

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	Date: 11/30/2015	Time: 14:11
		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 checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status	6. Date Received: _____	10. NPR Date: _____	
	(1) As Submitted	7. Contractor No.: _____	11. Contractor's Vendor Code: _____	
	(2) Settled without audit	8. <input type="checkbox"/> Initial Report for this Provider CCN	12. <input type="checkbox"/> If line 5, column 1 is 4:	
	(3) Settled with audit	9. <input type="checkbox"/> Final Report for this Provider CCN	Enter number of times reopened = 0-9.	
	(4) Reopened			
	(5) Amended			

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

ECR Encryption: 11/30/2015 14:11
kA4CfEZUgMw8HpEWLfh0UammVVwo10
yX5bT0FykvszQiqqn18WRAcfmoC2
wdIE1DBs40oA1qO

(Signed) X *Luis J. Molina*
Officer or Administrator of Provider(s)

T
Title
11/30/15
Date

PI Encryption: 11/30/2015 14:11
Qhn3CqNYQlxUHQGdEspCyL0IPLwN0
9es1A01mLeoi948XtyiH.tK8SxhFnF
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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		920,974	391,589	-312,084		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		-4,155	-22			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		916,819	391,567	-312,084		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	3
4	Subprovider - IPF									4
5	Subprovider - IRF	THE REHAB CENTER AT COMMUNITY	15-T125	23844	5	06 / 30 / 1996	N	P	P	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTG									11
12	Hospital-Based HHA	COMMUNITY HOME HEALTH SERVICES	15-7487	23844		01 / 07 / 1997	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015	20
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21	Type of control (see instructions)	2		21
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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	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	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.	5,348	322	1,091	789	7,628		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.	121	70		27			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
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
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

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)	N			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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

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

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

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

Inpatient Psychiatric Facility PPS

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

**WORKSHEET S-2
PART I**

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

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

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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

All Providers

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

If this facility is part of a chain organization, enter 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		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.50				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10 / 01 / 2013	09 / 30 / 2014			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. (see instructions)		N			171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
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	11/06/2015	Y	11/06/2015
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.	N		N	
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	

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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

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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			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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	336	122,640			42,781	3,482	75,620	1
2	HMO and other (see instructions)						6,400	9,369		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						517	97		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)		336	122,640			42,781	3,482	75,620	7
8	Intensive Care Unit	31	39	14,235			6,065	556	10,873	8
9	Coronary Care Unit	32								9
9.01	NEONATAL INTENSIVE CARE	32.01	32	11,680				813	5,337	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						455	3,806	13
14	Total (see instructions)		407	148,555			48,846	5,306	95,636	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	54	19,710			13,933	121	15,908	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					37,698		44,414	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)		461							27
28	Observation Bed Days								16,211	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							503	1,232	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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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)					8,669	590	17,105	1
2	HMO and other (see instructions)					1,058	1,548		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider						10		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)		2,422.86			8,669	590	17,105	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF		79.76			1,334	10	1,524	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		42.64						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)		2,545.26						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	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	156,504,476		156,504,476	5,151,214.00	30.38	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		9,092,874	33,457	9,126,331	353,289.00	25.83	10
OTHER WAGES & RELATED COSTS							
11		1,116,349		1,116,349	9,758.00	114.40	11
12							12
13		621,831		621,831	4,059.00	153.20	13
14		20,365,428		20,365,428	518,956.00	39.24	14
15							15
16							16
WAGE-RELATED COSTS							
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
OVERHEAD COSTS - DIRECT SALARIES							
26		887,079		887,079	33,039.00	26.85	26
27		14,701,121	-33,837	14,667,284	528,888.00	27.73	27
28		3,319,815		3,319,815	23,750.00	139.78	28
29							29
30		4,756,622		4,756,622	177,291.00	26.83	30
31		105,657		105,657	7,495.00	14.10	31
32		3,342,586		3,342,586	213,811.00	15.63	32
33							33
34		3,618,735	-1,206,535	2,412,200	140,708.00	17.14	34
35							35
36			1,206,535	1,206,535	78,422.00	15.39	36
37							37
38		1,927,155		1,927,155	37,162.00	51.86	38
39			33,837	33,837	2,288.00	14.79	39
40		3,968,660		3,968,660	106,714.00	37.19	40
41		123,381		123,381	4,131.00	29.87	41
42		654,166		654,166	25,477.00	25.68	42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	149,772,618		149,772,618	5,098,455.00	29.38	1
2	Excluded area salaries (see instructions)	9,092,874	33,457	9,126,331	353,289.00	25.83	2
3	Subtotal salaries (line 1 minus line 2)	140,679,744	-33,457	140,646,287	4,745,166.00	29.64	3
4	Subtotal other wages & related costs (see instructions)	22,103,608		22,103,608	532,773.00	41.49	4
5	Subtotal wage-related costs (see instructions)	40,279,018		40,279,018		28.64%	5
6	Total (sum of lines 3 through 5)	203,062,370	-33,457	203,028,913	5,277,939.00	38.47	6
7	Total overhead cost (see instructions)	37,404,977		37,404,977	1,379,176.00	27.12	7

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	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
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
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
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	20,247,948	8
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
	TAXES		
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
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	186,654	23
24	Total Wage Related cost (Sum of lines 1-23)	51,710,532	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	Supporting Exhibit for Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date	06/30/2013	1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)	06/30/2013	2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month		3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)		4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	Effective Date of Pension Plan	01/01/1973	6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date	07/01/2012	7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)		8

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

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable		9
10	Ending Date of Averaging Period from Line 5		10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S) 11
11.01			16,204.761 11.01
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)		12
13	Total Contributions Made During Averaging Period		13
14	Average Monthly Contribution (Line 13 divided by Line 12)		14
15	Number of MOonths in Provider Cost Reporting Period on Line 2		15
16	Average Pension Contributions (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)		17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)		18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

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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		4,892	30	268	5,190	1
2	Unduplicated Census Count (see instructions)		1,108.00	50.00	430.00	1,516.00	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)		2.34		2.34
5	Other Administrative Personnel		11.31		11.31
6	Direct Nursing Service		7.51		7.51
7	Nursing Supervisor				
8	Physical Therapy Service			7.09	7.09
9	Physical Therapy Supervisor				
10	Occupational Therapy Service			1.56	1.56
11	Occupational Therapy Supervisor				
12	Speech Pathology Service		0.18		0.18
13	Speech Pathology Supervisor				
14	Medical Social Service		0.01		0.01
15	Medical Social Service Supervisor				
16	Home Health Aide		2.34		2.34
17	Home Health Aide Supervisor				
18	PRIVATE DUTY		18.95		18.95

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	14,626	1,871	248	109	16,854	21
22	Skilled Nursing Visit Charges	2,344,254	299,700	39,759	17,481	2,701,194	22
23	Physical Therapy Visits	11,223	826	101	127	12,277	23
24	Physical Therapy Visit Charges	2,096,155	154,078	18,121	23,679	2,292,033	24
25	Occupational Therapy Visits	2,722	480	19	22	3,243	25
26	Occupational Therapy Visit Charges	508,114	89,384	3,004	4,094	604,596	26
27	Speech Pathology Visits	278	132	1	10	421	27
28	Speech Pathology Visit Charges	51,834	24,476	189	1,874	78,373	28
29	Medical Social Service Visits	11				11	29
30	Medical Social Service Visit Charges	2,345				2,345	30
31	Home Health Aide Visits	3,736	1,127	3	26	4,892	31
32	Home Health Aide Visit Charges	447,664	135,043	357	2,981	586,045	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	32,596	4,436	372	294	37,698	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	5,450,366	702,681	61,430	50,109	6,264,586	35
36	Total Number of Episodes (standard/non-outlier)	1,471		151	19	1,641	36
37	Total Number of Outlier Episodes		83		2	85	37
38	Total Non-Routine Medical Supply Charges	308,735	56,403	11,815	7,576	384,529	38

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list			11
12	Number of patients transplanted during the cost reporting period			12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider			13
14	Epoetin amount from Worksheet A for home dialysis program			14
15	Number of EPO units furnished relating to the renal dialysis department			15
16	Number of EPO units furnished relating to the home dialysis department			16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider			17
18	ARANESP amount from Worksheet A for home dialysis program			18
19	Number of ARANESP units furnished relating to the renal dialysis department			19
20	Number of ARANESP units furnished relating to the home dialysis department			20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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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)		0.269379	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		14,315,199	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		144,282,751	6
7	Medicaid cost (line 1 times line 6)		38,866,743	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.		24,551,544	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)		680	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		850	14
15	State or local indigent care program cost (line 1 times line 14)		229	15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.			16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		6,472	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)		24,551,544	19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)
		1	2	3
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	19,185,163		19,185,163
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,168,080		5,168,080
22	Partial payment by patients approved for charity care	71,028		71,028
23	Cost of charity care (line 21 minus line 22)	5,097,052		5,097,052

