

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**

**WORKSHEET S  
PARTS I, II & III**

**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 11/30/2017 Time: 15:40
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL (15-0125) (Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 11/30/2017 15:40  
Nm8iIMfzExMQ74kZghqQ.guA1Mz7d0  
qUzbG0vPckId.rj11IK2END6GSfs59  
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(Signed)   
\_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

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**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		161,029	-313,906		2,241	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		67,176	-52		28	3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		228,205	-313,958		2,269	200

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

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

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2016	To: 06 / 30 / 2017	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days
		1	2	3	4	5	6
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,565	398	569	1,096	11,018	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	20	135		12	106	25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status is in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	Y	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

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

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

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

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

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

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

**Teaching Hospitals that Claim Residents in Nonprovider Settings**

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
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**WORKSHEET S-2  
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2	3	4	5	
65						65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2	3	4	5	
67						67

**Inpatient Psychiatric Facility PPS**

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

**Inpatient Rehabilitation Facility PPS**

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N			76

**Long Term Care Hospital PPS**

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

**TEFRA Providers**

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

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**WORKSHEET S-2  
PART I**

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

**Rural Providers**

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

**Miscellaneous Cost Reporting Information**

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

**Transplant Center Information**

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

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**WORKSHEET S-2  
PART I**

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	15H054	140

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

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

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0	171

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

**COMPLETED BY ALL HOSPITALS**

		Y/N	Date		
<b>Provider Organization and Operation</b>					
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3

		Y/N	Type	Date	
<b>Financial Data and Reports</b>					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
<b>PS&amp;R Report Data</b>					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/05/2017	Y	10/05/2017
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Y		Y	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

**COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)**

Capital Related Cost			
22	Have assets been relieved for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

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

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

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

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

Cost Report Preparer Contact Information				
41	First name: CONNIE	Last name: BIEGEL	Title: DIRECTOR OF REIMBURSEMENT	41
42	Employer: COMMUNITY HOSPITAL			42
43	Phone number: 12198366789	E-mail Address: CBIEGEL@COMHS.ORG		43

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				
						Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	339	123,735			36,540	751	73,009	1
2	HMO and other (see instructions)						13,040	12,830		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						687	253		4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		339	123,735			36,540	751	73,009	7
8	Intensive Care Unit	31	39	14,235			4,774	180	11,231	8
9	Coronary Care Unit	32								9
9.01	NEONATAL INTENSIVE CARE	32.01	32	11,680				362	4,260	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						272	3,804	13
14	Total (see instructions)		410	149,650			41,314	1,565	92,304	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	54	19,710			12,619	20	15,687	17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					35,137		42,565	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		464							27
28	Observation Bed Days								15,148	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							251	588	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					7,554	182	17,158	1
2	HMO and other (see instructions)					2,076	2,184		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider						31		4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
9.01	NEONATAL INTENSIVE CARE								9.01
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		2,434.75			7,554	182	17,158	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF		78.69			1,260	5	1,561	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		31.41						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)		2,544.85						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL WAGE INDEX INFORMATION**

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

**Part II - Wage Data**

	Wkst A Line No.	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
<b>SALARIES</b>							
1	200	164,467,953		164,467,953	5,151,214.00	31.93	1
2							2
3		2,958,738		2,958,738	38,278.00	77.30	3
4							4
4.01							4.01
5		7,092,935		7,092,935	38,231.00	185.53	5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		9,580,027	112,167	9,692,194	353,289.00	27.43	10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11		1,116,349		1,116,349	9,758.00	114.40	11
12							12
13		671,445		671,445	3,740.00	179.53	13
14							14
14.01							14.01
14.02							14.02
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17		40,279,018		40,279,018			17
18							18
19		2,708,858		2,708,858			19
20							20
21		720,337		720,337			21
22							22
22.01							22.01
23		1,313,399		1,313,399			23
24							24
25							25
25.50							25.50
25.51							25.51
25.52							25.52
25.53							25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26		597,200		597,200	33,039.00	18.08	26
27		15,214,440	-28,970	15,185,470	528,888.00	28.71	27
28		3,319,815		3,319,815	23,750.00	139.78	28
29							29
30		5,123,626		5,123,626	177,291.00	28.90	30
31		106,127		106,127	7,495.00	14.16	31
32		3,306,642		3,306,642	213,811.00	15.47	32
33							33
34		3,681,835	-1,261,812	2,420,023	140,708.00	17.20	34
35							35
36			1,261,812	1,261,812	78,422.00	16.09	36
37							37
38		2,537,878		2,537,878	37,162.00	68.29	38
39			28,970	28,970	2,288.00	12.66	39
40		3,903,908	-78,605	3,825,303	106,714.00	35.85	40
41		89,929		89,929	4,131.00	21.77	41
42		714,285		714,285	25,477.00	28.04	42
43							43

**Part III - Hospital Wage Index Summary**

1	Net salaries (see instructions)	157,736,095		157,736,095	5,098,455.00	30.94	1
2	Excluded area salaries (see instructions)	9,580,027	112,167	9,692,194	353,289.00	27.43	2
3	Subtotal salaries (line 1 minus line 2)	148,156,068	-112,167	148,043,901	4,745,166.00	31.20	3
4	Subtotal other wages & related costs (see instructions)	1,787,794		1,787,794	13,498.00	132.45	4
5	Subtotal wage-related costs (see instructions)	40,279,018		40,279,018		27.21%	5
6	Total (sum of lines 3 through 5)	190,222,880	-112,167	190,110,713	4,758,664.00	39.95	6
7	Total overhead cost (see instructions)	38,595,685	-78,605	38,517,080	1,379,176.00	27.93	7

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**HOSPITAL WAGE RELATED COSTS**

**WORKSHEET S-3  
PART IV**

**Part IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
	<b>RETIREMENT COST</b>		
1	401K Employer Contributions	2,019,762	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	16,204,761	3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan	229,372	6
7	Employee Managed Care Program Administration Fees		7
	<b>HEALTH AND INSURANCE COST</b>		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	1,143,840	10
11	Life Insurance (If employee is owner or beneficiary)	118,725	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	62,635	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	530,850	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-Employers Portion Only	8,681,568	17
18	Medicare Taxes - Employers Portion Only	2,122,466	18
19	Unemployment Insurance	161,951	19
20	State or Federal Unemployment Taxes		20
	<b>OTHER</b>		
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	186,654	23
24	Total Wage Related cost (Sum of lines 1-23)	31,462,584	24

**Part B - Other Than Core Related Cost**

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**Part V - Contract Labor and Benefit Cost**

**Hospital and Hospital-Based Component Identification:**

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA**

**HHA CCN: 15-7487**

**WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA

County: LAKE

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		2,750	10	316	3,076	1
2	Unduplicated Census Count (see instructions)		971.00	56.00	421.00	1,576.00	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)		0.01		0.01
5	Other Administrative Personnel		16.55		16.55
6	Direct Nursing Service		8.55		8.55
7	Nursing Supervisor		5.20		5.20
8	Physical Therapy Service		0.70	6.80	7.50
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service		0.25	1.38	1.63
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service		0.17		0.17
13	Speech Pathology Supervisor				13
14	Medical Social Service		0.01		0.01
15	Medical Social Service Supervisor				15
16	Home Health Aide		1.86		1.86
17	Home Health Aide Supervisor				17
18	PRIVATE DUTY		12.59		12.59

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

	Description	Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	11,595	2,131	248	135	14,109	21
22	Skilled Nursing Visit Charges	1,954,895	358,503	41,664	22,699	2,377,761	22
23	Physical Therapy Visits	9,030	782	72	122	10,006	23
24	Physical Therapy Visit Charges	1,781,449	154,096	14,116	23,976	1,973,637	24
25	Occupational Therapy Visits	2,363	333	7	17	2,720	25
26	Occupational Therapy Visit Charges	465,709	65,769	1,361	9,321	542,160	26
27	Speech Pathology Visits	143	136			279	27
28	Speech Pathology Visit Charges	27,756	24,768			52,524	28
29	Medical Social Service Visits	6				6	29
30	Medical Social Service Visit Charges	1,336				1,336	30
31	Home Health Aide Visits	2,194	548	1	7	2,750	31
32	Home Health Aide Visit Charges	274,632	68,718	123	2,139	345,612	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	25,331	3,930	328	281	29,870	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	4,505,777	671,854	57,264	58,135	5,293,030	35
36	Total Number of Episodes (standard/non-outlier)	1,179		131	25	1,335	36
37	Total Number of Ourlier Episodes		91		2	93	37
38	Total Non-Routine Medical Supply Charges	196,119	53,025	8,330	1,511	258,985	38

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA**

**WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.248514	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		17,911,081	2
3	Did you receive DSH or supplemental payments from Medicaid?		N	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid			5
6	Medicaid charges		199,627,881	6
7	Medicaid cost (line 1 times line 6)		49,610,323	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		31,699,242	8

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

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

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

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		842	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		6,044	14
15	State or local indigent care program cost (line 1 times line 14)		1,502	15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		660	16

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

17	Private grants, donations, or endowment income restricted to fundng charity care			17
18	Government grants, appropriations of transfers for support of hospital operations			18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		31,699,902	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	20,331,201	15,515,915	35,847,116	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,052,588	15,515,915	20,568,503	21
22	Payments received from patients for amounts previously written off as charity care	166,813	519,925	686,738	22
23	Cost of charity care (line 21 minus line 22)	4,885,775	14,995,990	19,881,765	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit			25
26	Total bad debt expense for the entire hospital complex (see instructions)		13,939,242	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,056,548	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,625,460	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)		12,313,782	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,629,059	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		23,510,824	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		55,210,726	31

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt				13,611,762	13,611,762	248,501	13,860,263	1
2	00200	Cap Rel Costs-Mvble Equip				9,331,022	9,331,022	1,931,629	11,262,651	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	597,200	-3,005,020	-2,407,820	24,597,680	22,189,860	8,721,048	30,910,908	4
5	00500	Administrative & General	15,214,440	115,475,709	130,690,149	-11,105,685	119,584,464	-50,187,188	69,397,276	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	5,123,626	17,524,988	22,648,614	-4,442,434	18,206,180	-18,730	18,187,450	7
8	00800	Laundry & Linen Service	106,127	1,330,869	1,436,996	-17,239	1,419,757		1,419,757	8
9	00900	Housekeeping	3,306,642	2,266,537	5,573,179	-1,168,394	4,404,785	-66,063	4,338,722	9
10	01000	Dietary	3,681,835	4,005,838	7,687,673	-4,136,385	3,551,288		3,551,288	10
11	01100	Cafeteria				3,024,169	3,024,169	-2,034,644	989,525	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	2,537,878	1,282,913	3,820,791	-670,818	3,149,973	-74,722	3,075,251	13
14	01400	Central Services & Supply				28,970	28,970		28,970	14
15	01500	Pharmacy	3,903,908	16,422,027	20,325,935	-863,511	19,462,424		19,462,424	15
16	01600	Medical Records & Library	89,929	165,646	255,575	-6,212	249,363	5,558,644	5,808,007	16
17	01700	Social Service	714,285	241,868	956,153	-142,500	813,653		813,653	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	PARAMED ED PRGM-(SPECIFY)	93,805	30,844	124,649	65,430	190,079		190,079	23
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	35,647,651	18,381,457	54,029,108	-11,367,666	42,661,442	-20,768	42,640,674	30
31	03100	Intensive Care Unit	9,508,678	4,138,184	13,646,862	-2,071,877	11,574,985	-40	11,574,945	31
32.01	02060	NEONATAL INTENSIVE CARE	2,987,490	1,581,757	4,569,247	-903,689	3,665,558	-44,727	3,620,831	32.01
41	04100	Subprovider - IRF	4,204,372	3,103,826	7,308,198	-778,538	6,529,660		6,529,660	41
43	04300	Nursery				2,102,746	2,102,746		2,102,746	43
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	26,955,257	52,621,683	79,576,940	-35,649,872	43,927,068	-13,747,904	30,179,164	50
52	05200	Delivery Room & Labor Room	2,097,488	1,489,946	3,587,434	-983,954	2,603,480		2,603,480	52
54	05400	Radiology-Diagnostic	8,350,658	9,643,046	17,993,704	-2,149,672	15,844,032	-166,028	15,678,004	54
60	06000	Laboratory	6,089,121	9,033,884	15,123,005	-1,574,532	13,548,473	7,674	13,556,147	60
62	06200	Whole Blood & Packed Red Blood Cells	386,191	2,033,641	2,419,832	-77,303	2,342,529		2,342,529	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	3,604,813	1,967,659	5,572,472	-825,336	4,747,136	-38,547	4,708,589	65
66	06600	Physical Therapy	6,041,786	6,790,796	12,832,582	-1,260,263	11,572,319	-23,160	11,549,159	66
70	07000	Electroencephalography	720,621	616,711	1,337,332	-183,835	1,153,497	-31,822	1,121,675	70
71	07100	Medical Supplies Charged to Patients				18,493,946	18,493,946		18,493,946	71
72	07200	Impl. Dev. Charged to Patients				30,128,943	30,128,943		30,128,943	72
73	07300	Drugs Charged to Patients								73
76	03140	CARDIOLOGY	7,557,329	22,705,131	30,262,460	-18,616,330	11,646,130	-450,609	11,195,521	76
76.97	07697	CARDIAC REHABILITATION	762,339	350,288	1,112,627	-150,657	961,970	-58,988	902,982	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	09000	Clinic	2,564,789	1,428,196	3,992,985	-445,118	3,547,867	-80,868	3,466,999	90
91	09100	Emergency	6,337,845	3,648,289	9,986,134	-1,374,126	8,612,008	-19,237	8,592,771	91
92	09200	Observation Beds (Non-Distinct Part)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
101	10100	Home Health Agency	2,224,975	1,949,593	4,174,568	-240,392	3,934,176	11,109	3,945,285	101
		<b>SPECIAL PURPOSE COST CENTERS</b>								
118		SUBTOTALS (sum of lines 1-117)	161,411,078	297,226,306	458,637,384	178,330	458,815,714	-50,585,440	408,230,274	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
191	19100	Research	373,698	225,242	598,940	-54,889	544,051		544,051	191
192	19200	Physicians' Private Offices		332,563	332,563	45,583	378,146	2,603	380,749	192
194	07950	ADVERTISING				803,906	803,906		803,906	194
194.01	07951	FITNESS POINTE	1,557,884	1,779,597	3,337,481	-739,700	2,597,781		2,597,781	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	318,687	186,256	504,943	-41,393	463,550		463,550	194.02
194.03	07953	RETAIL PHARMACY	671,452	6,898,244	7,569,696	-106,983	7,462,713		7,462,713	194.03
194.04	07954	HOSPICE								194.04
194.05	07955	RUSH RESIDENTS								194.05
194.06	07956	EINSTEIN BAGELS	135,154	231,409	366,563	-84,854	281,709		281,709	194.06
200		TOTAL (sum of lines 118-199)	164,467,953	306,879,617	471,347,570		471,347,570	-50,582,837	420,764,733	200

