address (	of the home	office and enter	the home office contrac	tor name and contrac	ctor number	
41	Name: COMMUNITY FOUNDATION OF NW IN,	Contractor's Name: NGS			r's Number: 00450	tor name and contrac	ctor number.	141
42	Street: 10100 DON POWERS DRIVE	P.O. Box:		Contracto	1 3 1 valide1. 00+30			142
43	City: MUNSTER	State: IN	ZIP Code	· 46321				143
44	Are provider based physicians' costs included in Worksheet		ZII Code	. 10321		Y		144
45	If costs for renal services are claimed on Worksheet A, line		nt cervices (	only? Enter 'V' for	ves or 'N' for no	Y		145
	Has the cost allocation methodology changed from the previous							
46	Pub. 15-2, section 4020). If yes, enter the approval date (mr		1 1 101 yc.	and iv for no m	column 1. (see Civis	N		146
	1 ub. 13-2, section 4020). 11 yes, enter the approvar date (iii)	n/dd/yyyy) iii coluinii 2.					1	
47	Was there a change in the statistical basis? Enter 'Y' for yes	or 'N' for no				Y		147
48	Was there a change in the order of allocation? Enter 'Y' for					N		148
49		Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.				N		149
17	was there a change to the simplified cost finding method: I				11		147	
				Part A	Part B	Title V	Title XIX	
					1	2	3	
155	Hospital			N	N	N	N	155
156	Subprovider - IPF			N	N			
.57								156
	Subprovider - IRF			N	N N	N	N	157
58	Subprovider - Other			N	N	N	N	157 158
.58 .59	Subprovider - Other SNF			N N	N N			157 158 159
58 59 60	Subprovider - Other SNF HHA			N	N N N	N N	N N	157 158 159 160
58 59 60 61	Subprovider - Other SNF HHA CMHC			N N	N N			157 158 159 160 161
.58 .59 .60	Subprovider - Other SNF HHA			N N	N N N			157 158 159 160 161
58   59   60   61   61.10	Subprovider - Other SNF HHA CMHC CORF			N N	N N N			157 158 159 160
58 59 60 61 61.10	Subprovider - Other SNF HHA CMHC CORF	or more campuses in		N N	N N N			157 158 159 160 161 161.10
58 59 60 61 61.10	Subprovider - Other SNF HHA CMHC CORF  Impus Is this hospital part of a multicampus hospital that has one of the control of th	or more campuses in	N	N N	N N N			157 158 159 160 161
58 59 60 61 61.10	Subprovider - Other SNF HHA CMHC CORF  Impus Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no.	•		N N N	N N N N	N	N	157 158 159 160 161 161.10
58 59 60 61 61.10 fultica	Subprovider - Other SNF HHA CMHC CORF  Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no.  If line 165 is yes, for each campus, enter the name in colum	n 0, county in column 1, state		N N N 12, ZIP in column	N N N N 13, CBSA in column 4,	N  FTE/campus in colu	N mn 5.	157 158 159 160 161 161.10
58 59 60 61 61.10 fultica	Subprovider - Other SNF HHA CMHC CORF  Impus Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no.	•		N N N	N N N N	N	N	157 158 159 160 161 161.10
58 59 60 61 61.10 Jultica	Subprovider - Other SNF HHA CMHC CORF  Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no.  If line 165 is yes, for each campus, enter the name in colum Name	n 0, county in column 1, state		N N N State	N N N N N 13, CBSA in column 4,	N  FTE/campus in colu  CBSA	mn 5.	157 158 159 160 161 161.10
58 59 60 51 51.10 fultica 55	Subprovider - Other SNF HHA CMHC CORF Impus Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no. If line 165 is yes, for each campus, enter the name in colum Name 0	n 0, county in column 1, state County 1		N N N State	N N N N N 13, CBSA in column 4,	N  FTE/campus in colu  CBSA	mn 5.	157 158 159 160 161 161.10
58 59 60 61 61.10 Iultica 65	Subprovider - Other SNF HHA CMHC CORF  Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no.  If line 165 is yes, for each campus, enter the name in colum Name	n 0, county in column 1, state  County  I  very and Reinvestment Act		N N N State	N N N N N 13, CBSA in column 4,	N  FTE/campus in colu  CBSA	mn 5.	157 158 159 160 161 161.10
58 59 60 61 61.10 fultica 65 66	Subprovider - Other SNF HHA CMHC CORF  Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no.  If line 165 is yes, for each campus, enter the name in colum Name 0  Information Technology (HIT) incentive in the American Reco	n 0, county in column 1, state  County  I  very and Reinvestment Act for yes or 'N' for no.	e in column	N N N 12, ZIP in column State 2	N N N N 13, CBSA in column 4, ZIP Code 3	N  FTE/campus in colu  CBSA	mn 5.	157 158 159 160 161 161.1:
58 59 60 61 61.10 Multica 65	Subprovider - Other SNF HHA CMHC CORF  Inspus Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no. If line 165 is yes, for each campus, enter the name in colum Name 0  Information Technology (HIT) incentive in the American Reco Is this provider a meaningful user under §1886(n)? Enter 'Y	n 0, county in column 1, state  County  I  very and Reinvestment Act for yes or 'N' for no.	e in column	N N N 12, ZIP in column State 2	N N N N 13, CBSA in column 4, ZIP Code 3	N  FTE/campus in colu  CBSA	mn 5.	157 158 159 160 161 161.10
58 59 60 61 61.10 fultica 65 66	Subprovider - Other SNF HHA CMHC CORF Impus Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no. If line 165 is yes, for each campus, enter the name in colum Name 0 Information Technology (HIT) incentive in the American Reco Is this provider a meaningful user under §1886(n)? Enter 'Y If this provider is a CAH (line 105 is 'Y') and is a meaningful for the HIT assets. (see instructions)	County in Column 1, state County 1 very and Reinvestment Act for yes or 'N' for no. il user (line 167 is 'Y'), enter	e in column	N N N 12, ZIP in column State 2	N N N N N 13, CBSA in column 4, ZIP Code 3	N  FTE/campus in colu  CBSA	mn 5.	157 158 159 160 161 161.10 165 166
58 59 60 61 61.10 fultica 65 66	Subprovider - Other SNF HHA CMHC CORF  Is this hospital part of a multicampus hospital that has one of different CBSAs? Enter 'Y' for yes or 'N' for no.  If line 165 is yes, for each campus, enter the name in column Name  0  Information Technology (HIT) incentive in the American Records Is this provider a meaningful user under §1886(n)? Enter 'Y If this provider is a CAH (line 105 is 'Y') and is a meaningful user under §1886(n)?	County in Column 1, state County 1 very and Reinvestment Act for yes or 'N' for no. il user (line 167 is 'Y'), enter	e in column	N N N 12, ZIP in column State 2	N N N N 13, CBSA in column 4, ZIP Code 3	N  FTE/campus in colu  CBSA	mn 5.	157 158 159 160 161 161.1 165 166



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

## 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		
PROVI	DER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING O		N			1
	REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instruc	tions)		DATE	37/1	-
			Y/N 1	DATE 2	V/I 3	
	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES	FNTER IN	1		3	
2	COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FO INVOLUNTARY.		N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT OF WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSON MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY OTHER SIMILAR RELATIONSHIPS? (see instructions)	IAT ARE NEL, OR	Y			3
			Y/N	TYPE	DATE	
FINAN	CIAL DATA AND REPORTS		1/10	2	3	
11117111	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC AC	COUNTANT?	1			
4	COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SU COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	JBMIT	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	OSE ON THE	N			5
						_
A DDD C	WED EDUCATIONAL ACTIVITIES			Y/N	Y/N	
APPRO	OVED EDUCATIONAL ACTIVITIES  COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL?			1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NORSING SCHOOL?  COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?			N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.			N		7
	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENE	EWED DURING	THE COST			
8	REPORTING PERIOD?			N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT CONSTRUCTIONS.		•	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST SEE INSTRUCTIONS.			N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPI ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	ROVED TEACH	ING PROGRAM	N		11
DADD	PENTO.				1/2/	
BAD D		NIC			Y/N	12
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIO IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURIN		PEDODTING DEDIGE	79 IE VEC	Y	12
13	SUBMIT COPY.	G THIS COST R	REPORTING PERIOL	D? IF 1 E5,	N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES	S. SEE INSTRU	CTIONS.		N	14
		,				
BED C	OMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF Y	ES, SEE INSTR	UCTIONS.		N	15
		DAI	DT A	DAI	OT D	1
		Y/N	RT A DATE	Y/N	RT B DATE	
PS&R	REPORT DATA	1 / 1 N	2	3	DATE 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	N	2	N		16
	USED IN COLUMNS 2 AND 4. (see instructions)					
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	10/31/2013	Y	10/31/2013	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	N		N		18
10	PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.  IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR  CONDUCTIONS OF THE DESCRIPTION OF THE PROPERTY OF	N		2.7		10
19	CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.  INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21



	In Lieu of Form	Period :	Run Date: 01/05/2015
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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)

CAPI	TAL RELATED COSTS			
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 PERIOD? IF YES, SEE INSTRUCTIONS.	REPORTING		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIO INSTRUCTIONS.	D? IF YES, SEE		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INST	RUCTIONS		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUC			26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIO			27
INTE	REST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING P SEE INSTRUCTIONS.	ERIOD? IF YES,		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	AS A FUNDED		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTION	NS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCT			31
PURC	CHASED 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. SE	E INSTRUCTIONS		33
PROV	/IDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIAN INSTRUCTIONS.	IS? IF YES, SEE		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	PHYSICIANS		35
-	DURING THE COST REPORTING PERIOD! IF TES, SEE INSTRUCTIONS.			
		Y/N	DATE	
HOM	E OFFICE COSTS	1	2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1		36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE			37
	INSTRUCTIONS.  IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF			20
38	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
	REORT PREPARER INFORMATION			
41		RECTOR OF REIMBU	RSEMENT	41
42	EMPLOYER: COMMUNITY HOSPITAL			42
43	PHONE NUMBER: 12198366789 E-MAIL ADDRESS: CBIEGEL@COMHS.ORG			43



## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

						INPATIE	NT DAYS/OUTP	ATIENT VISIT	S/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	349	127,385			43,665	4,294	75,763	1
2	HMO AND OTHER (see instructions)						5,242	8,472		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER						438	38		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)		349	127,385			43,665	4,294	75,763	7
8	INTENSIVE CARE UNIT	31	34	12,410			5,752	476	9,836	8
9	CORONARY CARE UNIT	32								9
9.01	NEONATAL INTENSIVE CARE	32.01	25	9,125				447	4,697	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						308	3,694	
14	TOTAL (see instructions)		408	148,920			49,417	5,525	93,990	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41	47	17,155			12,944	277	14,705	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					34,058		42,925	
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		455							27
28	OBSERVATION BED DAYS								13,240	
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							87	1,166	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33



## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

		FULL	TIME EQUIVAL	ENTS		DISCHA	RGES		
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					8,907	972	17,272	1
2	HMO AND OTHER (see instructions)					816	2,134		2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
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)		2,361.83			8,907	972	17,272	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF		72.99			1,262	31	1,434	17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY		41.73						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)		2,476.55						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32



## 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	148,846,651		148,846,651	5,151,214.00	28.90	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B		2,958,738		2,958,738	38,278.00	77.30	3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		7,092,935		7,092,935	38,231.00	185.53	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved							7.01
8	program) HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)	44	8,344,887	42,562	8,387,449	353,289.00	23.74	10
10	OTHER WAGES & RELATED COSTS		0,544,007	42,302	0,307,447	333,207.00	23.74	10
11	CONTRACT LABOR (see instructions)		1,116,349		1,116,349	9,758.00	114.40	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE		1,110,517		1,110,515	2,730.00	111.10	12
	SERVICES CONTRACT LABOR: PHYSICIAN-PART A -							
13	ADMINISTRATIVE		621,831		621,831	4,059.00	153.20	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		20,365,428		20,365,428	518,956.00	39.24	14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE		20,303,426		20,303,426	318,930.00	39.24	15
	HOME OFFICE & CONTRACT PHYSICIANS PART A -							
16	TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		40,279,018		40,279,018			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		2,708,858		2,708,858			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B		720,337		720,337			21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		1,313,399		1,313,399			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
26	OVERHEAD COSTS - DIRECT SALARIES		015 024		015 024	22 020 00	27.72	26
26 27	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL		915,924 13,566,558	-34,771	915,924 13,531,787	33,039.00 528,888.00	27.72 25.59	26 27
21	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see		13,300,338	-34,//1	13,331,787	328,888.00	25.39	21
28	instructions)		3,319,815		3,319,815	23,750.00	139.78	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		4,757,170		4,757,170	177,291.00	26.83	30
31	LAUNDRY & LINEN SERVICE		106,528		106,528	7,495.00	14.21	31
32	HOUSEKEEPING		3,248,453		3,248,453	213,811.00	15.19	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		3,562,860	-1,150,596	2,412,264	140,708.00	17.14	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			1,150,596	1,150,596	78,422.00	14.67	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,666,412	24.55	1,666,412	37,162.00	44.84	38
39	CENTRAL SERVICES AND SUPPLY		2.010.772	34,771	34,771	2,288.00	15.20	39
40 41	PHARMACY  MEDICAL RECORDS & MEDICAL RECORDS LIDRARY		3,919,662		3,919,662	106,714.00	36.73	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY SOCIAL SERVICE		122,835 689,252		122,835 689,252	4,131.00 25,477.00	29.73 27.05	41
42	OTHER GENERAL SERVICE		089,232		089,232	23,477.00	27.03	42
-t-J	OTHER GENERAL SERVICE							+J

## PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	142,114,793		142,114,793	5,098,455.00	27.87	1
2	EXCLUDED AREA SALARIES (see instructions)	8,344,887	42,562	8,387,449	353,289.00	23.74	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	133,769,906	-42,562	133,727,344	4,745,166.00	28.18	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see	22,103,608		22,103,608	532,773.00	41.49	4
7	instructions)	22,103,000		22,103,006	332,773.00	41.49	7
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	40,279,018		40,279,018		30.12%	5
6	TOTAL (sum of lines 3 through 5)	196,152,532	-42,562	196,109,970	5,277,939.00	37.16	6
7	TOTAL OVERHEAD COST (see instructions)	35,875,469		35,875,469	1,379,176.00	26.01	7



## HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3 PART IV

### PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST	REF ORTED	
1	401K EMPLOYER CONTRIBUTIONS	2,084,915	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	77	2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	13,070,049	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	250,000	6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	17,810,522	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	154,956	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	78,110	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	704,172	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	8,500,042	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	2,088,243	18
19	UNEMPLOYMENT INSURANCE	102,732	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	177,872	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	45,021,613	24

TART B OTHER THAT CORE REPATED COST							
25	OTHER WAGE RELATED (OTHER WAGE REL		25				



## Compu-Max

	Supporting Exhibit for Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

## WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD		
1	WAGE INDEX FISCAL YEAR ENDING DATE	06/30/2014	1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	06/30/2014	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)		
6	EFFECTIVE DATE OF PENSION PLAN	01/01/1973	6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE	07/01/2013	7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

## IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIB- UTION(S)	11
11.01			13,200,000	11.01
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19



	In Lieu of Form	Period :	Run Date: 01/05/2015
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## HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3 PART V

### PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT	BENEFIT	
	COMI ONENI	LABOR	COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18



## HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 15-7487

COUNTY:

LAKE

WORKSHEET S-4

## HOME HEALTH AGENCY STATISTICAL DATA

		TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
	DESCRIPTION	1	2	3	4	5	
1	HOME HEALTH AIDE HOURS		3,967	14	140	4,121	1
2	UNDUPLICATED CENSUS COUNT (see instructions)		1,147.00		417.00	1,564.00	2

### HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00		NUMBER OF EMPLOYEES (Full Time Equivalent)				
		STAFF	CONTRACT	TOTAL			
		1	2	3			
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3		
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)	1.56		1.56	4		
5	OTHER ADMINISTRATIVE PERSONNEL	10.17		10.17	5		
6	DIRECT NURSING SERVICE	7.15		7.15	6		
7	NURSING SUPERVISOR				7		
8	PHYSICAL THERAPY SERVICE		6.50	6.50	8		
9	PHYSICAL THERAPY SUPERVISOR				9		
10	OCCUPATIONAL THERAPY SERVICE		1.54	1.54	10		
11	OCCUPATIONAL THERAPY SUPERVISOR				11		
12	SPEECH PATHOLOGY SERVICE	0.07		0.07	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	1.73		1.73	16		
17	HOME HEALTH AIDE SUPERVISOR				17		
18	PRIVATE DUTY	19.34		19.34	18		

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	1	19	l
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).	23844	20	ĺ

#### PPS ACTIVITY

TIDA	, 11 V 11 1						
		FULL EP	ISODES				
		WITHOUT OUTLIERS	WITH OUTLIERS	LUPA EPISODES	PEP ONLY EPISODES	TOTAL (columns 1 through 4)	
		1	2	3	4	5	
21	SKILLED NURSING VISITS	14,552	2,777	492	89	17,910	21
22	SKILLED NURSING VISIT CHARGES	2,156,686	430,732	55,810	12,561	2,655,789	22
23	PHYSICAL THERAPY VISITS	10,283	819	98	73	11,273	23
24	PHYSICAL THERAPY VISIT CHARGES	1,868,872	151,515	14,800	13,320	2,048,507	24
25	OCCUPATIONAL THERAPY VISITS	2,383	447	5	17	2,852	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	439,375	82,695	925	3,145	526,140	26
27	SPEECH PATHOLOGY VISITS	191	93			284	27
28	SPEECH PATHOLOGY VISIT CHARGES	35,335	17,205			52,540	28
29	MEDICAL SOCIAL SERVICE VISITS	17	2			19	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	3,587	422			4,009	30
31	HOME HEALTH AIDE VISITS	2,807	933	14	10	3,764	31
32	HOME HEALTH AIDE VISIT CHARGES	329,749	110,313	1,428	1,190	442,680	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	30,233	5,071	609	189	36,102	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	4,833,604	792,882	72,963	30,216	5,729,665	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	1,370		169	9	1,548	36
37	TOTAL NUMBER OF OUTLIER EPISODES		94		2	96	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	308,681	91,118	6,792	3,842	410,433	38



In Lieu of Form Run Date: 01/05/2015 Period: COMMUNITY HOSPITAL CMS-2552-10 From: 07/01/2013 Run Time: 13:42 To: 06/30/2014 Provider CCN: 15-0125 Version: 2014.10

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA						
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)			0.284287	1		
MEDICAID (see instructions for each line)						
2 NET REVENUE FROM MEDICAID			10,062,831	2		
DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?      IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			N	3		
4 IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?  5 IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				5		
6 MEDICAID CHARGES			118,683,365	6		
7 MEDICAID COST (line 1 times line 6)		33,740,138	7			
8 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 if LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.		23,677,307	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 11 STAND-ALONE SCHIP COST (line 1 times line 10)				10		
DIEEEDENICE DETWEEN NET DEVENUE AND COCTS FOR STAND ALONE SCHIR (in a 11 minus line 0)						
12 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9)  IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.			12			
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)						
13 NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)			13			
14 CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lin	nes 6 or 10)			14		
15 STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)  DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line	15 : 1: 12)			15		
16 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.	15 minus line 13)			16		
UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION						
17 PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			6,340	_		
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 PROGRAM	S (sum of lines 8, 12 an	d 16)	23,677,307	19		
	UNINSURED	INSURED	TOTAL (col. 1 +			
	PATIENTS	PATIENTS	col. 2)			
	1	2	3			
TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	22,706,684		22,706,684	20		
21 COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	6,455,215		6,455,215	21		
22 PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	146,043		146,043			
23 COST OF CHARITY CARE (line 21 minus line 22)	6,309,172		6,309,172	23		
DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF	F STAY LIMIT IMPOS	SED ON		24		
PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?  1 IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH	I OF STAV I IMIT (~~	instructions)		25		
26 TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	101 SIAI LIMII (SE	mon uctions)	16,804,053			
27 MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)			943,552			
28 NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)			15,860,501			
29 COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)			4,508,934	29		
30 COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)			10,818,106			
31 TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)			34,495,413	31		