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?			24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)			25
26	Total bad debt expense for the entire hospital complex (see instructions)		15,832,630	26
27	Medicare bad debts for the entire hospital complex (see instructions)		1,667,547	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		14,165,083	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,815,776	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		8,912,828	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		33,464,372	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				12,295,349	12,295,349	325,890	12,621,239	1
2	00200	Cap Rel Costs-Mvble Equip				9,618,791	9,618,791	5,591,540	15,210,331	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	887,079	465,299	1,352,378	40,717,201	42,069,579	4,833,789	46,903,368	4
5	00500	Administrative & General	14,701,121	145,549,955	160,251,076	-60,106,557	100,144,519	-46,589,609	53,554,910	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	4,756,622	8,466,218	13,222,840	975,722	14,198,562	-23,041	14,175,521	7
8	00800	Laundry & Linen Service	105,657	1,040,972	1,146,629	-4,523	1,142,106		1,142,106	8
9	00900	Housekeeping	3,342,586	1,297,633	4,640,219	-249,431	4,390,788		4,390,788	9
10	01000	Dietary	3,618,735	3,203,350	6,822,085	-2,838,539	3,983,546	-3,856	3,979,690	10
11	01100	Cafeteria				2,694,645	2,694,645	-1,975,305	719,340	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,927,155	233,896	2,161,051	-42,379	2,118,672		2,118,672	13
14	01400	Central Services & Supply		56	56	33,837	33,893		33,893	14
15	01500	Pharmacy	3,968,660	13,692,998	17,661,658	-86,712	17,574,946	-2,322	17,572,624	15
16	01600	Medical Records & Library	123,381	121,272	244,653	-3,669	240,984	4,163,077	4,404,061	16
17	01700	Social Service	654,166	74,547	728,713	-20,599	708,114		708,114	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	35,505,463	6,254,618	41,760,081	-3,047,403	38,712,678	-47,019	38,665,659	30
31	03100	Intensive Care Unit	8,661,622	1,379,555	10,041,177	-316,778	9,724,399		9,724,399	31
32.01	02060	NEONATAL INTENSIVE CARE	3,293,864	431,492	3,725,356	-87,410	3,637,946	-85,991	3,551,955	32.01
41	04100	Subprovider - IRF	4,122,338	2,033,357	6,155,695	-120,249	6,035,446	-20	6,035,426	41
43	04300	Nursery	-33,889	-406	-34,295	1,552,303	1,518,008		1,518,008	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	24,951,960	39,602,988	64,554,948	-26,673,629	37,881,319	-12,603,176	25,278,143	50
52	05200	Delivery Room & Labor Room	2,160,326	445,482	2,605,808	-127,382	2,478,426		2,478,426	52
54	05400	Radiology-Diagnostic	8,051,836	7,431,135	15,482,971	-365,969	15,117,002	-105,076	15,011,926	54
60	06000	Laboratory	5,757,098	6,337,880	12,094,978	-192,567	11,902,411	38,573	11,940,984	60
62	06200	Whole Blood & Packed Red Blood Cells	407,121	3,005,454	3,412,575	-10,597	3,401,978		3,401,978	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	3,682,316	840,317	4,522,633	-101,111	4,421,522	-4,821	4,416,701	65
66	06600	Physical Therapy	5,112,071	4,895,920	10,007,991	-261,972	9,746,019	-14,400	9,731,619	66
70	07000	Electroencephalography	654,505	359,777	1,014,282	-18,542	995,740	-22,060	973,680	70
71	07100	Medical Supplies Charged to Patients				16,813,935	16,813,935		16,813,935	71
72	07200	Impl. Dev. Charged to Patients				26,263,520	26,263,520		26,263,520	72
73	07300	Drugs Charged to Patients								73
76	03140	CARDIOLOGY	6,833,075	21,526,197	28,359,272	-16,093,506	12,265,766	-828,266	11,437,500	76
76.97	07697	CARDIAC REHABILITATION	438,151	31,185	469,336	-14,755	454,581	-55,872	398,709	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	2,019,928	640,015	2,659,943	-181,592	2,478,351	-26,416	2,451,935	90
91	09100	Emergency	5,830,993	1,673,216	7,504,209	-231,100	7,273,109	-37,553	7,235,556	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	2,204,300	1,375,313	3,579,613	-51,207	3,528,406	26,989	3,555,395	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	153,738,240	272,409,691	426,147,931	-282,875	425,865,056	-47,444,945	378,420,111	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
191	19100	Research	255,092	79,573	334,665	-11,008	323,657		323,657	191
192	19200	Physicians' Private Offices								192
194	07950	ADVERTISING				930,623	930,623		930,623	194
194.01	07951	FITNESS POINTE	1,577,820	1,583,233	3,161,053	-603,939	2,557,114		2,557,114	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	305,006	135,339	440,345	-15,344	425,001		425,001	194.02
194.03	07953	RETAIL PHARMACY	530,712	5,067,049	5,597,761	-10,745	5,587,016		5,587,016	194.03
194.04	07954	HOSPICE								194.04
194.05	07955	RUSH RESIDENTS								194.05
194.06	07956	EINSTEIN BAGELS	97,606	89,754	187,360	-6,712	180,648		180,648	194.06
200		TOTAL (sum of lines 118-199)	156,504,476	279,364,639	435,869,115		435,869,115	-47,444,945	388,424,170	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	OPERATING RM/CARDIOLOGY SUPPLIES	A	Medical Supplies Charged to P	71		15,954,531	1
2			Impl. Dev. Charged to Patient	72		26,263,520	2
3			Medical Supplies Charged to P	71		859,404	3
4							4
5							5
6							6
7							7
8							8
9							9
500	Total reclassifications					43,077,455	500
	Code Letter - A						
1	NURSING FLOAT SALARIES	B	Intensive Care Unit	31	51,830		1
2			NEONATAL INTENSIVE CARE	32.01	17,790		2
3			Delivery Room & Labor Room	52	13,289		3
4			Emergency	91	44,368		4
5			Subprovider - IRF	41	33,457		5
6			Nursery	43	8,226		6
500	Total reclassifications				168,960		500
	Code Letter - B						
1	STOREROOM SALARY RECLASS	C	Central Services & Supply	14	33,837		1
500	Total reclassifications				33,837		500
	Code Letter - C						
1	CAFETERIA EXPENSE	D	Cafeteria	11	1,206,535	1,488,110	1
500	Total reclassifications				1,206,535	1,488,110	500
	Code Letter - D						
1	INTEREST EXPENSE	E	Cap Rel Costs-Mvble Equip	2		13,707	1
500	Total reclassifications					13,707	500
	Code Letter - E						
1	BUILDING INSURANCE	F	Cap Rel Costs-Bldg & Fixt	1		201,750	1
2			Cap Rel Costs-Mvble Equip	2		8,080	2
500	Total reclassifications					209,830	500
	Code Letter - F						
1	UTILITY RECLASS	G	Operation of Plant	7		1,123,314	1
2							2
3							3
4							4
5							5
6							6
7							7
500	Total reclassifications					1,123,314	500
	Code Letter - G						
1	ADVERTISING NON-REIMBURSABLE	H	ADVERTISING	194		930,623	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
500	Total reclassifications					930,623	500
	Code Letter - H						
1	BENEFITS RECLASS	I	Employee Benefits Department	4		40,717,237	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9

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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	
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 Code Letter - I					40,717,237	500
1	DEPRECIATION RECLASS	J	Cap Rel Costs-Bldg & Fixt	1		12,093,599	1
2			Cap Rel Costs-Mvble Equip	2		9,597,004	2
3			Emergency	91		7,497	3
4							4
500	Total reclassifications Code Letter - J					21,698,100	500
1	RECLASS NURSERY	K	Nursery	43		1,306,401	237,676
500	Total reclassifications Code Letter - K					1,306,401	237,676
	GRAND TOTAL (Increases)					2,715,733	109,496,052

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

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RECLASSIFICATIONS

WORKSHEET A-6

		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		26,173,201	1	
2			CARDIOLOGY	76		15,890,256	2	
3			Radiology-Diagnostic	54		154,594	3	
4			Adults & Pediatrics	30		404,545	4	
5			Intensive Care Unit	31		176,516	5	
6			NEONATAL INTENSIVE CARE	32.01		22,533	6	
7			Subprovider - IRF	41		62,975	7	
8			Delivery Room & Labor Room	52		72,273	8	
9			Emergency	91		120,562	9	
500	Total reclassifications					43,077,455	500	
	Code letter - A							
1	NURSING FLOAT SALARIES	B	Adults & Pediatrics	30	168,960		1	
2							2	
3							3	
4							4	
5							5	
6							6	
500	Total reclassifications				168,960		500	
	Code letter - B							
1	STOREROOM SALARY RECLASS	C	Administrative & General	5	33,837		1	
500	Total reclassifications				33,837		500	
	Code letter - C							
1	CAFETERIA EXPENSE	D	Dietary	10	1,206,535	1,488,110	1	
500	Total reclassifications				1,206,535	1,488,110	500	
	Code letter - D							
1	INTEREST EXPENSE	E	Administrative & General	5		13,707	11	
500	Total reclassifications					13,707	500	
	Code letter - E							
1	BUILDING INSURANCE	F	Administrative & General	5		209,830	12	
2							12	
500	Total reclassifications					209,830	500	
	Code letter - F							
1	UTILITY RECLASS	G	Home Health Agency	101		9,702	1	
2			Administrative & General	5		647,219	2	
3			FITNESS POINTE	194.01		307,989	3	
4			Clinic	90		11,690	4	
5			Research	191		3,067	5	
6			Housekeeping	9		105,846	6	
7			Physical Therapy	66		37,801	7	
500	Total reclassifications					1,123,314	500	
	Code letter - G							
1	ADVERTISING NON-REIMBURSABLE	H	Employee Benefits Department	4		36	1	
2			Administrative & General	5		719,768	2	
3			Operation of Plant	7		559	3	
4			Nursing Administration	13		4,203	4	
5			Pharmacy	15		1,662	5	
6			Adults & Pediatrics	30		3,601	6	
7			Intensive Care Unit	31		1,796	7	
8			NEONATAL INTENSIVE CARE	32.01		248	8	
9			Operating Room	50		3,547	9	
10			Delivery Room & Labor Room	52		4,021	10	
11			Radiology-Diagnostic	54		6,948	11	
12			Physical Therapy	66		21,147	12	
13			Electroencephalography	70		1,349	13	
14			CARDIOLOGY	76		18,751	14	
15			Clinic	90		134,802	15	
16			Home Health Agency	101		8,185	16	
500	Total reclassifications					930,623	500	
	Code letter - H							
1	BENEFITS RECLASS	I	Administrative & General	5		37,113,017	1	
2			Operation of Plant	7		147,033	2	
3			Laundry & Linen Service	8		4,523	3	
4			Housekeeping	9		143,585	4	
5			Dietary	10		143,894	5	
6			Nursing Administration	13		38,176	6	
7			Pharmacy	15		85,050	7	
8			Medical Records & Library	16		3,669	8	

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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		
9			Social Service	17		20,599	9	
10			Adults & Pediatrics	30		926,220	10	
11			Intensive Care Unit	31		190,296	11	
12			NEONATAL INTENSIVE CARE	32.01		82,419	12	
13			Subprovider - IRF	41		90,731	13	
14			Operating Room	50		496,881	14	
15			Delivery Room & Labor Room	52		64,377	15	
16			Radiology-Diagnostic	54		204,427	16	
17			Laboratory	60		192,567	17	
18			Whole Blood & Packed Red Bloo	62		10,597	18	
19			Respiratory Therapy	65		101,111	19	
20			Physical Therapy	66		127,659	20	
21			Electroencephalography	70		17,193	21	
22			CARDIOLOGY	76		184,499	22	
23			CARDIAC REHABILITATION	76.97		14,755	23	
24			Clinic	90		35,100	24	
25			Emergency	91		162,403	25	
26			Home Health Agency	101		33,320	26	
27			Research	191		7,941	27	
28			FITNESS POINTE	194.01		48,276	28	
29			FITNESS POINTE SPA/PRO SHOP/D	194.02		9,462	29	
30			RETAIL PHARMACY	194.03		10,745	30	
31			EINSTEIN BAGELS	194.06		6,712	31	
500	Total reclassifications					40,717,237	500	
	Code letter - I							
1	DEPRECIATION RECLASS	J	Administrative & General	5		21,369,179	9	1
2			Physical Therapy	66		75,365	9	2
3			FITNESS POINTE	194.01		247,674		3
4			FITNESS POINTE SPA/PRO SHOP/D	194.02		5,882		4
500	Total reclassifications					21,698,100		500
	Code letter - J							
1	RECLASS NURSERY	K	Adults & Pediatrics	30	1,306,401	237,676		1
500	Total reclassifications				1,306,401	237,676		500
	Code letter - K							
	GRAND TOTAL (Decreases)				2,715,733	109,496,052		