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	OPERATING RM/CARDIOLOGY SUPPLIES	A	Medical Supplies Charged to P	71		17,618,282	1
2			Impl. Dev. Charged to Patient	72		30,128,943	2
3							3
4							4
5	NURSING UNITS ONLY	A	Medical Supplies Charged to P	71		875,664	5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					48,622,889	500
	Code Letter - A						
1	NURSING FLOAT SALARIES	B	Intensive Care Unit	31	54,047		1
2			NEONATAL INTENSIVE CARE	32.01	16,489		2
3			Delivery Room & Labor Room	52	12,633		3
4			Emergency	91	46,114		4
5			Subprovider - IRF	41	33,562		5
6			Nursery	43	9,062		6
500	Total reclassifications				171,907		500
	Code Letter - B						
1	STOREROOM SALARY RECLASS	C	Central Services & Supply	14	28,970		1
500	Total reclassifications				28,970		500
	Code Letter - C						
1	CAFETERIA EXPENSE	D	Cafeteria	11	1,261,812	1,762,357	1
500	Total reclassifications				1,261,812	1,762,357	500
	Code Letter - D						
1	INTEREST EXPENSE	E	Cap Rel Costs-Mvble Equip	2		168	1
500	Total reclassifications					168	500
	Code Letter - E						
1	BUILDING INSURANCE	F	Cap Rel Costs-Bldg & Fixt	1		196,420	1
2			Cap Rel Costs-Mvble Equip	2		9,447	2
500	Total reclassifications					205,867	500
	Code Letter - F						
1	UTILITY RECLASS	G	Operation of Plant	7		1,052,176	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					1,052,176	500
	Code Letter - G						
1	ADVERTISING NON-REIMBURSABLE	H	ADVERTISING	194		803,906	1
2			Operating Room	50		455	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
500	Total reclassifications					804,361	500
	Code Letter - H						
1	BENEFITS RECLASS	I	Employee Benefits Department	4		21,363,564	1
2			Employee Benefits Department	4		3,303,312	2
3							3

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
500	Total reclassifications					24,666,876	500
	Code Letter - I						
1	DEPRECIATION RECLASS	J	Cap Rel Costs-Bldg & Fixt	1		13,415,342	1
2	BUILDING	J					2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
500	Total reclassifications					13,415,342	500
	Code Letter - J						
1	RECLASS NURSERY	K	Nursery	43	1,426,501	667,183	1
500	Total reclassifications				1,426,501	667,183	500
	Code Letter - K						
1	DEPRECIATION RECLASS EQUIPMENT	L	Cap Rel Costs-Mvble Equip	2		9,321,407	1
2							2
3							3
4							4
5							5
6							6
7							7

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
500	Total reclassifications					9,321,407	500
	Code Letter - L						
1	RECLASS PRECEPTOR TIME	M	PARAMED ED PRGM-(SPECIFY)	23	78,605		1
500	Total reclassifications				78,605		500
	Code Letter - M						
1	LINEN RECLASS FOR OFFSITES SJ	N	Radiology-Diagnostic	54		6,124	1
2			Physical Therapy	66		2,450	2
3			CARDIOLOGY	76		1,225	3
4			Physicians' Private Offices	192		11,022	4
5							5
6	LINEN RECLASS CDC	N	Radiology-Diagnostic	54		15,480	6
7			CARDIOLOGY	76		6,634	7
8			Clinic	90		2,212	8
9							9
10	LINEN RECLASS SV	N	Radiology-Diagnostic	54		5,025	10
11			CARDIOLOGY	76		1,675	11
12			Physicians' Private Offices	192		1,675	12
13							13
14	RECLASS COSTS TO LAUNDRY	N	Laundry & Linen Service	8		25,394	14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
500	Total reclassifications					78,916	500
	Code Letter - N						
1	RECLASS OFFSITE HOUSEK COSTS SJ	O	Administrative & General	5		22,925	1
2			Operation of Plant	7		8,795	2
3			Housekeeping	9		180	3
4			Medical Records & Library	16		2,741	4
5			Radiology-Diagnostic	54		15,174	5
6			Laboratory	60		4,899	6
7			Physical Therapy	66		12,567	7
8			CARDIOLOGY	76		802	8
9			Physicians' Private Offices	192		44,520	9
10							10
11	RECLASS HOUSEKEEPING SV	O	Administrative & General	5		454	11
12			Operation of Plant	7		309	12
13			Radiology-Diagnostic	54		3,333	13
14			Laboratory	60		1,007	14
15			CARDIOLOGY	76		216	15
16			Physicians' Private Offices	192		6,385	16
500	Total reclassifications					124,307	500
	Code Letter - O						
1	RECLASS SERVICE CONTRACT EXP	P					1
2			Pharmacy	15		13,259	2

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
3			Operating Room	50		193,489	3
4			Radiology-Diagnostic	54		1,361,445	4
5			Laboratory	60		116,005	5
6			Whole Blood & Packed Red Bloo	62		27,168	6
7			CARDIOLOGY	76		54,240	7
500	Total reclassifications					1,765,606	500
	Code Letter - P						
1	RECLASS REPAIRS/MAINTENANCE EXP	Q	Administrative & General	5		23,544	1
2			Housekeeping	9		5,213	2
3			Dietary	10		27,760	3
4			Adults & Pediatrics	30		27,962	4
5			Operating Room	50		558,177	5
6			Radiology-Diagnostic	54		78,332	6
7			Laboratory	60		9,046	7
8			Respiratory Therapy	65		4,553	8
9			Physical Therapy	66		29,003	9
10			CARDIOLOGY	76		183,051	10
11			CARDIAC REHABILITATION	76.97		2,406	11
12			Clinic	90		5,182	12
13			Emergency	91		2,880	13
14			Research	191		1,037	14
500	Total reclassifications					958,146	500
	Code Letter - Q						
	GRAND TOTAL (Increases)					2,967,795	103,445,601

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9		
1	OPERATING RM/CARDIOLOGY SUPPLIES	A	Operating Room	50		31,014,419	1	
2			CARDIOLOGY	76		16,576,873	2	
3			Radiology-Diagnostic	54		155,932	3	
4							4	
5	NURSING UNITS ONLY	A	Adults & Pediatrics	30		421,047	5	
6			Intensive Care Unit	31		167,197	6	
7			NEONATAL INTENSIVE CARE	32.01		20,195	7	
8			Subprovider - IRF	41		45,909	8	
9			Delivery Room & Labor Room	52		71,031	9	
10			Emergency	91		150,286	10	
500	Total reclassifications					48,622,889	500	
	Code letter - A							
1	NURSING FLOAT SALARIES	B	Adults & Pediatrics	30	171,907		1	
2							2	
3							3	
4							4	
5							5	
6							6	
500	Total reclassifications				171,907		500	
	Code letter - B							
1	STOREROOM SALARY RECLASS	C	Administrative & General	5	28,970		1	
500	Total reclassifications				28,970		500	
	Code letter - C							
1	CAFETERIA EXPENSE	D	Dietary	10	1,261,812	1,762,357	1	
500	Total reclassifications				1,261,812	1,762,357	500	
	Code letter - D							
1	INTEREST EXPENSE	E	Radiology-Diagnostic	54		168	11 1	
500	Total reclassifications					168	500	
	Code letter - E							
1	BUILDING INSURANCE	F	Administrative & General	5		196,420	12 1	
2			Administrative & General	5		9,447	12 2	
500	Total reclassifications					205,867	500	
	Code letter - F							
1	UTILITY RECLASS	G	Administrative & General	5		543,229	1	
2			Laundry & Linen Service	8		354	2	
3			Housekeeping	9		139,908	3	
4			Physical Therapy	66		19,022	4	
5			CARDIAC REHABILITATION	76.97		2,337	5	
6			Clinic	90		6,783	6	
7			Home Health Agency	101		10,633	7	
8			Research	191		3,586	8	
9			Physicians' Private Offices	192		1,356	9	
10			FITNESS POINTE	194.01		324,968	10	
500	Total reclassifications					1,052,176	500	
	Code letter - G							
1	ADVERTISING NON-REIMBURSABLE	H	Employee Benefits Department	4		1,671	1	
2			Administrative & General	5		758,065	2	
3			Operation of Plant	7		4,236	3	
4			Housekeeping	9		134	4	
5			Dietary	10		720	5	
6			Nursing Administration	13		11,068	6	
7			Adults & Pediatrics	30		7,805	7	
8			Intensive Care Unit	31		215	8	
9			NEONATAL INTENSIVE CARE	32.01		428	9	
10			Delivery Room & Labor Room	52		25	10	
11			Radiology-Diagnostic	54		8,586	11	
12			Laboratory	60		1,952	12	
13			Physical Therapy	66		1,861	13	
14			CARDIOLOGY	76		930	14	
15			Clinic	90		1,045	15	
16			Emergency	91		70	16	
17			Research	191		110	17	
18			Home Health Agency	101		5,440	18	
500	Total reclassifications					804,361	500	
	Code letter - H							
1	BENEFITS RECLASS	I					1	
2			Administrative & General	5		2,423,265	2	

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9		
3			Operation of Plant	7		936,086	3	
4			Laundry & Linen Service	8		42,279	4	
5			Housekeeping	9		879,351	5	
6			Dietary	10		1,009,152	6	
7			Nursing Administration	13		260,909	7	
8			Pharmacy	15		455,915	8	
9			Medical Records & Library	16		7,731	9	
10			Social Service	17		126,848	10	
11			PARAMED ED PRGM-(SPECIFY)	23		13,175	11	
12			Adults & Pediatrics	30		5,499,424	12	
13			Intensive Care Unit	31		1,254,788	13	
14			NEONATAL INTENSIVE CARE	32.01		466,215	14	
15			Subprovider - IRF	41		613,120	15	
16			Operating Room	50		2,731,441	16	
17			Delivery Room & Labor Room	52		415,658	17	
18			Radiology-Diagnostic	54		1,257,508	18	
19			Laboratory	60		1,123,509	19	
20			Whole Blood & Packed Red Bloo	62		54,536	20	
21			Respiratory Therapy	65		625,528	21	
22			Physical Therapy	66		882,026	22	
23			Electroencephalography	70		129,886	23	
24			CARDIOLOGY	76		1,151,380	24	
25			CARDIAC REHABILITATION	76.97		136,289	25	
26			Clinic	90		357,162	26	
27			Emergency	91		1,054,544	27	
28			Home Health Agency	101		224,011	28	
29			Research	191		51,903	29	
30			FITNESS POINTE	194.01		322,334	30	
31			FITNESS POINTE SPA/PRO SHOP/D	194.02		36,562	31	
32			RETAIL PHARMACY	194.03		60,448	32	
33			EINSTEIN BAGELS	194.06		63,893	33	
500	Total reclassifications Code letter - I					24,666,876	500	
1	DEPRECIATION RECLASS	J	Employee Benefits Department	4		65,648	9	1
2	BUILDING	J	Administrative & General	5		6,766,101		2
3			Operation of Plant	7		1,550,438		3
4			Housekeeping	9		7,424		4
5			Dietary	10		56,504		5
6			Nursing Administration	13		15,203		6
7			Pharmacy	15		30,978		7
8			Social Service	17		15,652		8
9			Adults & Pediatrics	30		2,649,692		9
10			Intensive Care Unit	31		254,445		10
11			NEONATAL INTENSIVE CARE	32.01		203,682		11
12			Subprovider - IRF	41		129,177		12
13			Operating Room	50		397,926		13
14			Delivery Room & Labor Room	52		377,772		14
15			Radiology-Diagnostic	54		278,230		15
16			Laboratory	60		76,741		16
17			Whole Blood & Packed Red Bloo	62		7,100		17
18			Respiratory Therapy	65		21,397		18
19			Physical Therapy	66		251,913		19
20			Electroencephalography	70		11,206		20
21			CARDIOLOGY	76		76,626		21
22			CARDIAC REHABILITATION	76.97		3,453		22
23			Clinic	90		42,340		23
24			Emergency	91		7,184		24
25			Physicians' Private Offices	192		16,429		25
26			FITNESS POINTE	194.01		74,430		26
27			FITNESS POINTE SPA/PRO SHOP/D	194.02		1,385		27
28			RETAIL PHARMACY	194.03		16,192		28
29			EINSTEIN BAGELS	194.06		10,074		29
500	Total reclassifications Code letter - J					13,415,342		500
1	RECLASS NURSERY	K	Adults & Pediatrics	30	1,426,501	667,183		1
500	Total reclassifications Code letter - K				1,426,501	667,183		500
1	DEPRECIATION RECLASS EQUIPMENT	L	Employee Benefits Department	4		1,877	9	1
2			Administrative & General	5		376,830		2
3			Operation of Plant	7		287,239		3
4			Housekeeping	9		13,669		4
5			Dietary	10		64,581		5

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10
			COST CENTER	LINE #	SALARY	OTHER	
6			Nursing Administration	13		383,638	6
7			Pharmacy	15		311,272	7
8			Medical Records & Library	16		1,222	8
9			Adults & Pediatrics	30		551,383	9
10			Intensive Care Unit	31		449,279	10
11			NEONATAL INTENSIVE CARE	32.01		229,658	11
12			Subprovider - IRF	41		23,894	12
13			Operating Room	50		2,255,113	13
14			Delivery Room & Labor Room	52		132,101	14
15			Radiology-Diagnostic	54		1,934,161	15
16			Laboratory	60		503,287	16
17			Whole Blood & Packed Red Bloo	62		42,835	17
18			Respiratory Therapy	65		182,964	18
19			Physical Therapy	66		149,461	19
20			Electroencephalography	70		38,432	20
21			CARDIOLOGY	76		1,058,364	21
22			CARDIAC REHABILITATION	76.97		10,984	22
23			Clinic	90		44,614	23
24			Emergency	91		211,036	24
25			Home Health Agency	101		308	25
26			Research	191		327	26
27			Physicians' Private Offices	192		234	27
28			FITNESS POINTE	194.01		17,968	28
29			FITNESS POINTE SPA/PRO SHOP/D	194.02		3,446	29
30			RETAIL PHARMACY	194.03		30,343	30
31			EINSTEIN BAGELS	194.06		10,887	31
500	Total reclassifications					9,321,407	500
	Code letter - L						
1	RECLASS PRECEPTOR TIME	M	Pharmacy	15	78,605		1
500	Total reclassifications				78,605		500
	Code letter - M						
1	LINEN RECLASS FOR OFFSITES SJ	N	Administrative & General	5		20,821	1
2							2
3							3
4							4
5							5
6	LINEN RECLASS CDC	N	Housekeeping	9		24,326	6
7							7
8							8
9							9
10	LINEN RECLASS SV	N	Administrative & General	5		8,375	10
11							11
12							12
13							13
14	RECLASS COSTS TO LAUNDRY	N	Administrative & General	5		95	14
15			Operation of Plant	7		341	15
16			Housekeeping	9		7,280	16
17			Dietary	10		9,019	17
18			Adults & Pediatrics	30		686	18
19			Operating Room	50		3,094	19
20			Electroencephalography	70		4,311	20
21			Clinic	90		568	21
500	Total reclassifications					78,916	500
	Code letter - N						
1	RECLASS OFFSITE HOUSEK COSTS SJ	O	Housekeeping	9		101,695	1
2			Operation of Plant	7		1,622	2
3			Administrative & General	5		9,286	3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11	RECLASS HOUSEKEEPING SV	O	Administrative & General	5		11,704	11
12							12
13							13
14							14
15							15
16							16
500	Total reclassifications					124,307	500
	Code letter - O						