## 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					J		,	
1	00100	CAP REL COSTS-BLDG & FIXT				10,742,441	10,742,441	328,423	11,070,864	1
2	00200	CAP REL COSTS-MVBLE EQUIP				9,431,996	9,431,996	5,425,925	14,857,921	2
3	00300	OTHER CAP REL COSTS				7,131,770	7,131,770	3,123,723	-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	915,924	366,703	1,282,627	43,841,352	45,123,979	115,502	45.239.481	4
5	00500	ADMINISTRATIVE & GENERAL	13,566,558	156,446,322	170,012,880	-64.870.506	105,142,374	-47,369,275	57,773,099	5
6	00600	MAINTENANCE & REPAIRS	13,300,336	130,440,322	170,012,000	-04,870,300	103,142,374	-47,309,273	31,113,099	6
7	00700	OPERATION OF PLANT	4,757,170	7,691,203	12,448,373	869,057	13.317.430	-19,908	13.297.522	7
8	00800	LAUNDRY & LINEN SERVICE	106,528	1,161,326	1,267,854	809,037	1,267,854	-19,906	1.267.854	8
9	00900	HOUSEKEEPING	3,248,453	987,008	4,235,461	-72,725	4,162,736		4,162,736	
10	01000	DIETARY	3,562,860	2,859,859	6,422,719	-2,491,384	3,931,335	-4,047	3,927,288	10
11	01100	CAFETERIA	3,302,800	2,839,839	0,422,/19	2,489,059	2,489,059	-2,074,567	3,927,288 414,492	11
	01200					2,469,039	2,469,039	-2,074,307	414,492	12
12	01200	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION	1,666,412	120,635	1,787,047	-6,393	1,780,654		1,780,654	13
	01300		1,000,412							
14 15	01400	CENTRAL SERVICES & SUPPLY PHARMACY	3,919,662	17,670 11,909,539	17,670 15,829,201	34,771	52,441 15,829,201	-195	52,441 15,829,006	
	01500	MEDICAL RECORDS & LIBRARY						-195 -110		16
16 17	01600	SOCIAL SERVICE	122,835 689,252	135,401 12,360	258,236 701,612		258,236 701.612	-110	258,126 701.344	17
17	01700	NONPHYSICIAN ANESTHETISTS	089,232	12,300	/01,612		/01,612	-268	/01,344	17
20	02000	NURSING SCHOOL								20
21	02000	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02100	I&R SERVICES-SALART & FRINGES AFFRVD  I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02200	PARAMED ED PRGM-(SPECIFY)								23
23	02300	INPATIENT ROUTINE SERV COST CENTERS								23
30	03000	ADULTS & PEDIATRICS	32,593,427	4 660 990	37,254,307	596 022	26 667 205	-56.159	36,611,226	30
31	03100	INTENSIVE CARE UNIT	7,743,164	4,660,880 1,028,114	8,771,278	-586,922 -119,208	36,667,385 8,652,070	-30,139	8,652,070	
32.01	02060	NEONATAL INTENSIVE CARE	2,799,173	304.835	3,104,008	5,808	3.109.816	-41,760	3.068.056	
41	04100	SUBPROVIDER - IRF	3,640,129	1,757,419	5.397.548	-6,771	5,390,777	-41,700	5,390,777	41
43	04300	NURSERY	1,258,913	252,170	1,511,083	3,936	1,515,019		1,515,019	
40	04300	ANCILLARY SERVICE COST CENTERS	1,236,913	232,170	1,511,005	3,930	1,515,019		1,313,019	43
50	05000	OPERATING ROOM	24,120,520	38,548,730	62,669,250	-25,486,821	37,182,429	-12,351,370	24,831,059	50
52	05200	DELIVERY ROOM & LABOR ROOM	1,902,706	328,821	2,231,527	-48,812	2,182,715	-12,331,370	2,182,715	
54	05400	RADIOLOGY-DIAGNOSTIC	7,821,563	7,055,424	14,876,987	-167,160	14,709,827	-102,544	14,607,283	54
60	06000	LABORATORY	5,712,782	6,114,657	11,827,439	107,100	11,827,439	6,418	11,833,857	
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	401.036	2,560,174	, ,			0,110	11,000,007	00
62.30					2.961.210		2 961 210 1		2 961 210	62
	06250	BLOOD CLOTTING FOR HEMOPHILIACS	101,050	2,300,174	2,961,210		2,961,210		2,961,210	
65	06250	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	,,,,,	, ,	, ,			-9.753	, ,	62 62.30 65
	06250 06500 06600	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY PHYSICAL THERAPY	3,401,362 4,770,111	634,196 4,250,035	4,035,558 9,020,146	-180,572	4,035,558	-9,753 -20,600	2,961,210 4,025,805 8,818,974	62.30 65
65	06500	RESPIRATORY THERAPY	3,401,362	634,196	4,035,558	-180,572 -3,141		-20,600	4,025,805 8,818,974	62.30 65
65 66	06500 06600	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY	3,401,362 4,770,111	634,196 4,250,035	4,035,558 9,020,146		4,035,558 8,839,574		4,025,805	62.30 65 66
65 66 70	06500 06600 07000	RESPIRATORY THERAPY PHYSICAL THERAPY	3,401,362 4,770,111	634,196 4,250,035	4,035,558 9,020,146	-3,141	4,035,558 8,839,574 924,918	-20,600	4,025,805 8,818,974 880,851	62.30 65 66 70
65 66 70 71	06500 06600 07000 07100	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	3,401,362 4,770,111	634,196 4,250,035	4,035,558 9,020,146	-3,141 18,270,583	4,035,558 8,839,574 924,918 18,270,583	-20,600	4,025,805 8,818,974 880,851 18,270,583	62.30 65 66 70 71
65 66 70 71 72	06500 06600 07000 07100 07200	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	3,401,362 4,770,111	634,196 4,250,035	4,035,558 9,020,146	-3,141 18,270,583	4,035,558 8,839,574 924,918 18,270,583	-20,600	4,025,805 8,818,974 880,851 18,270,583	62.30 65 66 70 71 72
65 66 70 71 72 73	06500 06600 07000 07100 07200 07300	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	3,401,362 4,770,111 612,275	634,196 4,250,035 315,784	4,035,558 9,020,146 928,059	-3,141 18,270,583 26,275,904	4,035,558 8,839,574 924,918 18,270,583 26,275,904	-20,600 -44,067	4,025,805 8,818,974 880,851 18,270,583 26,275,904	62.30 65 66 70 71 72 73
65 66 70 71 72 73 76 76.97 76.98	06500 06600 07000 07100 07200 07300 03140	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY	3,401,362 4,770,111 612,275 6,676,458	634,196 4,250,035 315,784 22,072,152	4,035,558 9,020,146 928,059 28,748,610	-3,141 18,270,583 26,275,904 -18,087,255	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355	-20,600 -44,067 -845,889	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466	62.30 65 66 70 71 72 73 76
65 66 70 71 72 73 76 76.97	06500 06600 07000 07100 07200 07300 03140 07697	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION	3,401,362 4,770,111 612,275 6,676,458	634,196 4,250,035 315,784 22,072,152	4,035,558 9,020,146 928,059 28,748,610	-3,141 18,270,583 26,275,904 -18,087,255	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355	-20,600 -44,067 -845,889	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466	62.30 65 66 70 71 72 73 76 76.97
65 66 70 71 72 73 76 76.97 76.98 76.99	06500 06600 07000 07100 07200 07300 03140 07697 07698 07699	RESPIRATORY THERAPY PHYSICAL THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	3,401,362 4,770,111 612,275 6,676,458 432,860	634,196 4,250,035 315,784 22,072,152 15,018	4,035,558 9,020,146 928,059 28,748,610	-3,141 18,270,583 26,275,904 -18,087,255	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369	-20,600 -44,067 -845,889	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99
65 66 70 71 72 73 76 76.97 76.98	06500 06600 07000 07100 07200 07300 03140 07697 07698	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY	3,401,362 4,770,111 612,275 6,676,458	634,196 4,250,035 315,784 22,072,152	4,035,558 9,020,146 928,059 28,748,610	-3,141 18,270,583 26,275,904 -18,087,255	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355	-20,600 -44,067 -845,889	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466	62.30 65 66 70 71 72 73 76 76.97 76.98
65 66 70 71 72 73 76 76.97 76.98 76.99	06500 06600 07000 07100 07200 07300 03140 07697 07698 07699	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY	3,401,362 4,770,111 612,275 6,676,458 432,860	634,196 4,250,035 315,784 22,072,152 15,018	4,035,558 9,020,146 928,059 28,748,610 447,878	-3,141 18,270,583 26,275,904 -18,087,255 -69,509	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369	-20,600 -44,067 -845,889 -55,644	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 90 91
65 66 70 71 72 73 76 76.97 76.98 76.99	06500 06600 07000 07100 07200 07300 03140 07697 07698 07699	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	3,401,362 4,770,111 612,275 6,676,458 432,860	634,196 4,250,035 315,784 22,072,152 15,018	4,035,558 9,020,146 928,059 28,748,610 447,878 2,679,865	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369	-20,600 -44,067 -845,889 -55,644 -149,856	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99
65 66 70 71 72 73 76 76.97 76.98 76.99	06500 06600 07000 07100 07200 03140 07697 07698 07699 09000 09100	RESPIRATORY THERAPY PHYSICAL THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	3,401,362 4,770,111 612,275 6,676,458 432,860	634,196 4,250,035 315,784 22,072,152 15,018	4,035,558 9,020,146 928,059 28,748,610 447,878 2,679,865	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369	-20,600 -44,067 -845,889 -55,644 -149,856	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 90 91
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92	06500 06600 07000 07100 07200 07300 03140 07697 07698 07699 09000 09100 09200	RESPIRATORY THERAPY PHYSICAL THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF	3,401,362 4,770,111 612,275 6,676,458 432,860	634,196 4,250,035 315,784 22,072,152 15,018	4,035,558 9,020,146 928,059 28,748,610 447,878 2,679,865	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369	-20,600 -44,067 -845,889 -55,644 -149,856	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92	06500 06600 07000 07100 07200 07300 03140 07697 07698 07699 09000 09100 09200	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY	3,401,362 4,770,111 612,275 6,676,458 432,860	634,196 4,250,035 315,784 22,072,152 15,018	4,035,558 9,020,146 928,059 28,748,610 447,878 2,679,865	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369	-20,600 -44,067 -845,889 -55,644 -149,856	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725	62.30 65 66 70 71 72 73 76 76.97 76.98 90 91 92
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30	06500 06600 07000 07100 07200 03140 07697 07698 07699 09000 09100 09200 09910 09920 09930	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY	3,401,362 4,770,111 612,275 6,676,458 432,860	634,196 4,250,035 315,784 22,072,152 15,018	4,035,558 9,020,146 928,059 28,748,610 447,878 2,679,865	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369	-20,600 -44,067 -845,889 -55,644 -149,856	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 91 92 99.10 99.20 99.30
65 66 70 71 72 73 76 76.97 76.98 76.99 91 92 99.10 99.20 99.30 99.40	06500 06600 07000 07100 07200 07300 03140 07697 07698 07699 09100 09200 09910 09920 09930 09940	RESPIRATORY THERAPY PHYSICAL THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIACORY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595	634,196 4,250,035 315,784 22,072,152 15,018 709,700 1,516,856	28,748,610 447,878 2,679,865 7,246,451	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662	62.30 65 66 70 71 72 73 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30	06500 06600 07000 07100 07200 03140 07697 07698 07699 09000 09100 09200 09910 09920 09930	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY	3,401,362 4,770,111 612,275 6,676,458 432,860	634,196 4,250,035 315,784 22,072,152 15,018	4,035,558 9,020,146 928,059 28,748,610 447,878 2,679,865	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369	-20,600 -44,067 -845,889 -55,644 -149,856	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 91 92 99.10 99.20 99.30
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40	06500 06600 07000 07100 07200 07300 03140 07697 07698 07699 09100 09200 09910 09920 09930 09940	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595	634,196 4,250,035 315,784 22,072,152 15,018 709,700 1,516,856	28,748,610 447,878 2,679,865 7,246,451 3,454,459	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40
65 66 70 71 72 73 76 76.97 76.98 76.99 91 92 99.10 99.20 99.30 99.40	06500 06600 07000 07100 07200 07300 03140 07697 07698 07699 09100 09200 09910 09920 09930 09940	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117)	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595	634,196 4,250,035 315,784 22,072,152 15,018 709,700 1,516,856	28,748,610 447,878 2,679,865 7,246,451	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40 101	06500 06600 07000 07100 07200 07300 03140 07697 09000 09100 09200 09910 09920 09940 10100	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595	634,196 4,250,035 315,784 22,072,152 15,018 709,700 1,516,856	28,748,610 447,878 2,679,865 7,246,451 3,454,459	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662	62.30 65 66 70 71 72 73 76 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40 101
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92.0 99.10 99.20 99.30 99.40 101	06500 06600 07000 07100 07200 07300 03140 07698 07699 09000 09100 09200 09910 09920 09930 09940 10100	RESPIRATORY THERAPY PHYSICAL THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595 2,184,031 146,325,924	634,196 4,250,035 315,784 22,072,152 15,018 709,700 1,516,856 1,270,428 275,103,419	28,748,610 447,878 2,679,865 7,246,451 3,454,459 421,429,343	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733 -585 -472,256	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718 3,453,874 420,957,087	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662 3,466,270 363,614,683	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92.0 99.30 99.40 101 118
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40 101	06500 06600 07000 07100 07100 07200 03140 07697 07698 07699 09000 09100 09200 09910 09920 10100 19000 19100	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595	634,196 4,250,035 315,784 22,072,152 15,018 709,700 1,516,856	28,748,610 447,878 2,679,865 7,246,451 3,454,459	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40 101 118
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40 101 118 190 191 192	06500 06600 07000 07100 07100 07300 03140 07697 07698 09000 09100 09200 09910 09920 10100 19000 19100 19000 19100	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS' PRIVATE OFFICES	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595 2,184,031 146,325,924	634,196 4,250,035 315,784 22,072,152 15,018 709,700 1,516,856 1,270,428 275,103,419	28,748,610 447,878 2,679,865 7,246,451 3,454,459 421,429,343	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733 -585 -472,256	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718 3,453,874 420,957,087	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662 3,466,270 363,614,683	62.30 65 66 70 71 72 73 76.97 76.98 76.99 91 92 99.10 99.20 99.30 99.40 101
99.10 99.40 1118 190 191 192	06500 06600 07000 07100 07100 07300 03140 07697 09000 09100 09200 09910 09920 10100 19000 19100 19200 19200	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS' PRIVATE OFFICES ADVERTISING	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595 2,184,031 146,325,924 205,325	709,700 1,516,856 110,347	28,748,610 447,878 2,679,865 7,246,451 3,454,459 421,429,343	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733 -585 -472,256 -1,532 1,175,554	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718 3,453,874 420,957,087	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662 363,614,683 314,140	62.30 65 66 70 71 72 73 76 76.98 76.99 91 92 99.10 99.20 99.30 99.40 101 118
90 99.10 99.20 99.40 101 118	06500 06600 07000 07100 07100 07200 07300 03140 07698 07699 09100 09200 09910 09920 09910 10100 19000 19100 19100 19200 19200	RESPIRATORY THERAPY PHYSICAL THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS' PRIVATE OFFICES ADVERTISING FITNESS POINTE	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595 2,184,031 146,325,924 205,325	709,700 1,516,856 1,630,881 1,630,881	28,748,610 447,878 2,679,865 7,246,451 3,454,459 421,429,343 315,672	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733 -585 -472,256 -1,532 1,175,554 -698,924	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718 3,453,874 420,957,087 314,140 1,175,554 2,527,716	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662 3,466,270 363,614,683 314,140 1,175,554 2,527,716	62.30 65 66 70 71 72 73 76 76.97 76.98 90 91 92 99.10 99.20 99.30 99.40 101 118
65 66 70 71 72 73 76 76.97 76.98 76.99 91 92 99.10 99.20 99.30 99.40 101 118 190 191 192 194 194,01 194,02	06500 06600 07000 07100 07100 07200 07300 03140 07697 07698 09000 09100 09200 09910 09920 10100 19100 19200 19200 19750 19751 07951	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS PRIVATE OFFICES ADVERTISING FITNESS POINTE FITNESS POINTE	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595 2,184,031 146,325,924 205,325 1,595,759 301,766	709,700 1,516,856 1,630,881 1,630,881 1,64,162	2,679,865 7,246,451 3,454,459 421,429,343 315,672 3,226,640 465,928	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733 -585 -472,256 -1,532 1,175,554	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718 3,453,874 420,957,087 314,140 1,175,554 2,527,716 463,086	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662 363,614,683 314,140 1,175,554 2,527,716 463,086	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 91 92 99.10 99.20 99.30 99.40 101 118 190 191 192 194 194,01 194,01
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40 101 118 190 191 192 194 194.01 194.03	06500 06600 07000 07100 07100 07200 07300 03140 07697 07698 09000 09100 09200 09910 09920 10100 19100 19200 19200 19200 197952 07951 07952 07953	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT SPECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS' PRIVATE OFFICES ADVERTISING FITNESS POINTE SPA/PRO SHOP/DIETARY RETAIL PHARMACY	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595 2,184,031 146,325,924 205,325	709,700 1,516,856 1,630,881 1,630,881	28,748,610 447,878 2,679,865 7,246,451 3,454,459 421,429,343 315,672	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733 -585 -472,256 -1,532 1,175,554 -698,924	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718 3,453,874 420,957,087 314,140 1,175,554 2,527,716	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662 3,466,270 363,614,683 314,140 1,175,554 2,527,716	62.30 65 66 70 71 72 73 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40 101 118 190 191 194 194.01 194.02 194.03
90 90 99.10 99.20 99.30 99.40 101 118 190 194 194.01 194.02 194.03	06500 06600 07000 07100 07100 07200 07300 03140 07697 09900 09100 09200 09910 09920 10100 19000 19100 19200 19000 19	RESPIRATORY THERAPY PHYSICAL THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS' PRIVATE OFFICES ADVERTISING FITNESS POINTE FITNESS POINTE FITNESS POINTE FITNESS POINTE SPA/PRO SHOP/DIETARY RETAIL PHARMACY HOSPICE	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595 2,184,031 146,325,924 205,325 1,595,759 301,766	709,700 1,516,856 1,630,881 1,630,881 1,64,162	2,679,865 7,246,451 3,454,459 421,429,343 315,672 3,226,640 465,928	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733 -585 -472,256 -1,532 1,175,554 -698,924	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718 3,453,874 420,957,087 314,140 1,175,554 2,527,716 463,086	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662 363,614,683 314,140 1,175,554 2,527,716 463,086	62.30 65 66 70 71 72 73 76.98 76.99 91 92 99.10 99.20 99.30 99.40 101 118 190 191 192 194 194.01 194.02 194.03 194.04
65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92 99.10 99.20 99.30 99.40 101 118 190 191 192 194 194.01 194.03	06500 06600 07000 07100 07100 07200 07300 03140 07697 07698 09000 09100 09200 09910 09920 10100 19000 19100 19200 19200 197952 07951 07952 07953	RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDIOLOGY CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS CORF OUTPATIENT PHYSICAL THERAPY OUTPATIENT SPECH PATHOLOGY HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS' PRIVATE OFFICES ADVERTISING FITNESS POINTE SPA/PRO SHOP/DIETARY RETAIL PHARMACY	3,401,362 4,770,111 612,275 6,676,458 432,860 1,970,165 5,729,595 2,184,031 146,325,924 205,325 1,595,759 301,766	709,700 1,516,856 1,630,881 1,630,881 1,64,162	2,679,865 7,246,451 3,454,459 421,429,343 315,672 3,226,640 465,928	-3,141 18,270,583 26,275,904 -18,087,255 -69,509 -180,666 -58,733 -585 -472,256 -1,532 1,175,554 -698,924	4,035,558 8,839,574 924,918 18,270,583 26,275,904 10,661,355 378,369 2,499,199 7,187,718 3,453,874 420,957,087 314,140 1,175,554 2,527,716 463,086	-20,600 -44,067 -845,889 -55,644 -149,856 -85,056	4,025,805 8,818,974 880,851 18,270,583 26,275,904 9,815,466 322,725 2,349,343 7,102,662 363,614,683 314,140 1,175,554 2,527,716 463,086	62.30 65 66 70 71 72 73 76 76.97 76.98 76.99 90 91 92.00 99.30 99.40 101 118 190 191 194 194.01 194.03 194.03 194.04 194.05



# Сомри-Мах

	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

RECLASSIFICATIONS WORKSHEET A-6

1 2 3 3 4 5 6 7 7 8 8 9 10 500	EXPLANATION OF RECLASSIFICATION(S)  OPERATING RM/CARDIOLOGY SUPPLIES	CODE (1) 1 A	COST CENTER 2	REASES LINE #	SALARY	OTHER	
2 3 4 5 6 7 8 9 10 500		1	2			OTHER	
2 3 4 5 6 7 8 9 10 500	OPERATING RM/CARDIOLOGY SUPPLIES					-	
2 3 4 5 6 7 8 9 10 500	OLEKTINO ROBERT GETTELES	1	MEDICAL SUPPLIES CHARGED TO P	71	4	5 17,471,785	1
4 5 6 7 8 9 10 500			IMPL. DEV. CHARGED TO PATIENT	72		26,275,904	2
5 6 7 8 9 10 500			MEDICAL SUPPLIES CHARGED TO P	71		798,798	3
6 7 8 9 10 500							4
7 8 9 10 500							5
8 9 10 500							7
10 500 1 2							8
500 1 2							9
1 2	TOTAL PROPERTY AND VOLUME					11.516.105	10
2	TOTAL RECLASSIFICATIONS  CODE LETTER - A					44,546,487	500
2	CODE LETTER - A						
	NURSING FLOAT SALARIES	В	INTENSIVE CARE UNIT	31	68,333		1
			NURSERY	43	11,765		2
3			NEONATAL INTENSIVE CARE	32.01	22,844		3
5			DELIVERY ROOM & LABOR ROOM EMERGENCY	52 91	16,970 64,532		5
6			SUBPROVIDER - IRF	41	42,562		6
500	TOTAL RECLASSIFICATIONS		SOBI ROVIDER - IRI	41	227,006		500
	CODE LETTER - B						
	STOREROOM SALARY RECLASS	С	CENTRAL SERVICES & SUPPLY	14	34,771		1
500	TOTAL RECLASSIFICATIONS				34,771		500
	CODE LETTER - C						
1	CAFETERIA EXPENSE	D	CAFETERIA	11	1,150,596	1,338,463	1
500	TOTAL RECLASSIFICATIONS		CHETERIA		1,150,596	1,338,463	500
	CODE LETTER - D						
	INTEREST EXPENSE	Е	CAP REL COSTS-MVBLE EQUIP	2		18,992	1
500	TOTAL RECLASSIFICATIONS  CODE LETTER - E					18,992	500
$\overline{}$	CODE LETTER - E						
1	BUILDING INSURANCE	F	CAP REL COSTS-BLDG & FIXT	1		291,750	1
2			CAP REL COSTS-MVBLE EQUIP	2		7,780	2
500	TOTAL RECLASSIFICATIONS					299,530	500
	CODE LETTER - F						
1	UTILITY RECLASS	G	OPERATION OF PLANT	7		869,057	1
2	UTILIT I RECLASS	- 0	HOME HEALTH AGENCY	101		6,385	2
3			RADIOLOGY-DIAGNOSTIC	54		15,647	3
4							4
5							5
6							6
7 8							7 8
	TOTAL RECLASSIFICATIONS					891,089	500
	CODE LETTER - G					0,1,00	
	ADVERTISING NON-REIMBURSABLE	Н	ADVERTISING	194		1,175,554	1
2 3							2
4							3
5							5
6							6
7							7
8							8
9							9
10 11							10 11
12							12
13							13
14							14
15							15
16	TOTAL DECLA COFICA TIONS					1 175 554	16
500	TOTAL RECLASSIFICATIONS  CODE LETTER - H					1,175,554	500
$\rightarrow$	CODE LETTER - II						
1	DEPRECIATION AND BENEFIT RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		10,450,691	1
2			CAP REL COSTS-MVBLE EQUIP	2		9,405,224	2
3			EMPLOYEE BENEFITS DEPARTMENT	4		44,021,613	3
4							4
5							5
500	TOTAL RECLASSIFICATIONS					63,877,528	500



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

RECLASSIFICATIONS WORKSHEET A-6

		INCREASES				
EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE#	SALARY	OTHER	
	1	2	3	4	5	
CODE LETTER - I						
GRAND TOTAL (INCREASES)				1,412,373	112,147,643	

<sup>(1)</sup> 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.



COMPU-MAX
In Lieu of Form Run Date: 01/05/2015 Period: From: 07/01/2013 To: 06/30/2014 COMMUNITY HOSPITAL CMS-2552-10 Run Time: 13:42 Version: 2014.10 Provider CCN: 15-0125

RECLASSIFICATIONS WORKSHEET A-6

		_	DECRE	ACEC				
		CODE	DECRE	LASES			WKST	
	EXPLANATION OF RECLASSIFICATION(S)	(1)	COST CENTER	LINE #	SALARY	OTHER	A-7 REF.	
		1	6	7	8	9	10	
1	OPERATING RM/CARDIOLOGY SUPPLIES	A	OPERATING ROOM	50	-	25,483,991		1
2			CARDIOLOGY	76		18,084,725		2
3			RADIOLOGY-DIAGNOSTIC ADULTS & PEDIATRICS	54 30		178,973 358,421		3 4
5			INTENSIVE CARE UNIT	31		185,985		5
6			NEONATAL INTENSIVE CARE	32.01		15,786		6
7			SUBPROVIDER - IRF	41		49,333		7
8			NURSERY DELIVERY ROOM & LABOR ROOM	52		1,476 64,532		8
10			EMERGENCY	91		123,265		10
500	TOTAL RECLASSIFICATIONS					44,546,487		500
	CODE LETTER - A							
1	NURSING FLOAT SALARIES	В	ADULTS & PEDIATRICS	30	227,006			1
2	NORSING FEOAT SALARIES	В .	ADULTS & LEDIATRICS	30	227,000			2
3								3
4								4
5								5
500	TOTAL RECLASSIFICATIONS				227,006			500
	CODE LETTER - B							
	CTOPEROOM SALARY RECLASS		ADMINISTRATIVE & CENTERAL		24.771			
500	STOREROOM SALARY RECLASS TOTAL RECLASSIFICATIONS	С	ADMINISTRATIVE & GENERAL	5	34,771 34,771			500
500	CODE LETTER - C				31,771			300
500	CAFETERIA EXPENSE TOTAL RECLASSIFICATIONS	D	DIETARY	10	1,150,596 1,150,596	1,338,463 1,338,463		500
300	CODE LETTER - D				1,130,390	1,338,403		300
	CODE LETTER D							
1	INTEREST EXPENSE	Е	ADMINISTRATIVE & GENERAL	5		18,992	11	1
500	TOTAL RECLASSIFICATIONS					18,992		500
	CODE LETTER - E							
1	BUILDING INSURANCE	F	ADMINISTRATIVE & GENERAL	5		299,530	12	1
2							12	2
500	TOTAL RECLASSIFICATIONS  CODE LETTER - F					299,530		500
	CODE LETTER - F							
1	UTILITY RECLASS	G						1
2			ADMINISTRATIVE & GENERAL	5		487,680		2
3			FITNESS POINTE CLINIC	194.01 90		222,812 11,201		3 4
5			RESEARCH	191		1,532		5
6			HOUSEKEEPING	9		72,725		6
7			CARDIAC REHABILITATION	76.97		22,813		7
500	TOTAL RECLASSIFICATIONS		PHYSICAL THERAPY	66		72,326 891,089		500
300	CODE LETTER - G					891,089		300
1	ADVERTISING NON-REIMBURSABLE	Н	CLINIC	90		169,465		1
3		+	HOME HEALTH AGENCY NURSING ADMINISTRATION	101		6,970 6,393		3
4		+	ADMINISTRATION ADMINISTRATIVE & GENERAL	5		953,708		4
5			ADULTS & PEDIATRICS	30		1,495		5
6			INTENSIVE CARE UNIT	31		1,556		6
7 8		+	PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY	66 70		10,065 3,141		7 8
9			RADIOLOGY-DIAGNOSTIC	54		3,834		9
10			DIETARY	10		2,325		10
11			NURSERY DELIVERY BOOM & LABOR BOOM	43		6,353		11
12		+	DELIVERY ROOM & LABOR ROOM NEONATAL INTENSIVE CARE	52 32.01		1,250 1,250		12
14		1	OPERATING ROOM	50		2,830		14
15			EMPLOYEE BENEFITS DEPARTMENT	4		2,389		15
16	TOTAL DECLASSISICATIONS		CARDIOLOGY	76		2,530		16
500	TOTAL RECLASSIFICATIONS  CODE LETTER - H					1,175,554		500
	COSS EDITER II	+						
1	DEPRECIATION AND BENEFIT RECLASS	I	EMPLOYEE BENEFITS DEPARTMENT	4		177,872	9	1
2			ADMINISTRATIVE & GENERAL	5		63,075,825	9	2
3 4		+	PHYSICAL THERAPY CARDIAC REHABILITATION	66 76.97		98,181 46,696		3
5		1	FITNESS POINTE	194.01		476,112		5
6		1	FITNESS POINTE SPA/PRO SHOP/D	194.02		2,842		6



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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	
500	TOTAL RECLASSIFICATIONS					63,877,528		500
	CODE LETTER - I							
	GRAND TOTAL (DECREASES)				1,412,373	112,147,643		

<sup>(1)</sup> 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

1 /11	- ANALISIS OF CHANGES IN CALITIAL ASSETS BALANCES										
			ACQUISITIONS								
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS			
		1	2	3	4	5	6	7			
1	LAND	3,056,583	346,972		346,972		3,403,555		1		
2	LAND IMPROVEMENTS	6,747,854					6,747,854		2		
3	BUILDINGS AND FIXTURES	271,211,732	1,606,629		1,606,629	3,025	272,815,336		3		
4	BUILDING IMPROVEMENTS	57,692,299	3,569,722		3,569,722		61,262,021		4		
5	FIXED EQUIPMENT	2,379,122	1,196,877		1,196,877		3,575,999		5		
6	MOVABLE EQUIPMENT	124,855,163	10,538,628		10,538,628	5,140,151	130,253,640		6		
7	HIT DESIGNATED ASSETS								7		
8	SUBTOTAL (sum of lines 1-7)	465,942,753	17,258,828		17,258,828	5,143,176	478,058,405		8		
9	RECONCILING ITEMS								9		
10	TOTAL (line 7 minus line 9)	465,942,753	17,258,828		17,258,828	5,143,176	478,058,405		10		

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

				SUN	MMARY OF CAPI	ΓAL			
	DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)	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

<sup>(1)</sup> 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.

#### PART III - RECONCILIATION OF CAPITAL COST CENTERS

1 / 111	ART III - RECONCILIATION OF CALITAE COST CENTERS											
			COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL					
	DESCRIPTION	GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of (cols. 5 through 7)			
*		9	10	11	12	13	14	15	16			
1	CAP REL COSTS-BLDG & FI	347,804,765		347,804,765	0.727536					1		
2	CAP REL COSTS-MVBLE EQU	130,253,640		130,253,640	0.272464					2		
3	TOTAL (sum of lines 1-2)	478,058,405		478,058,405	1.000000					3		

			SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	10,779,114			291,750			11,070,864	1	
2	CAP REL COSTS-MVBLE EQUIP	14,850,141			7,780	-		14,857,921	2	
3	TOTAL (sum of lines 1-2)	25,629,255			299,530			25,928,785	3	

<sup>(2)</sup> 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.)

<sup>\*</sup> All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.



ADJUSTMENTS TO EXPENSES WORKSHEET A-8

		1 1		EVBENCE CLASSIFICATION ON		1	
				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)	В	-18,992	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (chapter 2) TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	В	-803	ADMINISTRATIVE & GENERAL	5		3
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)	ь	-803	ADMINISTRATIVE & GENERAL	1 3		5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
9	TELEVISION AND RADIO SERVICE (chapter 21) PARKING LOT (chapter 21)						8
		WKST					
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	A-8-2	-13,559,607				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST	-13,115,568				12
13	LAUNDRY AND LINEN SERVICE	A-8-1					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						16
17	PATIENTS SALE OF DRUGS TO OTHER THAN PATIENTS	В	105	PHARMACY	15		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	В		MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)		110	MEDICIE RECORD & EISTERCI	1.0		19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR						21
	PENALTY CHARGES (chapter 21) INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS				-		-
22	TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF	WKST		RESPIRATORY THERAPY	65		23
23	LIMITATION (chapter 14)	A-8-3		RESPIRATORT THERAPT	0.5		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST		PHYSICAL THERAPY	66		24
25	(chapter 14) UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)	A-8-3		UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATIONBUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATIONMOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF	WKST					29
30	LIMITATION (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION	WKST		SPEECH PATHOLOGY	68		31
	(chapter 14)	A-8-3		SI EEEI I IIII OEOO I	100		
32	CAH HIT ADJ FOR DEPRECIATION AND						32
34							34
35	A&G OTHER INCOME	В		ADMINISTRATIVE & GENERAL	5		35
36	OFFSET CARDIOLOGY DISCOUNTS	В		CARDIOLOGY	76		36
37	OFFSET MAMMO FEES PHYSICIAN RENTAL/X RAY SALES-RA	A B		RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGNOSTIC	54 54		37
39	OFFSET PT OTHER INCOME	В	, , ,	PHYSICAL THERAPY	66		39
40	PHYSICIAN RENTAL-LAB	В	-932	LABORATORY	60		40
41	REMOVE MEDICAID ASSESSMENT FEES	A		ADMINISTRATIVE & GENERAL	5		41
42	VARIOUS EH&W OFFSETS OFFSET HEART SCAN COSTS	B A	-14,123 -2,611	EMPLOYEE BENEFITS DEPARTMENT RADIOLOGY-DIAGNOSTIC	54		42
43.02	OFFSET RESEARCH COSTS HEART CTR	A	-2,611		76		43.02
44	OFFSET BIORTERRORISM GRANT	В	-2,732	t	5		44
45	MEDICAL RESTRICTED COSTS	A	-4,484	ADMINISTRATIVE & GENERAL	5		45
45.01	EMPLOYEE CAFETERIA REVENUE	В	-2,074,567	CAFETERIA	11		45.01
45.03 45.04	GUEST TRAYS/CANDLELIGHT DINNERS TELEPHONE SERVICE	B A	-347 -146,863	DIETARY ADMINISTRATIVE & GENERAL	10		45.03 45.04
45.06	TELEPHONE SERVICE TELEPHONE SERVICE	A	-16,107	CAP REL COSTS-MVBLE EQUIP	2	9	45.04
45.08	TELEVISION SERVICE	A	-9,611	OPERATION OF PLANT	7		45.08
45.09	TELEVISION SERVICE	A	-49,828	` `	2	9	45.09
45.10 45.18	PENSION CONTRIBTN EXCESS OF EXP RENTAL INCOME	A B	129,951 -295,578		5		45.10 45.18
45.18	CAPITALIZED INTEREST	A	1,589		1	9	45.18
45.21	PARETN ASSET DEP AJE	A		CAP REL COSTS-BLDG & FIXT	1	9	45.21
45.28	1996 ASSET LIFE ADJUSTMENT	A	6,312		1	9	45.28
45.29 45.30	OFFSET RELEASED TEMP REST OP IN	B B		ADMINISTRATIVE & GENERAL	5 76		45.29 45.30
45.31	OFFSET RELEASED TEMP REST OP IN OFFSET RELEASED TEMP REST OP IN	В	-3,595 -462	CARDIOLOGY ADMINISTRATIVE & GENERAL	5		45.30
45.32	OFFSET RELEASED TEMP REST OP IN	В	-4,200		5		45.32
45.33	NON-PT CARE RELATED EXPENSES	A	-10,500		5		45.33
45.37	OTHER DIETARY INCOME	В	-3,700	DIETARY	10		45.37



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ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	r			r			
				EXPENSE CLASSIFICATION ON			
				WORKSHEET A TO/FROM WHICH			
				THE AMOUNT IS TO BE ADJUSTED			
		BASIS/				WKST	
	DESCRIPTION(1)	CODE	AMOUNT	COST CENTER	LINE#	A-7	
		(2)				REF.	
		1	2	3	4	5	
45.40	OFFSET PHYSICIAN RENTAL	В	-810	CLINIC	90		45.40
46	OFFSET EINSTEIN BAGEL FRANCHISE	A	-12,500	ADMINISTRATIVE & GENERAL	5		46
47	OFFSET CARDIAC REHAB CLASS INCO	В	-55,644	CARDIAC REHABILITATION	76.97		47
47.02	MEDINA FEES	A	-1,190	RADIOLOGY-DIAGNOSTIC	54		47.02
47.03	CLEANING SERVICES-PHYSICIANS	A	-57,533	ADMINISTRATIVE & GENERAL	5		47.03
47.04	OFFSET PHYSICIAN ASSISTANT COST	A	-26,910	ADMINISTRATIVE & GENERAL	5		47.04
48							48
49							49
50	TOTAL (sum of lines 1 thru 49)		-57,342,404				50
30	(Transfer to worksheet A, column 6, line 200)		-37,342,404				30

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1 (2) Basis for adjustment (see instructions)

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

A. Costs - if cost, including applicable overhead, can be determined B. Amount Received - if cost cannot be determined

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



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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.