(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	3,403,555	604,417		604,417	62,180	3,945,792		1
2	Land Improvements	6,747,854	345,000		345,000		7,092,854		2
3	Buildings and Fixtures	272,815,336	18,386,824		18,386,824	1,016,910	290,185,250		3
4	Building Improvements	61,262,021	33,060,596		33,060,596	8,466	94,314,151		4
5	Fixed Equipment	3,575,999	306,452		306,452	4,433	3,878,018		5
6	Movable Equipment	130,253,640	7,434,575		7,434,575	2,118,114	135,570,101		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	478,058,405	60,137,864		60,137,864	3,210,103	534,986,166		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	478,058,405	60,137,864		60,137,864	3,210,103	534,986,166		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	399,416,065		399,416,065	0.746591					1
2	Cap Rel Costs-Mvble Equip	135,570,101		135,570,101	0.253409					2
3	Total (sum of lines 1-2)	534,986,166		534,986,166	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	12,419,489			201,750			12,621,239	1
2	Cap Rel Costs-Mvble Equip	15,202,251			8,080			15,210,331	2
3	Total (sum of lines 1-2)	27,621,740			209,830			27,831,570	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	-13,707	Cap Rel Costs-Mvble Equip	2	11
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)	B	-2,495	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	-13,480,795			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-16,129,030			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	-44	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	-328,167	Administrative & General	5	35
36	OFFSET NEONATE AMBULANCE COVERAGE	A	-50,935	NEONATAL INTENSIVE CARE	32.01	36
37	OFFSET MAMMO FEES	A	-16,243	Radiology-Diagnostic	54	37
38	PHYSICIAN RENTAL/X RAY SALES-RA	B	-3,570	Radiology-Diagnostic	54	38
39	OFFSET PT OTHER INCOME	B	-14,400	Physical Therapy	66	39
40	PHYSICIAN RENTAL-LAB	B	-195	Laboratory	60	40
41	REMOVE MEDICAID ASSESSMENT FEES	A	-19,535,823	Administrative & General	5	41
42	VARIOUS EH&W OFFSETS	B	-7,488	Employee Benefits Department	4	42
43						43
43.01	OFFSET OTHER INCOME REHAB	B	-20	Subprovider - IRF	41	43.01
43.02	OFFSET RESEARCH COSTS HEART CTR	A	-166,338	CARDIOLOGY	76	43.02
44	OFFSET EP DISCOUNTS	A	-1,192	CARDIOLOGY	76	44
45	MEDICAL RESTRICTED COSTS	A	-2,645	Administrative & General	5	45
45.01	EMPLOYEE CAFETERIA REVENUE	B	-1,975,305	Cafeteria	11	45.01
45.03	GUEST TRAYS/CANDLELIGHT DINNERS	B	-619	Dietary	10	45.03
45.04	TELEPHONE SERVICE	A	-114,524	Administrative & General	5	45.04
45.06	TELEPHONE SERVICE	A	-13,929	Cap Rel Costs-Mvble Equip	2	9
45.08	TELEVISION SERVICE	A	-10,091	Operation of Plant	7	45.08
45.09	TELEVISION SERVICE	A	-45,773	Cap Rel Costs-Mvble Equip	2	9
45.10	PENSION CONTRIBUTN EXCESS OF EXP	A	4,841,277	Employee Benefits Department	4	45.10
45.18	RENTAL INCOME	B	-182,585	Administrative & General	5	45.18
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
45.28	1996 ASSET LIFE ADJUSTMENT	A	6,312	Cap Rel Costs-Bldg & Fixt	1	9
45.29	OFFSET RELEASED TEMP REST OP IN	B	-49,441	Administrative & General	5	45.29
45.30	OFFSET RELEASED TEMP REST OP IN	B	-512	Clinic	90	45.30
45.31	OFFSET RELEASED TEMP REST OP IN	B	-3,551	Respiratory Therapy	65	45.31
45.32	OFFSET RELEASED TEMP REST OP IN	B	-2,322	Pharmacy	15	45.32
45.33	NON-PT CARE RELATED EXPENSES	A	-5,463	Administrative & General	5	45.33
45.37	OTHER DIETARY INCOME	B	-3,237	Dietary	10	45.37
45.40	OFFSET PHYSICIAN RENTAL	B	-997	Clinic	90	45.40

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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	
46	OFFSET SURGERY INCOME	B	-3.000	Operating Room	50		46
47	OFFSET CARDIAC REHAB CLASS INCO	B	-55.872	CARDIAC REHABILITATION	76.97		47
47.03	CLEANING SERVICES-PHYSICIANS	A	-71.143	Administrative & General	5		47.03
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-47,444,945				50

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

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	CFNI CORPORATE ALLOCATION	320,661		320,661	9	1
2	2	Cap Rel Costs-Mvble Equip		5,664,949		5,664,949	9	2
3	5	Administrative & General		32,018,626	48,077,699	-16,059,073		3
3.01	16	Medical Records & Library	CFNI ALLOCATION	4,163,121		4,163,121		3.01
3.02	5	Administrative & General	COMMUNICATIONS	1,199,675		1,199,675		3.02
3.04	5	Administrative & General	CDC LEASE		75,026	-75,026		3.04
3.05	7	Operation of Plant	CDC LEASE		25,344	-25,344		3.05
3.06	54	Radiology-Diagnostic	CDC LEASE		126,552	-126,552		3.06
3.07	60	Laboratory	CDC LEASE		11,800	-11,800		3.07
3.08	90	Clinic	CDC LEASE		12,851	-12,851		3.08
3.09	76	CARDIOLOGY	CDC LEASE		10,146	-10,146		3.09
3.10	5	Administrative & General	CDC LEASE DEPR	37,302		37,302		3.10
3.11	7	Operation of Plant	CDC LEASE DEPR	11,671		11,671		3.11
3.12	54	Radiology-Diagnostic	CDC LEASE DEPR	56,736		56,736		3.12
3.13	76	CARDIOLOGY	CDC LEASE DEPR	1,726		1,726		3.13
3.14	90	Clinic	CDC LEASE DEPR	9,020		9,020		3.14
3.15	60	Laboratory	CDC LEASE DEPR	5,415		5,415		3.15
3.16	5	Administrative & General	CDC LEASE A&G	2,311		2,311		3.16
3.17	7	Operation of Plant	CDC LEASE A&G	723		723		3.17
3.18	54	Radiology-Diagnostic	CDC LEASE A&G	3,516		3,516		3.18
3.19	60	Laboratory	CDC LEASE A&G	336		336		3.19
3.20	76	CARDIOLOGY	CDC LEASE A&G	107		107		3.20
3.21	90	Clinic	CDC LEASE A&G	559		559		3.21
3.23	5	Administrative & General	LEASE EXPENSE		46,310	-46,310		3.23
3.24	5	Administrative & General	800 MACARTHUR DEPR	80,669		80,669		3.24
3.25	5	Administrative & General	800 MACARTHUR A&G	171,906		171,906		3.25
3.26	101	Home Health Agency	800 MACARTHUR DEPR	8,620		8,620		3.26
3.27	101	Home Health Agency	800 MACARTHUR A&G	18,369		18,369		3.27
3.28	60	Laboratory	800 MACARTHUR DEPR	16,563		16,563		3.28
3.29	60	Laboratory	800 MACARTHUR A&G	35,295		35,295		3.29
3.31	5	Administrative & General	CCN COSTS		11,571,178	-11,571,178		3.31
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			43,827,876	59,956,906	-16,129,030		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	
	1	2	3	4	5	6
6	B		100.00	CFNI		PARENT
7						
8						
9						
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.

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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:

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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	178,226		178,226	211,500	1,383	140,627	7,031	2
3	50	Operating Room CRNA ANESTHESIO	12,600,176	10,327,441						3
4	30	Adults & Pediatrics AGGREGATE	84,133		84,133	211,500	365	37,114	1,856	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE	41,259	28,559	12,700	211,500	61	6,203	310	5
6	54	Radiology-Diagnostic AGGREGATE	27,706		27,706	271,900	186	24,314	1,216	6
7	54	Radiology-Diagnostic AGGREGATE	29,166	4,166	25,000	271,900	104	13,595	680	7
8	60	Laboratory AGGREGATE	28,816	2,083	26,733	260,300	174	21,775	1,089	8
9	65	Respiratory Therapy AGGREGATE	22,420		22,420	211,500	208	21,150	1,058	9
10	70	Electroencephalogram AGGREGATE	33,042	14,175	18,867	211,500	108	10,982	549	10
11	76	CARDIOLOGY AGGREGATE	704,891	521,516	183,375	211,500	516	52,468	2,623	11
12	90	Clinic AGGREGATE	62,918		62,918	211,500	406	41,283	2,064	12
13	91	Emergency AGGREGATE	125,000	8,334	116,666	211,500	860	87,447	4,372	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	13,937,753	10,906,274	758,744		4,371	456,958	22,848	200

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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					140,627	37,599	37,599	2
3	50	Operating Room CRNA ANESTHESIO	2,272,735						12,600,176	3
4	30	Adults & Pediatrics AGGREGATE					37,114	47,019	47,019	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE					6,203	6,497	35,056	5
6	54	Radiology-Diagnostic AGGREGATE					24,314	3,392	3,392	6
7	54	Radiology-Diagnostic AGGREGATE					13,595	11,405	15,571	7
8	60	Laboratory AGGREGATE					21,775	4,958	7,041	8
9	65	Respiratory Therapy AGGREGATE					21,150	1,270	1,270	9
10	70	Electroencephalogram AGGREGATE					10,982	7,885	22,060	10
11	76	CARDIOLOGY AGGREGATE					52,468	130,907	652,423	11
12	90	Clinic AGGREGATE					41,283	21,635	21,635	12
13	91	Emergency AGGREGATE					87,447	29,219	37,553	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,272,735				456,958	301,786	13,480,795	200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	12,621,239	12,621,239					1
2	Cap Rel Costs-Mvble Equip	15,210,331		15,210,331				2
4	Employee Benefits Department	46,903,368	38,734	13,741	46,955,843			4
5	Administrative & General	53,554,910	3,102,782	731,011	4,425,692	61,814,395	61,814,395	5
6	Maintenance & Repairs							6
7	Operation of Plant	14,175,521	1,727,678	427,363	1,435,258	17,765,820	3,362,377	7
8	Laundry & Linen Service	1,142,106	18,161		31,881	1,192,148	225,627	8
9	Housekeeping	4,390,788	48,081	95,148	1,008,589	5,542,606	1,048,999	9
10	Dietary	3,979,690	131,812	83,981	727,855	4,923,338	931,796	10
11	Cafeteria	719,340	136,648	72,846	364,059	1,292,893	244,694	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,118,672	21,884	622,882	581,498	3,344,936	633,066	13
14	Central Services & Supply	33,893			10,210	44,103	8,347	14
15	Pharmacy	17,572,624	53,068	428,526	1,197,499	19,251,717	3,643,599	15
16	Medical Records & Library	4,404,061	79,219	1,976	37,229	4,522,485	855,930	16
17	Social Service	708,114	3,143	1,472	197,387	910,116	172,249	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	38,665,659	1,836,343	886,347	10,268,215	51,656,564	9,776,478	30
31	Intensive Care Unit	9,724,399	322,977	723,852	2,629,188	13,400,416	2,536,176	31
32.01	NEONATAL INTENSIVE CARE	3,551,955	128,855	368,758	999,255	5,048,823	955,545	32.01
41	Subprovider - IRF	6,035,426	269,144	44,704	1,253,965	7,603,239	1,438,997	41
43	Nursery	1,518,008	26,001	8,997	386,449	1,939,455	367,063	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	25,278,143	923,251	3,075,043	7,528,979	36,805,416	6,965,830	50
52	Delivery Room & Labor Room	2,478,426	188,997	251,876	655,864	3,575,163	676,639	52
54	Radiology-Diagnostic	15,011,926	485,962	3,495,302	2,429,553	21,422,743	4,054,490	54
60	Laboratory	11,940,984	228,322	832,019	1,737,141	14,738,466	2,789,417	60
62	Whole Blood & Packed Red Blood Cells	3,401,978	10,588	43,163	122,844	3,578,573	677,284	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,416,701	38,676	352,883	1,111,098	5,919,358	1,120,304	65
66	Physical Therapy	9,731,619	403,785	150,359	1,542,511	11,828,274	2,238,631	66
70	Electroencephalography	973,680	31,231	137,398	197,490	1,339,799	253,572	70
71	Medical Supplies Charged to Patients	16,813,935				16,813,935	3,182,222	71
72	Impl. Dev. Charged to Patients	26,263,520				26,263,520	4,970,660	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	11,437,500	432,325	1,494,127	2,061,805	15,425,757	2,919,494	76
76.97	CARDIAC REHABILITATION	398,709	33,156	1,510	132,207	565,582	107,043	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2,451,935	119,171	43,629	609,491	3,224,226	610,220	90
91	Emergency	7,235,556	279,558	639,242	1,772,826	9,927,182	1,878,828	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
101	Home Health Agency	3,555,395	41,459	591	665,123	4,262,568	806,738	101
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	378,420,111	11,161,011	15,028,746	46,121,161	375,943,616	59,452,315	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen		14,009			14,009	2,651	190
191	Research	323,657		519	76,971	401,147	75,921	191
192	Physicians' Private Offices		768,257	15,272		783,529	148,291	192
194	ADVERTISING	930,623				930,623	176,131	194
194.01	FITNESS POINTE	2,557,114	552,853	106,692	476,090	3,692,749	698,893	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	425,001	19,089	6,585	92,032	542,707	102,713	194.02
194.03	RETAIL PHARMACY	5,587,016	17,094	32,597	160,137	5,796,844	1,097,116	194.03
194.04	HOSPICE		81,910			81,910	15,502	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	180,648	7,016	19,920	29,452	237,036	44,862	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	388,424,170	12,621,239	15,210,331	46,955,843	388,424,170	61,814,395	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 ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	21,128,197						7
8	Laundry & Linen Service	49,437	1,467,212					8
9	Housekeeping	130,886		6,722,491				9
10	Dietary	358,816	1,601	9,264	6,224,815			10
11	Cafeteria	371,980		31,219		1,940,786		11
12	Maintenance of Personnel							12
13	Nursing Administration	59,571		1,858		22,637	4,062,068	13
14	Central Services & Supply					1,194		14
15	Pharmacy	144,461		17,468		55,083		15
16	Medical Records & Library	215,649		69,500		2,257		16
17	Social Service	8,555		15,610		12,924		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,998,860	594,499	2,074,943	4,905,686	643,183	1,863,241	30
31	Intensive Care Unit	879,202	97,716	364,337	382,362	135,961	393,876	31
32.01	NEONATAL INTENSIVE CARE	350,765	3,318	98,267		46,662	135,175	32.01
41	Subprovider - IRF	732,658	93,010	324,300	852,519	87,758	254,211	41
43	Nursery	70,778	15,208	73,496		21,573	62,495	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,513,256	189,015	1,400,169		289,394	838,342	50
52	Delivery Room & Labor Room	514,483	53,479	207,218	84,248	34,856	100,960	52
54	Radiology-Diagnostic	1,322,876	124,310	205,379		93,346		54
60	Laboratory	621,535		133,983		105,175		60
62	Whole Blood & Packed Red Blood Cells	28,823				5,882		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	105,283		15,610		58,447		65
66	Physical Therapy	1,099,177	41,972	81,077		45,566		66
70	Electroencephalography	85,016	9,724	11,689		4,677		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	1,176,868	117,646	420,792		104,176		76
76.97	CARDIAC REHABILITATION	90,256	537			6,858		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	324,405	10,201	27,651		29,831	76,585	90
91	Emergency	761,007	111,526	862,332		116,396	337,183	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	112,860		11,150				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	17,127,463	1,463,762	6,457,312	6,224,815	1,923,836	4,062,068	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	63,865						190
191	Research					4,503		191
192	Physicians' Private Offices	2,091,334	3,450	265,179				192
194	ADVERTISING							194
194.01	FITNESS POINTE	1,504,967						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	51,963						194.02
194.03	RETAIL PHARMACY	46,533				8,356		194.03
194.04	HOSPICE	222,973						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	19,099				4,091		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,128,197	1,467,212	6,722,491	6,224,815	1,940,786	4,062,068	202