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS SERVICE CONTRACT EXP	P	Operation of Plant	7		1,765,606		
2								
3								
4								
5								
6								
7								
500	Total reclassifications					1,765,606	500	
	Code letter - P							
1	RECLASS REPAIRS/MAINTENANCE EXP	Q	Operation of Plant	7		958,146		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
500	Total reclassifications					958,146	500	
	Code letter - Q							
	GRAND TOTAL (Decreases)				2,967,795	103,445,601		

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

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**RECONCILIATION OF CAPITAL COST CENTERS**

**WORKSHEET A-7  
PARTS I, II & III**

**PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	14,376,371	93,946		93,946		14,470,317		1
2	Land Improvements	1,286,570					1,286,570		2
3	Buildings and Fixtures	359,710,970	11,138,651		11,138,651	51,052	370,798,569		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	146,152,896	15,127,467		15,127,467	9,662,468	151,617,895		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	521,526,807	26,360,064		26,360,064	9,713,520	538,173,351		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	521,526,807	26,360,064		26,360,064	9,713,520	538,173,351		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								3

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

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

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

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	386,555,456		386,555,456	0.718273					1
2	Cap Rel Costs-Mvble Equip	151,617,895		151,617,895	0.281727					2
3	Total (sum of lines 1-2)	538,173,351		538,173,351	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	13,663,843			196,420			13,860,263	1
2	Cap Rel Costs-Mvble Equip	11,253,204			9,447			11,262,651	2
3	Total (sum of lines 1-2)	24,917,047			205,867			25,122,914	3

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

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				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	
2	Investment income-movable equipment (chapter 2)	B	-168	Cap Rel Costs-Mvble Equip	2	11
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)	B	-1,500	Administrative & General	5	4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-14,352,128			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-20,258,534			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests					14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts	B	-20	Medical Records & Library	16	18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33						33
34						34
35	A&G OTHER INCOME	B	-195,784	Administrative & General	5	35
36						36
36.01	OFFSET CARDIOLOGY PHYSICIAN FEE	A	-250	CARDIOLOGY	76	36.01
36.02	OFFSET PHYSICIAN FEES	A	-264	Clinic	90	36.02
37	OFFSET MAMMO FEES	A	-21,151	Radiology-Diagnostic	54	37
38	PHYSICIAN RENTAL/X RAY SALES-RA	B	-35,750	Radiology-Diagnostic	54	38
39	OFFSET PT OTHER INCOME	B	-23,160	Physical Therapy	66	39
40	PHYSICIAN RENTAL-LAB	B	-930	Laboratory	60	40
41	REMOVE MEDICAID ASSESSMENT FEES	A	-21,834,239	Administrative & General	5	41
42	VARIOUS EH&W OFFSETS	B	-1,463	Employee Benefits Department	4	42
42.01	OTHER INCOME PLANT	B	-500	Operation of Plant	7	42.01
42.05	OTHER INCOME ACUTE	B	-4,202	Adults & Pediatrics	30	42.05
43	OFFSET OTHER INCOME ICU	B	-40	Intensive Care Unit	31	43
43.02	OFFSET RESEARCH COSTS HEART CTR	A	-112,977	CARDIOLOGY	76	43.02
43.06	OTHER INCOME CLINIC	B	-4,128	Clinic	90	43.06
43.07	OTHER INCOME ER	B	-56	Emergency	91	43.07
43.08	OTHER INCOME CARDIOLOGY	B	-8,534	CARDIOLOGY	76	43.08
44						44
45	OFFSET NEONATOLOGY FEES	A	-6,810	NEONATAL INTENSIVE CARE	32.01	45
45.01	EMPLOYEE CAFETERIA REVENUE	B	-2,034,440	Cafeteria	11	45.01
45.03	OTHER INCOME DIETARY	B	-204	Cafeteria	11	45.03
45.04	TELEPHONE SERVICE	A	-132,641	Administrative & General	5	45.04
45.06	TELEPHONE SERVICE	A	-5,629	Cap Rel Costs-Mvble Equip	2	9
45.08	TELEVISION SERVICE	A	-11,317	Operation of Plant	7	45.08
45.09	TELEVISION SERVICE	A	-33,345	Cap Rel Costs-Mvble Equip	2	9
45.10	PENSION CONTRIBTN EXCESS OF EXP	A	8,722,511	Employee Benefits Department	4	45.10
45.19	CAPITALIZED INTEREST	A	1,589	Cap Rel Costs-Bldg & Fixt	1	9
45.21	PARETN ASSET DEP AJE	A	-2,672	Cap Rel Costs-Bldg & Fixt	1	9
45.29	OFFSET RELEASED TEMP REST OP IN	B	-38,765	Administrative & General	5	45.29
45.30	OFFSET RELEASED TEMP REST OP IN	B	-4,680	Clinic	90	45.30
45.31	OFFSET RELEASED TEMP REST OP IN	B	-14,756	Respiratory Therapy	65	45.31

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
45.32	OFFSET RELEASED TEMP REST OP IN	B	-16,000	Emergency	91		45.32
45.33	NON-PT CARE RELATED EXPENSES	A	-2,957	Administrative & General	5		45.33
46							46
47	OFFSET CARDIAC REHAB CLASS INCO	B	-58,988	CARDIAC REHABILITATION	76.97		47
47.01	CLEANING SERVICES-SJ SV	A	-20,396	Administrative & General	5		47.01
47.02	CLEANING SERVICES SJ SV	A	-1,060	Operation of Plant	7		47.02
47.03	CLEANING SERVICES-SJ SV	A	-66,499	Housekeeping	9		47.03
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-50,582,837				50

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

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS**

**WORKSHEET A-8-1**

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	CFNI CORPORATE ALLOCATION	249,584		249,584	9	1
2	2	Cap Rel Costs-Mvble Equip	CFNI ALLOCATION	1,970,771		1,970,771	9	2
3	5	Administrative & General	CFNI ALLOCATION	27,528,614	46,580,071	-19,051,457		3
3.01	16	Medical Records & Library	CFNI ALLOCATION	5,558,664		5,558,664		3.01
3.02	5	Administrative & General	COMMUNICATIONS	1,383,207		1,383,207		3.02
3.03	5	Administrative & General	PATIENT ACCOUNTING	5,203,878		5,203,878		3.03
3.04	5	Administrative & General	CDC LEASE		80,107	-80,107		3.04
3.05	7	Operation of Plant	CDC LEASE		25,063	-25,063		3.05
3.06	54	Radiology-Diagnostic	CDC LEASE		121,842	-121,842		3.06
3.07	60	Laboratory	CDC LEASE		11,630	-11,630		3.07
3.08	90	Clinic	CDC LEASE		19,370	-19,370		3.08
3.09	76	CARDIOLOGY	CDC LEASE		3,707	-3,707		3.09
3.10	5	Administrative & General	CDC LEASE DEPR	71,253		71,253		3.10
3.11	7	Operation of Plant	CDC LEASE DEPR	7,424		7,424		3.11
3.12	9	Housekeeping	CDC LEASE DEPR	436		436		3.12
3.13	54	Radiology-Diagnostic	CDC LEASE DEPR	29,039		29,039		3.13
3.14	60	Laboratory	CDC LEASE DEPR	2,800		2,800		3.14
3.15	76	CARDIOLOGY	CDC LEASE DEPR	1,780		1,780		3.15
3.16	90	Clinic	CDC LEASE DEPR	3,319		3,319		3.16
3.17	101	Home Health Agency	CDC LEASE DEPR	911		911		3.17
3.18	192	Physicians' Private Offices	CDC LEASE DEPR	2,603		2,603		3.18
3.23	5	Administrative & General	LEASE EXPENSE		74,140	-74,140		3.23
3.24	5	Administrative & General	800 MACARTHUR DEPR	73,121		73,121		3.24
3.25	5	Administrative & General	800 MACARTHUR A&G	84,698		84,698		3.25
3.26	101	Home Health Agency	800 MACARTHUR DEPR	4,725		4,725		3.26
3.27	101	Home Health Agency	800 MACARTHUR A&G	5,473		5,473		3.27
3.28	60	Laboratory	800 MACARTHUR DEPR	12,101		12,101		3.28
3.29	60	Laboratory	800 MACARTHUR A&G	14,017		14,017		3.29
3.30	7	Operation of Plant	800 MACARTHUR DEPR	5,461		5,461		3.30
3.31	7	Operation of Plant	800 MACARTHUR A&G	6,325		6,325		3.31
3.33	5	Administrative & General	CCN COSTS		15,562,808	-15,562,808		3.33
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			42,220,204	62,478,738	-20,258,534		5

\* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		100.00	CFNI		PARENT	6
7							7
8							8
9							9
10							10

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

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

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET A-8-1**

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

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

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

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

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
	1									1
	2	5 Administrative & Gen AGGREGATE	68,646	7,475	61,171	211,500	591	60,095	3,005	2
	3	50 Operating Room CRNA ANESTHESIO	13,787,052	13,721,602	65,450	211,500	385	39,148	1,957	3
	4	30 Adults & Pediatrics AGGREGATE	42,495		42,495	211,500	255	25,929	1,296	4
	5	32.01 NEONATAL INTENSIVE C AGGREGATE	55,000	30,000	25,000	211,500	168	17,083	854	5
	6	54 Radiology-Diagnostic AGGREGATE	40,377		40,377	271,900	184	24,053	1,203	6
	7	13 Nursing Administrati AGGREGATE	102,583		102,583	211,500	274	27,861	1,393	7
	8	60 Laboratory	47,228		47,228	260,300	308	38,544	1,927	8
	9	65 Respiratory Therapy AGGREGATE	48,195	22,275	25,920	211,500	240	24,404	1,220	9
	10	70 Electroencephalogram AGGREGATE	50,633	30,633	20,000	211,500	185	18,811	941	10
	11	76 CARDIOLOGY AGGREGATE	368,103	281,007	87,096	211,500	405	41,182	2,059	11
	12	90 Clinic AGGREGATE	134,651		134,651	211,500	776	78,906	3,945	12
	13	91 Emergency AGGREGATE	12,231		12,231	211,500	89	9,050	453	13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	200	TOTAL	14,757,194	14,092,992	664,202		3,860	405,066	20,253	200

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2	5	Administrative & Gen AGGREGATE					60,095	1,076	8,551	2
3	50	Operating Room CRNA ANESTHESIO					39,148	26,302	13,747,904	3
4	30	Adults & Pediatrics AGGREGATE					25,929	16,566	16,566	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE					17,083	7,917	37,917	5
6	54	Radiology-Diagnostic AGGREGATE					24,053	16,324	16,324	6
7	13	Nursing Administrati AGGREGATE					27,861	74,722	74,722	7
8	60	Laboratory					38,544	8,684	8,684	8
9	65	Respiratory Therapy AGGREGATE					24,404	1,516	23,791	9
10	70	Electroencephalogram AGGREGATE					18,811	1,189	31,822	10
11	76	CARDIOLOGY AGGREGATE					41,182	45,914	326,921	11
12	90	Clinic AGGREGATE					78,906	55,745	55,745	12
13	91	Emergency AGGREGATE					9,050	3,181	3,181	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					405,066	259,136	14,352,128	200

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COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Cap Rel Costs-Bldg & Fixt	13,860,263	13,860,263					1
2	Cap Rel Costs-Mvble Equip	11,262,651		11,262,651				2
4	Employee Benefits Department	30,910,908	49,060		30,962,236			4
5	Administrative & General	69,397,276	3,453,501	455,307	2,869,188	76,175,272	76,175,272	5
6	Maintenance & Repairs							6
7	Operation of Plant	18,187,450	1,763,788	347,059	968,073	21,266,370	4,701,165	7
8	Laundry & Linen Service	1,419,757	19,430		20,052	1,459,239	322,581	8
9	Housekeeping	4,338,722	55,512	16,516	624,767	5,035,517	1,113,156	9
10	Dietary	3,551,288	143,048	47,333	457,246	4,198,915	928,216	10
11	Cafeteria	989,525	146,485	30,697	238,411	1,405,118	310,617	11
12	Maintenance of Personnel							12
13	Nursing Administration	3,075,251	30,920	463,533	479,514	4,049,218	895,124	13
14	Central Services & Supply	28,970			5,474	34,444	7,614	14
15	Pharmacy	19,462,424	56,318	376,097	722,764	20,617,603	4,557,748	15
16	Medical Records & Library	5,808,007	83,193	1,476	16,991	5,909,667	1,306,397	16
17	Social Service	813,653	13,227		134,959	961,839	212,625	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	190,079	1,489		32,576	224,144	49,549	23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	42,640,674	2,152,781	620,358	6,433,372	51,847,185	11,461,376	30
31	Intensive Care Unit	11,574,945	401,686	542,844	1,806,810	14,326,285	3,166,983	31
32.01	NEONATAL INTENSIVE CARE	3,620,831	110,044	277,486	567,581	4,575,942	1,011,562	32.01
41	Subprovider - IRF	6,529,660	308,430	28,870	800,728	7,667,688	1,695,027	41
43	Nursery	2,102,746	27,818	45,855	271,240	2,447,659	541,082	43
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	30,179,164	1,222,528	2,724,751	5,093,007	39,219,450	8,669,891	50
52	Delivery Room & Labor Room	2,603,480	202,208	159,612	398,693	3,363,993	743,648	52
54	Radiology-Diagnostic	15,678,004	543,121	2,336,964	1,577,798	20,135,887	4,451,259	54
60	Laboratory	13,556,147	220,770	608,100	1,150,497	15,535,514	3,434,296	60
62	Whole Blood & Packed Red Blood Cells	2,342,529	18,574	51,756	72,968	2,485,827	549,519	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,708,589	44,903	221,068	681,104	5,655,664	1,250,247	65
66	Physical Therapy	11,549,159	489,073	180,587	1,141,553	13,360,372	2,953,457	66
70	Electroencephalography	1,121,675	33,352	46,436	136,156	1,337,619	295,695	70
71	Medical Supplies Charged to Patients	18,493,946				18,493,946	4,088,290	71
72	Impl. Dev. Charged to Patients	30,128,943				30,128,943	6,660,334	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	11,195,521	372,677	1,278,776	1,427,904	14,274,878	3,155,619	76
76.97	CARDIAC REHABILITATION	902,982	35,474	13,271	144,039	1,095,766	242,231	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	3,466,999	108,977	53,905	484,599	4,114,480	909,551	90
91	Emergency	8,592,771	301,122	254,986	1,206,204	10,355,083	2,289,105	91
92	Observation Beds (Non-Distinct Part)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101	Home Health Agency	3,945,285		372	420,393	4,366,050	965,163	101
<b>SPECIAL PURPOSE COST CENTERS</b>								
118	SUBTOTALS (sum of lines 1-117)	408,230,274	12,409,509	11,186,283	30,384,661	406,125,577	72,939,127	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190	Gift, Flower, Coffee Shop & Canteen		14,988			14,988	3,313	190
191	Research	544,051		395	70,608	615,054	135,964	191
192	Physicians' Private Offices	380,749	732,859	283		1,113,891	246,238	192
194	ADVERTISING	803,906				803,906	177,712	194
194.01	FITNESS POINTE	2,597,781	567,353	21,710	294,351	3,481,195	769,556	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	463,550	18,388	4,164	60,214	546,316	120,769	194.02
194.03	RETAIL PHARMACY	7,462,713	22,024	36,662	126,866	7,648,265	1,690,733	194.03
194.04	HOSPICE		87,635			87,635	19,373	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	281,709	7,507	13,154	25,536	327,906	72,487	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	420,764,733	13,860,263	11,262,651	30,962,236	420,764,733	76,175,272	202