			ſ	Г				
	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST- MENTS (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	323,194		323,194	9	1
2	2	CAP REL COSTS-MVBLE EQUIP		5,510,852		5,510,852	9	2
3	5	ADMINISTRATIVE & GENERAL		36,015,235	45,714,665	-9,699,430		3
3.02	5	ADMINISTRATIVE & GENERAL	CCN		9,251,497	-9,251,497		3.02
3.04	5	ADMINISTRATIVE & GENERAL	CDC LEASE		75,026	-75,026		3.04
3.05	7	OPERATION OF PLANT	CDC LEASE		25,344	-25,344		3.05
3.06	54	RADIOLOGY-DIAGNOSTIC	CDC LEASE		126,552	-126,552		3.06
3.07	60	LABORATORY	CDC LEASE		11,800	-11,800		3.07
3.08	90	CLINIC	CDC LEASE		12,851	-12,851		3.08
3.09	76	CARDIOLOGY	CDC LEASE		10,146	-10,146		3.09
3.10	5	ADMINISTRATIVE & GENERAL	CDC LEASE DEPR	47,894		47,894		3.10
3.11	7	OPERATION OF PLANT	CDC LEASE DEPR	14,985		14,985		3.11
3.12	54	RADIOLOGY-DIAGNOSTIC	CDC LEASE DEPR	72,845		72,845		3.12
3.13	76	CARDIOLOGY	CDC LEASE DEPR	2,216		2,216		3.13
3.14	90	CLINIC	CDC LEASE DEPR	11,581		11,581		3.14
3.15	60	LABORATORY	CDC LEASE DEPR	6,953		6,953		3.15
3.16	5	ADMINISTRATIVE & GENERAL	CDC LEASE A&G	197		197		3.16
3.17	7	OPERATION OF PLANT	CDC LEASE A&G	62		62		3.17
3.18	54	RADIOLOGY-DIAGNOSTIC	CDC LEASE A&G	300		300		3.18
3.19	60	LABORATORY	CDC LEASE A&G	29		29		3.19
3.20	76	CARDIOLOGY	CDC LEASE A&G	9		9		3.20
3.21	90	CLINIC	CDC LEASE A&G	48		48		3.21
3.23	5	ADMINISTRATIVE & GENERAL	LEASE EXPENSE		46,309	-46,309		3.23
3.24	5	ADMINISTRATIVE & GENERAL	800 MACARTHUR DEPR	80,669	.,	80,669		3.24
3.25	5	ADMINISTRATIVE & GENERAL	800 MACARTHUR A&G	35,338		35,338		3.25
	101	HOME HEALTH AGENCY	800 MACARTHUR DEPR	8,620		8,620		3.26
	101	HOME HEALTH AGENCY	800 MACARTHUR A&G	3,776		3,776		3.27
	60	LABORATORY	800 MACARTHUR DEPR	16,563		16,563		3.28
	60 LABORATORY 800 MACARTHUR A&G		7,256		7,256		3.29	
4				1				4
5	TOTAL	S (SUM OF LINES 1-4) TRANSFER COLUMN 6, LIN	E 5 TO WORKSHEET A-8, COLUMN 2, LINE 12	42,158,622	55,274,190	-13,115,568		5

<sup>\*</sup> 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.

				RELATED ORGAN	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			
6	В		100.00	CFNI		PARENT	6		
7							7		
8							8		
9							9		
10							10		

- (1) Use the following symbols to indicate the interrelationship to related organizations:
  - A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
  - B. Corporation, partnership, or other organization has financial interest in provider.
  - C. Provider has financial interest in corporation, partnership, or other organization.
  - D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
  - E. Individual is director, officer, administrator, or key person of provider and related organization.
  - F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.



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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 ORGAN	IZATION(S) AND	OR HOME OFFICE	
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	

G. Other (financial Or non-financial) specify:



## PROVIDER-BASED PHYSICIANS ADJUSTMENTS

## WORKSHEET A-8-2

	WKST A LINE#	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	4	EMPLOYEE BENEFITS DE AGGREGATE	326	326						1
2	5	ADMINISTRATIVE & GEN AGGREGATE	195,899	80,600	115,299	171,400	1,198	98,720	4,936	2
3	17	SOCIAL SERVICE AGGREGATE	268	268						3
4	30	ADULTS & PEDIATRICS AGGREGATE	85,000	5,100	79,900	171,400	350	28,841	1,442	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE	50,000	30,000	20,000	171,400	100	8,240	412	5
6	50	OPERATING ROOM AGGREGATE	100	100						6
7	54	RADIOLOGY-DIAGNOSTIC AGGREGATE	50,000		50,000	171,400	273	22,496	1,125	7
8	60	LABORATORY AGGREGATE	25,000		25,000	171,400	162	13,349	667	8
9	65	RESPIRATORY THERAPY AGGREGATE	29,200	8,971	20,229	171,400	236	19,447	972	9
10	70	ELECTROENCEPHALOGRAP AGGREGATE	50,000	37,400	12,600	171,400	72	5,933	297	10
11	76	CARDIOLOGY AGGREGATE	751,130	582,930	168,200	171,400	782	64,440	3,222	11
12	90	CLINIC AGGREGATE	158,784	145,484	13,300	171,400	133	10,960	548	12
13	91	EMERGENCY AGGREGATE	141,667	42,052	99,615	171,400	687	56,611	2,831	13
14	50	OPERATING ROOM CRNA ANESTHESIO	12,351,270	10,051,673						14
15										15
16										16
17										17
18										18
19										19
20				-		-		-		20
200		TOTAL	13,888,644	10,984,904	604,143		3,993	329,037	16,452	200



## PROVIDER-BASED PHYSICIANS ADJUSTMENTS

## WORKSHEET A-8-2

		r								
	WKST A LINE#	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	4	EMPLOYEE BENEFITS DE AGGREGATE							326	1
2	5	ADMINISTRATIVE & GEN AGGREGATE					98,720	16,579	97,179	2
3	17	SOCIAL SERVICE AGGREGATE							268	3
4	30	ADULTS & PEDIATRICS AGGREGATE					28,841	51,059	56,159	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE					8,240	11,760	41,760	5
6	50	OPERATING ROOM AGGREGATE							100	6
7	54	RADIOLOGY-DIAGNOSTIC AGGREGATE					22,496	27,504	27,504	7
8	60	LABORATORY AGGREGATE					13,349	11,651	11,651	8
9	65	RESPIRATORY THERAPY AGGREGATE					19,447	782	9,753	9
10	70	ELECTROENCEPHALOGRAP AGGREGATE					5,933	6,667	44,067	10
11	76	CARDIOLOGY AGGREGATE					64,440	103,760	686,690	11
12	90	CLINIC AGGREGATE					10,960	2,340	147,824	12
13	91	EMERGENCY AGGREGATE					56,611	43,004	85,056	13
14	50	OPERATING ROOM CRNA ANESTHESIO	2,299,597						12,351,270	14
15										15
16										16
17				-						17
18										18
19										19
20										20
200		TOTAL	2,299,597				329,037	275,106	13,559,607	200



## COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
	CENEDAL CEDALCE COOT CENTEDO	0	1	2	4	4A	5	
1	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	11,070,864	11.070.864					1
2	CAP REL COSTS-BLDG & FIXT	14,857,921	11,070,804	14,857,921				2
4	EMPLOYEE BENEFITS DEPARTMENT	45,239,481	36,188	13,654	45,289,323			4
5	ADMINISTRATIVE & GENERAL	57,773,099	2,777,927	527,152	4,142,784	65,220,962	65,220,962	5
6	MAINTENANCE & REPAIRS	, ,	<i>y y</i> .	,	, ,,,,	, .,.	,	6
7	OPERATION OF PLANT	13,297,522	1,349,399	794,065	1,456,417	16,897,403	3,586,592	7
8	LAUNDRY & LINEN SERVICE	1,267,854	14,103		32,614	1,314,571	279,027	8
9	HOUSEKEEPING	4,162,736	42,277	110,356	994,520	5,309,889	1,127,061	9
10	DIETARY	3,927,288	120,013	80,333	738,519	4,866,153	1,032,875	10
11	CAFETERIA	414,492	126,230	83,311	352,257	976,290	207,224	11
12	MAINTENANCE OF PERSONNEL	1.700.654	17.602	466,000	510 175	2 775 420	500 104	12
13 14	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	1,780,654 52,441	17,602	466,999	510,175	2,775,430	589,104 13,390	13 14
15	PHARMACY	15,829,006	48,399	374,951	10,645 1,200,012	63,086 17,452,368	3,704,387	15
16	MEDICAL RECORDS & LIBRARY	258,126	76,161	3/4,931	37,606	371,893	78,937	16
17	SOCIAL SERVICE	701,344	20,541	1,800	211,016	934,701	198,397	17
19	NONPHYSICIAN ANESTHETISTS	701,514	20,5 11	1,000	211,010	751,701	170,371	19
20	NURSING SCHOOL	1						20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	36,611,226	1,713,583	762,429	9,909,081	48,996,319	10,399,840	30
31	INTENSIVE CARE UNIT	8,652,070	231,833	664,133	2,391,505	11,939,541	2,534,251	31
32.01	NEONATAL INTENSIVE CARE	3,068,056	63,041	209,868	863,966	4,204,931	892,526	32.01
41	SUBPROVIDER - IRF	5,390,777	270,833	39,201	1,127,463	6,828,274	1,449,349	41
43	NURSERY	1,515,019	24,178	7,012	389,021	1,935,230	410,766	43
50	ANCILLARY SERVICE COST CENTERS OPERATING ROOM	24,831,059	704,729	3,094,653	7,384,545	36,014,986	7,644,433	50
52	DELIVERY ROOM & LABOR ROOM	2,182,715	132,160	147,805	587,713	3,050,393	647,467	52
54	RADIOLOGY-DIAGNOSTIC	14,607,283	471,627	3,922,276	2,394,587	21,395,773	4,541,403	54
60	LABORATORY	11,833,857	222,900	642,578	1,748,980	14,448,315	3,066,756	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,961,210	15,985	43,068	122,778	3,143,041	667,132	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,025,805	38,133	246,603	1,041,334	5,351,875	1,135,973	65
66	PHYSICAL THERAPY	8,818,974	382,865	140,221	1,460,379	10,802,439	2,292,893	66
70	ELECTROENCEPHALOGRAPHY	880,851	25,056	148,497	187,449	1,241,853	263,592	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,270,583				18,270,583	3,878,059	71
72	IMPL. DEV. CHARGED TO PATIENTS	26,275,904				26,275,904	5,577,245	72 73
73 76	DRUGS CHARGED TO PATIENTS CARDIOLOGY	9,815,466	397,370	1,404,054	2,044,011	13,660,901	2,899,622	76
76.97	CARDIAC REHABILITATION	322,725	25,214	32,820	132,521	513,280	108,947	76.97
76.98	HYPERBARIC OXYGEN THERAPY	322,723	23,214	32,620	132,321	313,200	100,747	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,349,343	79,227	16,382	603,170	3,048,122	646,985	90
91	EMERGENCY	7,102,662	277,314	679,813	1,773,884	9,833,673	2,087,266	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
00.12	OTHER REIMBURSABLE COST CENTERS							00.15
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY	+ +						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY	3,466,270	37,795	689	668,645	4,173,399	885,833	99.40 101
101	SPECIAL PURPOSE COST CENTERS	3,400,270	37,793	089	008,043	4,173,399	883,833	101
118	SUBTOTALS (sum of lines 1-117)	363,614,683	9,742,683	14,654,723	44,517,597	361,311,578	62,847,332	118
110	NONREIMBURSABLE COST CENTERS	303,011,003	7,7 12,003	11,051,725	11,511,591	301,311,370	02,017,332	110
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		23,893			23,893	5,071	190
191	RESEARCH	314,140		518	62,861	377,519	80,131	
192	PHYSICIANS' PRIVATE OFFICES		692,645	15,221		707,866	150,250	192
194	ADVERTISING	1,175,554				1,175,554	249,520	194
194.01	FITNESS POINTE	2,527,716	503,988	143,131	488,545	3,663,380	777,578	
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	463,086	17,402	6,048	92,386	578,922	122,880	194.02
194.03	RETAIL PHARMACY	4,399,209	15,583	38,280	127,934	4,581,006	972,351	194.03
1 104 04	HOSPICE	1	74,670			74,670	15,849	194.04
194.04					i l			194.05
194.05	RUSH RESIDENTS  CROSS FOOT A DILISTMENTS							
	RUSH RESIDENTS CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER							200



## COST ALLOCATION - GENERAL SERVICE COSTS

1	GENERAL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT  CAP REL COSTS-BLDG & FIXT  CAP REL COSTS-BLDG & FIXT  EMPLOYEE BENEFITS DEPARTMENT  ADMINISTRATIVE & GENERAL  MAINTENANCE & REPAIRS  OPERATION OF PLANT  LAUNDRY & LINEN SERVICE  HOUSEKEEPING  DIETARY  CAFETERIA  MAINTENANCE OF PERSONNEL  NURSING ADMINISTRATION  CENTRAL SERVICES & SUPPLY  PHARMACY  MEDICAL RECORDS & LIBRARY  SOCIAL SERVICE  NONPHYSICIAN ANESTHETISTS  NURSING SCHOOL  I&R SERVICES-OTHER PRGM COSTS APPRVD  I&R SERVICES-OTHER PRGM COSTS APPRVD  PARAMED ED PRGM-(SPECIFY)  INPATIENT ROUTINE SERV COST CENTERS  ADULTS & PEDIATRICS  INTENSIVE CARE UNIT  NEONATAL INTENSIVE CARE  SUBPROVIDER - IRF  NURSERY  ANCILLARY SERVICE COST CENTERS	7 20,483,995 41,823 125,375 355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950 803,166	504 504 600,932 93,531 10,799	9 6,562,325 8,850 30,657 1,825 17,153 68,247 15,328	6,264,286	1,588,509 16,277 985 45,579 1,827 10,848	3,434,836	1 2 4 5 6 7 8 9 10 11 12 13 14 15 16 17 19 20 21 22 23
1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	20,483,995 41,823 125,375 355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	1,635,421 504 600,932 93,531	6,562,325 8,850 30,657 1,825 17,153 68,247 15,328	6,264,286	1,588,509 16,277 985 45,579 1,827 10,848	3,434,836	2 4 5 6 7 8 9 10 11 12 13 14 15 16 17 19 20 21 22 23
1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	141,823 125,375 355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	504 600,932 93,531	8,850 30,657 1,825 17,153 68,247 15,328	4,950,073	16,277 985 45,579 1,827 10,848	1,596,788	2 4 5 6 7 8 9 10 11 12 13 14 15 16 17 19 20 21 22 23
4	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	141,823 125,375 355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	504 600,932 93,531	8,850 30,657 1,825 17,153 68,247 15,328	4,950,073	16,277 985 45,579 1,827 10,848	1,596,788	4 5 6 7 8 9 10 11 12 13 14 15 16 17 19 20 21 22 23
5 6 17 7 18 19 11 11 11 11 11 11 11 11 11 11 11 11	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS  OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM (SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	141,823 125,375 355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	504 600,932 93,531	8,850 30,657 1,825 17,153 68,247 15,328	4,950,073	16,277 985 45,579 1,827 10,848	1,596,788	5 6 7 8 9 10 11 12 13 14 15 16 17 19 20 21 22 23
6   1   7   6   8   1   7   6   8   1   9   1   1   1   1   1   1   1   1	MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	141,823 125,375 355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	504 600,932 93,531	8,850 30,657 1,825 17,153 68,247 15,328	4,950,073	16,277 985 45,579 1,827 10,848	1,596,788	6 7 8 9 10 11 12 13 14 15 16 17 19 20 21 22 23
7 8 1 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	141,823 125,375 355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	504 600,932 93,531	8,850 30,657 1,825 17,153 68,247 15,328	4,950,073	16,277 985 45,579 1,827 10,848	1,596,788	7 8 9 10 11 12 13 14 15 16 17 19 20 21 22 23
8 11 9 11 11 11 11 11 11 11 11 11 11 11 1	LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	141,823 125,375 355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	504 600,932 93,531	8,850 30,657 1,825 17,153 68,247 15,328	4,950,073	16,277 985 45,579 1,827 10,848	1,596,788	8 9 10 11 12 13 14 15 16 17 19 20 21 22 23
9 110 1111 (112 113 114 115 115 116 117 117 119 117 119 1122 1111 1122 1111 1122 1111 1133 114 114 114 114 114 114 114 1	HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	125,375 355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	504 600,932 93,531	8,850 30,657 1,825 17,153 68,247 15,328	4,950,073	16,277 985 45,579 1,827 10,848	1,596,788	9 10 11 12 13 14 15 16 17 19 20 21 22 23
10	DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	355,904 374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	600,932 93,531	8,850 30,657 1,825 17,153 68,247 15,328	4,950,073	16,277 985 45,579 1,827 10,848	1,596,788	10 11 12 13 14 15 16 17 19 20 21 22 23
111	CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	374,338 52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	600,932 93,531	30,657 1,825 17,153 68,247 15,328 1,947,229	4,950,073	16,277 985 45,579 1,827 10,848	1,596,788	11 12 13 14 15 16 17 19 20 21 22 23
12	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	52,200 143,528 225,857 60,916 5,081,690 687,510 186,950	93,531	1,825 17,153 68,247 15,328 1,947,229		16,277 985 45,579 1,827 10,848	1,596,788	12 13 14 15 16 17 19 20 21 22 23
13	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	143,528 225,857 60,916 5,081,690 687,510 186,950	93,531	17,153 68,247 15,328		985 45,579 1,827 10,848	1,596,788	13 14 15 16 17 19 20 21 22 23
14	PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	143,528 225,857 60,916 5,081,690 687,510 186,950	93,531	17,153 68,247 15,328		985 45,579 1,827 10,848	1,596,788	14 15 16 17 19 20 21 22 23
16 1 17 5 19 19 19 19 19 19 19 19 19 19 19 19 19	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	225,857 60,916 5,081,690 687,510 186,950	93,531	68,247 15,328 1,947,229		1,827 10,848 517,342		16 17 19 20 21 22 23
17 S 19 1 1 20 1 1 22 1 1 22 1 23 1 1 30 1 1 32.01 1 341 S 43 1 44	SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	5,081,690 687,510 186,950	93,531	1,947,229		10,848 517,342		17 19 20 21 22 23
19 1 20 1 21 1 22 1 23 1 30 4 31 1 32.01 1 41 5 43 1	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	5,081,690 687,510 186,950	93,531	1,947,229		517,342		19 20 21 22 23 30
20 1 21 1 22 1 23 1 30 4 31 1 32.01 1 41 5 43 1	NURSING SCHOOL  I&R SERVICES-SALARY & FRINGES APPRVD  I&R SERVICES-OTHER PRGM COSTS APPRVD  PARAMED ED PRGM-(SPECIFY)  INPATIENT ROUTINE SERV COST CENTERS  ADULTS & PEDIATRICS  INTENSIVE CARE UNIT  NEONATAL INTENSIVE CARE  SUBPROVIDER - IRF  NURSERY	687,510 186,950	93,531	, , , ,				20 21 22 23 30
21 1 22 1 23 1 30 4 31 1 32.01 1 41 5 43 1	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	687,510 186,950	93,531	, , , ,				21 22 23 30
22 1 23 1 30 4 31 1 32.01 1 41 5 43 1	I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	687,510 186,950	93,531	, , , ,				22 23 30
23 II 30 A 31 II 32.01 II 41 S 43 II	PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	687,510 186,950	93,531	, , , ,				30
30 A 31 I 32.01 I 41 S 43 I	INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	687,510 186,950	93,531	, , , ,				30
30 A 31 I 32.01 I 41 S 43 I	ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	687,510 186,950	93,531	, , , ,				
31 I 32.01 I 41 S 43 I	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	687,510 186,950	93,531	, , , ,				
32.01 I 41 S 43 I	NEONATAL INTENSIVE CARE SUBPROVIDER - IRF NURSERY	186,950			401,217		320,705	31
41 S 43 I	SUBPROVIDER - IRF NURSERY			86,322	401,217	103,905 34,731	107.197	32.01
43 1 A	NURSERY	005,100	95,190	316,684	823,480	64,714	199,739	41
Α		71,701	8,495	78,229	023,400	17,889	55,216	43
		71,701	0,170	70,227		17,005	20,210	
50   0	OPERATING ROOM	2,089,900	251,407	1,382,181		232,016	716,119	50
52 I	DELIVERY ROOM & LABOR ROOM	391,927	83,030	256,931	89,516	25,799	79,630	52
54 I	RADIOLOGY-DIAGNOSTIC	1,398,628	107,030	196,950		75,875		54
	LABORATORY	661,018		125,181		87,924		60
	WHOLE BLOOD & PACKED RED BLOOD CELLS	47,404				4,873		62
	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
	RESPIRATORY THERAPY	113,085	3,232	15,930		44,970		65
	PHYSICAL THERAPY	1,135,399	55,521	82,052		40,070		66
	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	74,303	14,200	12,171		3,449		70 71
	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS							72
	DRUGS CHARGED TO PATIENTS							73
	CARDIOLOGY	1,178,414	141,372	415,077		85,210		76
	CARDIAC REHABILITATION	74,774	1,352	115,077		5,921		76.97
	HYPERBARIC OXYGEN THERAPY	, ,,,,,	1,302			0,721		76.98
	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
	CLINIC	234,949	31,183	28,312		24,250	56,599	90
	EMERGENCY	822,385	134,134	848,411		98,127	302,843	91
	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							00.11
	CORF							99.10
	OUTPATIENT PHYSICAL THERAPY							99.20
	OUTPATIENT OCCUPATIONAL THERAPY							99.30
	OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY	112.002	-	10,949		27.410		99.40
	SPECIAL PURPOSE COST CENTERS	112,082		10,949		37,418		101
	SUBTOTALS (sum of lines 1-117)	16,545,226	1,631,912	6,301,927	6,264,286	1,579,999	3,434,836	118
	NONREIMBURSABLE COST CENTERS	10,545,220	1,031,712	0,301,727	0,204,200	1,517,779	5,757,030	110
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,855						190
	RESEARCH	,				2,911		191
	PHYSICIANS' PRIVATE OFFICES	2,054,065	3,011	260,398				192
194	ADVERTISING							194
	FITNESS POINTE	1,494,595	498					194.01
	FITNESS POINTE SPA/PRO SHOP/DIETARY	51,605						194.02
	RETAIL PHARMACY	46,212				5,599		194.03
	HOSPICE	221,437						194.04
	RUSH RESIDENTS							194.05
	CROSS FOOT ADJUSTMENTS							200
	NEGATIVE COST CENTER TOTAL (sum of lines 118-201)	20,483,995	1,635,421	6,562,325	6,264,286	1,588,509	3,434,836	201



## COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	
	GENERAL SERVICE COST CENTERS	14	15	16	17	24	25	
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 DIETARY							9
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	77,461						14
15	PHARMACY		21,363,015					15
16	MEDICAL RECORDS & LIBRARY			746,761				16
17	SOCIAL SERVICE				1,220,190			17
19	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL							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			65,230	1,079,803	75,235,246		30
31	INTENSIVE CARE UNIT			10,404	103,670	16,551,992		31
32.01	NEONATAL INTENSIVE CARE			12,141		5,535,597		32.01
41	SUBPROVIDER - IRF			7,166	14.607	10,587,762		41
43	NURSERY ANCILLARY SERVICE COST CENTERS			2,734	14,687	2,594,947		43
50	OPERATING ROOM			97,781	1,296	48.430.119		50
52	DELIVERY ROOM & LABOR ROOM			4,388	1,270	4,629,081		52
54	RADIOLOGY-DIAGNOSTIC			139,264		27,854,923		54
60	LABORATORY			97,899		18,487,093		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			6,165		3,868,615		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			17,932		6,682,997		65
66 70	PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY			28,258 5,615		14,436,632 1,615,183		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,461		28,159		22,254,262		71
72	IMPL. DEV. CHARGED TO PATIENTS	77,101		33,718		31,886,867		72
73	DRUGS CHARGED TO PATIENTS		21,363,015	56,996		21,420,011		73
76	CARDIOLOGY			74,858		18,455,454		76
76.97	CARDIAC REHABILITATION			1,038		705,312		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
00	OUTPATIENT SERVICE COST CENTERS			2 (11		4 074 011		00
90	CLINIC EMERGENCY	+		3,611 49,493	20,734	4,074,011 14,197,066		90
92	OBSERVATION BEDS (NON-DISTINCT PART)			77,773	20,734	17,177,000		92
1-	OTHER REIMBURSABLE COST CENTERS							1-
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					7.000 -000		99.40
101	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS			3,911		5,223,592		101
118	SUBTOTALS (sum of lines 1-117)	77,461	21,363,015	746,761	1,220,190	354,726,762		118
110	NONREIMBURSABLE COST CENTERS	//,401	21,303,013	/40,/01	1,220,190	334,720,702		110
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					99,819		190
191	RESEARCH					460,561		191
192	PHYSICIANS' PRIVATE OFFICES					3,175,590		192
194	ADVERTISING					1,425,074		194
194.01	FITNESS POINTE					5,936,051		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY					753,407		194.02
194.03 194.04	RETAIL PHARMACY HOSPICE	+				5,605,168 311,956		194.03 194.04
194.04	RUSH RESIDENTS	+ -				311,730		194.04
	CROSS FOOT ADJUSTMENTS							200
1 200								
200	NEGATIVE COST CENTER							201



# Сомри-Мах

	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

## COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTIONS				
	COST CENTER DESCRIPTIONS	TOTAL			
		26			
1	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-BLDG & FIXT				2
4	EMPLOYEE BENEFITS DEPARTMENT				4
5	ADMINISTRATIVE & GENERAL				5
6	MAINTENANCE & REPAIRS				6
8	OPERATION OF PLANT LAUNDRY & LINEN SERVICE				7 8
9	HOUSEKEEPING				9
10	DIETARY				10
11	CAFETERIA				11
12	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION				12
14	CENTRAL SERVICES & SUPPLY				14
15	PHARMACY				15
16	MEDICAL RECORDS & LIBRARY				16
17 19	SOCIAL SERVICE				17
20	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL	<del> </del>			20
21	I&R SERVICES-SALARY & FRINGES APPRVD			 	 21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23	PARAMED ED PRGM-(SPECIFY)				23
30	INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	75,235,246			30
31	INTENSIVE CARE UNIT	16,551,992			31
32.01	NEONATAL INTENSIVE CARE	5,535,597			32.01
41	SUBPROVIDER - IRF	10,587,762			41
43	NURSERY ANCILLARY SERVICE COST CENTERS	2,594,947			43
50	OPERATING ROOM	48,430,119			50
52	DELIVERY ROOM & LABOR ROOM	4,629,081			52
54	RADIOLOGY-DIAGNOSTIC	27,854,923			54
60	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	18,487,093 3,868,615			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	3,868,615			62.30
65	RESPIRATORY THERAPY	6,682,997			65
66	PHYSICAL THERAPY	14,436,632			66
70	ELECTROENCEPHALOGRAPHY	1,615,183			70
71 72	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	22,254,262 31,886,867			71 72
73	DRUGS CHARGED TO PATIENTS	21,420,011			73
76	CARDIOLOGY	18,455,454			76
76.97	CARDIAC REHABILITATION	705,312			76.97
76.98 76.99	HYPERBARIC OXYGEN THERAPY LITHOTRIPSY				76.98 76.99
70.99	OUTPATIENT SERVICE COST CENTERS				70.99
90	CLINIC	4,074,011			90
91	EMERGENCY	14,197,066			91
92	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92
99.10	CORF				99.10
99.20	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY	5.223.592			99.40
101	SPECIAL PURPOSE COST CENTERS	5,225,592			101
118	SUBTOTALS (sum of lines 1-117)	354,726,762			118
	NONREIMBURSABLE COST CENTERS				
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	99,819			190
191 192	RESEARCH PHYSICIANS' PRIVATE OFFICES	460,561 3,175,590			191
194	ADVERTISING	1,425,074			192
194.01	FITNESS POINTE	5,936,051			194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	753,407			194.02
194.03 194.04	RETAIL PHARMACY HOSPICE	5,605,168 311,956			194.03 194.04
194.04	RUSH RESIDENTS	311,936			194.04
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	TOTAL (sum of lines 118-201)	372,494,388			202



## ALLOCATION OF CAPITAL-RELATED COSTS

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	
	GENERAL SERVICE COST CENTERS	U	1	2	2A	4	3	
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT	21,600	36,188	13,654	71,442	71,442		4
5	ADMINISTRATIVE & GENERAL	403,666	2,777,927	527,152	3,708,745	6,536	3,715,281	5
7	MAINTENANCE & REPAIRS OPERATION OF PLANT	6,018	1,349,399	794,065	2,149,482	2,298	204,306	7
8	LAUNDRY & LINEN SERVICE	18,070	14,103	774,003	32,173	51	15,894	8
9	HOUSEKEEPING	490	42,277	110,356	153,123	1,569	64,202	9
10	DIETARY	9,282	120,013	80,333	209,628	1,165	58,837	10
11	CAFETERIA		126,230	83,311	209,541	556	11,804	11
12	MAINTENANCE OF PERSONNEL		17 (02	466,999	404 (01	905	22.550	12
13	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	17,094	17,602	400,999	484,601 17,094	805 17	33,558 763	13 14
15	PHARMACY	21,251	48,399	374,951	444,601	1,893	211,017	15
16	MEDICAL RECORDS & LIBRARY		76,161	2,1,,22	76,161	59	4,497	16
17	SOCIAL SERVICE		20,541	1,800	22,341	333	11,301	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
23	I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY)	+						23
23	INPATIENT ROUTINE SERV COST CENTERS							23
30	ADULTS & PEDIATRICS	70,099	1,713,583	762,429	2,546,111	15,622	592,449	30
31	INTENSIVE CARE UNIT	30,303	231,833	664,133	926,269	3,773	144,361	31
32.01	NEONATAL INTENSIVE CARE		63,041	209,868	272,909	1,363	50,842	32.01
41	SUBPROVIDER - IRF	6,049	270,833	39,201	316,083	1,779	82,561	41
43	NURSERY ANCILLARY SERVICE COST CENTERS		24,178	7,012	31,190	614	23,399	43
50	OPERATING ROOM	1.127.920	704,729	3,094,653	4,927,302	11,650	435,457	50
52	DELIVERY ROOM & LABOR ROOM	1,121,720	132,160	147,805	279,965	927	36,882	52
54	RADIOLOGY-DIAGNOSTIC	591,217	471,627	3,922,276	4,985,120	3,778	258,696	54
60	LABORATORY	5,106	222,900	642,578	870,584	2,759	174,695	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		15,985	43,068	59,053	194	38,003	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	47,100	38,133	246,603	331,836	1,643	64,710	62.30
66	PHYSICAL THERAPY	12,150	382,865	140,221	535,236	2,304	130,612	66
70	ELECTROENCEPHALOGRAPHY	201,567	25,056	148,497	375,120	296	15,015	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						220,910	71
72	IMPL. DEV. CHARGED TO PATIENTS						317,702	72
73	DRUGS CHARGED TO PATIENTS	1 207 102	205.250	1 101 051	2 100 (07	2 22 5	125.151	73
76 76.97	CARDIOLOGY CARDIAC REHABILITATION	1,387,183	397,370 25,214	1,404,054 32,820	3,188,607 58,034	3,225	165,174 6,206	76 76.97
76.98	HYPERBARIC OXYGEN THERAPY		23,214	32,820	36,034	209	0,200	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	40,932	79,227	16,382	136,541	952	36,855	90
91	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	4,931	277,314	679,813	962,058	2,799	118,899	91
92	OTHER REIMBURSABLE COST CENTERS							92
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		37,795	689	38,484	1,055	50,461	101
118	SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117)	4,022,028	9,742,683	14,654,723	28,419,434	70,224	3,580,068	118
110	NONREIMBURSABLE COST CENTERS	1,022,028	7,772,003	11,007,723	20,717,734	70,224	5,500,008	110
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		23,893		23,893		289	190
191	RESEARCH			518	518	99	4,565	
192	PHYSICIANS' PRIVATE OFFICES		692,645	15,221	707,866		8,559	192
194	ADVERTISING EITNESS DOINTE		502.000	142 121	(47.110	771		
194.01 194.02	FITNESS POINTE FITNESS POINTE SPA/PRO SHOP/DIETARY		503,988 17,402	143,131 6,048	647,119 23,450	771 146	44,294 7,000	194.01 194.02
194.02	RETAIL PHARMACY		15,583	38,280	53,863	202	55,389	194.02
194.04	HOSPICE		74,670	30,200	74,670	202	903	194.04
194.05	RUSH RESIDENTS							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER	4 022 020	11.070.074	14 957 001	20.050.012	71 440	2.715.201	201
202	TOTAL (sum of lines 118-201)	4,022,028	11,070,864	14,857,921	29,950,813	71,442	3,715,281	202