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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	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	53,644						14
15	Pharmacy		23,112,328					15
16	Medical Records & Library			5,665,821				16
17	Social Service				1,119,454			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			499,503	985,644	77,998,601		30
31	Intensive Care Unit			84,863	115,926	18,390,835		31
32.01	NEONATAL INTENSIVE CARE			99,572		6,738,127		32.01
41	Subprovider - IRF			60,035		11,446,727		41
43	Nursery			17,823		2,567,891		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			762,623		49,764,045		50
52	Delivery Room & Labor Room			35,222		5,282,268		52
54	Radiology-Diagnostic			1,055,354		28,278,498		54
60	Laboratory			731,654		19,120,230		60
62	Whole Blood & Packed Red Blood Cells			48,095		4,338,657		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			143,301		7,362,303		65
66	Physical Therapy			209,962		15,544,659		66
70	Electroencephalography			41,863		1,746,340		70
71	Medical Supplies Charged to Patients	53,644		185,014		20,234,815		71
72	Impl. Dev. Charged to Patients			237,709		31,471,889		72
73	Drugs Charged to Patients		23,112,328	441,097		23,553,425		73
76	CARDIOLOGY			521,156		20,685,889		76
76.97	CARDIAC REHABILITATION			7,052		777,328		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			29,716		4,332,835		90
91	Emergency			425,894	17,884	14,438,232		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			28,313		5,221,629		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	53,644	23,112,328	5,665,821	1,119,454	369,295,223		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					80,525		190
191	Research					481,571		191
192	Physicians' Private Offices					3,291,783		192
194	ADVERTISING					1,106,754		194
194.01	FITNESS POINTE					5,896,609		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY					697,383		194.02
194.03	RETAIL PHARMACY					6,948,849		194.03
194.04	HOSPICE					320,385		194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS					305,088		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	53,644	23,112,328	5,665,821	1,119,454	388,424,170		202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	77,998,601					30
31	Intensive Care Unit	18,390,835					31
32.01	NEONATAL INTENSIVE CARE	6,738,127					32.01
41	Subprovider - IRF	11,446,727					41
43	Nursery	2,567,891					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	49,764,045					50
52	Delivery Room & Labor Room	5,282,268					52
54	Radiology-Diagnostic	28,278,498					54
60	Laboratory	19,120,230					60
62	Whole Blood & Packed Red Blood Cells	4,338,657					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	7,362,303					65
66	Physical Therapy	15,544,659					66
70	Electroencephalography	1,746,340					70
71	Medical Supplies Charged to Patients	20,234,815					71
72	Impl. Dev. Charged to Patients	31,471,889					72
73	Drugs Charged to Patients	23,553,425					73
76	CARDIOLOGY	20,685,889					76
76.97	CARDIAC REHABILITATION	777,328					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	4,332,835					90
91	Emergency	14,438,232					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	5,221,629					101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	369,295,223					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	80,525					190
191	Research	481,571					191
192	Physicians' Private Offices	3,291,783					192
194	ADVERTISING	1,106,754					194
194.01	FITNESS POINTE	5,896,609					194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	697,383					194.02
194.03	RETAIL PHARMACY	6,948,849					194.03
194.04	HOSPICE	320,385					194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS	305,088					194.06
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	388,424,170					202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	19,800	38,734	13,741	72,275	72,275		4
5	Administrative & General	500,983	3,102,782	731,011	4,334,776	6,806	4,341,582	5
6	Maintenance & Repairs							6
7	Operation of Plant	18,802	1,727,678	427,363	2,173,843	2,207	236,161	7
8	Laundry & Linen Service	22,717	18,161		40,878	49	15,847	8
9	Housekeeping		48,081	95,148	143,229	1,551	73,678	9
10	Dietary	3,620	131,812	83,981	219,413	1,119	65,446	10
11	Cafeteria		136,648	72,846	209,494	560	17,186	11
12	Maintenance of Personnel							12
13	Nursing Administration		21,884	622,882	644,766	894	44,464	13
14	Central Services & Supply					16	586	14
15	Pharmacy	31,175	53,068	428,526	512,769	1,841	255,913	15
16	Medical Records & Library		79,219	1,976	81,195	57	60,117	16
17	Social Service		3,143	1,472	4,615	304	12,098	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	170,329	1,836,343	886,347	2,893,019	15,858	686,631	30
31	Intensive Care Unit	23,637	322,977	723,852	1,070,466	4,043	178,132	31
32.01	NEONATAL INTENSIVE CARE		128,855	368,758	497,613	1,537	67,114	32.01
41	Subprovider - IRF	11,554	269,144	44,704	325,402	1,928	101,070	41
43	Nursery		26,001	8,997	34,998	594	25,781	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,044,228	923,251	3,075,043	5,042,522	11,578	489,254	50
52	Delivery Room & Labor Room		188,997	251,876	440,873	1,009	47,525	52
54	Radiology-Diagnostic	563,764	485,962	3,495,302	4,545,028	3,736	284,773	54
60	Laboratory	1,441	228,322	832,019	1,061,782	2,671	195,918	60
62	Whole Blood & Packed Red Blood Cells		10,588	43,163	53,751	189	47,570	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	82,210	38,676	352,883	473,769	1,709	78,686	65
66	Physical Therapy	13,958	403,785	150,359	568,102	2,372	157,233	66
70	Electroencephalography	219,094	31,231	137,398	387,723	304	17,810	70
71	Medical Supplies Charged to Patients						223,508	71
72	Impl. Dev. Charged to Patients						349,121	72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	953,119	432,325	1,494,127	2,879,571	3,171	205,055	76
76.97	CARDIAC REHABILITATION		33,156	1,510	34,666	203	7,518	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	67,122	119,171	43,629	229,922	937	42,860	90
91	Emergency	5,033	279,558	639,242	923,833	2,726	131,962	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		41,459	591	42,050	1,023	56,662	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,752,586	11,161,011	15,028,746	29,942,343	70,992	4,175,679	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		14,009		14,009		186	190
191	Research			519	519	118	5,332	191
192	Physicians' Private Offices		768,257	15,272	783,529		10,415	192
194	ADVERTISING						12,371	194
194.01	FITNESS POINTE	652	552,853	106,692	660,197	732	49,088	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		19,089	6,585	25,674	142	7,214	194.02
194.03	RETAIL PHARMACY		17,094	32,597	49,691	246	77,057	194.03
194.04	HOSPICE		81,910		81,910		1,089	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS		7,016	19,920	26,936	45	3,151	194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,753,238	12,621,239	15,210,331	31,584,808	72,275	4,341,582	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	2,412,211						7
8	Laundry & Linen Service	5,644	62,418					8
9	Housekeeping	14,943		233,401				9
10	Dietary	40,966	68	322	327,334			10
11	Cafeteria	42,469		1,084		270,793		11
12	Maintenance of Personnel							12
13	Nursing Administration	6,801		65		3,158	700,148	13
14	Central Services & Supply					167		14
15	Pharmacy	16,493		606		7,686		15
16	Medical Records & Library	24,621		2,413		315		16
17	Social Service	977		542		1,803		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	570,721	25,291	72,037	257,967	89,742	321,153	30
31	Intensive Care Unit	100,379	4,157	12,650	20,107	18,970	67,889	31
32.01	NEONATAL INTENSIVE CARE	40,047	141	3,412		6,511	23,299	32.01
41	Subprovider - IRF	83,648	3,957	11,260	44,830	12,245	43,816	41
43	Nursery	8,081	647	2,552		3,010	10,772	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	286,939	8,041	48,613		40,378	144,499	50
52	Delivery Room & Labor Room	58,739	2,275	7,195	4,430	4,863	17,402	52
54	Radiology-Diagnostic	151,033	5,288	7,131		13,024		54
60	Laboratory	70,961		4,652		14,675		60
62	Whole Blood & Packed Red Blood Cells	3,291				821		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	12,020		542		8,155		65
66	Physical Therapy	125,493	1,786	2,815		6,358		66
70	Electroencephalography	9,706	414	406		653		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	134,363	5,005	14,610		14,535		76
76.97	CARDIAC REHABILITATION	10,305	23			957		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	37,037	434	960		4,162	13,200	90
91	Emergency	86,884	4,744	29,940		16,240	58,118	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	12,885		387				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,955,446	62,271	224,194	327,334	268,428	700,148	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	7,291						190
191	Research					628		191
192	Physicians' Private Offices	238,768	147	9,207				192
194	ADVERTISING							194
194.01	FITNESS POINTE	171,822						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	5,933						194.02
194.03	RETAIL PHARMACY	5,313				1,166		194.03
194.04	HOSPICE	25,457						194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	2,181				571		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,412,211	62,418	233,401	327,334	270,793	700,148	202