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	25,967,535						7
8	Laundry & Linen Service	58,711	1,840,531					8
9	Housekeeping	167,736		6,316,409				9
10	Dietary	432,237	1,514	8,371	5,569,253			10
11	Cafeteria	442,622		29,421		2,187,778		11
12	Maintenance of Personnel							12
13	Nursing Administration	93,428		1,751		33,974	5,073,495	13
14	Central Services & Supply					1,094		14
15	Pharmacy	170,173		20,139		57,907		15
16	Medical Records & Library	251,379		37,826		1,702		16
17	Social Service	39,966		14,710		14,343		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	4,499				3,136		23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	6,504,884	834,242	1,950,873	4,316,489	689,419	2,244,054	30
31	Intensive Care Unit	1,213,742	129,988	359,150	400,180	157,203	511,697	31
32.01	NEONATAL INTENSIVE CARE	332,510	321	91,992		47,964	156,121	32.01
41	Subprovider - IRF	931,958	133,355	304,494	779,397	97,631	317,777	41
43	Nursery	84,055	20,591	56,424		26,365	85,811	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	3,694,014	211,361	1,308,593		330,573	1,075,997	50
52	Delivery Room & Labor Room	610,995	86,961	241,117	73,187	36,757	119,627	52
54	Radiology-Diagnostic	1,641,105	74,197	192,074		103,149		54
60	Laboratory	667,082		122,586		118,647		60
62	Whole Blood & Packed Red Blood Cells	56,124				6,029		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	135,681		18,388		63,535		65
66	Physical Therapy	1,477,793	13,984	96,676		53,665		66
70	Electroencephalography	100,777	7,075	11,663		5,312		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	1,126,088	144,844	328,906		128,432		76
76.97	CARDIAC REHABILITATION	107,188	1,009	23,265		13,614		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	329,286	6,827	26,426		38,641	125,789	90
91	Emergency	909,875	174,262	842,680		134,145	436,622	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency			10,507				101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	21,583,908	1,840,531	6,098,032	5,569,253	2,163,237	5,073,495	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	45,289						190
191	Research					7,706		191
192	Physicians' Private Offices	2,214,421		213,474				192
194	ADVERTISING							194
194.01	FITNESS POINTE	1,714,325						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	55,562						194.02
194.03	RETAIL PHARMACY	66,547		4,903		11,402		194.03
194.04	HOSPICE	264,801						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	22,682				5,433		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	25,967,535	1,840,531	6,316,409	5,569,253	2,187,778	5,073,495	202

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMED EDUCATION	SUBTOTAL	
		14	15	16	17	23	24	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	43,152						14
15	Pharmacy		25,423,570					15
16	Medical Records & Library			7,506,971				16
17	Social Service				1,243,483			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)					281,328		23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics			599,672	972,307		81,420,501	30
31	Intensive Care Unit			108,058	150,339		20,523,625	31
32.01	NEONATAL INTENSIVE CARE			101,084	57,025		6,374,521	32.01
41	Subprovider - IRF			74,414			12,001,741	41
43	Nursery			24,859	50,921		3,337,767	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room			1,108,561			55,618,440	50
52	Delivery Room & Labor Room			42,622			5,318,907	52
54	Radiology-Diagnostic			1,375,050			27,972,721	54
60	Laboratory			898,221			20,776,346	60
62	Whole Blood & Packed Red Blood Cells			51,877			3,149,376	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			158,283			7,281,798	65
66	Physical Therapy			241,765			18,197,712	66
70	Electroencephalography			56,220			1,814,361	70
71	Medical Supplies Charged to Patients	43,152		231,687			22,857,075	71
72	Impl. Dev. Charged to Patients			303,230			37,092,507	72
73	Drugs Charged to Patients		25,423,570	615,703		281,328	26,320,601	73
76	CARDIOLOGY			786,283			19,945,050	76
76.97	CARDIAC REHABILITATION			11,639			1,494,712	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic			48,901			5,599,901	90
91	Emergency			637,614	12,891		15,792,277	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency			31,228			5,372,948	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	43,152	25,423,570	7,506,971	1,243,483	281,328	398,262,887	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen						63,590	190
191	Research						758,724	191
192	Physicians' Private Offices						3,788,024	192
194	ADVERTISING						981,618	194
194.01	FITNESS POINTE						5,965,076	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						722,647	194.02
194.03	RETAIL PHARMACY						9,421,850	194.03
194.04	HOSPICE						371,809	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS						428,508	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	43,152	25,423,570	7,506,971	1,243,483	281,328	420,764,733	202

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics		81,420,501				30
31	Intensive Care Unit		20,523,625				31
32.01	NEONATAL INTENSIVE CARE		6,374,521				32.01
41	Subprovider - IRF		12,001,741				41
43	Nursery		3,337,767				43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room		55,618,440				50
52	Delivery Room & Labor Room		5,318,907				52
54	Radiology-Diagnostic		27,972,721				54
60	Laboratory		20,776,346				60
62	Whole Blood & Packed Red Blood Cells		3,149,376				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		7,281,798				65
66	Physical Therapy		18,197,712				66
70	Electroencephalography		1,814,361				70
71	Medical Supplies Charged to Patients		22,857,075				71
72	Impl. Dev. Charged to Patients		37,092,507				72
73	Drugs Charged to Patients		26,320,601				73
76	CARDIOLOGY		19,945,050				76
76.97	CARDIAC REHABILITATION		1,494,712				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic		5,599,901				90
91	Emergency		15,792,277				91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	Home Health Agency		5,372,948				101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)		398,262,887				118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen		63,590				190
191	Research		758,724				191
192	Physicians' Private Offices		3,788,024				192
194	ADVERTISING		981,618				194
194.01	FITNESS POINTE		5,965,076				194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		722,647				194.02
194.03	RETAIL PHARMACY		9,421,850				194.03
194.04	HOSPICE		371,809				194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS		428,508				194.06
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)		420,764,733				202

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		49,060	2,268	51,328	51,328		4
5	Administrative & General	305,496	3,453,501	455,307	4,214,304	4,753	4,219,057	5
6	Maintenance & Repairs							6
7	Operation of Plant	2,873	1,763,788	347,059	2,113,720	1,604	260,385	7
8	Laundry & Linen Service	22,688	19,430		42,118	33	17,867	8
9	Housekeeping		55,512	16,516	72,028	1,035	61,655	9
10	Dietary	24,174	143,048	47,333	214,555	757	51,412	10
11	Cafeteria		146,485	30,697	177,182	395	17,204	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,548	30,920	463,533	497,001	794	49,579	13
14	Central Services & Supply					9	422	14
15	Pharmacy		56,318	376,097	432,415	1,197	252,442	15
16	Medical Records & Library	159	83,193	1,476	84,828	28	72,358	16
17	Social Service		13,227		13,227	224	11,777	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)		1,489		1,489	54	2,744	23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	248,049	2,152,781	620,358	3,021,188	10,696	634,718	30
31	Intensive Care Unit	20,260	401,686	542,844	964,790	2,993	175,411	31
32.01	NEONATAL INTENSIVE CARE		110,044	277,486	387,530	940	56,028	32.01
41	Subprovider - IRF	5,401	308,430	28,870	342,701	1,326	93,883	41
43	Nursery	22	27,818	45,855	73,695	449	29,969	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	1,014,215	1,222,528	2,724,751	4,961,494	8,437	480,203	50
52	Delivery Room & Labor Room		202,208	159,612	361,820	660	41,189	52
54	Radiology-Diagnostic	465,325	543,121	2,336,964	3,345,410	2,614	246,544	54
60	Laboratory	44,513	220,770	608,100	873,383	1,906	190,217	60
62	Whole Blood & Packed Red Blood Cells		18,574	51,756	70,330	121	30,436	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	95,818	44,903	221,068	361,789	1,128	69,248	65
66	Physical Therapy	201,046	489,073	180,587	870,706	1,891	163,584	66
70	Electroencephalography	217,586	33,352	46,436	297,374	226	16,378	70
71	Medical Supplies Charged to Patients						226,440	71
72	Impl. Dev. Charged to Patients						368,899	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	166,802	372,677	1,278,776	1,818,255	2,365	174,782	76
76.97	CARDIAC REHABILITATION		35,474	13,271	48,745	239	13,417	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	55,836	108,977	53,905	218,718	803	50,378	90
91	Emergency	3,096	301,122	254,986	559,204	1,998	126,788	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency			372	372	696	53,458	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	2,895,907	12,409,509	11,186,283	26,491,699	50,371	4,039,815	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		14,988		14,988		184	190
191	Research			395	395	117	7,531	191
192	Physicians' Private Offices		732,859	283	733,142		13,638	192
194	ADVERTISING						9,843	194
194.01	FITNESS POINTE	220	567,353	21,710	589,283	488	42,624	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	272	18,388	4,164	22,824	100	6,689	194.02
194.03	RETAIL PHARMACY		22,024	36,662	58,686	210	93,645	194.03
194.04	HOSPICE		87,635		87,635		1,073	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS		7,507	13,154	20,661	42	4,015	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,896,399	13,860,263	11,262,651	28,019,313	51,328	4,219,057	202

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	2,375,709						7
8	Laundry & Linen Service	5,371	65,389					8
9	Housekeeping	15,346		150,064				9
10	Dietary	39,544	54	199	306,521			10
11	Cafeteria	40,494		699		235,974		11
12	Maintenance of Personnel							12
13	Nursing Administration	8,548		42		3,664	559,628	13
14	Central Services & Supply					118		14
15	Pharmacy	15,569		478		6,246		15
16	Medical Records & Library	22,998		899		184		16
17	Social Service	3,656		349		1,547		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	412				338		23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	595,116	29,637	46,348	237,571	74,361	247,530	30
31	Intensive Care Unit	111,042	4,618	8,533	22,025	16,956	56,442	31
32.01	NEONATAL INTENSIVE CARE	30,421	11	2,186		5,173	17,221	32.01
41	Subprovider - IRF	85,263	4,738	7,234	42,897	10,530	35,052	41
43	Nursery	7,690	732	1,341		2,844	9,465	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	337,957	7,509	31,089		35,656	118,687	50
52	Delivery Room & Labor Room	55,899	3,090	5,728	4,028	3,965	13,195	52
54	Radiology-Diagnostic	150,141	2,636	4,563		11,126		54
60	Laboratory	61,030		2,912		12,797		60
62	Whole Blood & Packed Red Blood Cells	5,135				650		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	12,413		437		6,853		65
66	Physical Therapy	135,200	497	2,297		5,788		66
70	Electroencephalography	9,220	251	277		573		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	103,023	5,146	7,814		13,853		76
76.97	CARDIAC REHABILITATION	9,806	36	553		1,468		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	30,126	243	628		4,168	13,875	90
91	Emergency	83,242	6,191	20,020		14,469	48,161	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency			250				101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	1,974,662	65,389	144,876	306,521	233,327	559,628	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	4,143						190
191	Research					831		191
192	Physicians' Private Offices	202,592		5,072				192
194	ADVERTISING							194
194.01	FITNESS POINTE	156,840						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	5,083						194.02
194.03	RETAIL PHARMACY	6,088		116		1,230		194.03
194.04	HOSPICE	24,226						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	2,075				586		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,375,709	65,389	150,064	306,521	235,974	559,628	202

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMED EDUCATION	SUBTOTAL	
		14	15	16	17	23	24	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	549						14
15	Pharmacy		708,347					15
16	Medical Records & Library			181,295				16
17	Social Service				30,780			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)					5,037		23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics			14,467	24,068		4,935,700	30
31	Intensive Care Unit			2,607	3,721		1,369,138	31
32.01	NEONATAL INTENSIVE CARE			2,439	1,412		503,361	32.01
41	Subprovider - IRF			1,795			625,419	41
43	Nursery			600	1,260		128,045	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room			26,744			6,007,776	50
52	Delivery Room & Labor Room			1,028			490,602	52
54	Radiology-Diagnostic			33,363			3,796,397	54
60	Laboratory			21,669			1,163,914	60
62	Whole Blood & Packed Red Blood Cells			1,252			107,924	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			3,819			455,687	65
66	Physical Therapy			5,833			1,185,796	66
70	Electroencephalography			1,356			325,655	70
71	Medical Supplies Charged to Patients	549		5,589			232,578	71
72	Impl. Dev. Charged to Patients			7,315			376,214	72
73	Drugs Charged to Patients		708,347	14,854			723,201	73
76	CARDIOLOGY			18,969			2,144,207	76
76.97	CARDIAC REHABILITATION			281			74,545	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic			1,180			320,119	90
91	Emergency			15,382	319		875,774	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency			753			55,529	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	549	708,347	181,295	30,780		25,897,581	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen						19,315	190
191	Research						8,874	191
192	Physicians' Private Offices						954,444	192
194	ADVERTISING						9,843	194
194.01	FITNESS POINTE						789,235	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						34,696	194.02
194.03	RETAIL PHARMACY						159,975	194.03
194.04	HOSPICE						112,934	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS						27,379	194.06
200	Cross Foot Adjustments					5,037	5,037	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	549	708,347	181,295	30,780	5,037	28,019,313	202

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics		4,935,700				30
31	Intensive Care Unit		1,369,138				31
32.01	NEONATAL INTENSIVE CARE		503,361				32.01
41	Subprovider - IRF		625,419				41
43	Nursery		128,045				43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room		6,007,776				50
52	Delivery Room & Labor Room		490,602				52
54	Radiology-Diagnostic		3,796,397				54
60	Laboratory		1,163,914				60
62	Whole Blood & Packed Red Blood Cells		107,924				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		455,687				65
66	Physical Therapy		1,185,796				66
70	Electroencephalography		325,655				70
71	Medical Supplies Charged to Patients		232,578				71
72	Impl. Dev. Charged to Patients		376,214				72
73	Drugs Charged to Patients		723,201				73
76	CARDIOLOGY		2,144,207				76
76.97	CARDIAC REHABILITATION		74,545				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic		320,119				90
91	Emergency		875,774				91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	Home Health Agency		55,529				101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)		25,897,581				118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen		19,315				190
191	Research		8,874				191
192	Physicians' Private Offices		954,444				192
194	ADVERTISING		9,843				194
194.01	FITNESS POINTE		789,235				194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		34,696				194.02
194.03	RETAIL PHARMACY		159,975				194.03
194.04	HOSPICE		112,934				194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS		27,379				194.06
200	Cross Foot Adjustments		5,037				200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)		28,019,313				202