## ALLOCATION OF CAPITAL-RELATED COSTS

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
	GENERAL SERVICE COST CENTERS	7	8	9	10	11	13	
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	2.25(.00)						6
7 8	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	2,356,086 4,811	52,929					7
9	HOUSEKEEPING	14,421	32,929	233,315				9
10	DIETARY	40,936	16	315	310.897			10
11	CAFETERIA	43,057		1,090	2 2 3,0 2 7	266,048		11
12	MAINTENANCE OF PERSONNEL	Í		, i		, i		12
13	NURSING ADMINISTRATION	6,004		65		2,726	527,759	13
14	CENTRAL SERVICES & SUPPLY					165		14
15	PHARMACY	16,509		610		7,634		15
16 17	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	25,978 7,007		2,426 545		306 1,817		16 17
19	NONPHYSICIAN ANESTHETISTS	7,007		343		1,817		19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	584,499	19,449	69,231	245,673	86,644	245,344	30
31	INTENSIVE CARE UNIT	79,078	3,027	12,702	19,912	17,402	49,276	31
32.01 41	NEONATAL INTENSIVE CARE SUBPROVIDER - IRF	21,503 92,381	349 3,081	3,069 11,259	40,869	5,817 10,838	16,471 30,690	32.01 41
43	NURSERY	8,247	275	2,781	40,009	2,996	8,484	43
15	ANCILLARY SERVICE COST CENTERS	0,217	273	2,701		2,770	0,101	13
50	OPERATING ROOM	240,382	8,137	49,142		38,859	110,031	50
52	DELIVERY ROOM & LABOR ROOM	45,080	2,687	9,135	4,443	4,321	12,235	52
54	RADIOLOGY-DIAGNOSTIC	160,871	3,464	7,002		12,708		54
60	LABORATORY	76,031		4,451		14,726		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,452				816		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	13,007	105	566		7,532		62.30
66	PHYSICAL THERAPY	130,595	1,797	2,917		6,711		66
70	ELECTROENCEPHALOGRAPHY	8,546	460	433		578		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY	135,542	4,575	14,758		14,271		76
76.97	CARDIAC REHABILITATION	8,601	44			992		76.97
76.98 76.99	HYPERBARIC OXYGEN THERAPY LITHOTRIPSY							76.98 76.99
70.99	OUTPATIENT SERVICE COST CENTERS							/0.99
90	CLINIC CLINIC	27,024	1,009	1,007		4,061	8,696	90
91	EMERGENCY	94,591	4,341	30,164		16,435	46,532	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30 99.40	OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY							99.30 99.40
101	HOME HEALTH AGENCY	12,892		389		6,267		101
101	SPECIAL PURPOSE COST CENTERS	12,072		309		0,207		101
118	SUBTOTALS (sum of lines 1-117)	1,903,045	52,816	224,057	310,897	264,622	527,759	118
	NONREIMBURSABLE COST CENTERS					Í		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,150						190
191	RESEARCH					488		191
192	PHYSICIANS' PRIVATE OFFICES	236,260	97	9,258				192
194 194.01	ADVERTISING FITNESS POINTE	171,910	16					194 194.01
194.01	FITNESS POINTE FITNESS POINTE SPA/PRO SHOP/DIETARY	5,936	16					194.01
194.02	RETAIL PHARMACY	5,315	+		+	938		194.02
194.04	HOSPICE	25,470				756		194.04
194.05	RUSH RESIDENTS	1						194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,356,086	52,929	233,315	310,897	266,048	527,759	202



COMPU-MAX
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## ALLOCATION OF CAPITAL-RELATED COSTS

		CENTRAL	PHARMACY	MEDICAL	SOCIAL		I&R COST &	
	COST CENTER DESCRIPTIONS	SERVICES &		RECORDS +	SERVICE		POST STEP-	
		SUPPLY		LIBRARY		SUBTOTAL	DOWN ADJS	
	CENTED AT CEDITICE COCK CENTEDS	14	15	16	17	24	25	
1	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-BLDG & FIXT							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 CAFETERIA							10
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	18,039						14
15	PHARMACY		682,264					15
16	MEDICAL RECORDS & LIBRARY			109,427				16
17	SOCIAL SERVICE				43,344			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD							21
23	PARAMED ED PRGM-(SPECIFY)							23
23	INPATIENT ROUTINE SERV COST CENTERS							-23
30	ADULTS & PEDIATRICS			9,599	38,356	4,452,977		30
31	INTENSIVE CARE UNIT			1,531	3,683	1,261,014		31
32.01	NEONATAL INTENSIVE CARE			1,787		374,110		32.01
41	SUBPROVIDER - IRF			1,054		590,595		41
43	NURSERY			402	522	78,910		43
50	ANCILLARY SERVICE COST CENTERS OPERATING ROOM			14,389	46	5,835,395		50
52	DELIVERY ROOM & LABOR ROOM			646	40	396,321		52
54	RADIOLOGY-DIAGNOSTIC			20,030		5,451,669		54
60	LABORATORY			14,407		1,157,653		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			907		104,425		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			2,639		422,038		65
66 70	PHYSICAL THERAPY			4,158 826		814,330 401,274		66 70
71	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	18,039		4,144		243,093		71
72	IMPL. DEV. CHARGED TO PATIENTS	18,039		4,962		322,664		72
73	DRUGS CHARGED TO PATIENTS		682,264	8,387		690,651		73
76	CARDIOLOGY			11,016		3,537,168		76
76.97	CARDIAC REHABILITATION			153		74,239		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
00	OUTPATIENT SERVICE COST CENTERS			521		217.777		00
90	CLINIC EMERGENCY			531 7,283	737	216,676 1,283,839		90
92	OBSERVATION BEDS (NON-DISTINCT PART)			1,263	131	1,203,039		91
/2	OTHER REIMBURSABLE COST CENTERS							12
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY			576		110,124		101
118	SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117)	18,039	682,264	109,427	43,344	27,819,165		118
110	NONREIMBURSABLE COST CENTERS	10,039	002,204	109,44/	43,344	47,017,103		110
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					32,332		190
191	RESEARCH					5,670		191
192	PHYSICIANS' PRIVATE OFFICES					962,040		192
194	ADVERTISING					14,214		194
194.01	FITNESS POINTE					864,110		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY					36,532		194.02
194.03 194.04	RETAIL PHARMACY HOSPICE					115,707 101,043		194.03 194.04
194.04	RUSH RESIDENTS					101,043		194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER		l l	1	1	I		201



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## ALLOCATION OF CAPITAL-RELATED COSTS

	COST CENTED DESCRIPTIONS					
	COST CENTER DESCRIPTIONS	TOTAL				
		26				
	GENERAL SERVICE COST CENTERS					
2	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP				1 2	•
4	EMPLOYEE BENEFITS DEPARTMENT					<u>4</u>
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS				6	
7	OPERATION OF PLANT				7	,
8	LAUNDRY & LINEN SERVICE HOUSEKEEPING				8	8
9	DIETARY				 	9 10
11	CAFETERIA				1	
12	MAINTENANCE OF PERSONNEL				12	12
13	NURSING ADMINISTRATION				13	
14	CENTRAL SERVICES & SUPPLY				14	
15 16	PHARMACY MEDICAL RECORDS & LIBRARY				1:	
17	SOCIAL SERVICE				 11	-
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL				20	
21	I&R SERVICES-SALARY & FRINGES APPRVD				2	
22	I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY)				 22	22
23	INPATIENT ROUTINE SERV COST CENTERS				2.	در
30	ADULTS & PEDIATRICS	4,452,977			30	30
31	INTENSIVE CARE UNIT	1,261,014			3	31
32.01	NEONATAL INTENSIVE CARE	374,110				32.01
41	SUBPROVIDER - IRF	590,595			4	
43	NURSERY ANCILLARY SERVICE COST CENTERS	78,910			4,	13
50	OPERATING ROOM	5,835,395			50	50
52	DELIVERY ROOM & LABOR ROOM	396,321				52
54	RADIOLOGY-DIAGNOSTIC	5,451,669			54	54
60	LABORATORY	1,157,653				50
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	104,425				52 20
62.30	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	422,038			 65	52.30
66	PHYSICAL THERAPY	814,330				56
70	ELECTROENCEPHALOGRAPHY	401,274			70	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,093			7:	
72	IMPL. DEV. CHARGED TO PATIENTS	322,664				72
73 76	DRUGS CHARGED TO PATIENTS CARDIOLOGY	690,651 3,537,168				73 76
76.97	CARDIAC REHABILITATION	74,239				76.97
76.98	HYPERBARIC OXYGEN THERAPY	71,237				76.98
76.99	LITHOTRIPSY				70	76.99
	OUTPATIENT SERVICE COST CENTERS					
90	CLINIC EMERGENCY	216,676 1,283,839			90	90
91	OBSERVATION BEDS (NON-DISTINCT PART)	1,283,839				92
/-	OTHER REIMBURSABLE COST CENTERS				92	
99.10	CORF					9.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY					99.30
99.40 101	HOME HEALTH AGENCY	110,124		-		99.40 01
101	SPECIAL PURPOSE COST CENTERS	110,124			10	V I
118	SUBTOTALS (sum of lines 1-117)	27,819,165			11	18
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,332				90
191 192	RESEARCH PHYSICIANS' PRIVATE OFFICES	5,670 962,040			 19	91 92
192	ADVERTISING	14,214				9 <u>2</u> 94
194.01	FITNESS POINTE	864,110				94.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	36,532			 19	94.02
10402	RETAIL PHARMACY	115,707				94.03
194.03		101.042	1		19	94.04
194.04	HOSPICE	101,043			 1.0	0405
194.04 194.05	RUSH RESIDENTS	101,043				94.05
194.04		101,043				00



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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 NEW- SQ FT	
	GENERAL SERVICE COST CENTERS	1	2	4	5A	5	7	
1	CAP REL COSTS-BLDG & FIXT	1.047.188						1
2	CAP REL COSTS-MVBLE EQUIP	2,017,200	9,386,408					2
4	EMPLOYEE BENEFITS DEPARTMENT	3,423	8,626	147,930,727				4
5	ADMINISTRATIVE & GENERAL	262,763	333,025	13,531,787	-65,220,962	307,273,426		5
6	MAINTENANCE & REPAIRS	127 (20	501 (16	4.555.450		1 4 00 5 400	(50.0/0	6
7 8	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	127,639	501,646	4,757,170 106.528		16,897,403 1,314,571	653,363 1,334	7 8
9	HOUSEKEEPING	3,999	69,717	3,248,453		5,309,889	3,999	9
10	DIETARY	11,352	50,750	2,412,264		4,866,153	11,352	10
11	CAFETERIA	11,940	52,631	1,150,596		976,290	11,940	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,665	295,024	1,666,412		2,775,430	1,665	13
14	CENTRAL SERVICES & SUPPLY	4.570	227, 072	34,771		63,086	4.570	14
15 16	PHARMACY MEDICAL RECORDS & LIBRARY	4,578 7,204	236,873	3,919,662 122,835		17,452,368 371,893	4,578 7,204	15 16
17	SOCIAL SERVICE	1,943	1,137	689,252		934,701	1,943	17
19	NONPHYSICIAN ANESTHETISTS	1,2 1.0	1,107	005,202		751,701	1,7.10	19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	<u> </u>						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS							2.5
30	ADULTS & PEDIATRICS	162,087	481.660	32,366,421		48,996,319	162,087	30
31	INTENSIVE CARE UNIT	21,929	419,562	7,811,497		11,939,541	21,929	31
32.01	NEONATAL INTENSIVE CARE	5,963	132,583	2,822,017		4,204,931	5,963	32.01
41	SUBPROVIDER - IRF	25,618	24,765	3,682,691		6,828,274	25,618	41
43	NURSERY	2,287	4,430	1,270,678		1,935,230	2,287	43
50	ANCILLARY SERVICE COST CENTERS OPERATING ROOM	66,660	1.955.029	24,120,520		26.014.096	66,660	50
52	DELIVERY ROOM & LABOR ROOM	12,501	93,375	1,919,676		36,014,986 3,050,393	12,501	52
54	RADIOLOGY-DIAGNOSTIC	44,611	2,477,878	7,821,563		21,395,773	44,611	54
60	LABORATORY	21,084	405,945	5,712,782		14,448,315	21,084	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,512	27,208	401,036		3,143,041	1,512	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,607	155,790	3,401,362		5,351,875	3,607	65
70	PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY	36,215 2,370	88,584 93,812	4,770,111 612,275		10,802,439 1,241,853	36,215 2,370	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,570	75,012	012,273		18,270,583	2,370	71
72	IMPL. DEV. CHARGED TO PATIENTS					26,275,904		72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY	37,587	887,003	6,676,458		13,660,901	37,587	76
76.97 76.98	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	2,385	20,734	432,860		513,280	2,385	76.97
76.98	LITHOTRIPSY							76.98 76.99
70.55	OUTPATIENT SERVICE COST CENTERS							10.77
90	CLINIC	7,494	10,349	1,970,165		3,048,122	7,494	90
91	EMERGENCY	26,231	429,468	5,794,127		9,833,673	26,231	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
99.10	OTHER REIMBURSABLE COST CENTERS							99.10
99.10	CORF OUTPATIENT PHYSICAL THERAPY	+						99.10
99.20	OUTPATIENT OCCUPATIONAL THERAPY	+						99.20
99.40		+						99.40
	OUTPATIENT SPEECH PATHOLOGY						3,575	
101	HOME HEALTH AGENCY	3,575	435	2,184,031		4,173,399	3,3/3	101
101	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS				/		·	
	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117)	3,575 921,556	9,258,039	2,184,031	-65,220,962	4,173,399 296,090,616	527,731	101
101	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS	921,556			-65,220,962	296,090,616	527,731	118
101	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117)				-65,220,962		·	
101	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	921,556	9,258,039	145,410,000	-65,220,962	296,090,616	527,731	118 190 191 192
101 118 190 191 192 194	HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS  SUBTOTALS (sum of lines 1-117)  NONREIMBURSABLE COST CENTERS  GIFT, FLOWER, COFFEE SHOP & CANTEEN  RESEARCH  PHYSICIANS' PRIVATE OFFICES  ADVERTISING	921,556 2,260 65,517	9,258,039 327 9,616	145,410,000 205,325	-65,220,962	296,090,616 23,893 377,519 707,866 1,175,554	527,731 2,260 65,517	118 190 191 192 194
101 118 190 191 192 194 194.01	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS' PRIVATE OFFICES ADVERTISING FITNESS POINTE	921,556 2,260 65,517 47,672	9,258,039 327 9,616 90,422	145,410,000 205,325 1,595,759	-65,220,962	296,090,616 23,893 377,519 707,866 1,175,554 3,663,380	527,731 2,260 65,517 47,672	118 190 191 192 194 194.01
101 118 190 191 192 194 194.01 194.02	HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS  SUBTOTALS (sum of lines 1-117)  NONREIMBURSABLE COST CENTERS  GIFT, FLOWER, COFFEE SHOP & CANTEEN  RESEARCH  PHYSICIANS' PRIVATE OFFICES  ADVERTISING  FITNESS POINTE  FITNESS POINTE SPA/PRO SHOP/DIETARY	921,556 2,260 65,517 47,672 1,646	9,258,039 327 9,616 90,422 3,821	145,410,000 205,325 1,595,759 301,766	-65,220,962	296,090,616 23,893 377,519 707,866 1,175,554 3,663,380 578,922	527,731 2,260 65,517 47,672 1,646	118 190 191 192 194 194.01 194.02
101 118 190 191 192 194 194.01 194.02 194.03	HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS  SUBTOTALS (sum of lines 1-117)  NONREIMBURSABLE COST CENTERS  GIFT, FLOWER, COFFEE SHOP & CANTEEN  RESEARCH  PHYSICIANS' PRIVATE OFFICES  ADVERTISING  FITNESS POINTE  FITNESS POINTE SPA/PRO SHOP/DIETARY  RETAIL PHARMACY	921,556 2,260 65,517 47,672 1,646 1,474	9,258,039 327 9,616 90,422	145,410,000 205,325 1,595,759	-65,220,962	296,090,616 23,893 377,519 707,866 1,175,554 3,663,380 578,922 4,581,006	527,731 2,260 65,517 47,672 1,646 1,474	118 190 191 192 194 194.01 194.02 194.03
101 118 190 191 192 194 194.01 194.02 194.03 194.04	HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS  SUBTOTALS (sum of lines 1-117)  NONREIMBURSABLE COST CENTERS  GIFT, FLOWER, COFFEE SHOP & CANTEEN  RESEARCH  PHYSICIANS' PRIVATE OFFICES  ADVERTISING  FITNESS POINTE  FITNESS POINTE SPA/PRO SHOP/DIETARY  RETAIL PHARMACY  HOSPICE	921,556 2,260 65,517 47,672 1,646	9,258,039 327 9,616 90,422 3,821	145,410,000 205,325 1,595,759 301,766	-65,220,962	296,090,616 23,893 377,519 707,866 1,175,554 3,663,380 578,922	527,731 2,260 65,517 47,672 1,646	118 190 191 192 194 194.01 194.02 194.03 194.04
101 118 190 191 192 194 194.01 194.02 194.03	HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS  SUBTOTALS (sum of lines 1-117)  NONREIMBURSABLE COST CENTERS  GIFT, FLOWER, COFFEE SHOP & CANTEEN  RESEARCH  PHYSICIANS' PRIVATE OFFICES  ADVERTISING  FITNESS POINTE  FITNESS POINTE SPA/PRO SHOP/DIETARY  RETAIL PHARMACY	921,556 2,260 65,517 47,672 1,646 1,474	9,258,039 327 9,616 90,422 3,821	145,410,000 205,325 1,595,759 301,766	-65,220,962	296,090,616 23,893 377,519 707,866 1,175,554 3,663,380 578,922 4,581,006	527,731 2,260 65,517 47,672 1,646 1,474	118 190 191 192 194 194.01 194.02 194.03
101 118 190 191 192 194 194.01 194.02 194.03 194.04 194.05	HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS  SUBTOTALS (sum of lines 1-117)  NONREIMBURSABLE COST CENTERS  GIFT, FLOWER, COFFEE SHOP & CANTEEN  RESEARCH  PHYSICIANS' PRIVATE OFFICES  ADVERTISING  FITNESS POINTE  FITNESS POINTE SPA/PRO SHOP/DIETARY  RETAIL PHARMACY  HOSPICE  RUSH RESIDENTS  CROSS FOOT ADJUSTMENTS  NEGATIVE COST CENTER	921,556 2,260 65,517 47,672 1,646 1,474	9,258,039 327 9,616 90,422 3,821	145,410,000 205,325 1,595,759 301,766 417,877	-65,220,962	296,090,616 23,893 377,519 707,866 1,175,554 3,663,380 578,922 4,581,006	527,731 2,260 65,517 47,672 1,646 1,474	118 190 191 192 194 194.01 194.02 194.03 194.04 194.05 200 201
101 118 190 191 192 194 194.01 194.02 194.03 194.04 194.05 200 201 202	HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS  SUBTOTALS (sum of lines 1-117)  NONREIMBURSABLE COST CENTERS  GIFT, FLOWER, COFFEE SHOP & CANTEEN  RESEARCH  PHYSICIANS' PRIVATE OFFICES  ADVERTISING  FITNESS POINTE  FITNESS POINTE SPA/PRO SHOP/DIETARY  RETAIL PHARMACY  HOSPICE  RUSH RESIDENTS  CROSS FOOT ADJUSTMENTS  NEGATIVE COST CENTER  COST TO BE ALLOC PER B PT I	921,556 2,260 65,517 47,672 1,646 1,474 7,063	9,258,039 327 9,616 90,422 3,821 24,183	145,410,000 205,325 1,595,759 301,766 417,877 45,289,323	-65,220,962	296,090,616 23,893 377,519 707,866 1,175,554 3,663,380 578,922 4,581,006 74,670	527,731 2,260 65,517 47,672 1,646 1,474 7,063 20,483,995	118 190 191 192 194 194.01 194.02 194.03 194.04 194.05 200 201 202
101 118 190 191 192 194 194.01 194.02 194.03 194.05 200 201	HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS  SUBTOTALS (sum of lines 1-117)  NONREIMBURSABLE COST CENTERS  GIFT, FLOWER, COFFEE SHOP & CANTEEN  RESEARCH  PHYSICIANS' PRIVATE OFFICES  ADVERTISING  FITNESS POINTE  FITNESS POINTE SPA/PRO SHOP/DIETARY  RETAIL PHARMACY  HOSPICE  RUSH RESIDENTS  CROSS FOOT ADJUSTMENTS  NEGATIVE COST CENTER	921,556 2,260 65,517 47,672 1,646 1,474 7,063	9,258,039 327 9,616 90,422 3,821 24,183	145,410,000 205,325 1,595,759 301,766 417,877	-65,220,962	296,090,616 23,893 377,519 707,866 1,175,554 3,663,380 578,922 4,581,006 74,670	527,731 2,260 65,517 47,672 1,646 1,474 7,063	118 190 191 192 194 194.01 194.02 194.03 194.04 194.05 200 201 202



COMPU-MAX
In Lieu of Form Run Date: 01/05/2015 Period: From: 07/01/2013 To: 06/30/2014 COMMUNITY HOSPITAL CMS-2552-10 Run Time: 13:42 Version: 2014.10 Provider CCN: 15-0125