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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	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	769						14
15	Pharmacy		795,308					15
16	Medical Records & Library			168,718				16
17	Social Service				20,339			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			14,865	17,908	4,965,192		30
31	Intensive Care Unit			2,526	2,106	1,481,425		31
32.01	NEONATAL INTENSIVE CARE			2,963		642,637		32.01
41	Subprovider - IRF			1,787		629,943		41
43	Nursery			530		86,965		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			22,696		6,094,520		50
52	Delivery Room & Labor Room			1,048		585,359		52
54	Radiology-Diagnostic			31,509		5,041,522		54
60	Laboratory			21,774		1,372,433		60
62	Whole Blood & Packed Red Blood Cells			1,431		107,053		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			4,265		579,146		65
66	Physical Therapy			6,249		870,408		66
70	Electroencephalography			1,246		418,262		70
71	Medical Supplies Charged to Patients	769		5,506		229,783		71
72	Impl. Dev. Charged to Patients			7,074		356,195		72
73	Drugs Charged to Patients		795,308	13,127		808,435		73
76	CARDIOLOGY			15,510		3,271,820		76
76.97	CARDIAC REHABILITATION			210		53,882		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			884		330,396		90
91	Emergency			12,675	325	1,267,447		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			843		113,850		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	769	795,308	168,718	20,339	29,306,673		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					21,486		190
191	Research					6,597		191
192	Physicians' Private Offices					1,042,066		192
194	ADVERTISING					12,371		194
194.01	FITNESS POINTE					881,839		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY					38,963		194.02
194.03	RETAIL PHARMACY					133,473		194.03
194.04	HOSPICE					108,456		194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS					32,884		194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	769	795,308	168,718	20,339	31,584,808		202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	4,965,192					30
31	Intensive Care Unit	1,481,425					31
32.01	NEONATAL INTENSIVE CARE	642,637					32.01
41	Subprovider - IRF	629,943					41
43	Nursery	86,965					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,094,520					50
52	Delivery Room & Labor Room	585,359					52
54	Radiology-Diagnostic	5,041,522					54
60	Laboratory	1,372,433					60
62	Whole Blood & Packed Red Blood Cells	107,053					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	579,146					65
66	Physical Therapy	870,408					66
70	Electroencephalography	418,262					70
71	Medical Supplies Charged to Patients	229,783					71
72	Impl. Dev. Charged to Patients	356,195					72
73	Drugs Charged to Patients	808,435					73
76	CARDIOLOGY	3,271,820					76
76.97	CARDIAC REHABILITATION	53,882					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	330,396					90
91	Emergency	1,267,447					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	113,850					101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	29,306,673					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	21,486					190
191	Research	6,597					191
192	Physicians' Private Offices	1,042,066					192
194	ADVERTISING	12,371					194
194.01	FITNESS POINTE	881,839					194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	38,963					194.02
194.03	RETAIL PHARMACY	133,473					194.03
194.04	HOSPICE	108,456					194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS	32,884					194.06
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	31,584,808					202

KPMG LLP Compu-Max 2552-10

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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 NEW- SQ FT	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,088,317						1
2	Cap Rel Costs-Mvble Equip		9,577,244					2
4	Employee Benefits Department	3,340	8,652	155,617,397				4
5	Administrative & General	267,550	460,284	14,667,284	-61,814,395	326,609,775		5
6	Maintenance & Repairs							6
7	Operation of Plant	148,976	269,091	4,756,622		17,765,820	669,266	7
8	Laundry & Linen Service	1,566		105,657		1,192,148	1,566	8
9	Housekeeping	4,146	59,910	3,342,586		5,542,606	4,146	9
10	Dietary	11,366	52,879	2,412,200		4,923,338	11,366	10
11	Cafeteria	11,783	45,868	1,206,535		1,292,893	11,783	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,887	392,200	1,927,155		3,344,936	1,887	13
14	Central Services & Supply			33,837		44,103		14
15	Pharmacy	4,576	269,823	3,968,660		19,251,717	4,576	15
16	Medical Records & Library	6,831	1,244	123,381		4,522,485	6,831	16
17	Social Service	271	927	654,166		910,116	271	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	158,346	558,092	34,030,102		51,656,564	158,346	30
31	Intensive Care Unit	27,850	455,776	8,713,452		13,400,416	27,850	31
32.01	NEONATAL INTENSIVE CARE	11,111	232,190	3,311,654		5,048,823	11,111	32.01
41	Subprovider - IRF	23,208	28,148	4,155,795		7,603,239	23,208	41
43	Nursery	2,242	5,665	1,280,738		1,939,455	2,242	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	79,611	1,936,213	24,951,960		36,805,416	79,611	50
52	Delivery Room & Labor Room	16,297	158,595	2,173,615		3,575,163	16,297	52
54	Radiology-Diagnostic	41,904	2,200,830	8,051,836		21,422,743	41,904	54
60	Laboratory	19,688	523,884	5,757,098		14,738,466	19,688	60
62	Whole Blood & Packed Red Blood Cells	913	27,178	407,121		3,578,573	913	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,335	222,194	3,682,316		5,919,358	3,335	65
66	Physical Therapy	34,818	94,674	5,112,071		11,828,274	34,818	66
70	Electroencephalography	2,693	86,513	654,505		1,339,799	2,693	70
71	Medical Supplies Charged to Patients					16,813,935		71
72	Impl. Dev. Charged to Patients					26,263,520		72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	37,279	940,783	6,833,075		15,425,757	37,279	76
76.97	CARDIAC REHABILITATION	2,859	951	438,151		565,582	2,859	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	10,276	27,471	2,019,928		3,224,226	10,276	90
91	Emergency	24,106	402,501	5,875,361		9,927,182	24,106	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,575	372	2,204,300		4,262,568	3,575	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	962,403	9,462,908	152,851,161	-61,814,395	314,129,221	542,537	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,208				14,009	2,023	190
191	Research		327	255,092		401,147		191
192	Physicians' Private Offices	66,246	9,616			783,529	66,246	192
194	ADVERTISING					930,623		194
194.01	FITNESS POINTE	47,672	67,179	1,577,820		3,692,749	47,672	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	1,646	4,146	305,006		542,707	1,646	194.02
194.03	RETAIL PHARMACY	1,474	20,525	530,712		5,796,844	1,474	194.03
194.04	HOSPICE	7,063				81,910	7,063	194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS	605	12,543	97,606		237,036	605	194.06
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	12,621,239	15,210,331	46,955,843		61,814,395	21,128,197	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.597025	1.588174	0.301739		0.189261	31.569207	203
204	Cost to be allocated (Per Wkst. B, Part II)			72,275		4,341,582	2,412,211	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000464		0.013293	3.604263	205

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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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	3,477,812						8
9	Housekeeping		723,512					9
10	Dietary	3,796	997	350,816				10
11	Cafeteria		3,360		178,846			11
12	Maintenance of Personnel							12
13	Nursing Administration		200			2,687,687		13
14	Central Services & Supply					110	100	14
15	Pharmacy		1,880			5,076		15
16	Medical Records & Library		7,480			208		16
17	Social Service		1,680			1,191		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,409,174	223,317	276,473	59,270	1,232,822		30
31	Intensive Care Unit	231,621	39,212	21,549	12,529	260,610		31
32.01	NEONATAL INTENSIVE CARE	7,865	10,576		4,300	89,439		32.01
41	Subprovider - IRF	220,467	34,903	48,046	8,087	168,200		41
43	Nursery	36,049	7,910		1,988	41,350		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	448,032	150,694		26,668	554,693		50
52	Delivery Room & Labor Room	126,763	22,302	4,748	3,212	66,801		52
54	Radiology-Diagnostic	294,658	22,104		8,602			54
60	Laboratory		14,420		9,692			60
62	Whole Blood & Packed Red Blood Cells				542			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,680		5,386			65
66	Physical Therapy	99,489	8,726		4,199			66
70	Electroencephalography	23,049	1,258		431			70
71	Medical Supplies Charged to Patients						100	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY	278,863	45,288		9,600			76
76.97	CARDIAC REHABILITATION	1,274			632			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	24,180	2,976		2,749	50,673		90
91	Emergency	264,355	92,809		10,726	223,099		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,200					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,469,635	694,972	350,816	177,284	2,687,687	100	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research				415			191
192	Physicians' Private Offices	8,177	28,540					192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY				770			194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS				377			194.06
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,467,212	6,722,491	6,224,815	1,940,786	4,062,068	53,644	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.421878	9.291471	17.743817	10.851716	1.511362	536.440000	203
204	Cost to be allocated (Per Wkst. B, Part II)	62,418	233,401	327,334	270,793	700,148	769	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.017947	0.322595	0.933065	1.514113	0.260502	7.690000	205

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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			
	15	16	17			

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	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		1,370,913,451				16
17	Social Service			129,882			17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		120,857,167	114,357			30
31	Intensive Care Unit		20,533,109	13,450			31
32.01	NEONATAL INTENSIVE CARE		24,091,831				32.01
41	Subprovider - IRF		14,525,726				41
43	Nursery		4,312,376				43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		184,520,383				50
52	Delivery Room & Labor Room		8,522,256				52
54	Radiology-Diagnostic		255,388,240				54
60	Laboratory		177,027,234				60
62	Whole Blood & Packed Red Blood Cells		11,636,934				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		34,672,391				65
66	Physical Therapy		50,801,243				66
70	Electroencephalography		10,129,076				70
71	Medical Supplies Charged to Patients		44,765,074				71
72	Impl. Dev. Charged to Patients		57,514,795				72
73	Drugs Charged to Patients	10,000	106,725,583				73
76	CARDIOLOGY		126,096,244				76
76.97	CARDIAC REHABILITATION		1,706,323				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	Clinic		7,189,880				90
91	Emergency		103,047,130	2,075			91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		6,850,456				101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,000	1,370,913,451	129,882			118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
191	Research						191
192	Physicians' Private Offices						192
194	ADVERTISING						194
194.01	FITNESS POINTE						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03	RETAIL PHARMACY						194.03
194.04	HOSPICE						194.04
194.05	RUSH RESIDENTS						194.05
194.06	EINSTEIN BAGELS						194.06
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	23,112,328	5,665,821	1,119,454			202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,311.232800	0.004133	8.619008			203
204	Cost to be allocated (Per Wkst. B, Part II)	795,308	168,718	20,339			204
205	Unit Cost Multiplier (Wkst. B, Part II)	79.530800	0.000123	0.156596			205

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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