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	1,117,072						1
2	Cap Rel Costs-Mvble Equip		9,321,407					2
4	Employee Benefits Department	3,954	1,877	163,870,753				4
5	Administrative & General	278,336	376,830	15,185,470	-76,175,272	344,589,461		5
6	Maintenance & Repairs							6
7	Operation of Plant	142,153	287,239	5,123,626		21,266,370	692,629	7
8	Laundry & Linen Service	1,566		106,127		1,459,239	1,566	8
9	Housekeeping	4,474	13,669	3,306,642		5,035,517	4,474	9
10	Dietary	11,529	39,175	2,420,023		4,198,915	11,529	10
11	Cafeteria	11,806	25,406	1,261,812		1,405,118	11,806	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,492	383,638	2,537,878		4,049,218	2,492	13
14	Central Services & Supply			28,970		34,444		14
15	Pharmacy	4,539	311,272	3,825,303		20,617,603	4,539	15
16	Medical Records & Library	6,705	1,222	89,929		5,909,667	6,705	16
17	Social Service	1,066		714,285		961,839	1,066	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	120		172,410		224,144	120	23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	173,504	513,432	34,049,243		51,847,185	173,504	30
31	Intensive Care Unit	32,374	449,279	9,562,725		14,326,285	32,374	31
32.01	NEONATAL INTENSIVE CARE	8,869	229,658	3,003,979		4,575,942	8,869	32.01
41	Subprovider - IRF	24,858	23,894	4,237,934		7,667,688	24,858	41
43	Nursery	2,242	37,951	1,435,563		2,447,659	2,242	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	98,530	2,255,113	26,955,257		39,219,450	98,530	50
52	Delivery Room & Labor Room	16,297	132,101	2,110,121		3,363,993	16,297	52
54	Radiology-Diagnostic	43,773	1,934,161	8,350,658		20,135,887	43,773	54
60	Laboratory	17,793	503,287	6,089,121		15,535,514	17,793	60
62	Whole Blood & Packed Red Blood Cells	1,497	42,835	386,191		2,485,827	1,497	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,619	182,964	3,604,813		5,655,664	3,619	65
66	Physical Therapy	39,417	149,461	6,041,786		13,360,372	39,417	66
70	Electroencephalography	2,688	38,432	720,621		1,337,619	2,688	70
71	Medical Supplies Charged to Patients					18,493,946		71
72	Impl. Dev. Charged to Patients					30,128,943		72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	30,036	1,058,364	7,557,329		14,274,878	30,036	76
76.97	CARDIAC REHABILITATION	2,859	10,984	762,339		1,095,766	2,859	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	8,783	44,614	2,564,789		4,114,480	8,783	90
91	Emergency	24,269	211,036	6,383,959		10,355,083	24,269	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency		308	2,224,975		4,366,050		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	1,000,148	9,258,202	160,813,878	-76,175,272	329,950,305	575,705	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	1,208				14,988	1,208	190
191	Research		327	373,698		615,054		191
192	Physicians' Private Offices	59,065	234			1,113,891	59,065	192
194	ADVERTISING					803,906		194
194.01	FITNESS POINTE	45,726	17,968	1,557,884		3,481,195	45,726	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	1,482	3,446	318,687		546,316	1,482	194.02
194.03	RETAIL PHARMACY	1,775	30,343	671,452		7,648,265	1,775	194.03
194.04	HOSPICE	7,063				87,635	7,063	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	605	10,887	135,154		327,906	605	194.06
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	13,860,263	11,262,651	30,962,236		76,175,272	25,967,535	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.407672	1.208257	0.188943		0.221061	37.491262	203
204	Cost to be allocated (Per Wkst. B, Part II)			51,328		4,219,057	2,375,709	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000313		0.012244	3.429988	205

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE POUNDS	HOUSE-KEEPING TIME SPENT	DIETARY PATIENT MEALS	CAFETERIA FTES	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY COSTED REQ	
		8	9	10	11	13	14	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	200,580						8
9	Housekeeping		721,371					9
10	Dietary	165	956	336,343				10
11	Cafeteria		3,360		179,987			11
12	Maintenance of Personnel							12
13	Nursing Administration		200		2,795	2,667,214		13
14	Central Services & Supply				90		100	14
15	Pharmacy		2,300		4,764			15
16	Medical Records & Library		4,320		140			16
17	Social Service		1,680		1,180			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)				258			23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	90,915	222,801	260,685	56,718	1,179,734		30
31	Intensive Care Unit	14,166	41,017	24,168	12,933	269,007		31
32.01	NEONATAL INTENSIVE CARE	35	10,506		3,946	82,075		32.01
41	Subprovider - IRF	14,533	34,775	47,070	8,032	167,060		41
43	Nursery	2,244	6,444		2,169	45,112		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	23,034	149,449		27,196	565,668		50
52	Delivery Room & Labor Room	9,477	27,537	4,420	3,024	62,890		52
54	Radiology-Diagnostic	8,086	21,936		8,486			54
60	Laboratory		14,000		9,761			60
62	Whole Blood & Packed Red Blood Cells				496			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,100		5,227			65
66	Physical Therapy	1,524	11,041		4,415			66
70	Electroencephalography	771	1,332		437			70
71	Medical Supplies Charged to Patients						100	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	15,785	37,563		10,566			76
76.97	CARDIAC REHABILITATION	110	2,657		1,120			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	744	3,018		3,179	66,129		90
91	Emergency	18,991	96,239		11,036	229,539		91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency		1,200					101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	200,580	696,431	336,343	177,968	2,667,214	100	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research				634			191
192	Physicians' Private Offices		24,380					192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY		560		938			194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS				447			194.06
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,840,531	6,316,409	5,569,253	2,187,778	5,073,495	43,152	202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.176044	8.756117	16.558255	12.155200	1.902170	431.520000	203
204	Cost to be allocated (Per Wkst. B, Part II)	65,389	150,064	306,521	235,974	559,628	549	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.326000	0.208026	0.911335	1.311061	0.209817	5.490000	205

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQ	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	PARAMED EDUCATION ASSIGNED TIME			
	15	16	17	23			

<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	10,000					15
16	Medical Records & Library		1,602,576,592				16
17	Social Service			92,894			17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)					100	23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics		128,025,572	72,636			30
31	Intensive Care Unit		23,069,645	11,231			31
32.01	NEONATAL INTENSIVE CARE		21,580,767	4,260			32.01
41	Subprovider - IRF		15,886,871				41
43	Nursery		5,307,123	3,804			43
<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		236,669,714				50
52	Delivery Room & Labor Room		9,099,416				52
54	Radiology-Diagnostic		293,456,317				54
60	Laboratory		191,763,656				60
62	Whole Blood & Packed Red Blood Cells		11,075,423				62
62.30	BLOOD CLOTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		33,792,265				65
66	Physical Therapy		51,615,106				66
70	Electroencephalography		12,002,519				70
71	Medical Supplies Charged to Patients		49,463,445				71
72	Impl. Dev. Charged to Patients		64,737,303				72
73	Drugs Charged to Patients	10,000	131,448,111			100	73
76	CARDIOLOGY		167,865,655				76
76.97	CARDIAC REHABILITATION		2,484,782				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic		10,440,000				90
91	Emergency		136,125,911	963			91
92	Observation Beds (Non-Distinct Part)						92
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency		6,666,991				101
<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	10,000	1,602,576,592	92,894		100	118
<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen						190
191	Research						191
192	Physicians' Private Offices						192
194	ADVERTISING						194
194.01	FITNESS POINTE						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03	RETAIL PHARMACY						194.03
194.04	HOSPICE						194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS						194.06
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	25,423,570	7,506,971	1,243,483	281,328		202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,542.357000	0.004684	13.386042	2,813.280000		203
204	Cost to be allocated (Per Wkst. B, Part II)	708.347	181.295	30.780	5.037		204
205	Unit Cost Multiplier (Wkst. B, Part II)	70.834700	0.000113	0.331345	50.370000		205

**KPMG LLP Compu-Max 2552-10**

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**POST STEPDOWN ADJUSTMENTS**

**WORKSHEET B-2**

	WORKSHEET			
DESCRIPTION	PART	LINE NO.	AMOUNT	
1	2	3	4	

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C  
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	81,420,501		81,420,501	16,566	81,437,067	30
31	Intensive Care Unit	20,523,625		20,523,625		20,523,625	31
32.01	NEONATAL INTENSIVE CARE	6,374,521		6,374,521	7,917	6,382,438	32.01
41	Subprovider - IRF	12,001,741		12,001,741		12,001,741	41
43	Nursery	3,337,767		3,337,767		3,337,767	43
<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	55,618,440		55,618,440	26,302	55,644,742	50
52	Delivery Room & Labor Room	5,318,907		5,318,907		5,318,907	52
54	Radiology-Diagnostic	27,972,721		27,972,721	16,324	27,989,045	54
60	Laboratory	20,776,346		20,776,346	8,684	20,785,030	60
62	Whole Blood & Packed Red Blood Cells	3,149,376		3,149,376		3,149,376	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	7,281,798		7,281,798	1,516	7,283,314	65
66	Physical Therapy	18,197,712		18,197,712		18,197,712	66
70	Electroencephalography	1,814,361		1,814,361	1,189	1,815,550	70
71	Medical Supplies Charged to Patients	22,857,075		22,857,075		22,857,075	71
72	Impl. Dev. Charged to Patients	37,092,507		37,092,507		37,092,507	72
73	Drugs Charged to Patients	26,320,601		26,320,601		26,320,601	73
76	CARDIOLOGY	19,945,050		19,945,050	45,914	19,990,964	76
76.97	CARDIAC REHABILITATION	1,494,712		1,494,712		1,494,712	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	5,599,901		5,599,901	55,745	5,655,646	90
91	Emergency	15,792,277		15,792,277	3,181	15,795,458	91
92	Observation Beds (Non-Distinct Part)	13,993,268		13,993,268		13,993,268	92
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency	5,372,948		5,372,948		5,372,948	101
200	Subtotal (sum of lines 30 thru 199)	412,256,155		412,256,155	183,338	412,439,493	200
201	Less Observation Beds	13,993,268		13,993,268		13,993,268	201
202	Total (line 200 minus line 201)	398,262,887		398,262,887		398,446,225	202

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	95,258,839		95,258,839				30
31	Intensive Care Unit	23,069,645		23,069,645				31
32.01	NEONATAL INTENSIVE CARE	21,580,767		21,580,767				32.01
41	Subprovider - IRF	15,886,871		15,886,871				41
43	Nursery	5,307,123		5,307,123				43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	93,033,187	143,636,527	236,669,714	0.235004	0.235004	0.235116	50
52	Delivery Room & Labor Room	6,151,008	2,948,408	9,099,416	0.584533	0.584533	0.584533	52
54	Radiology-Diagnostic	63,082,740	230,373,577	293,456,317	0.095322	0.095322	0.095377	54
60	Laboratory	65,907,176	125,856,480	191,763,656	0.108344	0.108344	0.108389	60
62	Whole Blood & Packed Red Blood Cells	7,493,583	3,581,840	11,075,423	0.284357	0.284357	0.284357	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	30,596,987	3,195,278	33,792,265	0.215487	0.215487	0.215532	65
66	Physical Therapy	28,001,412	23,613,694	51,615,106	0.352566	0.352566	0.352566	66
70	Electroencephalography	1,526,131	10,476,388	12,002,519	0.151165	0.151165	0.151264	70
71	Medical Supplies Charged to Patients	23,729,566	25,733,879	49,463,445	0.462100	0.462100	0.462100	71
72	Impl. Dev. Charged to Patients	43,532,473	21,204,830	64,737,303	0.572970	0.572970	0.572970	72
73	Drugs Charged to Patients	87,551,420	43,896,691	131,448,111	0.200236	0.200236	0.200236	73
76	CARDIOLOGY	67,280,965	100,584,690	167,865,655	0.118816	0.118816	0.119089	76
76.97	CARDIAC REHABILITATION	496,488	1,988,294	2,484,782	0.601547	0.601547	0.601547	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	396,053	10,043,947	10,440,000	0.536389	0.536389	0.541729	90
91	Emergency	39,782,963	96,342,948	136,125,911	0.116012	0.116012	0.116036	91
92	Observation Beds (Non-Distinct Part)	5,004,501	27,762,232	32,766,733	0.427057	0.427057	0.427057	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency		6,666,991	6,666,991				101
200	Subtotal (sum of lines 30 thru 199)	724,669,898	877,906,694	1,602,576,592				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	724,669,898	877,906,694	1,602,576,592				202

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D  
PART I**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	4,935,700		4,935,700	88,157	55.99	36,540	2,045,875	30
31	Intensive Care Unit	1,369,138		1,369,138	11,231	121.91	4,774	581,998	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	503,361		503,361	4,260	118.16			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	625,419		625,419	15,687	39.87	12,619	503,120	41
42	Subprovider I								42
43	Nursery	128,045		128,045	3,804	33.66			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,561,663		7,561,663	123,139		53,933	3,130,993	200