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

CAPARLA SERVICE COST CENTERS		COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE POUNDS	HOUSE- KEEPING TIME SPENT	DIETARY  PATIENT ME ALS 10	CAFETERIA FTES	NURSING ADMINIS- TRATION NURSING HO URS	CENTRAL SERVICES & SUPPLY COSTED REQ	
2   2   2   2   2   3   4   4   5   7   5   5   5   5   5   5   5   5		GENERAL SERVICE COST CENTERS							
MERICATE BENNETTS DEPARTMENT									
SAME									
MANTENANCE & REPAIRS									
1									
SALANDRY & LINES SERVICE   3,460,100   719,240   719,2									
MONSHAEPPING			2 460 106						
10   DIFTARY			3,400,100	719 240					
11   MANTENANCO OF PERSONNEL   13   177,26   118   13   MANTENANCO OF PERSONNEL   12   13   MANTENANCO OF PERSONNEL   13   13   13   13   13   13   13   1			1 066		337 230				
MANTENANCE OF PERSONNEL   200   1,377   2,581,950   131   111			1,000		337,230	177.326			
CENTRAL SERVICES & SUPPLY		MAINTENANCE OF PERSONNEL		- ,		,-			
15   MIRDEN RECORD & LIBRARY   1,540   204   161	13	NURSING ADMINISTRATION		200		1,817	2,583,950		13
MEDICAL RECORDS & LIBRARY	14	CENTRAL SERVICES & SUPPLY				110		100	14
17									
19   NORPHYSICIAN ANISTHETISTS									
NURSING SCHOOL				1,680		1,211			
1									
LER SERVICES-OTHER PERGA COSTS APPRVD									
PARAMED ED PROMASPICITY    INPATIENT ROUTINE SERV COST CENTERS   1,21,413   21,419   266,481   57,751   1,201,228   30     ADULT S. & PEDIATRICS   1,271,413   21,3419   266,481   51,759   24,259   31     3. INTENSIVE CARE UNIT   197,886   39,156   22,1599   11,599   24,259   31     3. 201   NIGONATA, INTENSIVE CARE UNIT   29,036   34,709   44,331   7,224   103,259   41     43   SUBPOVIDER, IRP   20,036   34,709   44,331   7,224   103,259   41     44   SUBPOVIDER, IRP   20,036   34,709   44,331   7,224   103,259   41     45   NURSELIAN SERVICE COST CENTERS   19,975   8,574   31   19,97   41,538   43     50   OPERATING ROOM   519,08   519,08   51,489   2,580   58,720   59, 20     51   RADIOLOGY DAGROSTIC   226,447   22,1586   4,819   2,880   59,994   52     52   DELIVERY ROOM & LABOR ROOM   175,669   28,160   4,819   2,880   59,994   52     52   RADIOLOGY DAGROSTIC   226,447   21,586   4,819   2,880   59,994   52     52   WHOLE BLOOD & PACKED RED BLOOD CELLS   62   62   62     52   BLOOD & PACKED RED BLOOD CELLS   62   62   62     53   BLOOD CLOTTING FOR ILIMOPHILLAS   63   65     65   RESPIRATION THERAPY   6,838   1,746   5,500   65     65   RESPIRATION THERAPY   117,468   8,993   4,473   66     66   PHYSICAL THERAPY   117,468   8,993   4,473   66     67   CARDIOLOGY   290,104   45,493   61   61   61     70   CARDIOLOGY   290,104   290,104   290,104   290,104     70   CARDIO									
INPATIENT ROUTINE SERV COST CENTERS   213,419   266,481   57,751   1,201,228   30   30   ADULTS & PEDIATRICS   1271,413   197,886   39,156   21,599   11,599   241,259   31   31   320   INFORMATION CARE   22,847   3,461   34700   44,331   7,224   150,259   41   41   41,588   43   43   43   43   43   43   43									
ADULTS & PEDIATRICS   1.271.413   213.419   266.481   57.751   1.201.228   30	23								
INTENSIVE CARE LINIT	30		1,271,413	213,419	266,481	57,751	1,201,228		30
SUBPROVIDER - IRF   201,396   34,709   44,331   7,224   150,259   41	31	INTENSIVE CARE UNIT	197,886	39,156	21,599	11,599	241,259		31
AURUSERY	32.01	NEONATAL INTENSIVE CARE	22,847	9,461		3,877	80,642		32.01
ANCILLARY SERVICE COST CENTERS	41		201,396	34,709	44,331	7,224	150,259		41
OPERATING ROOM	43		17,973	8,574		1,997	41,538		43
DELIVERY ROOM & LABOR ROOM									
SACRETIC   SACRETIC   SACRET   SACRET					1010				
ABORATORY					4,819		59,904		
WHOLE BLOOD & PACKED RED BLOOD CELLS			226,447						
62.30   BLOOD CLOTTING FOR HEMOPHILIACS   6.5   RESPIRATORY THERAPY   6.838   1.746   5.020   6.5				13,/20					
SEPRIATORY THERAPY						344			
66   PHYSICAL THERAPY   117.468   8.993   4.473   66     05   ELECTROENCEPHALOGRAPHY   30,043   1,334   388   70     10   MEDICAL SUPPLIES CHARGED TO PATIENTS   100   71     11   MEDICAL SUPPLIES CHARGED TO PATIENTS   72     12   MEDICAL SUPPLIES CHARGED TO PATIENTS   72     13   DRUGS CHARGED TO PATIENTS   73   75     15   DRUGS CHARGED TO PATIENTS   75   76     16   CARDIAC REHABILITATION   2,860   45,493   9,512   76     17   ORDITOR OF THE PATE OF THE			6.838	1 746		5 020			
To   ELECTROENCEPHALOGRAPHY   30,043   1,334   385   70   70   70   70   70   70   70   7									
172   IMPL DEV. CHARGED TO PATIENTS									
172   IMPL DEV. CHARGED TO PATIENTS	71	MEDICAL SUPPLIES CHARGED TO PATIENTS		,				100	71
CARDIOLOGY		IMPL. DEV. CHARGED TO PATIENTS							
16.97									
16.98				45,493					
76.99			2,860			661			
OUTPATIENT SERVICE COST CENTERS									
OCT   CLINIC   CLIN	/6.99								/6.99
SPECIAL PURPOSE COST CENTERS   10,954   227,822   91	90		65 975	3 103		2 707	12 578		90
OBSERVATION BEDS (NON-DISTINCT PART)									
OTHER REIMBURSABLE COST CENTERS   99.10   CORF   99.10   CORF   99.10   CORF   99.20   OUTPATIENT PHYSICAL THERAPY   99.20   99.20   OUTPATIENT OCCUPATIONAL THERAPY   99.20   99.30   OUTPATIENT OCCUPATIONAL THERAPY   99.40   99.30   Polith of the property of the prope			203,770	72,701		10,754	227,022		
99.10   CORF									
99.30 OUTPATIENT OCCUPATIONAL THERAPY 99.40 OUTPATIENT SPEECH PATHOLOGY 101 HOME HEALTH AGENCY 11200 4,177 99.40  SPECIAL PURPOSE COST CENTERS 118 SUBTOTALS (sum of lines 1-117) 3,452,683 690,700 337,230 176,376 2,583,950 100 118  NONREIMBURSABLE COST CENTERS 190 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191 RESEARCH 325 191 192 PHYSICIANS' PRIVATE OFFICES 6,370 28,540 192 194 ADVERTISING 194 194.01 FITNESS POINTE 1,053 194 194.01 FITNESS POINTE 1,053 194 194.02 FITNESS POINTE SPAPRO SHOP/DIETARY 194,03 194.04 HOSPICE 194,04 194.05 RUSH RESIDENTS 194,05 200 CROSS FOOT ADJUSTMENTS 201 NEGATIVE COST CENTER 200 201 NEGATIVE COST CENTER 200 201 NEGATIVE COST CENTER 201 202 COST TO BE ALLOC PER B PT I 1,635,421 6,562,325 6,264,286 1,588,509 3,434,836 77,461 202 203 UNIT COST MULT-WS B PT I 0,472651 9,123971 18,575708 8,958128 1,322997 774,610000 203 204 COST TO BE ALLOC PER B PT II 52,929 233,315 310,897 266,048 527,759 18,039 204		CORF							
99.40   OUTPATIENT SPEECH PATHOLOGY   1,200   4,177   101									
101   HOME HEALTH AGENCY   1,200   4,177     101									
SPECIAL PURPOSE COST CENTERS				1.200		4 155			
118   SUBTOTALS (sum of lines 1-117)   3,452,683   690,700   337,230   176,376   2,583,950   100   118	101			1,200		4,1 //			101
NONREIMBURSABLE COST CENTERS   190   GIFT, FLOWER, COFFEE SHOP & CANTEEN   190   190     191	118		3 452 683	690 700	337 230	176 376	2 583 050	100	118
190   GIFT, FLOWER, COFFEE SHOP & CANTEEN   190   191   192   1635,421   192   18.575708   194,836   194,836   194,039   194,041   194,051   194	110		3,432,003	030,700	331,230	170,370	2,303,330	100	110
191   RESEARCH	190								190
194   ADVERTISING   194   19						325			
194.01   FITNESS POINTE   1,053			6,370	28,540					
194.02       FITNESS POINTE SPA/PRO SHOP/DIETARY       194.02         194.03       RETAIL PHARMACY       625       194.03         194.04       HOSPICE       194.04         194.05       RUSH RESIDENTS       50       50       194.05         200       CROSS FOOT ADJUSTMENTS       200       200       200       200       200         201       NEGATIVE COST CENTER       201       201       201       201       201       201       201       202       203       204       205 TO BE ALLOC PER B PT I       1,635,421       6,562,325       6,264,286       1,588,509       3,434,836       77,461       202       203       203       204       205 TO BE ALLOC PER B PT II       0.472651       9,123971       18,575708       8,958128       1,329297       774.610000       203         204       COST TO BE ALLOC PER B PT II       52,929       233,315       310,897       266,048       527,759       18,039       204									
194.03       RETAIL PHARMACY       625       194.03         194.04       HOSPICE       194.04         194.05       RUSH RESIDENTS       194.05         200       CROSS FOOT ADJUSTMENTS       200         201       NEGATIVE COST CENTER       201         202       COST TO BE ALLOC PER B PT I       1,635,421       6,562,325       6,264,286       1,588,509       3,434,836       77,461       202         203       UNIT COST MULT-WS B PT I       0.472651       9,123971       18,575708       8,958128       1,329297       774.610000       203         204       COST TO BE ALLOC PER B PT II       52,929       233,315       310,897       266,048       527,759       18,039       204			1,053						
194.04     HOSPICE     194.04       194.05     RUSH RESIDENTS     194.05       200     CROSS FOOT ADJUSTMENTS     200       201     NEGATIVE COST CENTER     201       202     COST TO BE ALLOC PER B PT I     1,635,421     6,562,325     6,264,286     1,588,509     3,434,836     77,461     202       203     UNIT COST MULT-WS B PT I     0,472651     9,123971     18.575708     8,958128     1,329297     774,610000     203       204     COST TO BE ALLOC PER B PT II     52,929     233,315     310,897     266,048     527,759     18,039     204						·			
194.05   RUSH RESIDENTS   200   20		-				625			
200         CROSS FOOT ADJUSTMENTS         200           201         NEGATIVE COST CENTER         201           202         COST TO BE ALLOC PER B PT I         1,635,421         6,562,325         6,264,286         1,588,509         3,434,836         77,461         202           203         UNIT COST MULT-WS B PT I         0,472651         9,123971         18.575708         8,958128         1,329297         774.610000         203           204         COST TO BE ALLOC PER B PT II         52,929         233,315         310,897         266,048         527,759         18,039         204									
201         NEGATIVE COST CENTER         201           202         COST TO BE ALLOC PER B PT I         1,635,421         6,562,325         6,264,286         1,588,509         3,434,836         77,461         202           203         UNIT COST MULT-WS B PT I         0.472651         9.123971         18.575708         8.958128         1.329297         774.610000         203           204         COST TO BE ALLOC PER B PT II         52,929         233,315         310,897         266,048         527,759         18,039         204									
202     COST TO BE ALLOC PER B PT I     1,635,421     6,562,325     6,264,286     1,588,509     3,434,836     77,461     202       203     UNIT COST MULT-WS B PT I     0.472651     9.123971     18.575708     8.958128     1.329297     774.610000     203       204     COST TO BE ALLOC PER B PT II     52,929     233,315     310,897     266,048     527,759     18,039     204									
203         UNIT COST MULT-WS B PT I         0.472651         9.123971         18.575708         8.958128         1.329297         774.610000         203           204         COST TO BE ALLOC PER B PT II         52,929         233,315         310,897         266,048         527,759         18,039         204			1,635,421	6,562,325	6,264,286	1,588,509	3,434,836		
205         UNIT COST MULT-WS B PT II         0.015297         0.324391         0.921914         1.500333         0.204245         180.390000         205									
	205	UNIT COST MULT-WS B PT II	0.015297	0.324391	0.921914	1.500333	0.204245	180.390000	205

194

200

202 203 204 ADVERTISING

194.02 FITNESS POINTE 194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY 194.03 RETAIL PHARMACY

CROSS FOOT ADJUSTMENTS

UNIT COST MULT-WS B PT I

COST TO BE ALLOC PER B PT I

COST TO BE ALLOC PER B PT II

NEGATIVE COST CENTER

194.01 FITNESS POINTE

194.04 HOSPICE 194.05 RUSH RESIDENTS



### COMPU-MAX

	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

		PHARMACY	MEDICAL	SOCIAL	
	GOOT CENTER RECOMPTIONS		RECORDS +	SERVICE	
	COST CENTER DESCRIPTIONS	COSTED REQ	LIBRARY GROSS	GROSS	
			REVENUE	REVENUE	
		15	16	17	
	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT				1
	CAP REL COSTS-MVBLE EQUIP				2
	EMPLOYEE BENEFITS DEPARTMENT				4
	ADMINISTRATIVE & GENERAL				5
	MAINTENANCE & REPAIRS OPERATION OF PLANT				6 7
	LAUNDRY & LINEN SERVICE				8
	HOUSEKEEPING				9
)	DIETARY				10
	CAFETERIA				11
2	MAINTENANCE OF PERSONNEL				12
} 	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY				13
;	PHARMACY	10,000			14
, ,	MEDICAL RECORDS & LIBRARY	10,000	1,247,775,458		16
7	SOCIAL SERVICE		, .,,	141,240	17
)	NONPHYSICIAN ANESTHETISTS				19
)	NURSING SCHOOL				20
<u>1</u>	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD				21
;	PARAMED ED PRGM-(SPECIFY)				23
,	INPATIENT ROUTINE SERV COST CENTERS				23
)	ADULTS & PEDIATRICS		109,079,807	124,990	30
	INTENSIVE CARE UNIT		17,397,741	12,000	31
2.01	NEONATAL INTENSIVE CARE		20,303,194		32.
<u> </u>	SUBPROVIDER - IRF NURSERY		11,982,793	1.700	41
3	ANCILLARY SERVICE COST CENTERS		4,571,357	1,700	43
0	OPERATING ROOM		163,512,868	150	50
2	DELIVERY ROOM & LABOR ROOM		7,337,260		52
4	RADIOLOGY-DIAGNOSTIC		231,895,918		54
)	LABORATORY		163,711,142		60
2 20	WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD CLOTTING FOR HEMOPHILIACS		10,308,845		62 62.
2.30	RESPIRATORY THERAPY		29,986,203		65
5	PHYSICAL THERAPY		47,254,923		66
)	ELECTROENCEPHALOGRAPHY		9,389,312		70
1	MEDICAL SUPPLIES CHARGED TO PATIENTS		47,089,434		71
2	IMPL. DEV. CHARGED TO PATIENTS		56,384,882		72
3 5	DRUGS CHARGED TO PATIENTS CARDIOLOGY	10,000	95,311,081 125,180,338		73
5.97	CARDIAC REHABILITATION		1,735,577		76.
5.98	HYPERBARIC OXYGEN THERAPY		1,755,577		76.
5.99	LITHOTRIPSY				76.
	OUTPATIENT SERVICE COST CENTERS				
)	CLINIC		6,038,117	2.400	90
2	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)		82,763,966	2,400	91
	OTHER REIMBURSABLE COST CENTERS				92
0.10	CORF				99.
.20	OUTPATIENT PHYSICAL THERAPY				99.
0.30	OUTPATIENT OCCUPATIONAL THERAPY				99.
0.40	OUTPATIENT SPEECH PATHOLOGY		( 540 500		99.
1	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		6,540,700		101
3	SUBTOTALS (sum of lines 1-117)	10,000	1,247,775,458	141,240	118
-	NONREIMBURSABLE COST CENTERS	10,000	1,211,113,130	111,270	110
)	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
	RESEARCH				191
2	PHYSICIANS' PRIVATE OFFICES ADVERTISING				192
4					

21,363,015

2,136.301500

746,761

0.000598

109,427

1,220,190

8.639125

43,344

194 194.01

194.02 194.03

194.04 194.05

200

201

202 203 204 Compu-Max 2552-10



# Сомри-Мах

	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE		
		COSTED REQ	GROSS	GROSS		
			REVENUE	REVENUE		
		15	16	17		
205	LINIT COST MULT-WS R PT II	68 226400	0.000088	0.306882		205



COMPU-MAX
In Lieu of Form Run Date: 01/05/2015 Period: COMMUNITY HOSPITAL CMS-2552-10 From: 07/01/2013 Run Time: 13:42 To: 06/30/2014 Provider CCN: 15-0125 Version: 2014.10

#### COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

					COCTC		
		TOTAL GOOT			COSTS		
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	75,235,246		75,235,246	51,059	75,286,305	30
31	INTENSIVE CARE UNIT	16,551,992		16,551,992		16,551,992	31
32.01	NEONATAL INTENSIVE CARE	5,535,597		5,535,597	11,760	5,547,357	32.01
41	SUBPROVIDER - IRF	10,587,762		10,587,762		10,587,762	41
43	NURSERY	2,594,947		2,594,947		2,594,947	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	48,430,119		48,430,119		48,430,119	50
52	DELIVERY ROOM & LABOR ROOM	4,629,081		4,629,081		4,629,081	52
54	RADIOLOGY-DIAGNOSTIC	27,854,923		27,854,923	27,504	27,882,427	54
60	LABORATORY	18,487,093		18,487,093	11,651	18,498,744	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,868,615		3,868,615		3,868,615	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	6,682,997		6,682,997	782	6,683,779	65
66	PHYSICAL THERAPY	14,436,632		14,436,632		14,436,632	66
70	ELECTROENCEPHALOGRAPHY	1,615,183		1,615,183	6,667	1,621,850	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,254,262		22,254,262		22,254,262	71
72	IMPL. DEV. CHARGED TO PATIENTS	31,886,867		31,886,867		31,886,867	72
73	DRUGS CHARGED TO PATIENTS	21,420,011		21,420,011		21,420,011	73
76	CARDIOLOGY	18,455,454		18,455,454	103,760	18,559,214	76
76.97	CARDIAC REHABILITATION	705,312		705,312		705,312	76.97
76.98	HYPERBARIC OXYGEN THERAPY			,			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	4,074,011		4,074,011	2,340	4,076,351	90
91	EMERGENCY	14,197,066		14,197,066	43,004	14,240,070	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	11,199,584		11,199,584	·	11,199,584	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	5,223,592		5,223,592		5.223.592	101
200	SUBTOTAL (SEE INSTRUCTIONS)	365,926,346		365.926.346	258.527	366.184.873	200
201	LESS OBSERVATION BEDS	11,199,584		11,199,584	,-2/	11,199,584	201
202	TOTAL (SEE INSTRUCTIONS)	354,726,762		354,726,762		354,985,289	202



COMPU-MAX
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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 SERV COST CENTERS							
30	ADULTS & PEDIATRICS	84,537,023		84,537,023				30
31	INTENSIVE CARE UNIT	17,397,741		17,397,741				31
32.01	NEONATAL INTENSIVE CARE	20,303,194		20,303,194				32.01
41	SUBPROVIDER - IRF	11,982,793		11,982,793				41
43	NURSERY	4,571,357		4,571,357				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	70,095,091	93,417,777	163,512,868	0.296185	0.296185	0.296185	50
52	DELIVERY ROOM & LABOR ROOM	5,206,463	2,130,797	7,337,260	0.630900	0.630900	0.630900	52
54	RADIOLOGY-DIAGNOSTIC	56,569,991	175,325,927	231,895,918	0.120118	0.120118	0.120237	54
60	LABORATORY	65,758,022	97,953,120	163,711,142	0.112925	0.112925	0.112996	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,323,220	2,985,625	10,308,845	0.375271	0.375271	0.375271	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	1 1	, ,					62.30
65	RESPIRATORY THERAPY	27,648,148	2,338,055	29,986,203	0.222869	0.222869	0.222895	65
66	PHYSICAL THERAPY	27,175,028	20,079,895	47,254,923	0.305505	0.305505	0.305505	66
70	ELECTROENCEPHALOGRAPHY	1,697,500	7,691,812	9,389,312	0.172024	0.172024	0.172734	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,311,631	24,777,803	47,089,434	0.472596	0.472596	0.472596	71
72	IMPL. DEV. CHARGED TO PATIENTS	36,298,112	20,086,770	56,384,882	0.565522	0.565522	0.565522	72
73	DRUGS CHARGED TO PATIENTS	69,931,111	25,379,970	95,311,081	0.224738	0.224738	0.224738	73
76	CARDIOLOGY	46,379,863	78,800,475	125,180,338	0.147431	0.147431	0.148260	76
76.97	CARDIAC REHABILITATION	338,874	1,396,703	1,735,577	0.406385	0.406385	0.406385	76.97
76.98	HYPERBARIC OXYGEN THERAPY		, ,	, ,				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	240,740	5,797,377	6,038,117	0.674715	0.674715	0.675103	90
91	EMERGENCY	26,531,592	56,232,374	82,763,966	0.171537	0.171537	0.172056	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,204,416	21,338,368	24,542,784	0.456329	0.456329	0.456329	92
	OTHER REIMBURSABLE COST CENTERS		, ,					
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		6,540,700	6,540,700				101
200	SUBTOTAL (SEE INSTRUCTIONS)	605,501,910	642,273,548	1,247,775,458		i		200
201	LESS OBSERVATION BEDS	, ,	, ,					201
202	TOTAL (SEE INSTRUCTIONS)	605,501,910	642,273,548	1,247,775,458				202



#### APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

CHECK [ ] TITLE V [XX] PPS APPLICABLE [XX] TITLE XVIII, PART A [ ] TEFRA BOXES: [ ] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST- MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	4,452,977		4,452,977	89,003	50.03	43,665	2,184,560	30
31	INTENSIVE CARE UNIT	1,261,014		1,261,014	9,836	128.20	5,752	737,406	31
32	CORONARY CARE UNIT								32
32.01	NEONATAL INTENSIVE CARE	374,110		374,110	4,697	79.65			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	590,595		590,595	14,705	40.16	12,944	519,831	41
42	SUBPROVIDER I								42
43	NURSERY	78,910		78,910	3,694	21.36			43
44	SKILLED NURSING FACILITY						•		44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	6,757,606		6,757,606	121,935		62,361	3,441,797	200

<sup>(</sup>A) Worksheet A line numbers



## Compu-Max

	In Lieu of Form	Period :	Run Date: 01/05/2015
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0125

WORKSHEET D PART II

CHECK	[ ]	TITLE	v		[X	X]	HOSPITAL	[	]	SUB	(OTHER)	[XX]	PPS
APPLICABLE	[XX]	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	5,835,395	163,512,868	0.035688	32,991,852	1,177,413	50
52	DELIVERY ROOM & LABOR ROOM	396,321	7,337,260	0.054015	3,170	171	52
54	RADIOLOGY-DIAGNOSTIC	5,451,669	231,895,918	0.023509	30,475,745	716,454	54
60	LABORATORY	1,157,653	163,711,142	0.007071	36,368,396	257,161	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	104,425	10,308,845	0.010130	3,863,084	39,133	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	422,038	29,986,203	0.014074	16,893,596	237,760	65
66	PHYSICAL THERAPY	814,330	47,254,923	0.017233	8,458,396	145,764	66
70	ELECTROENCEPHALOGRAPHY	401,274	9,389,312	0.042737	971,050	41,500	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,093	47,089,434	0.005162	13,676,120	70,596	71
72	IMPL. DEV. CHARGED TO PATIENTS	322,664	56,384,882	0.005723	19,696,362	112,722	72
73	DRUGS CHARGED TO PATIENTS	690,651	95,311,081	0.007246	36,742,706	266,238	73
76	CARDIOLOGY	3,537,168	125,180,338	0.028257	29,503,844	833,690	76
76.97	CARDIAC REHABILITATION	74,239	1,735,577	0.042775	216,461	9,259	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	216,676	6,038,117	0.035885	60,561	2,173	90
91	EMERGENCY	1,283,839	82,763,966	0.015512	14,523,868	225,294	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	662,422	24,542,784	0.026990			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	21,613,857	1,102,442,650		244,445,211	4,135,328	200

<sup>(</sup>A) Worksheet A line numbers



	In Lieu of Form	Period :	Run Date: 01/05/2015
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Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

#### APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK	[	]	TITLE	V			[X	X]	PPS
APPLICABLE	[XX	]	TITLE	XVIII,	PART	A	[	]	TEFRA
BOXES:	Г	1	TITLE	XIX					

		NURSING SCHOOL	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	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	(General Routine Care)						
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

<sup>(</sup>A) Worksheet A line numbers



## Compu-Max

	In Lieu of Form	Period :	Run Date: 01/05/2015
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Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

#### APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK [ ] TITLE V [XX] PPS APPLICABLE [XX] TITLE XVIII, PART A [ ] TEFRA BOXES: [ ] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	89,003		43,665		30
	(General Routine Care)	*		,		
31	INTENSIVE CARE UNIT	9,836		5,752		31
32	CORONARY CARE UNIT					32
32.01	NEONATAL INTENSIVE CARE	4,697				32.01
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	14,705		12,944		41
42	SUBPROVIDER I					42
43	NURSERY	3,694				43
44	SKILLED NURSING FACILITY		-			44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	121,935		62,361		200

<sup>(</sup>A) Worksheet A line numbers



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
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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	[XX]	HOSPITAL	[	]	SUB (OTHER)	[	1	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE	XVIII, PART A	[ ]	IPF	[	]	SNF				[ ]	TEFRA
BOXES:	[ ] TITLE	XIX	[ ]	IRF	[	]	NF					

		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	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 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							
200	TOTAL (sum of lines 50-199)							200

<sup>(</sup>A) Worksheet A line numbers



# APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

WORKSHEET D PART IV

CHECK	[ ] TITLE V	[XX] HOSPITAL [ ] SUB (OTHE	R) [ ] ICF/MR [XX] PPS
APPLICABLE	[XX] TITLE XVIII, PART A	[ ] IPF	[ ] TEFRA
BOXES:	[ ] TITLE XIX	[ ] IRF [ ] NF	

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS	1.62.512.060			22 001 052		20.455.205		50
50	OPERATING ROOM	163,512,868			32,991,852		28,455,385		50
52	DELIVERY ROOM & LABOR ROOM	7,337,260			3,170				52
54	RADIOLOGY-DIAGNOSTIC	231,895,918			30,475,745		63,665,485		54
60	LABORATORY	163,711,142			36,368,396		10,577,321		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,308,845			3,863,084		994,562		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	29,986,203			16,893,596		1,025,824		65
66	PHYSICAL THERAPY	47,254,923			8,458,396		126,928		66
70	ELECTROENCEPHALOGRAPHY	9,389,312			971,050		2,633,728		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,089,434			13,676,120		13,182,224		71
72	IMPL. DEV. CHARGED TO PATIENTS	56,384,882			19,696,362		10,859,869		72
73	DRUGS CHARGED TO PATIENTS	95,311,081			36,742,706		10,741,547		73
76	CARDIOLOGY	125,180,338			29,503,844		45,922,439		76
76.97	CARDIAC REHABILITATION	1,735,577			216,461		827,673		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	6,038,117			60,561		3,102,038		90
91	EMERGENCY	82,763,966			14,523,868		11,844,400		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	24,542,784					7,974,121		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,102,442,650			244,445,211		211,933,544		200

<sup>(</sup>A) Worksheet A line numbers



	In Lieu of Form	Period :	Run Date: 01/05/2015
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125 WORKSHEET D PART V

CHECK	[ ] TITLE V - O/P	[XX] HOSPITAL	[	] SUB (OTHER)	[	]	SWING BED SNF
APPLICABLE	[XX] TITLE XVIII, PART B	[ ] IPF	[	] SNF	[	]	SWING BED NF
BOXES:	[ ] TITLE XIX - O/P	[ ] IRF	[	] NF	[	]	ICF/MR

			PR	OGRAM CHARG	ES	I	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	0.296185	28,455,385			8,428,058			50
52	DELIVERY ROOM & LABOR ROOM	0.630900							52
54	RADIOLOGY-DIAGNOSTIC	0.120118	63,665,485			7,647,371			54
60	LABORATORY	0.112925	10,577,321			1,194,444			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271	994,562			373,230			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.222869	1,025,824			228,624			65
66	PHYSICAL THERAPY	0.305505	126,928			38,777			66
70	ELECTROENCEPHALOGRAPHY	0.172024	2,633,728			453,064			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596	13,182,224			6,229,866			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522	10,859,869			6,141,495			72
73	DRUGS CHARGED TO PATIENTS	0.224738	10,741,547		84,799	2,414,034		19,058	73
76	CARDIOLOGY	0.147431	45,922,439			6,770,391			76
76.97	CARDIAC REHABILITATION	0.406385	827,673			336,354			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.674715	3,102,038			2,092,992			90
91	EMERGENCY	0.171537	11,844,400			2,031,753			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329	7,974,121			3,638,823			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		211,933,544		84,799	48,019,276		19,058	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		211,933,544		84,799	48,019,276		19,058	202

<sup>(</sup>A) Worksheet A line numbers



#### APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T125

WORKSHEET D PART II

CHECK	[ ]	TITLE V	[	]	HOSPITAL	[	]	SUB	(OTHER)	[X	X]	PPS
APPLICABLE	[XX]	TITLE XVIII, PART A	[	]	IPF					[	]	TEFRA
BOXES:	Γ 1	TITLE XIX	ſΧ	X1	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	5,835,395	163,512,868	0.035688	274,347	9,791	50
52	DELIVERY ROOM & LABOR ROOM	396,321	7,337,260	0.054015			52
54	RADIOLOGY-DIAGNOSTIC	5,451,669	231,895,918	0.023509	1,190,860	27,996	54
60	LABORATORY	1,157,653	163,711,142	0.007071	2,588,612	18,304	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	104,425	10,308,845	0.010130	228,031	2,310	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	422,038	29,986,203	0.014074	1,180,719	16,617	65
66	PHYSICAL THERAPY	814,330	47,254,923	0.017233	12,878,520	221,936	66
70	ELECTROENCEPHALOGRAPHY	401,274	9,389,312	0.042737	161,700	6,911	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,093	47,089,434	0.005162	1,352,280	6,980	71
72	IMPL. DEV. CHARGED TO PATIENTS	322,664	56,384,882	0.005723	81,338	465	72
73	DRUGS CHARGED TO PATIENTS	690,651	95,311,081	0.007246	4,927,031	35,701	73
76	CARDIOLOGY	3,537,168	125,180,338	0.028257	598,824	16,921	76
76.97	CARDIAC REHABILITATION	74,239	1,735,577	0.042775			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	216,676	6,038,117	0.035885	12,444	447	90
91	EMERGENCY	1,283,839	82,763,966	0.015512	1,303	20	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		24,542,784				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	20,951,435	1,102,442,650		25,476,009	364,399	200

<sup>(</sup>A) Worksheet A line numbers



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

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/MR	[XX] PPS
APPLICABLE	[XX] TITLE XVIII, PART A	[ ] IPF	[ ] SNF	[ ] TEFRA
BOXES:	[ ] TITLE XIX	[XX] IRF	[ ] NF	

		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	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 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							
200	TOTAL (sum of lines 50-199)							200

<sup>(</sup>A) Worksheet A line numbers



# 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/MR	[XX] PPS
APPLICABLE	[XX] TITLE XVIII, PART A	[ ] IPF	[ ] SNF	[ ] TEFRA
BOXES:	[ ] TITLE XIX	[XX] IRF	[ ] NF	

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS	1.62.512.060			251215				50
50	OPERATING ROOM	163,512,868			274,347				50
52	DELIVERY ROOM & LABOR ROOM	7,337,260							52
54	RADIOLOGY-DIAGNOSTIC	231,895,918			1,190,860		308		54
60	LABORATORY	163,711,142			2,588,612				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,308,845			228,031				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	29,986,203			1,180,719		97		65
66	PHYSICAL THERAPY	47,254,923			12,878,520				66
70	ELECTROENCEPHALOGRAPHY	9,389,312			161,700		339		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,089,434			1,352,280		2,496		71
72	IMPL. DEV. CHARGED TO PATIENTS	56,384,882			81,338				72
73	DRUGS CHARGED TO PATIENTS	95,311,081			4,927,031		6,118		73
76	CARDIOLOGY	125,180,338			598,824				76
76.97	CARDIAC REHABILITATION	1,735,577							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	6,038,117			12,444				90
91	EMERGENCY	82,763,966			1,303				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	24,542,784							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,102,442,650			25,476,009		9,358	•	200

<sup>(</sup>A) Worksheet A line numbers



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T125

WORKSHEET D PART V

CHECK	[ ] TITLE V - O/P	[ ] HOSPITAL	[ ] SUB (OTHER)	[	]	SWING BED SNF
APPLICABLE	[XX] TITLE XVIII, PART B	[ ] IPF	[ ] SNF	[	]	SWING BED NF
BOXES:	[ ] TITLE XIX - O/P	[XX] IRF	[ ] NF	[	]	ICF/MR

			PR	OGRAM CHARG	ES	I	PROGRAM COST	7	
		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	0.296185							50
52	DELIVERY ROOM & LABOR ROOM	0.630900							52
54	RADIOLOGY-DIAGNOSTIC	0.120118	308			37			54
60	LABORATORY	0.112925							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.222869	97			22			65
66	PHYSICAL THERAPY	0.305505							66
70	ELECTROENCEPHALOGRAPHY	0.172024	339			58			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596	2,496			1,180			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522							72
73	DRUGS CHARGED TO PATIENTS	0.224738	6,118		5,551	1,375		1,248	73
76	CARDIOLOGY	0.147431							76
76.97	CARDIAC REHABILITATION	0.406385							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.674715							90
91	EMERGENCY	0.171537							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		9,358		5,551	2,672		1,248	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		9,358		5,551	2,672		1,248	202

<sup>(</sup>A) Worksheet A line numbers



#### APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

CHECK [ ] TITLE V [XX] PPS APPLICABLE [ ] TITLE XVIII, PART A [ ] TEFRA BOXES: [XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST- MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	4,452,977		4,452,977	89,003	50.03	4,294	214,829	30
31	INTENSIVE CARE UNIT	1,261,014		1,261,014	9,836	128.20	476	61,023	31
32	CORONARY CARE UNIT								32
32.01	NEONATAL INTENSIVE CARE	374,110		374,110	4,697	79.65	447	35,604	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	590,595		590,595	14,705	40.16	277	11,124	41
42	SUBPROVIDER I								42
43	NURSERY	78,910		78,910	3,694	21.36	308	6,579	43
44	SKILLED NURSING FACILITY						•		44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	6,757,606		6,757,606	121,935		5,802	329,159	200