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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	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	77,998,601		77,998,601	47,019	78,045,620	30
31	Intensive Care Unit	18,390,835		18,390,835		18,390,835	31
32.01	NEONATAL INTENSIVE CARE	6,738,127		6,738,127	6,497	6,744,624	32.01
41	Subprovider - IRF	11,446,727		11,446,727		11,446,727	41
43	Nursery	2,567,891		2,567,891		2,567,891	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	49,764,045		49,764,045		49,764,045	50
52	Delivery Room & Labor Room	5,282,268		5,282,268		5,282,268	52
54	Radiology-Diagnostic	28,278,498		28,278,498	14,797	28,293,295	54
60	Laboratory	19,120,230		19,120,230	4,958	19,125,188	60
62	Whole Blood & Packed Red Blood Cells	4,338,657		4,338,657		4,338,657	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	7,362,303		7,362,303	1,270	7,363,573	65
66	Physical Therapy	15,544,659		15,544,659		15,544,659	66
70	Electroencephalography	1,746,340		1,746,340	7,885	1,754,225	70
71	Medical Supplies Charged to Patients	20,234,815		20,234,815		20,234,815	71
72	Impl. Dev. Charged to Patients	31,471,889		31,471,889		31,471,889	72
73	Drugs Charged to Patients	23,553,425		23,553,425		23,553,425	73
76	CARDIOLOGY	20,685,889		20,685,889	130,907	20,816,796	76
76.97	CARDIAC REHABILITATION	777,328		777,328		777,328	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	4,332,835		4,332,835	21,635	4,354,470	90
91	Emergency	14,438,232		14,438,232	29,219	14,467,451	91
92	Observation Beds (Non-Distinct Part)	13,777,405		13,777,405		13,777,405	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	5,221,629		5,221,629		5,221,629	101
200	Subtotal (sum of lines 30 thru 199)	383,072,628		383,072,628	264,187	383,336,815	200
201	Less Observation Beds	13,777,405		13,777,405		13,777,405	201
202	Total (line 200 minus line 201)	369,295,223		369,295,223		369,559,410	202

KPMG LLP Compu-Max 2552-10

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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	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	89,709,722		89,709,722				30
31	Intensive Care Unit	20,533,109		20,533,109				31
32.01	NEONATAL INTENSIVE CARE	24,091,831		24,091,831				32.01
41	Subprovider - IRF	14,525,726		14,525,726				41
43	Nursery	4,312,376		4,312,376				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	76,554,095	107,966,288	184,520,383	0.269694	0.269694	0.269694	50
52	Delivery Room & Labor Room	5,833,713	2,688,543	8,522,256	0.619820	0.619820	0.619820	52
54	Radiology-Diagnostic	57,782,221	197,606,019	255,388,240	0.110727	0.110727	0.110785	54
60	Laboratory	68,026,337	109,000,897	177,027,234	0.108007	0.108007	0.108035	60
62	Whole Blood & Packed Red Blood Cells	8,282,027	3,354,907	11,636,934	0.372835	0.372835	0.372835	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	31,442,709	3,229,682	34,672,391	0.212339	0.212339	0.212376	65
66	Physical Therapy	29,010,929	21,790,314	50,801,243	0.305990	0.305990	0.305990	66
70	Electroencephalography	1,528,290	8,600,786	10,129,076	0.172409	0.172409	0.173187	70
71	Medical Supplies Charged to Patients	20,882,987	23,882,087	44,765,074	0.452022	0.452022	0.452022	71
72	Impl. Dev. Charged to Patients	38,142,169	19,372,626	57,514,795	0.547196	0.547196	0.547196	72
73	Drugs Charged to Patients	78,267,472	28,458,111	106,725,583	0.220691	0.220691	0.220691	73
76	CARDIOLOGY	48,626,436	77,469,808	126,096,244	0.164048	0.164048	0.165087	76
76.97	CARDIAC REHABILITATION	324,701	1,381,622	1,706,323	0.455557	0.455557	0.455557	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	443,332	6,746,548	7,189,880	0.602630	0.602630	0.605639	90
91	Emergency	31,947,323	71,099,807	103,047,130	0.140113	0.140113	0.140396	91
92	Observation Beds (Non-Distinct Part)	4,997,235	26,150,210	31,147,445	0.442329	0.442329	0.442329	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		6,850,456	6,850,456				101
200	Subtotal (sum of lines 30 thru 199)	655,264,740	715,648,711	1,370,913,451				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	655,264,740	715,648,711	1,370,913,451				202

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	4,965,192		4,965,192	91,831	54.07	42,781	2,313,169	30
31	Intensive Care Unit	1,481,425		1,481,425	10,873	136.25	6,065	826,356	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	642,637		642,637	5,337	120.41			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	629,943		629,943	15,908	39.60	13,933	551,747	41
42	Subprovider I								42
43	Nursery	86,965		86,965	3,806	22.85			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,806,162		7,806,162	127,755		62,779	3,691,272	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,094,520	184,520,383	0.033029	36,454,117	1,204,043	50
52	Delivery Room & Labor Room	585,359	8,522,256	0.068686	7,175	493	52
54	Radiology-Diagnostic	5,041,522	255,388,240	0.019741	30,609,763	604,267	54
60	Laboratory	1,372,433	177,027,234	0.007753	36,572,442	283,546	60
62	Whole Blood & Packed Red Blood	107,053	11,636,934	0.009199	4,485,664	41,264	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	579,146	34,672,391	0.016703	18,250,064	304,831	65
66	Physical Therapy	870,408	50,801,243	0.017134	8,383,676	143,646	66
70	Electroencephalography	418,262	10,129,076	0.041293	802,185	33,125	70
71	Medical Supplies Charged to Pat	229,783	44,765,074	0.005133	12,160,807	62,421	71
72	Impl. Dev. Charged to Patients	356,195	57,514,795	0.006193	21,774,966	134,852	72
73	Drugs Charged to Patients	808,435	106,725,583	0.007575	40,833,945	309,317	73
76	CARDIOLOGY	3,271,820	126,096,244	0.025947	29,571,102	767,281	76
76.97	CARDIAC REHABILITATION	53,882	1,706,323	0.031578	195,580	6,176	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	330,396	7,189,880	0.045953	132,907	6,107	90
91	Emergency	1,267,447	103,047,130	0.012300	17,349,364	213,397	91
92	Observation Beds (Non-Distinct	876,505	31,147,445	0.028141			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	22,263,166	1,210,890,231		257,583,757	4,114,766	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	91,831		42,781		30
31	Intensive Care Unit	10,873		6,065		31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE	5,337				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	15,908		13,933		41
42	Subprovider I					42
43	Nursery	3,806				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	127,755		62,779		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
52	Delivery Room & Labor Room						52
54	Radiology-Diagnostic						54
60	Laboratory						60
62	Whole Blood & Packed Red Blood						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
70	Electroencephalography						70
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
76	CARDIOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency						91
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)						200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0125

**WORKSHEET D
PART IV**

Check [] Title V [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [XX] 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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	184,520,383			36,454,117		33,800,370		50
52	Delivery Room & Labor Room	8,522,256			7,175				52
54	Radiology-Diagnostic	255,388,240			30,609,763		70,794,047		54
60	Laboratory	177,027,234			36,572,442		17,977,926		60
62	Whole Blood & Packed Red Blood	11,636,934			4,485,664		1,107,136		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	34,672,391			18,250,064		1,638,683		65
66	Physical Therapy	50,801,243			8,383,676		312,492		66
70	Electroencephalography	10,129,076			802,185		2,842,050		70
71	Medical Supplies Charged to Pat	44,765,074			12,160,807		12,639,073		71
72	Impl. Dev. Charged to Patients	57,514,795			21,774,966		10,443,945		72
73	Drugs Charged to Patients	106,725,583			40,833,945		10,750,083		73
76	CARDIOLOGY	126,096,244			29,571,102		44,612,408		76
76.97	CARDIAC REHABILITATION	1,706,323			195,580		857,976		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	7,189,880			132,907		3,621,929		90
91	Emergency	103,047,130			17,349,364		15,430,458		91
92	Observation Beds (Non-Distinct	31,147,445					10,414,594		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,210,890,231			257,583,757		237,243,170		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.269694	33,800,370			9,115,757			50
52	Delivery Room & Labor Room	0.619820							52
54	Radiology-Diagnostic	0.110727	70,794,047			7,838,812			54
60	Laboratory	0.108007	17,977,926		5,527	1,941,742		597	60
62	Whole Blood & Packed Red Blood	0.372835	1,107,136			412,779			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.212339	1,638,683			347,956			65
66	Physical Therapy	0.305990	312,492			95,619			66
70	Electroencephalography	0.172409	2,842,050			489,995			70
71	Medical Supplies Charged to Pat	0.452022	12,639,073			5,713,139			71
72	Impl. Dev. Charged to Patients	0.547196	10,443,945			5,714,885			72
73	Drugs Charged to Patients	0.220691	10,750,083		91,718	2,372,447		20,241	73
76	CARDIOLOGY	0.164048	44,612,408			7,318,576			76
76.97	CARDIAC REHABILITATION	0.455557	857,976			390,857			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.602630	3,621,929			2,182,683			90
91	Emergency	0.140113	15,430,458			2,162,008			91
92	Observation Beds (Non-Distinct	0.442329	10,414,594			4,606,677			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		237,243,170		97,245	50,703,932		20,838	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		237,243,170		97,245	50,703,932		20,838	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,094,520	184,520,383	0.033029	308,051	10,175	50
52	Delivery Room & Labor Room	585,359	8,522,256	0.068686			52
54	Radiology-Diagnostic	5,041,522	255,388,240	0.019741	1,535,001	30,302	54
60	Laboratory	1,372,433	177,027,234	0.007753	2,945,350	22,835	60
62	Whole Blood & Packed Red Blood	107,053	11,636,934	0.009199	260,490	2,396	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	579,146	34,672,391	0.016703	1,487,208	24,841	65
66	Physical Therapy	870,408	50,801,243	0.017134	13,770,174	235,938	66
70	Electroencephalography	418,262	10,129,076	0.041293	162,508	6,710	70
71	Medical Supplies Charged to Pat	229,783	44,765,074	0.005133	1,468,063	7,536	71
72	Impl. Dev. Charged to Patients	356,195	57,514,795	0.006193	69,214	429	72
73	Drugs Charged to Patients	808,435	106,725,583	0.007575	5,619,617	42,569	73
76	CARDIOLOGY	3,271,820	126,096,244	0.025947	663,444	17,214	76
76.97	CARDIAC REHABILITATION	53,882	1,706,323	0.031578	109	3	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	330,396	7,189,880	0.045953	17,568	807	90
91	Emergency	1,267,447	103,047,130	0.012300	266	3	91
92	Observation Beds (Non-Distinct		31,147,445				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	21,386,661	1,210,890,231		28,307,063	401,758	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	184,520,383			308,051				50
52	Delivery Room & Labor Room	8,522,256							52
54	Radiology-Diagnostic	255,388,240			1,535,001				54
60	Laboratory	177,027,234			2,945,350				60
62	Whole Blood & Packed Red Blood	11,636,934			260,490				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	34,672,391			1,487,208				65
66	Physical Therapy	50,801,243			13,770,174				66
70	Electroencephalography	10,129,076			162,508				70
71	Medical Supplies Charged to Pat	44,765,074			1,468,063				71
72	Impl. Dev. Charged to Patients	57,514,795			69,214				72
73	Drugs Charged to Patients	106,725,583			5,619,617		297		73
76	CARDIOLOGY	126,096,244			663,444				76
76.97	CARDIAC REHABILITATION	1,706,323			109				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	7,189,880			17,568				90
91	Emergency	103,047,130			266				91
92	Observation Beds (Non-Distinct	31,147,445							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,210,890,231			28,307,063		297		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.269694							50
52	Delivery Room & Labor Room	0.619820							52
54	Radiology-Diagnostic	0.110727							54
60	Laboratory	0.108007							60
62	Whole Blood & Packed Red Blood	0.372835							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.212339							65
66	Physical Therapy	0.305990							66
70	Electroencephalography	0.172409							70
71	Medical Supplies Charged to Pat	0.452022							71
72	Impl. Dev. Charged to Patients	0.547196							72
73	Drugs Charged to Patients	0.220691	297		1,172	66		259	73
76	CARDIOLOGY	0.164048							76
76.97	CARDIAC REHABILITATION	0.455557							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.602630							90
91	Emergency	0.140113							91
92	Observation Beds (Non-Distinct	0.442329							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		297		1,172	66		259	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		297		1,172	66		259	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	4,965,192		4,965,192	91,831	54.07	3,482	188,272	30
31	Intensive Care Unit	1,481,425		1,481,425	10,873	136.25	556	75,755	31
32	Coronary Care Unit								32
32.01	NEONATAL INTENSIVE CARE	642,637		642,637	5,337	120.41	813	97,893	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	629,943		629,943	15,908	39.60	121	4,792	41
42	Subprovider I								42
43	Nursery	86,965		86,965	3,806	22.85	455	10,397	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,806,162		7,806,162	127,755		5,427	377,109	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	1 Nursing School	2 Allied Health Cost	3 All Other Medical Education Cost	4 Swing-Bed Adjustment Amount (see instructions)	5 Total Costs (sum of cols. 1 through 3 minus col 4.)
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE					32.01
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	91,831		3,482		30
31	Intensive Care Unit	10,873		556		31
32	Coronary Care Unit					32
32.01	NEONATAL INTENSIVE CARE	5,337		813		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	15,908		121		41
42	Subprovider I					42
43	Nursery	3,806		455		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	127,755		5,427		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	184,520,383			2,032,019				50
52	Delivery Room & Labor Room	8,522,256			154,525				52
54	Radiology-Diagnostic	255,388,240			2,518,460				54
60	Laboratory	177,027,234			3,060,486				60
62	Whole Blood & Packed Red Blood	11,636,934			444,569				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	34,672,391			838,238				65
66	Physical Therapy	50,801,243			649,893				66
70	Electroencephalography	10,129,076			46,695				70
71	Medical Supplies Charged to Pat	44,765,074			1,136,712				71
72	Impl. Dev. Charged to Patients	57,514,795			768,879				72
73	Drugs Charged to Patients	106,725,583			3,888,296				73
76	CARDIOLOGY	126,096,244			1,907,821				76
76.97	CARDIAC REHABILITATION	1,706,323			11,765				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	7,189,880			38,316				90
91	Emergency	103,047,130			1,226,979				91
92	Observation Beds (Non-Distinct	31,147,445							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,210,890,231			18,723,653				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART V