(A) Worksheet A line numbers



**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check            [ ] Title V                            [XX] PPS  
Applicable    [XX] Title XVIII, Part A        [ ] TEFRA  
Boxes:        [ ] Title XIX                        [ ] Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE					32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check            [ ] Title V                            [XX] PPS  
Applicable    [XX] Title XVIII, Part A        [ ] TEFRA  
Boxes:         [ ] Title XIX                       [ ] Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6	7	8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	88,157		36,540		30
31	Intensive Care Unit	11,231		4,774		31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE	4,260				32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	15,687		12,619		41
42	Subprovider I					42
43	Nursery	3,804				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	123,139		53,933		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-0125**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			281,328		281,328	281,328	73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)			281,328		281,328	281,328	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-0125**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	7	8	9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	236,669,714			39,486,074		38,770,442		50
52	Delivery Room & Labor Room	9,099,416			16,015				52
54	Radiology-Diagnostic	293,456,317			29,067,834		74,901,439		54
60	Laboratory	191,763,656			30,355,533		16,459,434		60
62	Whole Blood & Packed Red Blood	11,075,423			3,204,010		998,288		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,792,265			15,083,946		1,269,346		65
66	Physical Therapy	51,615,106			6,821,836		532,481		66
70	Electroencephalography	12,002,519			772,500		3,210,167		70
71	Medical Supplies Charged to Pat	49,463,445			11,739,584		10,694,080		71
72	Impl. Dev. Charged to Patients	64,737,303			22,951,027		9,185,481		72
73	Drugs Charged to Patients	131,448,111	0.002140	0.002140	38,020,138	81,363	18,496,528	39,583	73
76	CARDIOLOGY	167,865,655			34,864,222		47,095,179		76
76.97	CARDIAC REHABILITATION	2,484,782			243,386		1,034,421		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	10,440,000			93,884		4,808,768		90
91	Emergency	136,125,911			19,423,576		18,212,264		91
92	Observation Beds (Non-Distinct	32,766,733					8,711,112		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	1,434,806,356			252,143,565	81,363	254,379,430	39,583	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.235004	38,770,442			9,111,209			50
52	Delivery Room & Labor Room	0.584533							52
54	Radiology-Diagnostic	0.095322	74,901,439			7,139,755			54
60	Laboratory	0.108344	16,459,434		2,982	1,783,281		323	60
62	Whole Blood & Packed Red Blood	0.284357	998,288			283,870			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.215487	1,269,346			273,528			65
66	Physical Therapy	0.352566	532,481			187,735			66
70	Electroencephalography	0.151165	3,210,167			485,265			70
71	Medical Supplies Charged to Pat	0.462100	10,694,080			4,941,734			71
72	Impl. Dev. Charged to Patients	0.572970	9,185,481			5,263,005			72
73	Drugs Charged to Patients	0.200236	18,496,528		133,518	3,703,671		26,735	73
76	CARDIOLOGY	0.118816	47,095,179			5,595,661			76
76.97	CARDIAC REHABILITATION	0.601547	1,034,421			622,253			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	0.536389	4,808,768			2,579,370			90
91	Emergency	0.116012	18,212,264			2,112,841			91
92	Observation Beds (Non-Distinct	0.427057	8,711,112			3,720,141			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		254,379,430		136,500	47,803,319		27,058	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		254,379,430		136,500	47,803,319		27,058	202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 15-T125**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	6,007,776	236,669,714	0.025385	249,284	6,328	50
52	Delivery Room & Labor Room	490,602	9,099,416	0.053916			52
54	Radiology-Diagnostic	3,796,397	293,456,317	0.012937	1,418,851	18,356	54
60	Laboratory	1,163,914	191,763,656	0.006070	2,473,445	15,014	60
62	Whole Blood & Packed Red Blood	107,924	11,075,423	0.009744	213,516	2,080	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	455,687	33,792,265	0.013485	1,427,631	19,252	65
66	Physical Therapy	1,185,796	51,615,106	0.022974	12,494,645	287,052	66
70	Electroencephalography	325,655	12,002,519	0.027132	93,317	2,532	70
71	Medical Supplies Charged to Pat	232,578	49,463,445	0.004702	1,181,806	5,557	71
72	Impl. Dev. Charged to Patients	376,214	64,737,303	0.005811	26,819	156	72
73	Drugs Charged to Patients	723,201	131,448,111	0.005502	5,871,594	32,306	73
76	CARDIOLOGY	2,144,207	167,865,655	0.012773	719,638	9,192	76
76.97	CARDIAC REHABILITATION	74,545	2,484,782	0.030001			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	320,119	10,440,000	0.030663	17,705	543	90
91	Emergency	875,774	136,125,911	0.006434	5,756	37	91
92	Observation Beds (Non-Distinct		32,766,733				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	18,280,389	1,434,806,356		26,194,007	398,405	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-T125**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			281,328		281,328	281,328	73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)			281,328		281,328	281,328	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-T125**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7		8		9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	236,669,714			249,284				50
52	Delivery Room & Labor Room	9,099,416							52
54	Radiology-Diagnostic	293,456,317			1,418,851		6,662		54
60	Laboratory	191,763,656			2,473,445				60
62	Whole Blood & Packed Red Blood	11,075,423			213,516				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,792,265			1,427,631				65
66	Physical Therapy	51,615,106			12,494,645				66
70	Electroencephalography	12,002,519			93,317		800		70
71	Medical Supplies Charged to Pat	49,463,445			1,181,806		3,145		71
72	Impl. Dev. Charged to Patients	64,737,303			26,819				72
73	Drugs Charged to Patients	131,448,111	0.002140	0.002140	5,871,594	12,565	2,078	4	73
76	CARDIOLOGY	167,865,655			719,638		3,965		76
76.97	CARDIAC REHABILITATION	2,484,782							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	10,440,000			17,705				90
91	Emergency	136,125,911			5,756				91
92	Observation Beds (Non-Distinct	32,766,733					2,304		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	1,434,806,356			26,194,007	12,565	18,954	4	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T125

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.235004							50
52	Delivery Room & Labor Room	0.584533							52
54	Radiology-Diagnostic	0.095322	6,662			635			54
60	Laboratory	0.108344							60
62	Whole Blood & Packed Red Blood	0.284357							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.215487							65
66	Physical Therapy	0.352566							66
70	Electroencephalography	0.151165	800			121			70
71	Medical Supplies Charged to Pat	0.462100	3,145			1,453			71
72	Impl. Dev. Charged to Patients	0.572970							72
73	Drugs Charged to Patients	0.200236	2,078		3,735	416		748	73
76	CARDIOLOGY	0.118816	3,965			471			76
76.97	CARDIAC REHABILITATION	0.601547							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	0.536389							90
91	Emergency	0.116012							91
92	Observation Beds (Non-Distinct	0.427057	2,304			984			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		18,954		3,735	4,080		748	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		18,954		3,735	4,080		748	202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D  
PART I**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	4,935,700		4,935,700	88,157	55.99	751	42,048	30
31	Intensive Care Unit	1,369,138		1,369,138	11,231	121.91	180	21,944	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	503,361		503,361	4,260	118.16	362	42,774	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	625,419		625,419	15,687	39.87	20	797	41
42	Subprovider I								42
43	Nursery	128,045		128,045	3,804	33.66	272	9,156	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,561,663		7,561,663	123,139		1,585	116,719	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 15-0125**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	6,007,776	236,669,714	0.025385	705,604	17,912	50
52	Delivery Room & Labor Room	490,602	9,099,416	0.053916	169,173	9,121	52
54	Radiology-Diagnostic	3,796,397	293,456,317	0.012937	522,198	6,756	54
60	Laboratory	1,163,914	191,763,656	0.006070	803,666	4,878	60
62	Whole Blood & Packed Red Blood	107,924	11,075,423	0.009744	86,954	847	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	455,687	33,792,265	0.013485	206,637	2,786	65
66	Physical Therapy	1,185,796	51,615,106	0.022974	150,573	3,459	66
70	Electroencephalography	325,655	12,002,519	0.027132	9,760	265	70
71	Medical Supplies Charged to Pat	232,578	49,463,445	0.004702	249,237	1,172	71
72	Impl. Dev. Charged to Patients	376,214	64,737,303	0.005811	55,218	321	72
73	Drugs Charged to Patients	723,201	131,448,111	0.005502	1,047,065	5,761	73
76	CARDIOLOGY	2,144,207	167,865,655	0.012773	449,608	5,743	76
76.97	CARDIAC REHABILITATION	74,545	2,484,782	0.030001	1,815	54	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	320,119	10,440,000	0.030663	7,343	225	90
91	Emergency	875,774	136,125,911	0.006434	291,754	1,877	91
92	Observation Beds (Non-Distinct	848,104	32,766,733	0.025883			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	19,128,493	1,434,806,356		4,756,605	61,177	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check            [ ] Title V                            [XX] PPS  
Applicable    [ ] Title XVIII, Part A            [ ] TEFRA  
Boxes:         [XX] Title XIX                    [ ] Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
32.01	NEONATAL INTENSIVE CARE						32.01
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX  Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6	7	8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	88,157		751		30
31	Intensive Care Unit	11,231		180		31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE	4,260		362		32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF	15,687		20		41
42	Subprovider I					42
43	Nursery	3,804		272		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	123,139		1,585		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-0125**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			281,328		281,328	281,328	73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)			281,328		281,328	281,328	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-0125**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7		8		9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	236,669,714			705,604				50
52	Delivery Room & Labor Room	9,099,416			169,173				52
54	Radiology-Diagnostic	293,456,317			522,198				54
60	Laboratory	191,763,656			803,666				60
62	Whole Blood & Packed Red Blood	11,075,423			86,954				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,792,265			206,637				65
66	Physical Therapy	51,615,106			150,573				66
70	Electroencephalography	12,002,519			9,760				70
71	Medical Supplies Charged to Pat	49,463,445			249,237				71
72	Impl. Dev. Charged to Patients	64,737,303			55,218				72
73	Drugs Charged to Patients	131,448,111	0.002140	0.002140	1,047,065	2,241			73
76	CARDIOLOGY	167,865,655			449,608				76
76.97	CARDIAC REHABILITATION	2,484,782			1,815				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	10,440,000			7,343				90
91	Emergency	136,125,911			291,754				91
92	Observation Beds (Non-Distinct	32,766,733							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	1,434,806,356			4,756,605	2,241			200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.235004							50
52	Delivery Room & Labor Room	0.584533							52
54	Radiology-Diagnostic	0.095322							54
60	Laboratory	0.108344							60
62	Whole Blood & Packed Red Blood	0.284357							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.215487							65
66	Physical Therapy	0.352566							66
70	Electroencephalography	0.151165							70
71	Medical Supplies Charged to Pat	0.462100							71
72	Impl. Dev. Charged to Patients	0.572970							72
73	Drugs Charged to Patients	0.200236							73
76	CARDIOLOGY	0.118816							76
76.97	CARDIAC REHABILITATION	0.601547							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	0.536389							90
91	Emergency	0.116012							91
92	Observation Beds (Non-Distinct	0.427057							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T125

WORKSHEET D  
PART II

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	6,007,776	236,669,714	0.025385			50
52	Delivery Room & Labor Room	490,602	9,099,416	0.053916			52
54	Radiology-Diagnostic	3,796,397	293,456,317	0.012937	12,231	158	54
60	Laboratory	1,163,914	191,763,656	0.006070	10,479	64	60
62	Whole Blood & Packed Red Blood	107,924	11,075,423	0.009744	6,600	64	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	455,687	33,792,265	0.013485	126	2	65
66	Physical Therapy	1,185,796	51,615,106	0.022974	26,601	611	66
70	Electroencephalography	325,655	12,002,519	0.027132			70
71	Medical Supplies Charged to Pat	232,578	49,463,445	0.004702	191	1	71
72	Impl. Dev. Charged to Patients	376,214	64,737,303	0.005811			72
73	Drugs Charged to Patients	723,201	131,448,111	0.005502	13,085	72	73
76	CARDIOLOGY	2,144,207	167,865,655	0.012773	1,254	16	76
76.97	CARDIAC REHABILITATION	74,545	2,484,782	0.030001			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	320,119	10,440,000	0.030663			90
91	Emergency	875,774	136,125,911	0.006434			91
92	Observation Beds (Non-Distinct		32,766,733				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	18,280,389	1,434,806,356		70,567	988	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-T125**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			281,328		281,328	281,328	73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)			281,328		281,328	281,328	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 15-T125**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	236,669,714							50
52	Delivery Room & Labor Room	9,099,416							52
54	Radiology-Diagnostic	293,456,317			12,231				54
60	Laboratory	191,763,656			10,479				60
62	Whole Blood & Packed Red Blood	11,075,423			6,600				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	33,792,265			126				65
66	Physical Therapy	51,615,106			26,601				66
70	Electroencephalography	12,002,519							70
71	Medical Supplies Charged to Pat	49,463,445			191				71
72	Impl. Dev. Charged to Patients	64,737,303							72
73	Drugs Charged to Patients	131,448,111	0.002140	0.002140	13,085	28			73
76	CARDIOLOGY	167,865,655			1,254				76
76.97	CARDIAC REHABILITATION	2,484,782							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	10,440,000							90
91	Emergency	136,125,911							91
92	Observation Beds (Non-Distinct	32,766,733							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	1,434,806,356			70,567	28			200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T125

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	0.235004						50
52	Delivery Room & Labor Room	0.584533						52
54	Radiology-Diagnostic	0.095322						54
60	Laboratory	0.108344						60
62	Whole Blood & Packed Red Blood	0.284357						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.215487						65
66	Physical Therapy	0.352566						66
70	Electroencephalography	0.151165						70
71	Medical Supplies Charged to Pat	0.462100						71
72	Impl. Dev. Charged to Patients	0.572970						72
73	Drugs Charged to Patients	0.200236						73
76	CARDIOLOGY	0.118816						76
76.97	CARDIAC REHABILITATION	0.601547						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	0.536389						90
91	Emergency	0.116012						91
92	Observation Beds (Non-Distinct	0.427057						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	88,157	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	88,157	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	25,218	3
4	Semi-private room days (excluding swing-bed private room days)	47,791	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	36,540	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	81,437,067	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	81,437,067	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)	1,348836	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)	842.44	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	81,437,067	37

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
38	Adjusted general inpatient routine service cost per diem (see instructions)					923.77	38	
39	Program general inpatient routine service cost (line 9 x line 38)					33,754,556	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)					33,754,556	41	
42	Nursery (Titles V and XIX only)	1	2	3	4	5	42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	20,523,625	11,231	1,827.41	4,774	8,724,055	43	
44	Coronary Care Unit						44	
44.01	NEONATAL INTENSIVE CARE	6,382,438	4,260	1,498.22			44.01	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					54,831,091	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					97,309,702	49	

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,627,873	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,035,428	51
52	Total Program excludable cost (sum of lines 50 and 51)					5,663,301	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					91,646,401	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					15,148	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					923.77	88
89	Observation bed cost (line 87 x line 88) (see instructions)					13,993,268	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	4,935,700	81,437,067	0.060608	13,993,268	848,104	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 15-T125**

**WORKSHEET D-1  
PART I**

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

**PART I - ALL PROVIDER COMPONENTS**

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,687	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,687	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,524	3
4	Semi-private room days (excluding swing-bed private room days)	14,163	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	12,619	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)	1,317	14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	12,001,741	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,001,741	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	5,447,659	28
29	Private room charges (excluding swing-bed charges)	646,362	29
30	Semi-private room charges (excluding swing-bed charges)	4,801,297	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2,203,101	31
32	Average private room per diem charge (line 29 ÷ line 3)	424.12	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	339.00	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	85.12	34
35	Average per diem private room cost differential (line 34 x line 31)	187.53	35
36	Private room cost differential adjustment (line 3 x line 35)	285,796	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,715,945	37

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	765.08	38
39	Program general inpatient routine service cost (line 9 x line 38)	9,654,545	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	9,654,545	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,082,892	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	16,737,437	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	503,120	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	410,970	51
52	Total Program excludable cost (sum of lines 50 and 51)	914,090	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	15,823,347	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 15-0125**

**WORKSHEET D-1  
PART I**

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

**PART I - ALL PROVIDER COMPONENTS**

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	88,157	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	88,157	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	25,218	3
4	Semi-private room days (excluding swing-bed private room days)	47,791	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	751	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	3,804	15
16	Nursery days (title V or XIX only)	272	16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	81,437,067	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	81,437,067	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)	1,348836	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)	842.44	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	81,437,067	37