<sup>(</sup>A) Worksheet A line numbers



#### APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0125

WORKSHEET D PART II

CHECK	[	1	TITLE	v			[X	X]	HOSPITAL	[	]	SUB	(OTHER)	[XX	<b>K</b> ]	PPS
APPLICABLE	[	]	TITLE	XVIII,	PART	A	[	]	IPF					[	]	TEFRA
BOXES:	[X	<b>X</b> ]	TITLE	XIX			[	1	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	5,835,395	163,512,868	0.035688	2,047,330	73,065	50
52	DELIVERY ROOM & LABOR ROOM	396,321	7,337,260	0.054015	160,618	8,676	52
54	RADIOLOGY-DIAGNOSTIC	5,451,669	231,895,918	0.023509	2,890,327	67,949	54
60	LABORATORY	1,157,653	163,711,142	0.007071	3,131,063	22,140	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	104,425	10,308,845	0.010130	431,659	4,373	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	422,038	29,986,203	0.014074	791,583	11,141	65
66	PHYSICAL THERAPY	814,330	47,254,923	0.017233	440,521	7,591	66
70	ELECTROENCEPHALOGRAPHY	401,274	9,389,312	0.042737	72,667	3,106	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,093	47,089,434	0.005162	1,072,184	5,535	71
72	IMPL. DEV. CHARGED TO PATIENTS	322,664	56,384,882	0.005723	925,068	5,294	72
73	DRUGS CHARGED TO PATIENTS	690,651	95,311,081	0.007246	4,156,615	30,119	73
76	CARDIOLOGY	3,537,168	125,180,338	0.028257	1,460,788	41,277	76
76.97	CARDIAC REHABILITATION	74,239	1,735,577	0.042775	4,346	186	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	216,676	6,038,117	0.035885	23,762	853	90
91	EMERGENCY	1,283,839	82,763,966	0.015512	1,110,240	17,222	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	662,422	24,542,784	0.026990			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	21,613,857	1,102,442,650		18,718,771	298,527	200

<sup>(</sup>A) Worksheet A line numbers



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

#### APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK [ ] TITLE V [XX] PPS APPLICABLE [ ] TITLE XVIII, PART A [ ] TEFRA BOXES: [XX] TITLE XIX

		NURSING SCHOOL	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	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	(General Routine Care)						
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

<sup>(</sup>A) Worksheet A line numbers



#### APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

CHECK [ ] TITLE V [XX] PPS APPLICABLE [ ] TITLE XVIII, PART A [ ] TEFRA BOXES: [XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	INPATIENT ROUTINE SERV COST CENTERS	0	/	0	,	
30	ADULTS & PEDIATRICS (General Routine Care)	89,003		4,294		30
31	INTENSIVE CARE UNIT	9,836		476		31
32	CORONARY CARE UNIT					32
32.01	NEONATAL INTENSIVE CARE	4,697		447		32.01
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	14,705		277		41
42	SUBPROVIDER I					42
43	NURSERY	3,694	•	308		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	121,935		5,802		200

<sup>(</sup>A) Worksheet A line numbers



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

WORKSHEET D PART IV

CHECK	[	]	TITLE	v		[X	۲]	HOSPITAL	[	]	SUB	(OTHER)	[	1	ICF/MR	[XX]	PPS
APPLICABLE	[	]	TITLE	XVIII,	PART A	[	]	IPF	[	]	SNF					[ ]	TEFRA
BOXES:	[X	X]	TITLE	XIX		[	]	IRF	[	]	NF						

		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	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 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							
200	TOTAL (sum of lines 50-199)							200

<sup>(</sup>A) Worksheet A line numbers



# APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

WORKSHEET D PART IV

CHECK	[	]	TITLE	v		[X	x]	HOSPITAL	[	]	SUB	(OTHER)	[	]	ICF/MR	[X	x]	PPS
APPLICABLE	[	]	TITLE	XVIII,	PART A	[	]	IPF	[	]	SNF					[	]	TEFRA
BOXES:	[X	X]	TITLE	XIX		[	]	IRF	[	]	NF							

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT 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	163,512,868			2,047,330				50
52	DELIVERY ROOM & LABOR ROOM	7,337,260			160,618				52
54	RADIOLOGY-DIAGNOSTIC	231,895,918			2,890,327				54
60	LABORATORY	163,711,142			3,131,063				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,308,845			431,659				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	29,986,203			791,583				65
66	PHYSICAL THERAPY	47,254,923			440,521				66
70	ELECTROENCEPHALOGRAPHY	9,389,312			72,667				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,089,434			1,072,184				71
72	IMPL. DEV. CHARGED TO PATIENTS	56,384,882			925,068				72
73	DRUGS CHARGED TO PATIENTS	95,311,081			4,156,615				73
76	CARDIOLOGY	125,180,338			1,460,788				76
76.97	CARDIAC REHABILITATION	1,735,577			4,346				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	6,038,117			23,762				90
91	EMERGENCY	82,763,966			1,110,240				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	24,542,784							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,102,442,650			18,718,771				200

<sup>(</sup>A) Worksheet A line numbers



# Сомри-Мах

	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125

WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[XX]	[]	HOSPITAL	[	]	SUB (OTHER)	]	1	SWING BED	SNF
APPLICABLE	[ ]	TITLE XVIII, PART B	[	]	IPF	[	]	SNF	[	]	SWING BED	NF
BOXES:	[XX]	TITLE XIX - O/P	[	]	IRF	[	]	NF	[	]	ICF/MR	

COST TO CHARGE RATIO (TOSH FOR PER PER PER PER PER PER PER PER PER PE				DD	OGRAM CHARG	EC	1	PROGRAM COST	,	
COST TO CHARGE RATIO (Home SERVICES Wast C, Part I, col. 9)				PK	OGRAM CHARO		,	ROOKAWI COST		+
ANCILLARY SERVICE COST CENTERS			CHARGE RATIO (from Wkst C, Part I,	BURSED SERVICES (see	REIM- BURSED SUBJECT TO DED. & COINS. (see	REIM- BURSED NOT SUBJECT TO DED. & COINS. (see	SERVICES (see	REIM- BURSED SUBJECT TO DED. & COINS. (see	REIM- BURSED NOT SUBJECT TO DED. & COINS. (see	
SO   OPERATING ROOM   O.296185   SO   DELIVERY ROOM & LABOR ROOM   O.630900   ST   ST   ST   ST   ST   ST   ST	(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
S2   DELIVERY ROOM & LABOR ROOM   0.630900     52		ANCILLARY SERVICE COST CENTERS								
S4   RADIOLOGY-DIAGNOSTIC   0.120118	50	OPERATING ROOM	0.296185							50
CARDIOLOGY		DELIVERY ROOM & LABOR ROOM	0.630900							52
62   WHOLE BLOOD & PACKED RED BLOOD CELLS   0.375271     62   62.30   62.30   62.30   62.30   65   65   65   65   66   65   66   65   66	54	RADIOLOGY-DIAGNOSTIC	0.120118							54
62.30   BLOOD CLOTTING FOR HEMOPHILIACS   62.30   65   RESPIRATORY THERAPY   0.222869   65   65   66   PHYSICAL THERAPY   0.305505   66   PHYSICAL THERAPY   0.172024   67   70   ELECTROENCEPHALOGRAPHY   0.172024   70   71   MEDICAL SUPPLIES CHARGED TO PATIENTS   0.472596   71   72   IMPL. DEV. CHARGED TO PATIENTS   0.565522   72   72   73   DRUGS CHARGED TO PATIENTS   0.224738   76   CARDIOLOGY   0.147431   76   76   76   76   76   76   76   7	60	LABORATORY	0.112925							60
65   RESPIRATORY THERAPY   0.222869     65     66   PHYSICAL THERAPY   0.305505     66     70   ELECTROENCEPHALOGRAPHY   0.172024     70     11   MEDICAL SUPPLIES CHARGED TO PATIENTS   0.472596     71     12   IMPL. DEV. CHARGED TO PATIENTS   0.565522     72     13   DRUGS CHARGED TO PATIENTS   0.224738     73     76   CARDIOLOGY   0.147431     76     76.97   CARDIAC REHABILITATION   0.406385     76.97     76.98   HYPERBARIC OXYGEN THERAPY     76.98     76.99   LITHOTRIPSY     76.99     OUTPATIENT SERVICE COST CENTERS     90     90   CLINIC   0.674715     91     91   EMERGENCY   0.171537     91     92   OBSERVATION BEDS (NON-DISTINCT PART)   0.456329   0.456329   0.456329     00   CLINIC   0.456329   0.456329   0.456329   0.456329     01   LESS PBP CLINIC LAB. SERVICES PROGRAM   0.0NLY CHARGES   201			0.375271							
66   PHYSICAL THERAPY   0.305505   66     70										62.30
To   ELECTROENCEPHALOGRAPHY   0.172024										
T1	66									
72   IMPL. DEV. CHARGED TO PATIENTS   0.565522   72   73   DRUGS CHARGED TO PATIENTS   0.224738   73   76   76   76   76   76   76   76	70									
73   DRUGS CHARGED TO PATIENTS   0.224738   73   76   CARDIOLOGY   0.147431   76   76.97   CARDIAC REHABILITATION   0.406385   76.97   CARDIAC REHABILITATION   0.406385   76.99   LITHOTRIPSY   76.99   LITHOTRIPSY   76.99   LITHOTRIPSY   76.99   OUTPATIENT SERVICE COST CENTERS   90   CLINIC   0.674715   90   91   EMERGENCY   0.171537   91   92   OBSERVATION BEDS (NON-DISTINCT PART)   0.456329   92   OTHER REIMBURSABLE COST CENTERS   92   OTHER REIMBURSABLE COST CENTERS   92   92   OTHER REIMBURSABLE COST CENTERS   90   92   92   92   93   94   94   94   94   94   94   94	71									
76										
76.97   CARDIAC REHABILITATION   0.406385   76.97   76.98   HYPERBARIC OXYGEN THERAPY   76.98   The property   76.99   The property   7										
76.98   HYPERBARIC OXYGEN THERAPY   76.98   76.99   1/1   1/1   1/2										
76.99   LITHOTRIPSY   76.99			0.406385							
OUTPATIENT SERVICE COST CENTERS   90   CLINIC   0.674715   90   91   EMERGENCY   0.171537   91   92   OBSERVATION BEDS (NON-DISTINCT PART)   0.456329   92   OTHER REIMBURSABLE COST CENTERS   90   92   92   93   94   94   95   95   95   95   95   95										
90         CLINIC         0.674715         90           91         EMERGENCY         0.171537         91           92         OBSERVATION BEDS (NON-DISTINCT PART)         0.456329         92           OTHER REIMBURSABLE COST CENTERS         200         SUBTOTAL (see instructions)         200           201         LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES         201	76.99									76.99
91         EMERGENCY         0.171537         91           92         OBSERVATION BEDS (NON-DISTINCT PART)         0.456329         92           OTHER REIMBURSABLE COST CENTERS         200         SUBTOTAL (see instructions)         200           201         LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES         201										
92         OBSERVATION BEDS (NON-DISTINCT PART)         0.456329         92           OTHER REIMBURSABLE COST CENTERS         200         SUBTOTAL (see instructions)         200           201         LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES         201										
OTHER REIMBURSABLE COST CENTERS  200 SUBTOTAL (see instructions)  201 LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES  201 ONLY CHARGES										
200     SUBTOTAL (see instructions)     200       201     LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES     201	92		0.456329							92
201 LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES 201										
201 ONLY CHARGES 201	200	,								200
	201									201
	202									202

<sup>(</sup>A) Worksheet A line numbers



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T125

WORKSHEET D PART II

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] PPS
APPLICABLE [ ] TITLE XVIII, PART A [ ] IPF
BOXES: [XX] TITLE XIX [XX] 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	5,835,395	163,512,868	0.035688	5,338	191	50
52	DELIVERY ROOM & LABOR ROOM	396,321	7,337,260	0.054015			52
54	RADIOLOGY-DIAGNOSTIC	5,451,669	231,895,918	0.023509	28,196	663	54
60	LABORATORY	1,157,653	163,711,142	0.007071	46,121	326	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	104,425	10,308,845	0.010130	3,019	31	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	422,038	29,986,203	0.014074	32,046	451	65
66	PHYSICAL THERAPY	814,330	47,254,923	0.017233	248,850	4,288	66
70	ELECTROENCEPHALOGRAPHY	401,274	9,389,312	0.042737	1,539	66	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,093	47,089,434	0.005162	21,609	112	71
72	IMPL. DEV. CHARGED TO PATIENTS	322,664	56,384,882	0.005723			72
73	DRUGS CHARGED TO PATIENTS	690,651	95,311,081	0.007246	143,588	1,040	73
76	CARDIOLOGY	3,537,168	125,180,338	0.028257	8,605	243	76
76.97	CARDIAC REHABILITATION	74,239	1,735,577	0.042775			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	216,676	6,038,117	0.035885	122	4	90
91	EMERGENCY	1,283,839	82,763,966	0.015512			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		24,542,784				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	20,951,435	1,102,442,650		539,033	7,415	200

<sup>(</sup>A) Worksheet A line numbers



#### COMPLI-MAX

| In Lieu of Form | Period : | Run Date: 01/05/2015 | COMMUNITY HOSPITAL | CMS-2552-10 | From: 07/01/2013 | Run Time: 13:42 | Provider CCN: 15-0125 | To: 06/30/2014 | Version: 2014.10

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/MR [XX] PPS
APPLICABLE [ ] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA
BOXES: [XX] TITLE XIX [XX] IRF [ ] NF

		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	T
	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							
200	TOTAL (sum of lines 50-199)							200

<sup>(</sup>A) Worksheet A line numbers



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T125

WORKSHEET D PART IV

CHECK	[	]	TITLE	v		[	]	HOSPITAL	[	]	SUB	(OTHER)	]	1	ICF/MR	[XX]	[]	PPS
APPLICABLE	[	]	TITLE	XVIII,	PART A	[	]	IPF	[	]	SNF					[	1	TEFRA
BOXES:	[X	X]	TITLE	XIX		[X	[]	IRF	[	]	NF							

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
50	ANCILLARY SERVICE COST CENTERS	1/2 512 0/0			5 220				50
50	OPERATING ROOM	163,512,868			5,338				50
_	DELIVERY ROOM & LABOR ROOM	7,337,260			20.106				_
54	RADIOLOGY-DIAGNOSTIC	231,895,918			28,196				54
60	LABORATORY	163,711,142			46,121				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,308,845			3,019				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	20.007.202			22.046				62.30
65	RESPIRATORY THERAPY	29,986,203			32,046				65
66	PHYSICAL THERAPY	47,254,923			248,850				66
70	ELECTROENCEPHALOGRAPHY	9,389,312			1,539				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,089,434			21,609				71
72	IMPL. DEV. CHARGED TO PATIENTS	56,384,882							72
73	DRUGS CHARGED TO PATIENTS	95,311,081			143,588				73
76	CARDIOLOGY	125,180,338			8,605				76
76.97	CARDIAC REHABILITATION	1,735,577							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	6,038,117			122				90
91	EMERGENCY	82,763,966							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	24,542,784							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,102,442,650			539,033				200

<sup>(</sup>A) Worksheet A line numbers



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T125 WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[	]	HOSPITAL	[	]	SUB (OTHER)	]	]	SWING BED SNF
APPLICABLE	[ ]	TITLE XVIII, PART B	[	]	IPF	[	]	SNF	[	]	SWING BED NF
BOXES:	[XX]	TITLE XIX - O/P	[XX	[]	IRF	[	]	NF	]	]	ICF/MR

COST TO CHARGE RATIO (CHARGE RATIO (From West C, Part), col. 9)				PR	OGRAM CHARG	FS	1	PROGRAM COST	,	
ANCILLARY SERVICE COST CENTERS			CHARGE RATIO (from Wkst C, Part I,	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.)	
SO   OPERATING ROOM   O.296185   SO	(A)		1	2	3	4	5	6	7	
DELIVERY ROOM & LABOR ROOM		ANCILLARY SERVICE COST CENTERS								
S4   RADIOLOGY-DIAGNOSTIC   0.120118										
CARDIOLOGY   CARDIAC REHABILITATION   CARDIOLOGY   CARD	52	DELIVERY ROOM & LABOR ROOM	0.630900							52
62   WHOLE BLOOD & PACKED RED BLOOD CELLS   0.375271     62   62.30   62.30   62.30   62.30   62.30   62.30   62.30   65   65   65   65   66   67   65   66   67   66   67   66   67   66   67   66   67   66   67   66   67   66   67   66   67   6	54	RADIOLOGY-DIAGNOSTIC	0.120118							54
62.30   BLOOD CLOTTING FOR HEMOPHILIACS   62.30	60	LABORATORY	0.112925							60
65         RESPIRATORY THERAPY         0.222869         65           66         PHYSICAL THERAPY         0.305505         66           70         ELECTROENCEPHALOGRAPHY         0.172024         70           71         MEDICAL SUPPLIES CHARGED TO PATIENTS         0.472596         71           72         IMPL. DEV. CHARGED TO PATIENTS         0.565522         72           73         DRUGS CHARGED TO PATIENTS         0.224738         73           76.97         CARDIOLOGY         0.147431         76           76.97         CARDIAC REHABILITATION         0.406385         76.97           76.98         HYPERBARIC OXYGEN THERAPY         8         76.98           76.99         LITHOTRIPSY         90         76.99           OUTPATIENT SERVICE COST CENTERS         90         CLINIC         90           90         CLINIC         0.674715         90           91         EMERGENCY         0.171537         91           92         OBSERVATION BEDS (NON-DISTINCT PART)         0.456329         92           OTHER REIMBURSABLE COST CENTERS         90         200           201         LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES         201	62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271							62
66         PHYSICAL THERAPY         0.305505         66           70         ELECTROENCEPHALOGRAPHY         0.172024         70           71         MEDICAL SUPPLIES CHARGED TO PATIENTS         0.472596         71           72         IMPL, DEV. CHARGED TO PATIENTS         0.565522         72           73         DRUGS CHARGED TO PATIENTS         0.224738         73           76         CARDIOLOGY         0.147431         76           76.97         CARDIAC REHABILITATION         0.406385         76.97           76.98         HYPERBARIC OXYGEN THERAPY         8         76.98           76.99         LITHOTRIPSY         9         76.98           90         CLINIC         0.674715         90           91         EMERGENCY         0.171537         91           92         OBSERVATION BEDS (NON-DISTINCT PART)         0.456329         92           OTHER REIMBURSABLE COST CENTERS         90         200           201         LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES         201	62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
To	65	RESPIRATORY THERAPY	0.222869							65
T1	66	PHYSICAL THERAPY	0.305505							66
T2	70	ELECTROENCEPHALOGRAPHY	0.172024							70
73   DRUGS CHARGED TO PATIENTS   0.224738   73   76   CARDIOLOGY   0.147431   76   76   76   76   76   76   76   7	71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596							71
76	72	IMPL. DEV. CHARGED TO PATIENTS	0.565522							72
76.97   CARDIAC REHABILITATION   0.406385   76.97   76.98   HYPERBARIC OXYGEN THERAPY   76.98   T6.99   T6.9	73	DRUGS CHARGED TO PATIENTS	0.224738							73
76.98   HYPERBARIC OXYGEN THERAPY   76.98   76.99   1/1	76	CARDIOLOGY	0.147431							76
76.99   LITHOTRIPSY	76.97	CARDIAC REHABILITATION	0.406385							76.97
OUTPATIENT SERVICE COST CENTERS   90   CLINIC   0.674715   90   91	76.98	HYPERBARIC OXYGEN THERAPY								76.98
90         CLINIC         0.674715         90           91         EMERGENCY         0.171537         91           92         OBSERVATION BEDS (NON-DISTINCT PART)         0.456329         92           OTHER REIMBURSABLE COST CENTERS           200         SUBTOTAL (see instructions)         200           201         LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES         201	76.99	LITHOTRIPSY								76.99
91         EMERGENCY         0.171537         91           92         OBSERVATION BEDS (NON-DISTINCT PART)         0.456329         92           OTHER REIMBURSABLE COST CENTERS         200         SUBTOTAL (see instructions)         200           201         LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES         201		OUTPATIENT SERVICE COST CENTERS								
92         OBSERVATION BEDS (NON-DISTINCT PART)         0.456329         92           OTHER REIMBURSABLE COST CENTERS         200         SUBTOTAL (see instructions)         200           201         LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES         201	90	CLINIC	0.674715							90
OTHER REIMBURSABLE COST CENTERS  200 SUBTOTAL (see instructions)  201 LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES  201  201	91	EMERGENCY	0.171537							91
200     SUBTOTAL (see instructions)     200       201     LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES     201	92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329							92
201 LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES 201		OTHER REIMBURSABLE COST CENTERS								
201 ONLY CHARGES 201	200	SUBTOTAL (see instructions)								200
	201									201
	202									202

<sup>(</sup>A) Worksheet A line numbers



#### COMPLI-MAX

	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-0125 WORKSHEET D-1 PART I [ ] SUB (OTHER) CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] ICF/MR [XX] PPS ] SNF ] TEFRA APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF Γ [ ] TITLE XIX - I/P ] OTHER BOXES: [ ] IRF ] NF PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1 INPATIENT DAYS (including private room days and swing-bed days, excluding newborn) 89 003 INPATIENT DAYS (including private room days, excluding swing-bed and newborn days) 89.003 PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE. 25 218 4 SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days) 50.545 4 5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar 6 year, enter 0 on this line) TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, 8 enter 0 on this line) INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)

SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST 43.665 9 10 REPORTING PERIOD (see instructions) SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 11 REPORTING PERIOD (if calendar year, enter 0 on this line)
SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE 12 COST REPORTING PERIOD SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 13 REPORTING PERIOD (if calendar year, enter 0 on this line) MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days) 14 14 TOTAL NURSERY DAYS (Title V or Title XIX only) 15 16 TITLE V OR XIX NURSERY DAYS (Title V or Title 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 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)
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DE 75.286.305 21 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17) 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) 26 TOTAL SWING-BED COST (see instructions)

4	5 TOTAL SWING-BED COST (SEE HISH UCHORS)	1	20
2	7 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	75,286,305	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
2	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	60,375,827	28
2	PRIVATE ROOM CHARGES (excluding swing-bed charges)	20,114,954	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	40,260,873	30
3	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.246961	31
3:		797.64	32
3:		796.54	33
3.		1.10	34
3:		1.37	35
3	6 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	34,549	36
3	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	75,251,756	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART II

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS
APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
BOXES: [ ] TITLE XIX - I/P [ ] IRF [ ] OTHER

#### PART II - HOSPITALS AND SUBPROVIDERS ONLY

				· · · · ·					
20		THROUGH COS	ST ADJUSTME	NTS		1	20		
38	(211 21 111 2)					845.89	38		
		14 1' 25)				36,935,787	40		
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)  TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)  TOTAL INPATIENT (COST DAYS COL. 2)  NEATHER TOTAL INPATIENT (COST DAYS COL. 2)  NURSERY (Titles V and XIX only)  NURSERY (Titles V and XIX								
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)		I	AMEDACE		36,935,787 PROGRAM	41		
		TOTAL	TOTAL		DDOCDAM	COST			
		INPATIENT	INPATIENT			(col. 3 x			
		COST	DAYS	,	DATS	col. 4)			
		1	2		4	5			
12	NUDCEDY (Tide-V and VIV and A)	1	2	3	4	3	42		
42							42		
42		16 551 002	0.926	1,692,90	5 752	9,679,466	43		
43		16,551,992	9,836	1,682.80	5,/52	9,6/9,466	43		
44.01		5 5 47 3 57	4.607	1 101 04			44.01		
44.01		5,547,557	4,697	1,181.04			44.01		
46							45		
46							46		
4/	OTHER SPECIAL CARE (SPECIFY)					1	4/		
48	DDOCD AM INDATIENT ANCH LADV CEDVICE COCT (Workshoot D.2. ashuma 2. line 200)					58,376,002	48		
49						104,991,255			
49		ATENITO .				104,991,255	49		
50			) annu of Donto I	and III)		2.921.966	50		
51						4.135.328	51		
52									
		NIDITY CICIANI A	MECTHETICT A	ND MEDICAL I	EDUCATION	7,057,294	32		
53		INPIT I SICIAN A	MESTRETIST A	IND MEDICAL I	EDUCATION	97,933,961	53		
		DUTATION							
54		TUTATION					54		
55							55		
56							56		
57		LINIT (lina 56 mir	ug ling 52)				57		
58		ONT (fille 30 filli	ius iiie 55)				58		
		IC 1006 LIDDAT	ED AND COMP	OUNDED BY T	HE MADVET		36		
59		IG 1990, UFDA1	ED AND COMF	OUNDED B1 11	HE WAKKE I		59		
60		DV THE MADI	ZET BASKET				60		
				HICH ODED AT	ING COSTS				
61							61		
62		51 <b>V1</b> (IIIC 50), O	THER WISE ENT	EK ZEKO (SCC II	isti uctions)		62		
63							63		
0.5		G RED COST				L	0.5		
			PORTING PERIO	OD (see instruction	one) (Title				
64		THE COST RE	CKTINGTEK	OD (See Histraction	ons) (Title		64		
		IE COST REPOR	TING PERIOD	(see instructions)	(Title XVIII				
65	only)	IL COST KLI OF	TING I ERIOD	see msu detions)	(THE AVIII		65		
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For C	AH see instruct	ione)				66		
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (THE XVIII OHLY, FOR			ERIOD (line 12 s	line 10)		67		
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS I THROUGH DECEMBER 31 OF						68		
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF	THE COST KE	OKTINGTERN	OLD (IIII) CIC	201		69		
07	TOTAL TITLE YOR ALA SWING-DED IN THE ATTENT ROUTINE COSTS (IIIIC 07 + IIIIC 08)						L 07		



# Сомри-Мах

	In Lieu of Form	Period :	Run Date: 01/05/2015
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Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1 PARTS III & IV

CHECK	[ ] TITLE V - I/P	[XX] HOSPITAL [ ] SUB (OTH	ER) [ ] ICF/MR [XX] PPS
APPLICABLE	[XX] TITLE XVIII, PART A	[ ] IPF [ ] SNF	[ ] TEFRA
BOXES:	[ ] TITLE XIX - I/P	[ ] IRF [ ] NF	[ ] OTHER

#### PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					13,240	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					845.89	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					11,199,584	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV- ATION BED COST (from line89)	OBSERV- ATION BED PASS- THROUGH COST col. 3 x col. 4) (see instr- uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	4,452,977	75,286,305	0.059147	11,199,584	662,422	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



#### COMPLI-MAX

	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-T125 WORKSHEET D-1 PART I CHECK [ ] TITLE V - I/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS ] TEFRA APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF ] SNF Γ ] TITLE XIX - I/P BOXES: [XX] TRF ] NF ] OTHER PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1 INPATIENT DAYS (including private room days and swing-bed days, excluding newborn) 14 705 14,705 INPATIENT DAYS (including private room days, excluding swing-bed and newborn days) PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE. 1 524 4 SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days) 13,181 4 5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar 6 year, enter 0 on this line) TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, 8 enter 0 on this line) INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days) 12.944 9 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST 10 REPORTING PERIOD (see instructions) SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 11 REPORTING PERIOD (if calendar year, enter 0 on this line) SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE 12 COST REPORTING PERIOD SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 13 REPORTING PERIOD (if calendar year, enter 0 on this line) MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days) 14 14 1,317 TOTAL NURSERY DAYS (Title V or Title XIX only) 15 16 TITLE V OR XIX NURSERY DAYS (Title V or Title 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 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 10,587,762 21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DE 21 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17) 23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18) 23 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19) 24 25 25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20) TOTAL SWING-BED COST (see instructions) 26 27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST 10,587,762 27 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges) 5.447.659 28 29 PRIVATE ROOM CHARGES (excluding swing-bed charges) 646,362 29 4,801,297 30 1.943543 31 30 SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges) 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28) AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3) 424.12 32

33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)

35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)

34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)

37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)

364.26 33

59.86 34 116.34 35

177,302 | 36

10.410.460 37



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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)	[XX] PPS
APPLICABLE	[XX] TITLE XVIII, PART A	[ ] IPF	[ ] TEFRA
BOXES:	[ ] TITLE XIX - I/P	[XX] IRF	[ ] OTHER

#### PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS—THROUGH COST ADJUSTMENTS   720.01   38   38   ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST (dine 9 x line 38)   PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (dine 9 x line 38)   9,319,809   39   40   41   TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (dine 9 x line 38)   40   41   TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (dine 39 + line 40)   9,319,809   41   42   43   44   44   45   45   45   45   45				
PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)		PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)	38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	720.01	38
TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 30 + line 40)   9,319,809   41     PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D.3, column 3, line 200)   6,717,855   48     TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)   16,037,664   49     TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)   16,037,664   49     TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)   16,037,664   49     PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)   519,831   50     TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)   584,230   52     TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION   18,153,434   53     COSTS (line 49 minus line 52)   TARGET AMOUNT AND LIMIT COMPUTATION   15,153,434   53     TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION   15,153,434   53     TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION   15,153,434   53     TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION   15,153,434   53     TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION   15,153,434   53     TOTAL PROGRAM INPATIENT ROUTINE OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)   15,153,434   53     TOTAL PROGRAM INPATIENT ROUTINE COST AND TARGET AMOUNT (line 56 minus line 53)   57     TOTAL PROGRAM INPATIENT ROUTINE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET   59     BONUS PAYMENT (see instructions)   58   56     TOTAL PROGRAM INPATIENT ROUTINE COST REPORTING PERIOD (see instructions) (Title XVIII only)   15     TOTAL PROGRAM INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)   67     TOTAL PROGRA	39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	9,319,809	39
PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D.3, column 3, line 200)	40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)   16,037,664   49	41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	9,319,809	41
PASS-THROUGH COST ADJUSTMENTS  O PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)  51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts II and IV)  52 TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)  53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION  COSTS (line 49 minus line 52)  TARGET AMOUNT (and 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54 PROGRAM DISCHARGES  55 TARGET AMOUNT PER DISCHARGE  55 TARGET AMOUNT PER DISCHARGE  56 TARGET AMOUNT PER DISCHARGE  57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)  58 BONUS PAYMENT (see instructions)  59 BASKET  60 LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET  59 BASKET  60 LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET  61 IF LINE 53 + STA LIS LESS THAN THE LOWER OF LINES 55, 59 OR 06 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS  61 (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)  62 RELIEF PAYMENT (see instructions)  63 ALLOWABLE INPATIENT COST FLUS INCENTIVE PAYMENT (see instructions)  64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  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 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)	48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	6,717,855	48
So	49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	16,037,664	49
S1   PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)   364,399   51		PASS-THROUGH COST ADJUSTMENTS		
TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)  TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION  15,153,434  15,1	50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	519,831	50
TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION  TARGET AMOUNT AND LIMIT COMPUTATION  15,153,434 53  TARGET AMOUNT PER DISCHARGES 55 TARGET AMOUNT (line 54 x line 55) 56 TARGET AMOUNT (line 54 x line 55) 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53) 58 BONUS PAYMENT (see instructions) 59 LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM THE COST REPORT, UPDATED BY THE MARKET BASKET 50 LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 50 LESSER OF LINE 53 + LINE 54 OR LINE 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 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions) 62 RELIEF PAYMENT (see instructions) 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions) 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only) 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions) 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions) 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE	51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	364,399	51
TARGET AMOUNT AND LIMIT COMPUTATION  TARGET AMOUNT AND LIMIT COMPUTATION  54 PROGRAM DISCHARGES  55 TARGET AMOUNT PER DISCHARGE  55 TARGET AMOUNT PER DISCHARGE  56 TARGET AMOUNT (line 54 x line 55)  57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)  58 BONUS PAYMENT (see instructions)  59 LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET  59 BASKET  60 LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET  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)  62 RELIEF PAYMENT (see instructions)  63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)  64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only) FOR CAH, see instructions)  66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, FOR CAH, see instructions)  67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  69 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)  60 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)  60 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)	52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	884,230	52
TARGET AMOUNT AND LIMIT COMPUTATION  54 PROGRAM DISCHARGES 55 TARGET AMOUNT (PER DISCHARGE 56 TARGET AMOUNT (line 54 x line 55) 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53) 58 BONUS PAYMENT (see instructions) 59 LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET 59 BASKET 60 LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60 LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 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 63 (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions) 64 RELIEF PAYMENT (see instructions) 65 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions) 66 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions) 67 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only) 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 69 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 60 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 60 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 61 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20) 62 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20) 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 15 x line 20)	52	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION	15 152 424	52
54   PROGRAM DISCHARGES   54   55   55   56   56   56   56   57   56   56	33	COSTS (line 49 minus line 52)	15,155,454	33
55 TARGET AMOUNT PER DISCHARGE 56 TARGET AMOUNT (line 54 x line 55) 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53) 58 BONUS PAYMENT (see instructions) 59 LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET 59 BASKET 60 LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 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) 62 RELIEF PAYMENT (see instructions) 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions) 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only) 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only) 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 68		TARGET AMOUNT AND LIMIT COMPUTATION		
TARGET AMOUNT (line 54 x line 55)  TARGET AMOUNT (line 54 x line 53)  TARGET AMOUNT (line 54 x line 53)  TARGET AMOUNT (line 54 x line 53)  TARGET AMOUNT (line 56 minus line 53)  TARGET AMOUNT (line 56 minus line 53)  TARGET AMOUNT (line 56)  TARGET AMOUNT (line 53)  TARGET AMOUNT (line 56)  TARGET AMOUNT (line 53)  TARGET AMOUNT (line 55)  TARGET AMOUNT (line 56)  TARGET AMOUNT (line 53)  TARGET AMOUNT (line 56)  TARGET AMOUNT (line 53)  TARGET AMOUNT (line 56)  TARGET AMOUNT	54	PROGRAM DISCHARGES		54
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)  58 BONUS PAYMENT (see instructions)  59 LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET  59 BASKET  60 LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET  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)  62 RELIEF PAYMENT (see instructions)  63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)  64 PROGRAM INPATIENT ROUTINE SWING BED COST  65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions)  67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  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	55	TARGET AMOUNT PER DISCHARGE		55
58   BONUS PAYMENT (see instructions)   58     59	56	TARGET AMOUNT (line 54 x line 55)		56
LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET  60 LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET  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)  62 RELIEF PAYMENT (see instructions) 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)  64 PROGRAM INPATIENT ROUTINE SWING BED COST  65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  66 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  67 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68	57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
BASKET  60 LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET  61 LESSER OF 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)  62 RELIEF PAYMENT (see instructions)  63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)  64 PROGRAM INPATIENT ROUTINE SWING BED COST  65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  66 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  67 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 20)  68	58	BONUS PAYMENT (see instructions)		58
BASKE1  60 LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET  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)  62 RELIEF PAYMENT (see instructions)  63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)  64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions)  67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 20)  68	50	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET		50
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)  62 RELIEF PAYMENT (see instructions)  63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)  7 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)  65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)  67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  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	39	BASKET		39
Cline 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)   Cline 52	60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
(Ime 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)  62 RELIEF PAYMENT (see instructions)  63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)  64 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)  65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)  67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  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	(1	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		(1
63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)  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)  65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions)  67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  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	01	(line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		01
PROGRAM INPATIENT ROUTINE SWING BED COST  MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  65  TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)  66  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	62	RELIEF PAYMENT (see instructions)		62
MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)  65  TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)  66  TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  67  TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)  68	63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
XVIII only)		PROGRAM INPATIENT ROUTINE SWING BED COST		
XVIII only)  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)  67  TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  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	64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title		64
only)  65  66  TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)  67  TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  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	04	XVIII only)		04
only)  66  TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)  67  TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)  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		MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII		65
67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19) 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 68	65	only)		65
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	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
69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68) 69	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



#### COMPLI-MAX

	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST COMPONENT CCN: 15-0125 WORKSHEET D-1 PART I [ ] SUB (OTHER) CHECK 1 TITLE V - T/P [XX] HOSPITAL [ ] ICF/MR [XX] PPS ] SNF ] TEFRA APPLICABLE ] TITLE XVIII, PART A [ ] IPF Γ Γ [XX] TITLE XIX - I/P ] OTHER BOXES: [ ] IRF ] NF PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1 INPATIENT DAYS (including private room days and swing-bed days, excluding newborn) 89 003 INPATIENT DAYS (including private room days, excluding swing-bed and newborn days) 89.003 PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE. 25 218 4 SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days) 50.545 4 5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar 6 year, enter 0 on this line) TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, 8 enter 0 on this line) INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days) 4 294 9 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST 10 REPORTING PERIOD (see instructions) SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 11 REPORTING PERIOD (if calendar year, enter 0 on this line) SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE 12 COST REPORTING PERIOD SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST 13 REPORTING PERIOD (if calendar year, enter 0 on this line) MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days) 14 14 TOTAL NURSERY DAYS (Title V or Title XIX only) 3 694 | 15 16 TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only) 308 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 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)
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DE 75.286.305 21 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17) 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) 26 TOTAL SWING-BED COST (see instructions) 26

27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	75,286,305	27			
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	60,375,827	28			
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	20,114,954	29			
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	40,260,873	30			
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.246961	31			
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	797.64	32			
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	796.54	33			
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	1.10	34			
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	1.37	35			
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	34,549	36			
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	75,251,756	37			



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COMPUTATION OF INPATIENT OPERATING COST

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WORKSHEET D-1
PART II

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS
APPLICABLE [ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
BOXES: [XX] TITLE XIX - I/P [ ] IRF [ ] OTHER

#### PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-	THROUGH COS	ST ADJUSTME	NTS		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	i intocon co.	or about and	115		845.89	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					3,632,252	
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line	14 x line 35)				3,032,202	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	11 N IIII 55)				3.632.252	
				AVERAGE		PROGRAM	
		TOTAL	TOTAL	PER DIEM	PROGRAM	COST	
		INPATIENT	INPATIENT	(col. 1 ÷	DAYS	(col. 3 x	
		COST	DAYS	col. 2)		col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)	2,594,947	3,694	702.48	308	216,364	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	16,551,992	9,836	1,682.80	476	801,013	43
44	CORONARY CARE UNIT						44
44.01	NEONATAL INTENSIVE CARE	5,547,357	4,697	1,181.04	447	527,925	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 (Worksheet D-3, column 3, line 200)					4,284,018	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					9,461,572	49
	PASS-THROUGH COST ADJUST!						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					318,035	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					298,527	
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					616,562	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NO	NPHYSICIAN A	NESTHETIST A	ND MEDICAL I	EDUCATION	8,845,010	53
	COSTS (line 49 minus line 52)					0,010,010	
	TARGET AMOUNT AND LIMIT COM	PUTATION					
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)	. n.m. (1:	1: 52)				56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMO	UN1 (line 56 mir	ius line 53)				57
58	BONUS PAYMENT (see instructions)	10 1006 IMP 17	ED IND COLD	OLDUDED DILLE	TE MARKET		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDIN BASKET	NG 1996, UPDAT	ED AND COMP	OUNDED BY T	HE MARKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATE	D BY THE MARI	KET BASKET				60
<i>C</i> 1	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER (	OF 50% OF THE	AMOUNT BY W	HICH OPERAT	ING COSTS		<i>C</i> 1
61	(line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMO	UNT (line 56), O'	THERWISE ENT	ER ZERO (see in	nstructions)		61
62	RELIEF PAYMENT (see instructions)					62	
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWIN						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 O XVIII only)	F THE COST RE	PORTING PERI	OD (see instruction	ons) (Title		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII				65		
66	only) 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 (THE AVIII OIII). FOR			EDIOD (line 12 :	lina 10)		67
68							68
69	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)  TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)				69		
57	TOTAL TITLE TOTAL SWING-DED IN INTATIENT ROOTINE COSTS (line 07 + line 08)						107



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COMPUTATION OF INPATIENT OPERATING COST

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WORKSHEET D-1 PARTS III & IV

CHECK	[ ]	TITLE V -	I/P	[XX]	HOSPITAL	[	]	SUB	(OTHER)	[	]	ICF/MR	[X	X]	PPS
APPLICABLE	[ ]	TITLE XVII	I, PART A	[ ]	IPF	[	]	SNF					[	]	TEFRA
BOXES:	[XX]	TITLE XIX	- I/P	[ ]	IRF	[	]	NF					[	]	OTHER

#### PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)							
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)							
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)							
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV- ATION BED COST (from line89)	OBSERV- ATION BED PASS- THROUGH COST col. 3 x col. 4) (see instructions		
		1	2	3	4	5		
90	CAPITAL-RELATED COST						90	
91	NURSING SCHOOL COST						91	
92	ALLIED HEALTH COST						92	
93	ALL OTHER MEDICAL EDUCATION						93	



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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/MR	[X	K]	PPS
APPLICABLE	[	]	TITLE	XVIII,	PART A	[	]	IPF	[	]	SNF					[	1	TEFRA
BOXES:	[X	X]	TITLE	XIX -	I/P	[XX	[]	IRF	[	]	NF					[	]	OTHER

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	14,705	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	14,705	
	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	1,524	
	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	13,181	
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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	277	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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
	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	10.507.7(2	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	10,587,762	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)  SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		22
	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)  SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		
	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		24
25 26	TOTAL SWING-BED COST (see instructions)		-
26 27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	10,587,762	26
21	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	10,387,762	21
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	5,447,659	28
28 29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	5,447,639	
	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	4,801,297	
30 31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.943543	
	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	424.12	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 3)	364.26	
	AVERAGE PER DIEM PRIVATE ROOM PER DIEM CHARGE (line 30 = line 4)  AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	59.86	
	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 32 linius line 33) (see insudctions)  AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	116.34	-
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 34 A line 35)	177.302	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	10,410,460	



### Compu-Max

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WORKSHEET D-1
PART II

CHECK [ ] TITLE V - I/P [ ] HOSPITAL [ ] SUB (OTHER) [XX] PPS
APPLICABLE [ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
BOXES: [XX] TITLE XIX - I/P [XX] 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)	720.01	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	199,443	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)	199,443	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	138,589	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	338,032	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	11,124	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	7,415	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	18,539	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION	210.402	53
33	COSTS (line 49 minus line 52)	319,493	33
	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		59
39	BASKET		39
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		61
01	(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		64
04	XVIII only)		04
	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII		
65	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
	( )		



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COMPONENT CCN: 15-0125

WORKSHEET D-3

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

CHECK	[ ] TITLE V	[XX] HOSPITAL	[ ] SUB (OTHER)	[ ] SWING BED SNF	[XX] PPS
APPLICABLE	[XX] TITLE XVIII, PART A	[ ] IPF	[ ] SNF	[ ] SWING BED NF	[ ] TEFRA
BOXES:	[ ] TITLE XIX	[ ] IRF	[ ] NF	[ ] ICF/MR	[ ] OTHER

				INPATIENT	
		RATIO OF	INPATIENT	PROGRAM	[
					ĺ
		COST TO	PROGRAM	COSTS	ĺ
		CHARGES	CHARGES	(col. 1 x	ĺ
(4)	GOOT CENTED DESCRIPTION	1		col. 2)	
(A)	COST CENTER DESCRIPTION	I	2		
20	INPATIENT ROUTINE SERVICE COST CENTERS		52.754.610		20
30	ADULTS & PEDIATRICS		52,754,610		30
31	INTENSIVE CARE UNIT		11,300,825		31
32.01	NEONATAL INTENSIVE CARE				32.01
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.296185	32,991,852	9,771,692	50
52	DELIVERY ROOM & LABOR ROOM	0.630900	3,170	2,000	52
54	RADIOLOGY-DIAGNOSTIC	0.120237	30,475,745	3,664,312	54
60	LABORATORY	0.112996	36,368,396	4,109,483	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271	3,863,084	1,449,703	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.222895	16,893,596	3,765,498	65
66	PHYSICAL THERAPY	0.305505	8,458,396	2,584,082	66
70	ELECTROENCEPHALOGRAPHY	0.172734	971,050	167,733	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596	13,676,120	6,463,280	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522	19,696,362	11,138,726	72
73	DRUGS CHARGED TO PATIENTS	0.224738	36,742,706	8,257,482	73
76	CARDIOLOGY	0.148260	29,503,844	4,374,240	76
76.97	CARDIAC REHABILITATION	0.406385	216,461	87,967	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.675103	60,561	40,885	90
91	EMERGENCY	0.172056	14,523,868	2,498,919	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329	, , , , , , , , , , , ,	, , ,	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		244,445,211	58,376,002	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)		, .,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	201
202	NET CHARGES (line 200 minus line 201)		244,445,211		202
	·				

<sup>(</sup>A) Worksheet A line numbers



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

COMPONENT CCN: 15-T125

WORKSHEET D-3

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

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/MR	[ ] 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				<b>.</b>
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
32.01	NEONATAL INTENSIVE CARE		11.012.101		32.01
41	SUBPROVIDER - IRF		11,012,181		41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.296185	274,347	81,257	50
52	DELIVERY ROOM & LABOR ROOM	0.630900			52
54	RADIOLOGY-DIAGNOSTIC	0.120237	1,190,860	143,185	54
60	LABORATORY	0.112996	2,588,612	292,503	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271	228,031	85,573	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.222895	1,180,719	263,176	65
66	PHYSICAL THERAPY	0.305505	12,878,520	3,934,452	66
70	ELECTROENCEPHALOGRAPHY	0.172734	161,700	27,931	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596	1,352,280	639,082	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522	81,338	45,998	72
73	DRUGS CHARGED TO PATIENTS	0.224738	4,927,031	1,107,291	73
76	CARDIOLOGY	0.148260	598,824	88,782	76
76.97	CARDIAC REHABILITATION	0.406385			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.675103	12,444	8,401	90
91	EMERGENCY	0.172056	1,303	224	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329	,,,,,,		92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		25,476,009	6,717,855	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		25,476,009		202
	• • • • • • • • • • • • • • • • • • • •				

<sup>(</sup>A) Worksheet A line numbers



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COMPONENT CCN: 15-0125

WORKSHEET D-3

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

CHECK	[ ] TITLE V	[XX] HOSPITAL [	] SUB (OTHER)	[ ] SWING BED SNF	[XX] PPS
APPLICABLE	[ ] TITLE XVIII, PART A	[ ] IPF [	] SNF	[ ] SWING BED NF	[ ] TEFRA
BOXES:	[XX] TITLE XIX	[ ] IRF [	] NF	[ ] ICF/MR	[ ] OTHER

				INPATIENT	
		RATIO OF	INPATIENT	PROGRAM	
		COST TO	PROGRAM	COSTS	
		CHARGES	CHARGES	(col. 1 x	
				col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		4,222,119		30
31	INTENSIVE CARE UNIT		620,560		31
32.01	NEONATAL INTENSIVE CARE		1,210,000		32.01
41	SUBPROVIDER - IRF				41
43	NURSERY		248,000		43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.296185	2,047,330	606,388	50
52	DELIVERY ROOM & LABOR ROOM	0.630900	160,618	101,334	52
54	RADIOLOGY-DIAGNOSTIC	0.120237	2,890,327	347,524	54
60	LABORATORY	0.112996	3,131,063	353,798	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271	431,659	161,989	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.222895	791,583	176,440	65
66	PHYSICAL THERAPY	0.305505	440,521	134,581	66
70	ELECTROENCEPHALOGRAPHY	0.172734	72,667	12,552	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596	1,072,184	506,710	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522	925,068	523,146	72
73	DRUGS CHARGED TO PATIENTS	0.224738	4,156,615	934,149	73
76	CARDIOLOGY	0.148260	1,460,788	216,576	76
76.97	CARDIAC REHABILITATION	0.406385	4,346	1,766	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.675103	23,762	16,042	90
91	EMERGENCY	0.172056	1,110,240	191,023	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		18,718,771	4,284,018	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		18,718,771		202

<sup>(</sup>A) Worksheet A line numbers



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

(OTHER) [ ] SWING RED SNF [XX] PPS

WORKSHEET D-3

COMPONENT CCN: 15-T125

CHECK	[ ] TITLE V	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] SWING BED SNF	[XX] PPS
APPLICABLE	[ ] TITLE XVIII, PART A	A [ ] IPF	[ ] SNF	[ ] SWING BED NF	[ ] TEFRA
BOXES:	[XX] TITLE XIX	[XX] IRF	[ ] NF	[ ] ICF/MR	[ ] OTHER

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
20	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
32.01	NEONATAL INTENSIVE CARE		201.550		32.01
41	SUBPROVIDER - IRF		201,770		41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.296185	5,338	1,581	50
52	DELIVERY ROOM & LABOR ROOM	0.630900			52
54	RADIOLOGY-DIAGNOSTIC	0.120237	28,196	3,390	54
60	LABORATORY	0.112996	46,121	5,211	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271	3,019	1,133	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.222895	32,046	7,143	65
66	PHYSICAL THERAPY	0.305505	248,850	76,025	66
70	ELECTROENCEPHALOGRAPHY	0.172734	1,539	266	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596	21,609	10,212	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522			72
73	DRUGS CHARGED TO PATIENTS	0.224738	143,588	32,270	73
76	CARDIOLOGY	0.148260	8,605	1,276	76
76.97	CARDIAC REHABILITATION	0.406385			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.675103	122	82	90
91	EMERGENCY	0.172056			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		539,033	138,589	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		539,033		202
	• • • • • • • • • • • • • • • • • • • •				

(A) Worksheet A line numbers



# Compu-Max

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#### CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

[XX] HOSPITAL

		1	1.01	1.02	
	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	21,445,610			1.0
02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	58,291,500			1.0
03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.0
05	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	1,833,169			2
01	OUTLIER RECONCILIATION AMOUNT	1,055,107			2.0
02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				2.0
02	MANAGED CARE SIMULATED PAYMENTS				3
	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see				
	instructions)	371.73			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST				
	REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
	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
	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR				
	\$412.105(f)(1)(iv)(B)(1)				7
	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR				-
)1	§412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.
	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)				
	AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE				8
	50069, AUGUST 1, 2002				
	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503				
)1	OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.0
	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED				
)2	TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.0
	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR				
	RECORDS				10
	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER				
	SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
	ADJUSTED ROLLING AVERAGE FTE COUNT				18
	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42				23
	SEC. 412.105(f)(1)(iv)(C)				23
	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24				25
	(see instructions)				
	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
	IME PAYMENTS ADJUSTMENT (see instructions)				27
	IME ADJUSTMENT (see instructions)				28
	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0307			30
	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1480			31
	SUM OF LINES 30 AND 31	0.1787			32
	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0437			33
	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	1,574,008	011.00		34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
01	FACTOR 3 (see instructions)		0.000472800		35.
02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		4,277,129		35.
03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		3,199,057		35.
	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	3,199,057			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs				40



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#### CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

CHECK

[XX] HOSPITAL APPLICABLE BOX:

#### PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
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				41.01
41.01	AND 685 (see instructions)			Į.	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				43
43	instructions)			Į.	43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	86,343,344			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 SCH AND MDH ONLY (see instructions)	86,343,344			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	6,723,697			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L. Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES	1,705			54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)	-,,			55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	93,068,746			59
60	PRIMARY PAYER PAYMENTS	66,726			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	93,002,020			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	7.199.360			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	460,248			63
64	ALLOWABLE BAD DEBTS (see instructions)	629,581			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	409,228			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	215,595			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	85,751,640			67
-	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see	00,701,010			
68	instructions)			Į.	68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (OTHER ADJUSTMENTS)	39,139			70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	134,943			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-634,168			70.94
71	AMOUNT DUE PROVIDER (see instructions)	85,291,554			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	1,705,831			71.01
72	INTERIM PAYMENTS	83,260,582			72
73	TENTATIVE SETTLEMENT (for contractor use only)	05,200,502			73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	325,141			74
	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION	,			
75	115.2	372,186			75
	11.7.2				

IODE	COMPLETED BY CONTRACTOR		
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART 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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0125

WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] 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)	19,058			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	48,019,276			2
3	PPS PAYMENTS	45,962,718			3
4	OUTLIER PAYMENT (see instructions)	132,404			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5			i e	6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6			<del>                                     </del>	7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
.0	ORGAN ACQUISITION				10
1	TOTAL COST (sum of lines 1 and 10) (see instructions)	19,058			11
1	COMPUTATION OF LESSER OF COST OR CHARGES	17,030			11
	REASONABLE CHARGES				
2	ANCILLARY SERVICE CHARGES	84,799			12
3	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)	84,799			13
4	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	04.700			14
4		84,799		<u> </u>	14
	CUSTOMARY CHARGES				
5	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR				15
	SERVICES ON A CHARGE BASIS				
	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR				
6	SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR				16
	413.13(e)				
7	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
8	TOTAL CUSTOMARY CHARGES (see instructions)	84,799			18
9	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see	65,741			19
9	instructions)	65,741			19
^	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see				20
.0	instructions)				20
1	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	19,058		i e	21
2	INTERNS AND RESIDENTS (see instructions)				22
:3	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
4	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	46,095,122			24
-	COMPUTATION OF REIMBURSEMENT SETTLEMENT	,,,,,,,,,			
.5	DEDUCTIBLES AND COINSURANCE (see instructions)				25
6	DEDUCTIBLES AND COINSURANCE (see instructions)  DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	9,482,322			26
7	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	36,631,858			27
8	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	30,031,030			28
9	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)			<del>                                     </del>	29
0	SUBTOTAL (sum of lines 27 through 29)	36,631,858		-	30
				<u> </u>	
1	PRIMARY PAYER PAYMENTS	7,324			31
2	SUBTOTAL (line 30 minus line 31)	36,624,534			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
3	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
4	ALLOWABLE BAD DEBTS (see instructions)	808,062			34
5	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	525,240			35
6	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	447,922			36
7	SUBTOTAL (see instructions)	37,149,774			37
8	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	233			38
9	OTHER ADJUSTMENTS (FDO LOSS)				39
0	SUBTOTAL (see instructions)	37,149,541			40
0.01	SEQUESTRATION ADJUSTMENT (see instructions)	742,991			40.01
1	INTERIM PAYMENTS	36,422,512			41
2	TENTATIVE SETTLEMENT (for contractor use only)	, 122,012			42
3	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-15,962			43
	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION	-13,702			
4	115.2				44
	ش. ب. 1 1				

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



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E PART B

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [ ] SNF

### PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	1,248	1.01	1.02	1
2	MEDICAL AND OTHER SERVICES (See instructions)  MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	2,672			2
3	PPS PAYMENTS	1,336			3
4	OUTLIER PAYMENT (see instructions)	1,550			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10					
	ORGAN ACQUISITION	1.240			10
1	TOTAL COST (sum of lines 1 and 10) (see instructions)	1,248			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				1.0
12	ANCILLARY SERVICE CHARGES	5,551			12
.3	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
4	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	5,551			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR				15
13	SERVICES ON A CHARGE BASIS				13
	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR				
6	SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR				16
	413.13(e)				
.7	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
8	TOTAL CUSTOMARY CHARGES (see instructions)	5,551			18
	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see				
9	instructions)	4,303			19
	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see				
.0	instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	1,248		<u> </u>	21
2	INTERNS AND RESIDENTS (see instructions)	1,240			22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
. <u>3</u> .4	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	1,336			24
:4		1,330			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				25
.5	DEDUCTIBLES AND COINSURANCE (see instructions)	50			25
6	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	52			26
:7	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	2,532			27
.8	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
.9	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
0	SUBTOTAL (sum of lines 27 through 29)	2,532			30
1	PRIMARY PAYER PAYMENTS				31
2	SUBTOTAL (line 30 minus line 31)	2,532			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
3	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
4	ALLOWABLE BAD DEBTS (see instructions)				34
5	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
6	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
7	SUBTOTAL (see instructions)	2,532			37
8	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	2,552			38
9	OTHER ADJUSTMENTS ()				39
0	SUBTOTAL (see instructions)	2,532			40
0.01					40.01
	SEQUESTRATION ADJUSTMENT (see instructions)	51			
1	INTERIM PAYMENTS	2,345			41
2	TENTATIVE SETTLEMENT (for contractor use only)	10.0			42
.3	BALANCE DUE PROVIDER/PROGRAM (see instructions)	136			43
14	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION				44
	115.2				

90	ORIGINAL OUTLIER AMOUNT (see instructions)		90
01	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		01
91	(22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		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



### COMPLI-MAX

#### ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0125

WORKSHEET E-1 PART I

CHECK [XX] HOSPITAL [ ] SUB (OTHER) APPLICABLE [ ] IPF [ ] SNF

BOXES: [ ] IRF [ ] SWING BED SNF

				INPATIENT PART A		ΓВ	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
DESCRIPTION			1	2	3	4	
TOTAL INTERIM PAYMENTS PAID TO PROVIDER				82,721,994		35,885,338	1
INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUB SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO		BE		444,588		537,174	2
LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	02/12/2014	94,000			3.01
AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
	PROVIDER	.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50					3.50
	DD OLUBED	.51					3.51
	PROVIDER	.52					3.52
	TO	.53					3.53
	PROGRAM	.54					3.54
		.55					3.55
		.57					3.56
							3.58
		.58					3.58
SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		94,000			3.99
TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99)		.99		94,000			
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				83,260,582		36,422,512	4
TO BE COMPLETED BY CONTRACTOR							
LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
	TO	.04					5.04
	PROVIDER	.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
	DDOVIDED	.51					5.51
	PROVIDER	.52					5.52
	TO PROGRAM	.53					5.53 5.54
	PROGRAM	.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
DETERMINED NET SETTLEMENT AMOUNT (balance due)		.99		2.030.972		727.029	6.01
BASED ON THE COST REPORT (1)		.01		2,030,972		121,029	6.01
TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		.02		85,291,554		37,149,541	7
	1	l		03,471,334		21,147,341	
NAME OF CONTRACTOR			CONTRACTOR NU	IMRER	NPR DATE (Month/	Day/Year)	8

<sup>(1)</sup> 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.



### COMPLI-MAX

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: [XX] IRF [ ] SWING BED SNF

			INPAT PAR		PAR	T B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
DESCRIPTION			1	2	3	4	
TOTAL INTERIM PAYMENTS PAID TO PROVIDER				19,940,571		2,345	1
INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUB SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO		BE					2
LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
	PROVIDER	.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50					3.50
	PROVIDER	.52					3.52
-	TO	.53					3.53
	PROGRAM	.54					3.54
	TROGRESS	.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
TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				19,940,571		2,345	4
TO BE COMPLETED BY CONTRACTOR							
LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
	TO	.04					5.04
	PROVIDER	.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
	DDOMBER	.51					5.51
+	PROVIDER TO	.52					5.52
	PROGRAM	.53					5.54
+	I KOOKAWI	.55					5.55
+		.56					5.56
	1	.57					5.57
		1.3/					
							5.58
		.58					5.58
SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.58					
SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) DETERMINED NET SETTLEMENT AMOUNT (balance due)		.58 .59		478,756		187	5.59
		.58 .59 .99		478,756		187	5.59 5.99
DETERMINED NET SETTLEMENT AMOUNT (balance due)		.58 .59 .99		478,756		2,532	5.59 5.99 6.01

<sup>(1)</sup> 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.