Check Title V - O/P 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
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.269694						50
52	Delivery Room & Labor Room	0.619820						52
54	Radiology-Diagnostic	0.110727						54
60	Laboratory	0.108007						60
62	Whole Blood & Packed Red Blood	0.372835						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.212339						65
66	Physical Therapy	0.305990						66
70	Electroencephalography	0.172409						70
71	Medical Supplies Charged to Pat	0.452022						71
72	Impl. Dev. Charged to Patients	0.547196						72
73	Drugs Charged to Patients	0.220691						73
76	CARDIOLOGY	0.164048						76
76.97	CARDIAC REHABILITATION	0.455557						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	0.602630						90
91	Emergency	0.140113						91
92	Observation Beds (Non-Distinct	0.442329						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,094,520	184,520,383	0.033029			50
52	Delivery Room & Labor Room	585,359	8,522,256	0.068686			52
54	Radiology-Diagnostic	5,041,522	255,388,240	0.019741	11,353	224	54
60	Laboratory	1,372,433	177,027,234	0.007753	26,418	205	60
62	Whole Blood & Packed Red Blood	107,053	11,636,934	0.009199	1,280	12	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	579,146	34,672,391	0.016703	10,902	182	65
66	Physical Therapy	870,408	50,801,243	0.017134	128,586	2,203	66
70	Electroencephalography	418,262	10,129,076	0.041293	762	31	70
71	Medical Supplies Charged to Pat	229,783	44,765,074	0.005133	5,503	28	71
72	Impl. Dev. Charged to Patients	356,195	57,514,795	0.006193			72
73	Drugs Charged to Patients	808,435	106,725,583	0.007575	80,420	609	73
76	CARDIOLOGY	3,271,820	126,096,244	0.025947	2,002	52	76
76.97	CARDIAC REHABILITATION	53,882	1,706,323	0.031578			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	330,396	7,189,880	0.045953	3,888	179	90
91	Emergency	1,267,447	103,047,130	0.012300			91
92	Observation Beds (Non-Distinct		31,147,445				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	21,386,661	1,210,890,231		271,114	3,725	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	2	3	4	5	6
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
52	Delivery Room & Labor Room						52
54	Radiology-Diagnostic						54
60	Laboratory						60
62	Whole Blood & Packed Red Blood						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						73
76	CARDIOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency						91
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)						200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	184,520,383							50
52	Delivery Room & Labor Room	8,522,256							52
54	Radiology-Diagnostic	255,388,240			11,353				54
60	Laboratory	177,027,234			26,418				60
62	Whole Blood & Packed Red Blood	11,636,934			1,280				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	34,672,391			10,902				65
66	Physical Therapy	50,801,243			128,586				66
70	Electroencephalography	10,129,076			762				70
71	Medical Supplies Charged to Pat	44,765,074			5,503				71
72	Impl. Dev. Charged to Patients	57,514,795							72
73	Drugs Charged to Patients	106,725,583			80,420				73
76	CARDIOLOGY	126,096,244			2,002				76
76.97	CARDIAC REHABILITATION	1,706,323							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	7,189,880			3,888				90
91	Emergency	103,047,130							91
92	Observation Beds (Non-Distinct	31,147,445							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,210,890,231			271,114				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.269694						50
52	Delivery Room & Labor Room	0.619820						52
54	Radiology-Diagnostic	0.110727						54
60	Laboratory	0.108007						60
62	Whole Blood & Packed Red Blood	0.372835						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.212339						65
66	Physical Therapy	0.305990						66
70	Electroencephalography	0.172409						70
71	Medical Supplies Charged to Pat	0.452022						71
72	Impl. Dev. Charged to Patients	0.547196						72
73	Drugs Charged to Patients	0.220691						73
76	CARDIOLOGY	0.164048						76
76.97	CARDIAC REHABILITATION	0.455557						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	0.602630						90
91	Emergency	0.140113						91
92	Observation Beds (Non-Distinct	0.442329						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [XX] 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)	91,831	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	91,831	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)	50,402	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	42,781	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)	78,045,620	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)	78,045,620	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)	1.292663	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)	798.80	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)	78,045,620	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)					849.88	38	
39	Program general inpatient routine service cost (line 9 x line 38)					36,358,716	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)					36,358,716	41	
42	Nursery (Titles V and XIX only)	1	2	3	4	5	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	18,390,835	10,873	1,691.42	6,065	10,258,462	43	
44	Coronary Care Unit						44	
44.01	NEONATAL INTENSIVE CARE	6,744,624	5,337	1,263.75			44.01	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					59,341,637	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					105,958,815	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					3,139,525	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,114,766	51
52	Total Program excludable cost (sum of lines 50 and 51)					7,254,291	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					98,704,524	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)					16,211	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					849.88	88
89	Observation bed cost (line 87 x line 88) (see instructions)					13,777,405	89
		Cost	Routine Cost (from line 27)	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	4,965,192	78,045,620	0.063619	13,777,405	876,505	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,908	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,908	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)	14,384	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)	13,933	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)	11,446,727	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,446,727	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)	2,101,219	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)	333.79	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	90.33	34
35	Average per diem private room cost differential (line 34 x line 31)	189.80	35
36	Private room cost differential adjustment (line 3 x line 35)	289,255	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,157,472	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)	719,56	38
39	Program general inpatient routine service cost (line 9 x line 38)	10,025,629	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)	10,025,629	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,287,906	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	17,313,535	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	551,747	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	401,758	51
52	Total Program excludable cost (sum of lines 50 and 51)	953,505	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	16,360,030	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

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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)	91,831	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	91,831	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)	50,402	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)	3,482	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)	3,806	15
16	Nursery days (title V or XIX only)	455	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)	78,045,620	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)	78,045,620	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)	1,292,663	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)	798.80	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)	78,045,620	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)					849.88	38	
39	Program general inpatient routine service cost (line 9 x line 38)					2,959,282	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					2,959,282	41	
42	Nursery (Titles V and XIX only)	2,567,891	3,806	674.70	455	306,989	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	18,390,835	10,873	1,691.42	556	940,430	43	
44	Coronary Care Unit						44	
44.01	NEONATAL INTENSIVE CARE	6,744,624	5,337	1,263.75	813	1,027,429	44.01	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,112,614	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					9,346,744	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					372,317	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					289,107	51
52	Total Program excludable cost (sum of lines 50 and 51)					661,424	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					8,685,320	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)					16,211	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 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,908	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,908	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)	14,384	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)	121	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	11,446,727	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,446,727	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)	2,101,219	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)	333.79	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	90.33	34
35	Average per diem private room cost differential (line 34 x line 31)	189.80	35
36	Private room cost differential adjustment (line 3 x line 35)	289,255	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,157,472	37

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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

38	Adjusted general inpatient routine service cost per diem (see instructions)	719,56	38
39	Program general inpatient routine service cost (line 9 x line 38)	87,067	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)	87,067	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	69,303	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	156,370	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	4,792	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,725	51
52	Total Program excludable cost (sum of lines 50 and 51)	8,517	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	147,853	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		55,458,136		30
31	Intensive Care Unit		12,893,494		31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.269694	36,454,117	9,831,457	50
52	Delivery Room & Labor Room	0.619820	7,175	4,447	52
54	Radiology-Diagnostic	0.110785	30,609,763	3,391,103	54
60	Laboratory	0.108035	36,572,442	3,951,104	60
62	Whole Blood & Packed Red Blood Cells	0.372835	4,485,664	1,672,413	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.212376	18,250,064	3,875,876	65
66	Physical Therapy	0.305990	8,383,676	2,565,321	66
70	Electroencephalography	0.173187	802,185	138,928	70
71	Medical Supplies Charged to Patients	0.452022	12,160,807	5,496,952	71
72	Impl. Dev. Charged to Patients	0.547196	21,774,966	11,915,174	72
73	Drugs Charged to Patients	0.220691	40,833,945	9,011,684	73
76	CARDIOLOGY	0.165087	29,571,102	4,881,805	76
76.97	CARDIAC REHABILITATION	0.455557	195,580	89,098	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.605639	132,907	80,494	90
91	Emergency	0.140396	17,349,364	2,435,781	91
92	Observation Beds (Non-Distinct Part)	0.442329			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		257,583,757	59,341,637	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		257,583,757		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T125

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF		13,086,533		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.269694	308,051	83,080	50
52	Delivery Room & Labor Room	0.619820			52
54	Radiology-Diagnostic	0.110785	1,535,001	170,055	54
60	Laboratory	0.108035	2,945,350	318,201	60
62	Whole Blood & Packed Red Blood Cells	0.372835	260,490	97,120	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.212376	1,487,208	315,847	65
66	Physical Therapy	0.305990	13,770,174	4,213,536	66
70	Electroencephalography	0.173187	162,508	28,144	70
71	Medical Supplies Charged to Patients	0.452022	1,468,063	663,597	71
72	Impl. Dev. Charged to Patients	0.547196	69,214	37,874	72
73	Drugs Charged to Patients	0.220691	5,619,617	1,240,199	73
76	CARDIOLOGY	0.165087	663,444	109,526	76
76.97	CARDIAC REHABILITATION	0.455557	109	50	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.605639	17,568	10,640	90
91	Emergency	0.140396	266	37	91
92	Observation Beds (Non-Distinct Part)	0.442329			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		28,307,063	7,287,906	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		28,307,063		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0125