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					923.77	38	
39	Program general inpatient routine service cost (line 9 x line 38)					693,751	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)					693,751	41	
42	Nursery (Titles V and XIX only)	3,337,767	3,804	877.44	272	238,664	42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	20,523,625	11,231	1,827.41	180	328,934	43	
44	Coronary Care Unit						44	
44.01	NEONATAL INTENSIVE CARE	6,382,438	4,260	1,498.22	362	542,356	44.01	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					974,464	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,778,169	49	

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					115,922	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					63,418	51
52	Total Program excludable cost (sum of lines 50 and 51)					179,340	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					2,598,829	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					15,148	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,687	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,687	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,524	3
4	Semi-private room days (excluding swing-bed private room days)	14,163	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	20	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	12,001,741	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,001,741	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	5,447,659	28
29	Private room charges (excluding swing-bed charges)	646,362	29
30	Semi-private room charges (excluding swing-bed charges)	4,801,297	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2,203,101	31
32	Average private room per diem charge (line 29 ÷ line 3)	424.12	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	339.00	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	85.12	34
35	Average per diem private room cost differential (line 34 x line 31)	187.53	35
36	Private room cost differential adjustment (line 3 x line 35)	285,796	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,715,945	37

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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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 [ ] 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)	765.08	38
39	Program general inpatient routine service cost (line 9 x line 38)	15,302	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)	15,302	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	16,443	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	31,745	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	797	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,016	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,813	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	29,932	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0125

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		49,847,836		30
31	Intensive Care Unit		11,893,183		31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF				41
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.235116	39,486,074	9,283,808	50
52	Delivery Room & Labor Room	0.584533	16,015	9,361	52
54	Radiology-Diagnostic	0.095377	29,067,834	2,772,403	54
60	Laboratory	0.108389	30,355,533	3,290,206	60
62	Whole Blood & Packed Red Blood Cells	0.284357	3,204,010	911,083	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.215532	15,083,946	3,251,073	65
66	Physical Therapy	0.352566	6,821,836	2,405,147	66
70	Electroencephalography	0.151264	772,500	116,851	70
71	Medical Supplies Charged to Patients	0.462100	11,739,584	5,424,862	71
72	Impl. Dev. Charged to Patients	0.572970	22,951,027	13,150,250	72
73	Drugs Charged to Patients	0.200236	38,020,138	7,613,000	73
76	CARDIOLOGY	0.119089	34,864,222	4,151,945	76
76.97	CARDIAC REHABILITATION	0.601547	243,386	146,408	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	0.541729	93,884	50,860	90
91	Emergency	0.116036	19,423,576	2,253,834	91
92	Observation Beds (Non-Distinct Part)	0.427057			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		252,143,565	54,831,091	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		252,143,565		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T125

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF		13,252,223		41
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.235116	249,284	58,611	50
52	Delivery Room & Labor Room	0.584533			52
54	Radiology-Diagnostic	0.095377	1,418,851	135,326	54
60	Laboratory	0.108389	2,473,445	268,094	60
62	Whole Blood & Packed Red Blood Cells	0.284357	213,516	60,715	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.215532	1,427,631	307,700	65
66	Physical Therapy	0.352566	12,494,645	4,405,187	66
70	Electroencephalography	0.151264	93,317	14,116	70
71	Medical Supplies Charged to Patients	0.462100	1,181,806	546,113	71
72	Impl. Dev. Charged to Patients	0.572970	26,819	15,366	72
73	Drugs Charged to Patients	0.200236	5,871,594	1,175,704	73
76	CARDIOLOGY	0.119089	719,638	85,701	76
76.97	CARDIAC REHABILITATION	0.601547			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	0.541729	17,705	9,591	90
91	Emergency	0.116036	5,756	668	91
92	Observation Beds (Non-Distinct Part)	0.427057			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		26,194,007	7,082,892	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		26,194,007		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0125

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		959,491		30
31	Intensive Care Unit		323,490		31
32.01	NEONATAL INTENSIVE CARE		1,210,531		32.01
41	Subprovider - IRF				41
43	Nursery		258,606		43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.235116	705,604	165,899	50
52	Delivery Room & Labor Room	0.584533	169,173	98,887	52
54	Radiology-Diagnostic	0.095377	522,198	49,806	54
60	Laboratory	0.108389	803,666	87,109	60
62	Whole Blood & Packed Red Blood Cells	0.284357	86,954	24,726	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.215532	206,637	44,537	65
66	Physical Therapy	0.352566	150,573	53,087	66
70	Electroencephalography	0.151264	9,760	1,476	70
71	Medical Supplies Charged to Patients	0.462100	249,237	115,172	71
72	Impl. Dev. Charged to Patients	0.572970	55,218	31,638	72
73	Drugs Charged to Patients	0.200236	1,047,065	209,660	73
76	CARDIOLOGY	0.119089	449,608	53,543	76
76.97	CARDIAC REHABILITATION	0.601547	1,815	1,092	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	0.541729	7,343	3,978	90
91	Emergency	0.116036	291,754	33,854	91
92	Observation Beds (Non-Distinct Part)	0.427057			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		4,756,605	974,464	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,756,605		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T125

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF		27,840		41
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.235116			50
52	Delivery Room & Labor Room	0.584533			52
54	Radiology-Diagnostic	0.095377	12,231	1,167	54
60	Laboratory	0.108389	10,479	1,136	60
62	Whole Blood & Packed Red Blood Cells	0.284357	6,600	1,877	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.215532	126	27	65
66	Physical Therapy	0.352566	26,601	9,379	66
70	Electroencephalography	0.151264			70
71	Medical Supplies Charged to Patients	0.462100	191	88	71
72	Impl. Dev. Charged to Patients	0.572970			72
73	Drugs Charged to Patients	0.200236	13,085	2,620	73
76	CARDIOLOGY	0.119089	1,254	149	76
76.97	CARDIAC REHABILITATION	0.601547			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	0.541729			90
91	Emergency	0.116036			91
92	Observation Beds (Non-Distinct Part)	0.427057			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		70,567	16,443	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		70,567		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

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

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	18,211,275			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	55,833,056			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,758,381			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	368.50			4
	<b>Indirect Medical Education Adjustment Calculation for Hospitals</b>				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	<b>Disproportionate Share Adjustment</b>				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0305			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1577			31
32	Sum of lines 30 and 31	0.1882			32
33	Allowable disproportionate share percentage (see instructions)	0.0498			33
34	Disproportionate share adjustment (see instructions)	921,852			34
		<b>Prior to</b>		<b>On or after</b>	
		<b>October 1 (1.00)</b>	<b>(1.01)</b>	<b>October 1 (2.00)</b>	
	<b>Uncompensated Care Adjustment</b>				
35	Total uncompensated care amount (see instructions)	6,406,145,534		5,977,483,147	35
35.01	Factor 3 (see instructions)	0.000447984		0.000441699	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,869,851		2,640,248	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	721,383		1,974,760	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,696,143			36
	<b>Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)</b>				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

**KPMG LLP Compu-Max 2552-10**

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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

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

		1	1.01	1.02	
47	Subtotal (see instructions)	79,420,707			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	79,420,707			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	6,308,018			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	29,552			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	81,363			58
59	Total (sum of amounts on lines 49 through 58)	85,839,640			59
60	Primary payer payments	53,455			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	85,786,185			61
62	Deductibles billed to program beneficiaries	6,570,928			62
63	Coinsurance billed to program beneficiaries	405,713			63
64	Allowable bad debts (see instructions)	639,096			64
65	Adjusted reimbursable bad debts (see instructions)	415,412			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	239,524			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	79,224,956			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (OTHER ADJUSTMENTS)				70
70.93	HVBP payment adjustment amount (see instructions)	277,286			70.93
70.94	HRR adjustment amount (see instructions)	-522,042			70.94
71	Amount due provider (see instructions)	78,980,200			71
71.01	Sequestration adjustment (see instructions)	1,579,604			71.01
72	Interim payments	77,239,567			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	161,029			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,073,103			75

**TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)**

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

**HSP Bonus Payment Amount**

**Prior to 10/1**

**On or After 10/1**

100	HSP bonus amount (see instructions)				100
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**HVBP Adjustment for HSP Bonus Payment**

**Prior to 10/1**

**On or After 10/1**

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

**HRR Adjustment for HSP Bonus Payment**

**Prior to 10/1**

**On or After 10/1**

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

**KPMG LLP Compu-Max 2552-10**

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0125

WORKSHEET E  
PART B

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

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	27,058			1
2	Medical and other services reimbursed under OPPS (see instructions)	47,763,736			2
3	PPS payments	45,525,501			3
4	Outlier payment (see instructions)	96,218			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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	39,583			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	27,058			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	136,500			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	136,500			14
	<b>CUSTOMARY CHARGES</b>				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	136,500			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	109,442			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	27,058			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	45,661,302			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	8,459,193			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	37,229,167			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	37,229,167			30
31	Primary payer payments	11,157			31
32	Subtotal (line 30 minus line 31)	37,218,010			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	963,876			34
35	Adjusted reimbursable bad debts (see instructions)	626,519			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	581,718			36
37	Subtotal (see instructions)	37,844,529			37
38	MSP-LCC reconciliation amount from PS&R	-321			38
39	Other adjustments (FDO LOSS)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	37,844,850			40
40.01	Sequestration adjustment (see instructions)	756,897			40.01
41	Interim payments	37,401,859			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-313,906			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

**TO BE COMPLETED BY CONTRACTOR**

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

**KPMG LLP Compu-Max 2552-10**

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E  
PART B

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

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	748			1
2	Medical and other services reimbursed under OPPS (see instructions)	4,076			2
3	PPS payments	1,541			3
4	Outlier payment (see instructions)				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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	4			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	748			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	3,735			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	3,735			14
	<b>CUSTOMARY CHARGES</b>				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	3,735			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	2,987			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	748			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,545			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	233			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,060			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,060			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,060			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	2,060			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ( )				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,060			40
40.01	Sequestration adjustment (see instructions)	41			40.01
41	Interim payments	2,071			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-52			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

**TO BE COMPLETED BY CONTRACTOR**

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

**KPMG LLP Compu-Max 2552-10**

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0125

WORKSHEET E-1  
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		76,508,367		36,423,636	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero		731,200		936,523	2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)			01/06/2017	41,700	3.01
						3.02
		Program				3.03
		to				3.04
		Provider				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		Provider				3.52
		to				3.53
		Program				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)				41,700	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		77,239,567		37,401,859	4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					5.01
						5.02
		Program				5.03
		to				5.04
		Provider				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		Provider				5.52
		to				5.53
		Program				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		161,029		-313,906	6.01
						6.02
7	Total Medicare program liability (see instructions)		77,400,596		37,087,953	7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-T125

WORKSHEET E-1  
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		21,405,679		2,071	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		21,405,679		2,071	4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	67,176			6.01
		.02			-52	6.02
7	Total Medicare program liability (see instructions)		21,472,855		2,019	7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT**

**WORKSHEET E-1  
PART II**

Check applicable box:             Hospital             CAH

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

**HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION**

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	17,158	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	41,314	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	13,040	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	88,500	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	1,602,576,592	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	35,847,116	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

**INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH**

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(\*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E-3  
PART III

Check [ ] Hospital  
Applicable [XX] Subprovider IRF  
Box:

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

		1	1.01	
1	Net Federal PPS payment (see instructions)	21,677,009		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.024200		2
3	Inpatient Rehabilitation LIP payments (see instructions)	281,801		3
4	Outlier payments	175,650		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	42.978082		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	22,134,460		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	22,134,460		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	22,134,460		19
20	Deductibles	166,712		20
21	Subtotal (line 19 minus line 20)	21,967,748		21
22	Coinsurance	83,853		22
23	Subtotal (line 21 minus line 22)	21,883,895		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	22,488		24
25	Adjusted reimbursable bad debts (see instructions)	14,617		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,016		26
27	Subtotal (sum of lines 23 and 25)	21,898,512		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)	12,565		29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	21,911,077		32
32.01	Sequestration adjustment (see instructions)	438,222		32.01
33	Interim payments	21,405,679		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	67,176		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	186,385		36

**TO BE COMPLETED BY CONTRACTOR**

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0125

WORKSHEET E-3  
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8	2,752,118		8
9	4,756,605		9
10			10
11			11
12	7,508,723		12
<b>CUSTOMARY CHARGES</b>			
13			13
14			14
15	1.000000	1.000000	15
16	7,508,723		16
17	7,508,723		17
18			18
19			19
20			20
21			21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22			22
23			23
24			24
25			25
26	2,241		26
27	2,241		27
28			28
29	2,241		29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30			30
31	2,241		31
32			32
33			33
34			34
35			35
36	2,241		36
37			37
38	2,241		38
39			39
40	2,241		40
41			41
42	2,241		42
43			43



**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**BALANCE SHEET**

**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
<b>Assets</b> (Omit Cents)		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	Cash on hand and in banks	131,164				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	129,986,389				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-65,194,446				6
7	Inventory	11,283,997				7
8	Prepaid expenses	3,333,055				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	79,540,159				11
<b>FIXED ASSETS</b>						
12	Land					12
13	Land improvements	14,470,317				13
14	Accumulated depreciation	-6,330,104				14
15	Buildings	370,804,020				15
16	Accumulated depreciation	-217,727,802				16
17	Leasehold improvements	1,286,570				17
18	Accumulated depreciation	-1,153,748				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	151,568,273				23
24	Accumulated depreciation	-109,746,736				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	2,666,774				29
30	Total fixed assets (sum of lines 12-29)	205,837,564				30
<b>OTHER ASSETS</b>						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	5,081,234				34
35	Total other assets (sum of lines 31-34)	5,081,234				35
36	Total assets (sum of lines 11, 30 and 35)	290,458,957				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	2,662,102				37
38	Salaries, wages and fees payable	20,420,227				38
39	Payroll taxes payable	2,040,854				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	9,809,045				44
45	Total current liabilities (sum of lines 37 thru 44)	34,932,228				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	49,614,473				49
50	Total long term liabilities (sum of lines 46 thru 49)	49,614,473				50
51	Total liabilities (sum of lines 45 and 50)	84,546,701				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	205,912,256				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	205,912,256				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	290,458,957				60

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**STATEMENT OF CHANGES IN FUND BALANCES**

**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		162,586,390			1
2	Net income (loss) (from Worksheet G-3, line 29)		55,606,802			2
3	Total (sum of line 1 and line 2)		218,193,192			3
4	Additions (credit adjustments) (specify)					4
5	PENSION RELATED CHANGES	20,254,000				5
6	RESTRICTED CONTRIBUTIONS	123,000				6
7	NET ASSETS RELEASED FROM RESTRICTN	20,000				7
8	OTHER	9,064				8
9						9
10	Total additions (sum of lines 4-9)		20,406,064			10
11	Subtotal (line 3 plus line 10)		238,599,256			11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS RELEASED FROM RESTRCTN	95,000				13
14	PENSION-RELATED ADJ-NOT NET COST					14
15	NET ASSETS TRANSFERRD TO AFFILIATE	32,592,000				15
16	OTHER					16
17						17
18	Total deductions (sum of lines 12-17)		32,687,000			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		205,912,256			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	PENSION RELATED CHANGES					5
6	RESTRICTED CONTRIBUTIONS					6
7	NET ASSETS RELEASED FROM RESTRICTN					7
8	OTHER					8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS RELEASED FROM RESTRCTN					13
14	PENSION-RELATED ADJ-NOT NET COST					14
15	NET ASSETS TRANSFERRD TO AFFILIATE					15
16	OTHER					16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
PARTS I & II

**PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	107,097,342		107,097,342	1
2	Subprovider IPF				2
3	Subprovider IRF	16,104,078		16,104,078	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)	123,201,420		123,201,420	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	Intensive Care Unit	23,851,050		23,851,050	11
12	Coronary Care Unit				12
12.01	NEONATAL INTENSIVE CARE	21,644,781		21,644,781	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)	45,495,831		45,495,831	16
17	Total inpatient routine care services (sum of lines 10 and 16)	168,697,251		168,697,251	17
18	Ancillary services	555,942,646		555,942,646	18
19	Outpatient services		871,279,091	871,279,091	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		6,666,991	6,666,991	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIAN REVENUES	19,382,315	36,728,081	56,110,396	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	744,022,212	914,674,163	1,658,696,375	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		471,347,570	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)		471,347,570	43

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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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)	1,658,696,375	1
2	Less contractual allowances and discounts on patients' accounts	1,145,222,207	2
3	Net patient revenues (line 1 minus line 2)	513,474,168	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	471,347,570	4
5	Net income from service to patients (line 3 minus line 4)	42,126,598	5

**OTHER INCOME**

6	Contributions, donations, bequests, etc.	252,457	6
7	Income from investments	233,202	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	2,386,001	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	7,978,544	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	24,464	21
22	Rental of hosptial space	1,534,255	22
23	Governmental appropriations		23
24	Other (OTHER REVENUE)	267,519	24
24.01	Other (REVENUE-CLASSES)	43,475	24.01
24.02	Other (ASSETS RELEASED FROM RESTRICTION)	74,201	24.02
24.03	Other (FITNESS REVENUE)	3,644,822	24.03
24.04	Other (SALE OF XRAY SCRAP)	3,950	24.04
24.05	Other (GAIN ON FIXED ASSETS)	363,963	24.05
25	Total other income (sum of lines 6-24)	16,806,853	25
26	Total (line 5 plus line 25)	58,933,451	26
27	Other expenses (PENSION SETTLEMENT)	3,326,648	27
27.01	Other expenses (ROUNDING)	1	27.01
28	Total other expenses (sum of line 27 and subscripts)	3,326,649	28
29	Net income (or loss) for the period (line 26 minus line 28)	55,606,802	29

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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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	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	778,659	433,991	15,546	2,025	106,361	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	1,135,298					6
7	Physical Therapy	87,273			1,000,435		7
8	Occupational Therapy	25,455			183,438		8
9	Speech Pathology	31,700					9
10	Medical Social Services	975					10
11	Home Health Aide	74,727					11
12	Supplies (see instructions)					197,103	12
13	Drugs						13
14	DME						14
	<b>HHA NONREIMBURSABLE SERVICES</b>						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing	90,888	9,351			1,343	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)	2,224,975	443,342	15,546	1,185,898	304,807	24

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 15-7487**

**WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	1,336,582	-251,522	1,085,060	11,109	1,096,169	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	1,135,298		1,135,298		1,135,298	6
7	Physical Therapy	1,087,708	11,130	1,098,838		1,098,838	7
8	Occupational Therapy	208,893		208,893		208,893	8
9	Speech Pathology	31,700		31,700		31,700	9
10	Medical Social Services	975		975		975	10
11	Home Health Aide	74,727		74,727		74,727	11
12	Supplies (see instructions)	197,103		197,103		197,103	12
13	Drugs						13
14	DME						14
	<b>HHA NONREIMBURSABLE SERVICES</b>						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing	101,582		101,582		101,582	17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	4,174,568	-240,392	3,934,176	11,109	3,945,285	24

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 15-7487**

**WORKSHEET H-1  
PART I**

		CAPITAL RELATED COSTS				
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
<b>GENERAL SERVICE COST CENTERS</b>						
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	1,096,169				5
<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	1,135,298				6
7	Physical Therapy	1,098,838				7
8	Occupational Therapy	208,893				8
9	Speech Pathology	31,700				9
10	Medical Social Services	975				10
11	Home Health Aide	74,727				11
12	Supplies (see instructions)	197,103				12
13	Drugs					13
14	DME					14
<b>HHA NONREIMBURSABLE SERVICES</b>						
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing	101,582				17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	3,945,285				24

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 15-7487**

**WORKSHEET H-1  
PART I**

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	<b>GENERAL SERVICE COST CENTERS</b>					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		1,096,169	1,096,169		5
	<b>HHA REIMBURSABLE SERVICES</b>					
6	Skilled Nursing Care		1,135,298	429,672	1,564,970	6
7	Physical Therapy		1,098,838	364,726	1,463,564	7
8	Occupational Therapy		208,893	82,112	291,005	8
9	Speech Pathology		31,700	6,160	37,860	9
10	Medical Social Services		975	459	1,434	10
11	Home Health Aide		74,727	41,846	116,573	11
12	Supplies (see instructions)		197,103	71,536	268,639	12
13	Drugs					13
14	DME					14
	<b>HHA NONREIMBURSABLE SERVICES</b>					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing		101,582	99,658	201,240	17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		3,945,285		3,945,285	24

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-1  
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-1,096,169	21,813,712	5
<b>HHA REIMBURSABLE SERVICES</b>								
6	Skilled Nursing Care					7,415,062	8,550,360	6
7	Physical Therapy					6,159,242	7,258,080	7
8	Occupational Therapy					1,425,135	1,634,028	8
9	Speech Pathology					90,890	122,590	9
10	Medical Social Services					8,151	9,126	10
11	Home Health Aide					758,019	832,746	11
12	Supplies (see instructions)					1,226,471	1,423,574	12
13	Drugs							13
14	DME							14
<b>HHA NONREIMBURSABLE SERVICES</b>								
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing					1,881,626	1,983,208	17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					17,868,427	21,813,712	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						1,096,169	25
26	Unit Cost Multiplier						0.050251	26

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 15-7487**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4) 4A	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4		5	
1	Administrative and General			372	420,393	420,765	93,015	1
2	Skilled Nursing Care	1,564,970				1,564,970	345,953	2
3	Physical Therapy	1,463,564				1,463,564	323,537	3
4	Occupational Therapy	291,005				291,005	64,330	4
5	Speech Pathology	37,860				37,860	8,369	5
6	Medical Social Services	1,434				1,434	317	6
7	Home Health Aide	116,573				116,573	25,770	7
8	Supplies	268,639				268,639	59,386	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing	201,240				201,240	44,486	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)	3,945,285		372	420,393	4,366,050	965,163	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 15-7487**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General				10,507			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)				10,507			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 15-7487**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SOCIAL SERVICE 17	
1	Administrative and General					31,228		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)					31,228		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 15-7487**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						555,515	1
2	Skilled Nursing Care						1,910,923	2
3	Physical Therapy						1,787,101	3
4	Occupational Therapy						355,335	4
5	Speech Pathology						46,229	5
6	Medical Social Services						1,751	6
7	Home Health Aide						142,343	7
8	Supplies						328,025	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing						245,726	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)						5,372,948	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 15-7487**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PtII) 27	TOTAL HHA COSTS 28		
1	Administrative and General		555,515				1
2	Skilled Nursing Care		1,910,923	220,356	2,131,279		2
3	Physical Therapy		1,787,101	206,076	1,993,177		3
4	Occupational Therapy		355,335	40,975	396,310		4
5	Speech Pathology		46,229	5,331	51,560		5
6	Medical Social Services		1,751	202	1,953		6
7	Home Health Aide		142,343	16,414	158,757		7
8	Supplies		328,025	37,826	365,851		8
9	Drugs						9
10	DME						10
11	Home Dialysis Aide Services						11
12	Respiratory Therapy						12
13	Private Duty Nursing		245,726	28,335	274,061		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)		5,372,948	555,515	5,372,948		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.115313			21

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

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-2  
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	Administrative and General		308	2,224,975		420,765		1
2	Skilled Nursing Care					1,564,970		2
3	Physical Therapy					1,463,564		3
4	Occupational Therapy					291,005		4
5	Speech Pathology					37,860		5
6	Medical Social Services					1,434		6
7	Home Health Aide					116,573		7
8	Supplies					268,639		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing					201,240		13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		308	2,224,975		4,366,050		20
21	Total cost to be allocated		372	420,393		965,163		21
22	Unit Cost Multiplier			0.188943		0.221061		22
22	Unit Cost Multiplier		1.207792					22

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS**

**HHA CCN: 15-7487**

**WORKSHEET H-2  
PART II**

	HHA COST CENTER	OPERATION OF PLANT  SQUARE FEET	LAUNDRY + LINEN SERVICE POUNDS	HOUSE- KEEPING  TIME SPENT	DIETARY  PATIENT ME ALS	CAFETERIA  FTES	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	Administrative and General			1,200				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)			1,200				20
21	Total cost to be allocated			10,507				21
22	Unit Cost Multiplier			8.755833				22
22	Unit Cost Multiplier							22

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-2  
PART II

	HHA COST CENTER	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY COSTED REQ	PHARMACY COSTED REQ	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General				6,666,991			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)				6,666,991			20
21	Total cost to be allocated				31,228			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				0.004684			22

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-2  
PART II

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED 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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**APPORTIONMENT OF PATIENT SERVICE COSTS**

**HHA CCN: 15-7487**

**WORKSHEET H-3  
PARTS I & II**

Check applicable box:         Title V         Title XVIII         Title XIX

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

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		1	2	3	4	5		
1	Skilled Nursing Care	2	2,131,279		2,131,279	19,828	107.49	1
2	Physical Therapy	3	1,993,177		1,993,177	14,447	137.96	2
3	Occupational Therapy	4	396,310		396,310	3,373	117.49	3
4	Speech Pathology	5	51,560		51,560	422	122.18	4
5	Medical Social Services	6	1,953		1,953	13	150.23	5
6	Home Health Aide	7	158,757		158,757	4,482	35.42	6
7	Total (sum of lines 1-6)		4,733,036		4,733,036	42,565		7

Limitation Cost Computation				Program Visits		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	23844		14,109		8
9	Physical Therapy	23844		10,006		9
10	Occupational Therapy	23844		2,720		10
11	Speech Pathology	23844		279		11
12	Medical Social Services	23844		6		12
13	Home Health Aide	23844		2,750		13
14	Total (sum of lines 8-13)			29,870		14

Supplies and Drugs Cost Computations							
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
		1	2	3	4	5	
15	Cost of Medical Supplies	8	365,851		365,851	423,024	0.864847
16	Cost of Drugs	9					

**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	0.352566			col. 2, line 2
2	Occupational Therapy	67				col. 2, line 3
3	Speech Pathology	68				col. 2, line 4
4	Medical Supplies Charged to Pat	71	0.462100			col. 2, line 15
5	Drugs Charged to Patients	73	0.200236			col. 2, line 16

**KPMG LLP Compu-Max 2552-10**

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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 Per Visit Computation		Program Visits			Cost of Services				
		Part B			Part B			Total Program Cost (sum of cols 9-10)	
Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6	7	8	9	10	11	12		
1 Skilled Nursing Care		14,109			1,516,576		1,516,576	1	
2 Physical Therapy		10,006			1,380,428		1,380,428	2	
3 Occupational Therapy		2,720			319,573		319,573	3	
4 Speech Pathology		279			34,088		34,088	4	
5 Medical Social Services		6			901		901	5	
6 Home Health Aide		2,750			97,405		97,405	6	
7 Total (sum of lines 1-6)		29,870			3,348,971		3,348,971	7	

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services				
		Part B			Part B			Total Program Cost (sum of cols 9-10)	
Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6	7	8	9	10	11	12		
15 Cost of Medical Supplies			258,985			223,982		258,985	15
16 Cost of Drugs									16

**KPMG LLP Compu-Max 2552-10**

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**CALCULATION OF HHA REIMBURSEMENT SETTLEMENT**

**HHA CCN: 15-7487**

**WORKSHEET H-4  
PARTS I & II**

Check applicable box:         Title V         Title XVIII         Title XIX

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

		Part 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 in accordance with 42 CFR 413.13(b)			4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)			5
6	Total customary charges (see instructions)			6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)			7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)			8
9	Primary payer amounts		304	9

**PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT**

		Part A Services	Part B Services	
Description		1	2	
10	Total reasonable cost (see instructions)		-304	10
11	Total PPS Reimbursement - Full Episodes without Outliers		3,873,255	11
12	Total PPS Reimbursement - Full Episodes with Outliers		320,820	12
13	Total PPS Reimbursement - LUPA Episodes		53,076	13
14	Total PPS Reimbursement - PEP Episodes		25,697	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		72,207	15
16	Total PPS Outlier Reimbursement - PSP Episodes		682	16
17	Total Other Payments		2,938	17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		4,348,371	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		4,348,371	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		4,348,371	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		4,348,371	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		4,348,371	31
31.01	Sequestration adjustment (see instructions)		86,968	31.01
32	Interim payments (see instructions)		4,261,403	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, §115-2			35

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES HHA CCN: 15-7487

WORKSHEET H-5

	DESCRIPTION	Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1	2	3	4	
1	Total interim payments paid to provider				4,261,403	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				4,261,403	4
	<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	<b>TOTAL MEDICARE PROGRAM LIABILITY (see instructions)</b>				4,261,403	7
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

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

**KPMG LLP Compu-Max 2552-10**

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**CALCULATION OF CAPITAL PAYMENT**

**COMPONENT CCN: 15-0125**

**WORKSHEET L**

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

**PART I - FULLY PROSPECTIVE METHOD**

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	5,980,649	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	95,320	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)	244.08	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0305	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1577	8
9	Sum of lines 7 and 8	0.1882	9
10	Allowable disproportionate share percentage (see instructions)	0.0388	10
11	Disproportionate share adjustment (see instructions)	232,049	11
12	Total prospective capital payments (see instructions)	6,308,018	12

**PART II - PAYMENT UNDER REASONABLE COST**

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

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**CALCULATION OF CAPITAL PAYMENT**

**COMPONENT CCN: 15-0125**

**WORKSHEET L**

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

**PART I - FULLY PROSPECTIVE METHOD**

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

**PART II - PAYMENT UNDER REASONABLE COST**

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

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

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

**KPMG LLP Compu-Max 2552-10**

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 15:40 Version: 2017.10 (10/09/2017)
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**ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
32.01	NEONATAL INTENSIVE CARE							32.01
41	Subprovider - IRF							41
43	Nursery							43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency							101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)							118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY							194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS							194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202