	In Lieu of Form	Period :	Run Date: 01/05/2015
COMMUNITY HOSPITAL	CMS-2552-10	From: 07/01/2013	Run Time: 13:42
Provider CCN: 15-0125		To: 06/30/2014	Version: 2014.10

#### CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1 PART II

CHECK [XX] HOSPITAL [ ] CAH

APPLICABLE BOX:

#### TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

HEAL	THE INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	17,272	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	49,417	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	5,242	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	90,296	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,247,775,458	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	22,706,684	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I,		7
'	LINE 168		, ,
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	2,416,116	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	48,322	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	2 367 794	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

INTERNATIONAL DERVICES CONDENTED & COM					
30	INITIAL/INTERIM HIT PAYMENT(S)	2,796,363	30		
31	OTHER ADJUSTMENTS ()		31		
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-428,569	32		



# Сомри-Мах

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E-3 PART III

CHECK APPLICABLE [ ] HOSPITAL

[XX] SUBPROVIDER IRF

BOX:

#### PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	4,605,998	15,467,559	1
2	MEDICARE SSI RATIO (see instructions)	0.019400		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	85,672	197,985	3
4	OUTLIER PAYMENTS	270,037		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 CLOSUE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTES IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)			9
10	AVERAGE DAILY CENSUS (see instructions)	40.287671		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	20,627,251		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	20,627,251		17
18	PRIMARY PAYER PAYMENTS	3,816		18
19	SUBTOTAL (line 17 less line 18)	20,623,435		19
20	DEDUCTIBLES	155,488		20
21	SUBTOTAL (line 19 minus line 20)	20,467,947		21
22	COINSURANCE	57,704		22
23	SUBTOTAL (line 21 minus line 22)	20,410,243		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	13,976		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	9,084		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	8,134		26
27	SUBTOTAL (sum of lines 23 and 25)	20,419,327		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	20,419,327		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	408,387		32.01
33	INTERIM PAYMENTS	19.940.571		33
34	TENTATIVE SETTLEMENT (for contractor use only)	17,7 10,071		34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	70,369		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	416.646		36

10 11	TO BE COMILETED BY CONTRACTOR					
50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART 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		



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0125

WORKSHEET E-3
PART VII

CHECK	[ ] TITLE V	[XX] HOSPITAL	[ ] NF	[XX] PPS
APPLICABLE	[XX] TITLE XIX	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] TEFRA
BOXES:		[ ] SNF		[ ] OTHER

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

	,			_
		INPATIENT	OUTPAT-	
		TITLE V	IENT	
		OR	TITLE V	
		TITLE XIX	OR	
		IIILE AIA	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	6,037,234		8
9	ANCILLARY SERVICE CHARGES	18,718,771		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)	24,756,005		12
	CUSTOMARY CHARGES			1
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
1.4	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE			1.4
14	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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	24,756,005		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	24,756,005		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 TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			1
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			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)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



	In Lieu of Form	Period :	Run Date: 01/05/2015
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE	v	[	]	HOSPITAL	[	1	NF	[XX	[]	PPS
APPLICABLE	[XX]	TITLE	XIX	[XX	[]	SUBPROVIDER IRF	[	]	ICF/MR	[	]	TEFRA
BOXES:				[	]	SNF				[	]	OTHER

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

	,			
		INPATIENT	OUTPAT-	
		TITLE V	IENT	
		OR	TITLE V	
		TITLE XIX	OR	
		TITLE AIX	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	201,770		8
9	ANCILLARY SERVICE CHARGES	539,033		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)	740,803		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE			14
	BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			1 .
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	740,803		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	740,803		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 TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			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)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 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)

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
1	CURRENT ASSETS  CASH ON HAND AND IN BANKS	12,655,029				1
2	TEMPORARY INVESTMENTS	12,000,029				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	101,901,551				4
6	OTHER RECEIVABLES ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-44,071,437				5
7	INVENTORY	9,873,456				7
8	PREPAID EXPENSES	3,070,432				8
9	OTHER CURRENT ASSETS	1,538,066				9
10	DUE FROM OTHER FUNDS TOTAL CURRENT ASSETS (sum of lines 1-10)	84,967,097				10
11	FIXED ASSETS	04,707,077				
12	LAND	3,403,554				12
13	LAND IMPROVEMENTS	6,747,854				13
14 15	ACCUMULATED DEPRECIATION BUILDINGS	-5,513,914 272,818,361				14
16	ACCUMULATED DEPRECIATION	-196,158,572				16
17	LEASEHOLD IMPROVEMENTS	984,452				17
18	ACCUMULATED AMORTIZATION	-974,875				18
19	FIXED EQUIPMENT ACCUMULATED DEPRECIATION	60,277,569				19
20	AUTOMOBILES AND TRUCKS	-20,508,729 563,089				20
22	ACCUMULATED DEPRECIATION	-411,522				22
23	MAJOR MOVABLE EQUIPMENT	132,244,871				23
24	ACCUMULATED DEPRECIATION	-96,782,776				24
25 26	MINOR EQUIPMENT DEPRECIABLE ACCUMULATED DEPRECIATION					25
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE	39,792,777				29
30	TOTAL FIXED ASSETS (sum of lines 12-29)  OTHER ASSETS	196,482,139				30
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34 35	OTHER ASSETS TOTAL OTHER ASSETS (sum of lines 31-34)	8,400,334 8,400,334				34
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	289,849,570				36
	, and a second s					
		GENERAL	SPECIFIC PURPOSE	ENDOWMENT	PLANT	
	LIABILITIES AND FUND BALANCES	FUND	FUND	FUND	FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES	15.550.150				
37	ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE	15,570,170 17,538,516				37
39	PAYROLL TAXES PAYABLE	2,176,016				39
40	NOTES & LOANS PAYABLE (short term)	536,273				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS  DUE TO OTHER PUNIOS					42
43	DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES	34,025,957				43
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	69,846,932				45
46	LONG TERM LIABILITIES  MORTGAGE PAYABLE					46
46	NOTES PAYABLE  NOTES PAYABLE			+		46
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	42,648,621				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	42,648,621				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)  CAPITAL ACCOUNTS	112,495,553				51
52	GENERAL FUND BALANCE	177,354,017				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55 56	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE			_		55 56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT,					58
	AND EXPANSION	155 25121				
59 60	TOTAL FUND BALANCES (sum of lines 52-58) TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	177,354,017 289,849,570				59 60
I DU	TOTAL LIABILITIES AND FUND DALANCES (SUM OF lines 31 and 39)	289,849,370				00



# Сомри-Мах

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#### STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PU	RPOSE FUND	
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		101,037,483			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		36,297,404			2
3	TOTAL (sun of line 1 and line 2)		137,334,887			3
4	ADDITIONS (credit adjustments)					4
5	NET ASSETS TRANSFERRED TO AFFILITES	-13,587,870				5
6	PENSION-RELATED CHGS-NOT NET COST	53,625,000				6
7	RELEASED ASSETS	5,000				7
8	OTHER					8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		40,042,130			10
11	SUBTOTAL (line 3 plus line 10)		177,377,017			11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS RELEASED FROM RESTRCTN	-70,000				13
14	RESTRICTED CONTRIBUTIONS	88,000				14
15	NET ASSETS TRANSFERRED					15
16	OTHER	5,000		-		16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		23,000			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		177,354,017			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 (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	NET ASSETS TRANSFERRED TO AFFILITES					5
6	PENSION-RELATED CHGS-NOT NET COST					6
7	RELEASED ASSETS					7
8	OTHER					8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS RELEASED FROM RESTRCTN					13
14	RESTRICTED CONTRIBUTIONS					14
15	NET ASSETS TRANSFERRED					15
16	OTHER					16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



# Сомри-Мах

	In Lieu of Form	Period :	Run Date: 01/05/2015
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#### STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2 PARTS I & II

#### PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	89,203,896		89,203,896	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	12,224,069		12,224,069	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)	101,427,965		101,427,965	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	18,149,237		18,149,237	11
12	CORONARY CARE UNIT				12
12.01	NEONATAL INTENSIVE CARE	20,362,820		20,362,820	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)	38,512,057		38,512,057	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	139,940,022		139,940,022	17
18	ANCILLARY SERVICES	489,955,807		489,955,807	18
19	OUTPATIENT SERVICES		611,355,972	611,355,972	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		6,540,700	6,540,700	22
23	AMBULANCE				23
25	ASC			•	25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		44,209,617	44,209,617	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	629,895,829	662,106,289	1,292,002,118	28

#### PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		429,836,792	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)		429,836,792	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)	1,292,002,118	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	840,740,541	2
3	NET PATIENT REVENUES (line 1 minus line 2)	451,261,577	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	429,836,792	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	21,424,785	5

### OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	252,000	6
7	INCOME FROM INVESTMENTS	489,212	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	4,835	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	2,074,913	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	5,199,761	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	15,037	21
22	RENTAL OF HOSPITAL SPACE	1,965,655	
23	GOVERNMENTAL APPROPRIATIONS	139,684	23
24	OTHER (OTHER REVENUE)	436,338	24
24.01	OTHER (REVENUE-CLASSES)	64,166	24.01
24.02	OTHER (ASSETS RELEASED FROM RESTRICTION)	32,859	24.02
24.03	OTHER (FITNESS REVENUE)	4,193,107	24.03
24.04	OTHER (SALE OF XRAY SCRAP)	2,952	24.04
24.05	OTHER (GAIN ON FIXED ASSETS)	2,100	24.05
25	TOTAL OTHER INCOME (sum of lines 6-24)	14,872,619	
26	TOTAL (line 5 plus line 25)	36,297,404	
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	36,297,404	29



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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 CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	626,711		29,340	14,491	35,340	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	1,044,841					6
7	PHYSICAL THERAPY				816,584		7
8	OCCUPATIONAL THERAPY				193,568		8
9	SPEECH PATHOLOGY	12,050					9
10	MEDICAL SOCIAL SERVICES	1,180					10
11	HOME HEALTH AIDE	77,379					11
12	SUPPLIES (see instructions)					168,690	12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING	421,870				12,415	17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	2,184,031		29,340	1,024,643	216,445	24



#### 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 CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	705,882	-585	705,297	12,396	717,693	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	1,044,841		1,044,841		1,044,841	6
7	PHYSICAL THERAPY	816,584		816,584		816,584	7
8	OCCUPATIONAL THERAPY	193,568		193,568		193,568	8
9	SPEECH PATHOLOGY	12,050		12,050		12,050	9
10	MEDICAL SOCIAL SERVICES	1,180		1,180		1,180	10
11	HOME HEALTH AIDE	77,379		77,379		77,379	11
12	SUPPLIES (see instructions)	168,690		168,690		168,690	12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING	434,285		434,285		434,285	17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	3,454,459	-585	3,453,874	12,396	3,466,270	24

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



#### ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

			CAPITAL RE	LATED COSTS		
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL	717,693				5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE	1,044,841				6
7	PHYSICAL THERAPY	816,584				7
8	OCCUPATIONAL THERAPY	193,568				8
9	SPEECH PATHOLOGY	12,050				9
10	MEDICAL SOCIAL SERVICES	1,180				10
11	HOME HEALTH AIDE	77,379				11
12	SUPPLIES (see instructions)	168,690				12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING	434,285				17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)	3,466,270				24



#### ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		717,693	717,693		5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		1,044,841	279,874	1,324,715	6
7	PHYSICAL THERAPY		816,584	219,991	1,036,575	7
8	OCCUPATIONAL THERAPY		193,568	53,831	247,399	8
9	SPEECH PATHOLOGY		12,050	1,615	13,665	9
10	MEDICAL SOCIAL SERVICES		1,180	352	1,532	10
11	HOME HEALTH AIDE		77,379	26,620	103,999	11
12	SUPPLIES (see instructions)		168,690	46,035	214,725	12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING		434,285	89,375	523,660	17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)	·	3,466,270		3,466,270	24



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#### COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 15-7487

		CAPITAL REL	ATED 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 CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL					-717,693	21,413,852	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE					7,305,655	8,350,496	6
7	PHYSICAL THERAPY					5,747,360	6,563,944	7
8	OCCUPATIONAL THERAPY					1,412,596	1,606,164	8
9	SPEECH PATHOLOGY					36,150	48,200	9
10	MEDICAL SOCIAL SERVICES					9,320	10,500	10
11	HOME HEALTH AIDE					716,901	794,280	11
12	SUPPLIES (see instructions)					1,204,874	1,373,564	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING					2,232,419	2,666,704	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)					17,947,582	21,413,852	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)					J	717,693	25
26	UNIT COST MULTIPLIER						0.033515	26



In Lieu of Form Period: Run Date: 01/05/2015 COMMUNITY HOSPITAL CMS-2552-10 From: 07/01/2013 Run Time: 13:42 To: 06/30/2014 Version: 2014.10 Provider CCN: 15-0125

#### ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

		*****	CLD	CAR	EL PLOTEE		1 D1 D TG	
	HHA COST CENTER	HHA	CAP	CAP	EMPLOYEE	arinman, r	ADMINIS-	
	(omit cents)	TRIAL	BLDGS &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	
	(omit conto)	BALANCE(1)	FIXTURES	EQUIPMENT	DEPARTMENT	(cols.0-4)	GENERAL	
		0	1	2	4	4A	5	
1	ADMINISTRATIVE AND GENERAL		37,795	689	668,645	707,129	150,093	1
2	SKILLED NURSING CARE	1,324,715				1,324,715	281,180	2
3	PHYSICAL THERAPY	1,036,575				1,036,575	220,020	3
4	OCCUPATIONAL THERAPY	247,399				247,399	52,512	4
5	SPEECH PATHOLOGY	13,665				13,665	2,900	5
6	MEDICAL SOCIAL SERVICES	1,532				1,532	325	6
7	HOME HEALTH AIDE	103,999				103,999	22,075	7
8	SUPPLIES	214,725				214,725	45,577	8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING	523,660				523,660	111,151	13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	3,466,270	37,795	689	668,645	4,173,399	885,833	20
	UNIT COST MULTIPLIER: COLUMN 26, LINE 1							
2.1	DIVIDED BY THE SUM OF COLUMN 26, LINE 20							
21	MINUS COLUMN 26, LINE 1, ROUNDED TO 6							21
	DECIMAL PLACES.							

<sup>(1)</sup> 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.



In Lieu of Form Period: Run Date: 01/05/2015 COMMUNITY HOSPITAL CMS-2552-10 From: 07/01/2013 Run Time: 13:42 To: 06/30/2014 Version: 2014.10 Provider CCN: 15-0125

#### ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

	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		112,082		10,949		37,418	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)		112,082		10,949		37,418	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

<sup>(1)</sup> 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.



In Lieu of Form Period: Run Date: 01/05/2015 COMMUNITY HOSPITAL CMS-2552-10 From: 07/01/2013 Run Time: 13:42 To: 06/30/2014 Version: 2014.10 Provider CCN: 15-0125

#### ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

	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					3,911		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)					3,911		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

<sup>(1)</sup> 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.



In Lieu of Form Period: Run Date: 01/05/2015 COMMUNITY HOSPITAL CMS-2552-10 From: 07/01/2013 Run Time: 13:42 To: 06/30/2014 Version: 2014.10 Provider CCN: 15-0125

#### ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

	T	NONDLIVEIC	NILIDODIC	10 D	10 D	PARAMED	CLIDTOTAL	1
	HHA COST CENTER	NONPHYSIC. ANESTHET	NURSING	I&R	I&R PROGRAM		SUBTOTAL	
	(omit cents)	ANESTHET.	SCHOOL	SALARY &		EDUCATION	(sum of	
	` ′	10	20	FRINGES	COSTS	22	col.4A-23)	
	A DA MARTIN ATTURE AND GENERAL	19	20	21	22	23	24	
1	ADMINISTRATIVE AND GENERAL						1,021,582	1
2	SKILLED NURSING CARE						1,605,895	2
3	PHYSICAL THERAPY						1,256,595	3
4	OCCUPATIONAL THERAPY						299,911	4
5	SPEECH PATHOLOGY						16,565	5
6	MEDICAL SOCIAL SERVICES						1,857	6
7	HOME HEALTH AIDE						126,074	7
8	SUPPLIES						260,302	8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING						634,811	13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)						5,223,592	20
	UNIT COST MULTIPLIER: COLUMN 26, LINE 1							
21	DIVIDED BY THE SUM OF COLUMN 26, LINE 20							١.,
21	MINUS COLUMN 26, LINE 1, ROUNDED TO 6							21
	DECIMAL PLACES.							

<sup>(1)</sup> 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.



In Lieu of Form Period: Run Date: 01/05/2015 COMMUNITY HOSPITAL CMS-2552-10 From: 07/01/2013 Run Time: 13:42 To: 06/30/2014 Version: 2014.10 Provider CCN: 15-0125

#### ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

	HHA COST CENTER	I&R COST &	SUBTOTAL	ALLOCATED			
	(omit cents)	POST STEP-	(sum of	HHA A&G	TOTAL		
	(omit cents)	DOWN ADJS	col.4A-23)	(see Pt.2)	HHA COSTS		
		25	26	27	28		
1	ADMINISTRATIVE AND GENERAL		1,021,582				1
2	SKILLED NURSING CARE		1,605,895	390,423	1,996,318		2
3	PHYSICAL THERAPY		1,256,595	305,500	1,562,095		3
4	OCCUPATIONAL THERAPY		299,911	72,913	372,824		4
5	SPEECH PATHOLOGY		16,565	4,027	20,592		5
6	MEDICAL SOCIAL SERVICES		1,857	451	2,308		6
7	HOME HEALTH AIDE		126,074	30,651	156,725		7
8	SUPPLIES		260,302	63,284	323,586		8
9	DRUGS		·	·	·		9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING		634,811	154,333	789,144		13
14	CLINIC				-		14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
20	TOTALS (sum of lines 1-19)(2)		5,223,592	1,021,582	5,223,592		20
	UNIT COST MULTIPLIER: COLUMN 26, LINE 1			, ,			
1 21	DIVIDED BY THE SUM OF COLUMN 26, LINE 20			0.2421.5			١,,
21	MINUS COLUMN 26, LINE 1, ROUNDED TO 6			0.243117			21
	DECIMAL PLACES.						

<sup>(1)</sup> 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.



#### ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

		CAR	CAR	EMBLOWEE		4 D) (D) (G)	MADI	1
		CAP BLDGS &	CAP	EMPLOYEE	DECOM	ADMINIS-	MAIN-	
	THE GOOD OF THE		MOVABLE	BENEFITS	RECON-	TRATIVE &	TENANCE &	
	HHA COST CENTER	FIXTURES	EQUIPMENT	DEPARTMENT	CILIATION	GENERAL	REPAIRS	
		NEW- SQ	NEW-\$	GROSS		ACCUM	SQUARE	
		FT	VALUE	SALARIES		COST	FEET	
_		1	2	4	4A	5	6	
1	ADMINISTRATIVE AND GENERAL	3,575	435	2,184,031		707,129		1
2	SKILLED NURSING CARE					1,324,715		2
3	PHYSICAL THERAPY					1,036,575		3
4	OCCUPATIONAL THERAPY					247,399		4
5	SPEECH PATHOLOGY					13,665		5
6	MEDICAL SOCIAL SERVICES					1,532		6
7	HOME HEALTH AIDE					103,999		7
8	SUPPLIES					214,725		8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING					523,660		13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	3,575	435	2,184,031		4,173,399		20
21	TOTAL COST TO BE ALLOCATED	37,795	689	668,645		885,833		21
22	UNIT COST MULTIPLIER	10.572028		0.306152		0.212257		22
22	UNIT COST MULTIPLIER		1.583908					22



#### ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

		OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	MAIN-	
		OF PLANT	+ LINEN	KEEPING			TENANCE OF	
	HHA COST CENTER		SERVICE				PERSONNEL	
		NEW- SQ	POUNDS	TIME SPENT	PATIENT ME	FTES	NUMBER	
		FT			ALS		HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL	3,575		1,200		4,177		1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	3,575		1,200		4,177		20
21	TOTAL COST TO BE ALLOCATED	112,082		10,949		37,418		21
22	UNIT COST MULTIPLIER	31.351608		9.124167		8.958104		22
22	UNIT COST MULTIPLIER							22



#### ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

		NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL	NONPHYSIC.	
		ADMINIS-	SERVICES &		RECORDS +	SERVICE	ANESTHET.	
	HHA COST CENTER	TRATION	SUPPLY		LIBRARY			
		NURSING HO	COSTED REQ	COSTED REQ	GROSS	GROSS	ASSIGNED	
		URS			REVENUE	REVENUE	TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL				6,540,700			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)				6,540,700			20
21	TOTAL COST TO BE ALLOCATED				3,911			21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER				0.000598			22



ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

		NURSING	I&R	I&R	PARAMED		
		SCHOOL	SALARY &	PROGRAM	EDUCATION		
	HHA COST CENTER		FRINGES	COSTS			
	THE COOT CENTER	ASSIGNED	ASSIGNED	ASSIGNED	ASSIGNED		
		TIME	TIME	TIME	TIME		
		20	21	22	23		
1	ADMINISTRATIVE AND GENERAL	-					1
2	SKILLED NURSING CARE						2
3	PHYSICAL THERAPY						3
4	OCCUPATIONAL THERAPY						4
5	SPEECH PATHOLOGY						5
6	MEDICAL SOCIAL SERVICES						6
7	HOME HEALTH AIDE						7
8	SUPPLIES						8
9	DRUGS						9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING						13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
19.50	TELEMEDICINE						19.50
20	TOTALS (sum of lines 1-19)						20
21	TOTAL COST TO BE ALLOCATED						21
22	UNIT COST MULTIPLIER						22
22	UNIT COST MULTIPLIER						22



APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7487

WORKSHEET H-3 PARTS I & II

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

### PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST F	ER VISIT COMPUTATION							
	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PEr VISIT (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	1,996,318		1,996,318	21,446	93.09	1
2	PHYSICAL THERAPY	3	1,562,095		1,562,095	13,780	113.36	2
3	OCCUPATIONAL THERAPY	4	372,824		372,824	3,233	115.32	3
4	SPEECH PATHOLOGY	5	20,592		20,592	322	63.95	4
5	MEDICAL SOCIAL SERVICES	6	2,308		2,308	23	100.35	5
6	HOME HEALTH AIDE	7	156,725		156,725	4,121	38.03	6
7	TOTAL (sum of lines 1-6)		4,110,862		4,110,862	42,925		7

LIMITA	TION COST COMPUTATION			PROGRAM VISITS		
				PAF	RT 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	3,869	14,041		8
9	PHYSICAL THERAPY	23844	2,534	8,739		9
10	OCCUPATIONAL THERAPY	23844	714	2,138		10
11	SPEECH PATHOLOGY	23844	66	218		11
12	MEDICAL SOCIAL SERVICES	23844	5	14		12
13	HOME HEALTH AIDE	23844	615	3,149		13
14	TOTAL (sum of lines 8-13)		7,803	28,299		14

SUPPLI	ES AND DRUGS COSTS 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 Record)	RATIO (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	323,586		323,586	462,751	0.699266	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	0.305505			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	0.472596			col. 2, line 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.224738			col. 2, line 16	5



APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7487

WORKSHEET H-3 PARTS I & II

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII

[ ] TITLE XIX

### PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST I	PER VISIT COMPUTATION		PROGRAM VISITS		(	COST OF SERVICES	3		
			PAR	RT B		PAR	RT B		
	PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	TOTAL PROGRAM COST (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	3,869	14,041		360,165	1,307,077		1,667,242	1
2	PHYSICAL THERAPY	2,534	8,739		287,254	990,653		1,277,907	2
3	OCCUPATIONAL THERAPY	714	2,138		82,338	246,554		328,892	3
4	SPEECH PATHOLOGY	66	218		4,221	13,941		18,162	4
5	MEDICAL SOCIAL SERVICES	5	14		502	1,405		1,907	5
6	HOME HEALTH AIDE	615	3,149		23,388	119,756		143,144	6
7	TOTAL (sum of lines 1-6)	7,803	28,299		757,868	2,679,386		3,437,254	7

SUPPL	IES AND DRUGS COSTS COMPUTATIONS	PROGF	RAM COVERED CH PAI	ARGES RT B		COST OF SERVICES PAR	S RT B	
	OTHER PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINS- URANCE	SUBJECT TO DEDUCTIBLES & COINS- URANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINS- URANCE	SUBJECT TO DEDUCTIBLES & COINS- URANCE	
		6	7	8	9	10	11	
15	COST OF MEDICAL SUPPLIES							15
16	COST OF DRUGS							16



	In Lieu of Form	Period :	Run Date: 01/05/2015
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 15-7487

WORKSHEET H-4 PARTS I & II

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

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

			PAF	T B	
		PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
	DESCRIPTION	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 I 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 PAYMENTS	5,000			9

### COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		PART A	PART B	
		SERVICES	SERVICES	
	DESCRIPTION	1	2	
10	TOTAL REASONABLE COST (see instructions)	-5,000		10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	926,018	3,321,880	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	92,472	233,505	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	7,429	51,312	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	3,128	10,533	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	12,250	58,940	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES		271	16
17	TOTAL OTHER PAYMENTS			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 10-20 minus line 21)	1,036,297	3,676,441	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	1,036,297	3,676,441	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	1,036,297	3,676,441	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	1,036,297	3,676,441	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	324	-191	30
31	SUBTOTAL (line 29 plus/minus line 30)	1,036,621	3,676,250	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	20,732	73,525	31.01
32	INTERIM PAYMENTS (see instructions)	1,015,889	3,602,725	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35



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

WORKSHEET H-5

				DAD	т .	DADO	r D	
				PAR mm/dd/yyyy	AMOUNT	PAR7	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1	1,015,889	3	·	1
1		MITTED OD TO	DE		1,015,889		3,602,725	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUB SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN 1		BE					2
2		пе созт						2
3	REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	1	0.1					2.01
<u> </u>			.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	PROCE AND	.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	ТО	.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
	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99)							
4	(transfer to Wkst. H-4, Part II, column as appropriate, line 32)				1,015,889		3,602,725	4
	(transfer to white if i, rate ii, obtains as appropriate, into 32)							
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
	II NONE, WRITE NONE OR ENTER A ZERO. (1)	TO	.04					5.04
		PROVIDER	.05					5.05
		TROVIDER	.06					5.06
			.07					5.07
			.08					5.08
			.08					
			.10					5.09
			.50					5.50
		DROVIDER	.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		20,732		73,525	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,036,621		3,676,250	7
8	NAME OF CONTRACTOR			CONTRACTOR NU	JMBER	NPR DATE (Month/	Day/Year)	8

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



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CALCULATION OF CAPITAL PAYMENT COMPONENT CCN: 15-0125 WORKSHEET L

[XX] PPS

CHECK [ ] TITLE V [XX] HOSPITAL
APPLICABLE [XX] TITLE XVIII, PART A [ ] SUB (OTHER)
BOXES: [ ] TITLE XIX [ ] COST METHOD

PART I - FUL	LY PROSPECTIV	E METHOD
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I AIN	11-FULLI FROSFECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	6,363,667	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	125,211	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)	247.39	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0307	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1480	8
9	SUM OF LINES 7 AND 8	0.1787	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0369	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	234,819	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	6,723,697	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	14
14	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



### COMPLI-MAX

	In Lieu of Form	Period :	Run Date: 01/05/2015
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CALCULATION OF CAPITAL PAYMENT COMPONENT CCN: 15-0125 WORKSHEET L [ ] TITLE V [XX] HOSPITAL CHECK [XX] PPS APPLICABLE [ ] TITLE XVIII, PART A [ ] SUB (OTHER) [ ] COST METHOD BOXES: [XX] TITLE XIX PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT CAPITAL DRG OTHER THAN OUTLIER MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER 1.01 CAPITAL DRG OUTLIER PAYMENTS MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS 2.01 2.01 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions) NUMBER OF INTERNS & RESIDENTS (see instructions) INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions) 5 INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01) 6 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions) PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions) SUM OF LINES 7 AND 8 9 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions) 10 DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01) TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11) 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

PARI	TII - 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	14
14	negative, enter the amount on this line)	14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)	15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)	16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)	17



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#### ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1 PART I

				1				
	COCT CENTED DESCRIPTIONS	EXTRAORDI-	CLIDTOTAL		I&R COST &			
	COST CENTER DESCRIPTIONS	NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		+
	GENERAL SERVICE COST CENTERS	Ů	2.1	2.	23	20		
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS							5
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 CENTRAL SERVICES & SUPPLY							13
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	+					-	21 22
23	PARAMED ED PRGM-(SPECIFY)							23
-23	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
32.01	NEONATAL INTENSIVE CARE							32.01
41	SUBPROVIDER - IRF							41
43	NURSERY ANCILLARY SERVICE COST CENTERS							43
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 PHYSICAL THERAPY							65
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 76.99	HYPERBARIC OXYGEN THERAPY LITHOTRIPSY							76.98 76.99
10.33	OUTPATIENT SERVICE COST CENTERS							10.33
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
00.10	OTHER REIMBURSABLE COST CENTERS							00.10
99.10 99.20	CORF OUTPATIENT PHYSICAL THERAPY	+			1		-	99.10
99.20	OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY	<del>                                     </del>						99.20
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
100	NONREIMBURSABLE COST CENTERS							100
190 191	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	+						190
191	PHYSICIANS' PRIVATE OFFICES							191
194	ADVERTISING	1						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
194.05 200	RUSH RESIDENTS CROSS FOOT ADJUSTMENTS							194.05
200	NEGATIVE COST CENTER							200
202	TOTAL (sum of lines 118-201)	+						202
					1			