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		4,330,856		30
31	Intensive Care Unit		852,690		31
32.01	NEONATAL INTENSIVE CARE		3,384,750		32.01
41	Subprovider - IRF				41
43	Nursery		229,600		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.269694	2,032,019	548,023	50
52	Delivery Room & Labor Room	0.619820	154,525	95,778	52
54	Radiology-Diagnostic	0.110785	2,518,460	279,008	54
60	Laboratory	0.108035	3,060,486	330,640	60
62	Whole Blood & Packed Red Blood Cells	0.372835	444,569	165,751	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.212376	838,238	178,022	65
66	Physical Therapy	0.305990	649,893	198,861	66
70	Electroencephalography	0.173187	46,695	8,087	70
71	Medical Supplies Charged to Patients	0.452022	1,136,712	513,819	71
72	Impl. Dev. Charged to Patients	0.547196	768,879	420,728	72
73	Drugs Charged to Patients	0.220691	3,888,296	858,112	73
76	CARDIOLOGY	0.165087	1,907,821	314,956	76
76.97	CARDIAC REHABILITATION	0.455557	11,765	5,360	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.605639	38,316	23,206	90
91	Emergency	0.140396	1,226,979	172,263	91
92	Observation Beds (Non-Distinct Part)	0.442329			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		18,723,653	4,112,614	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		18,723,653		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
32.01	NEONATAL INTENSIVE CARE				32.01
41	Subprovider - IRF		107,790		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.269694			50
52	Delivery Room & Labor Room	0.619820			52
54	Radiology-Diagnostic	0.110785	11,353	1,258	54
60	Laboratory	0.108035	26,418	2,854	60
62	Whole Blood & Packed Red Blood Cells	0.372835	1,280	477	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.212376	10,902	2,315	65
66	Physical Therapy	0.305990	128,586	39,346	66
70	Electroencephalography	0.173187	762	132	70
71	Medical Supplies Charged to Patients	0.452022	5,503	2,487	71
72	Impl. Dev. Charged to Patients	0.547196			72
73	Drugs Charged to Patients	0.220691	80,420	17,748	73
76	CARDIOLOGY	0.165087	2,002	331	76
76.97	CARDIAC REHABILITATION	0.455557			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.605639	3,888	2,355	90
91	Emergency	0.140396			91
92	Observation Beds (Non-Distinct Part)	0.442329			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		271,114	69,303	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		271,114		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)	20,191,964			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	61,009,609			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	2,384,565			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)	362.59			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0300			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1567			31
32	Sum of lines 30 and 31	0.1867			32
33	Allowable disproportionate share percentage (see instructions)	0.0489			33
34	Disproportionate share adjustment (see instructions)	992,690			34
		Prior to	On or after		
		October 1	October 1		
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)	9,046,380,143	7,647,644,885		35
35.01	Factor 3 (see instructions)	0.000472800	0.000451725		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	4,277,129	3,454,632		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,078,072	2,583,875		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,661,947			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

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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)	88,240,775			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)	88,240,775			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	6,898,547			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	6,064			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	95,145,386			59
60	Primary payer payments	96,631			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	95,048,755			61
62	Deductibles billed to program beneficiaries	7,290,332			62
63	Coinsurance billed to program beneficiaries	544,319			63
64	Allowable bad debts (see instructions)	1,117,384			64
65	Adjusted reimbursable bad debts (see instructions)	726,300			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	294,288			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	87,940,404			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)	47,578			70
70.93	HVBP payment adjustment amount (see instructions)	240,241			70.93
70.94	HRR adjustment amount (see instructions)	-633,505			70.94
71	Amount due provider (see instructions)	87,594,718			71
71.01	Sequestration adjustment (see instructions)	1,751,894			71.01
72	Interim payments	84,921,850			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	920,974			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	6,482,825			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

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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)	20,838			1
2	Medical and other services reimbursed under OPPS (see instructions)	50,703,932			2
3	PPS payments	48,724,787			3
4	Outlier payment (see instructions)	75,243			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				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	20,838			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	97,245			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)	97,245			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	97,245			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	76,407			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)	20,838			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)	48,800,030			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	9,712,363			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)	39,108,505			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)	39,108,505			30
31	Primary payer payments	27,462			31
32	Subtotal (line 30 minus line 31)	39,081,043			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	1,418,562			34
35	Adjusted reimbursable bad debts (see instructions)	922,065			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	624,280			36
37	Subtotal (see instructions)	40,003,108			37
38	MSP-LCC reconciliation amount from PS&R	-521			38
39	Other adjustments (FDO LOSS)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	40,003,629			40
40.01	Sequestration adjustment (see instructions)	800,073			40.01
41	Interim payments	38,811,967			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	391,589			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 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)	259			1
2	Medical and other services reimbursed under OPPS (see instructions)	66			2
3	PPS payments	127			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				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	259			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,172			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)	1,172			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	1,172			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	913			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)	259			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)	127			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	386			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)	386			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	386			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	386			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)	386			40
40.01	Sequestration adjustment (see instructions)	8			40.01
41	Interim payments	400			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-22			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0125

WORKSHEET E-1
PART I

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

		INPATIENT PART A		PART B	
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		84,504,554		38,295,753
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		417,296		516,214
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	02/03/2015		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)		84,921,850		38,811,967
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	920,974		391,589
		.02			6.02
7	Total Medicare program liability (see instructions)		85,842,824		39,203,556
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)
					8

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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		22,153,324		400
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
		.03			3.03
		.04			3.04
		.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
		.52			3.52
		.53			3.53
		.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			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)		22,153,324		400
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
		.03			5.03
		.04			5.04
		.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		.52			5.52
		.53			5.53
		.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		22,149,169		378
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)	

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)	17,105	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	48,846	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	6,400	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	91,830	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	1,370,913,451	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	19,185,163	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)	1,583,835	8
9	Sequestration adjustment amount (see instructions)	31,677	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1,552,158	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	1,864,242	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-312,084	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 CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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)	22,410,222		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.019400		2
3	Inpatient Rehabilitation LIP payments (see instructions)	233,066		3
4	Outlier payments	198,189		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)	43.583562		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	22,841,477		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)	22,841,477		17
18	Primary payer payments	17,221		18
19	Subtotal (line 17 less line 18)	22,824,256		19
20	Deductibles	175,400		20
21	Subtotal (line 19 minus line 20)	22,648,856		21
22	Coinsurance	66,845		22
23	Subtotal (line 21 minus line 22)	22,582,011		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29,510		24
25	Adjusted reimbursable bad debts (see instructions)	19,182		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,122		26
27	Subtotal (sum of lines 23 and 25)	22,601,193		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)			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)	22,601,193		32
32.01	Sequestration adjustment (see instructions)	452,024		32.01
33	Interim payments	22,153,324		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	-4,155		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	2,146,615		36

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E-3
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	107,790		8
9	271,114		9
10			10
11			11
12	378,904		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	378,904		16
17	378,904		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	16,176,082				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	106,652,165				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-48,984,611				6
7	Inventory	9,504,766				7
8	Prepaid expenses	3,992,452				8
9	Other current assets	1,664,315				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	89,005,169				11
FIXED ASSETS						
12	Land	3,945,791				12
13	Land improvements	7,092,854				13
14	Accumulated depreciation	-5,763,150				14
15	Buildings	290,185,251				15
16	Accumulated depreciation	-201,349,683				16
17	Leasehold improvements	1,286,471				17
18	Accumulated depreciation	-992,642				18
19	Fixed equipment	93,329,699				19
20	Accumulated depreciation	-26,315,637				20
21	Automobiles and trucks	579,538				21
22	Accumulated depreciation	-415,614				22
23	Major movable equipment	137,534,753				23
24	Accumulated depreciation	-104,282,287				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	5,549,177				29
30	Total fixed assets (sum of lines 12-29)	200,384,521				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,170,154				34
35	Total other assets (sum of lines 31-34)	4,170,154				35
36	Total assets (sum of lines 11, 30 and 35)	293,559,844				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	2,678,949				37
38	Salaries, wages and fees payable	18,243,477				38
39	Payroll taxes payable	7,601,206				39
40	Notes and loans payable (short term)	544,211				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	9,120,725				44
45	Total current liabilities (sum of lines 37 thru 44)	38,188,568				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	91,482				47
48	Unsecured loans					48
49	Other long term liabilities	59,797,062				49
50	Total long term liabilities (sum of lines 46 thru 49)	59,888,544				50
51	Total liabilities (sum of lines 45 and 50)	98,077,112				51
CAPITAL ACCOUNTS						
52	General fund balance	195,482,732				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)	195,482,732				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	293,559,844				60

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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		177,353,000			1
2	Net income (loss) (from Worksheet G-3, line 29)		58,228,143			2
3	Total (sum of line 1 and line 2)		235,581,143			3
4	Additions (credit adjustments) (specify)					4
5	NET ASSETS TRANSFERRED TO AFFILITES					5
6	RESTRICTED CONTRIBUTIONS			217,567		6
7	NET ASSETS RELEASED FROM RESTRICTN	108,932				7
8	OTHER					8
9						9
10	Total additions (sum of lines 4-9)		108,932		217,567	10
11	Subtotal (line 3 plus line 10)		235,690,075		217,567	11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS RELEASED FROM RESTRICTN			201,000		13
14	PENSION-RELATED ADJ-NOT NET COST	19,548,350				14
15	NET ASSETS TRANSFERRD TO AFFILIATE	20,671,502				15
16	OTHER	4,058				16
17						17
18	Total deductions (sum of lines 12-17)		40,223,910		201,000	18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		195,466,165		16,567	19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	NET ASSETS TRANSFERRED TO AFFILITES					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 RESTRICTN					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 CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	100,492,824		100,492,824	1
2	Subprovider IPF				2
3	Subprovider IRF	14,821,041		14,821,041	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)	115,313,865		115,313,865	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	21,262,084		21,262,084	11
12	Coronary Care Unit				12
12.01	NEONATAL INTENSIVE CARE	24,165,248		24,165,248	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)	45,427,332		45,427,332	16
17	Total inpatient routine care services (sum of lines 10 and 16)	160,741,197		160,741,197	17
18	Ancillary services	519,920,888		519,920,888	18
19	Outpatient services		683,259,909	683,259,909	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		6,850,456	6,850,456	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		47,775,938	47,775,938	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	680,662,085	737,886,303	1,418,548,388	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		435,869,115	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)		435,869,115	43

KPMG LLP Compu-Max 2552-10

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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)	1,418,548,388	1
2	Less contractual allowances and discounts on patients' accounts	941,073,530	2
3	Net patient revenues (line 1 minus line 2)	477,474,858	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	435,869,115	4
5	Net income from service to patients (line 3 minus line 4)	41,605,743	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	252,175	6
7	Income from investments	762,263	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	8,515	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	2,196,463	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients	6,100,661	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	19,183	21
22	Rental of hospital space	2,150,080	22
23	Governmental appropriations	2,311,692	23
24	Other (OTHER REVENUE)	374,189	24
24.01	Other (REVENUE-CLASSES)	34,615	24.01
24.02	Other (ASSETS RELEASED FROM RESTRICTION)	55,826	24.02
24.03	Other (FITNESS REVENUE)	3,835,498	24.03
24.04	Other (SALE OF XRAY SCRAP)	3,360	24.04
24.05	Other (GAIN ON FIXED ASSETS)	301,776	24.05
25	Total other income (sum of lines 6-24)	18,406,296	25
26	Total (line 5 plus line 25)	60,012,039	26
27	Other expenses (PENSION SETTLEMENT)	1,783,896	27
28	Total other expenses (sum of line 27 and subscripts)	1,783,896	28
29	Net income (or loss) for the period (line 26 minus line 28)	58,228,143	29

KPMG LLP Compu-Max 2552-10

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	609,255	30,605	23,637	11,612	56,536	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,054,316					6
7	Physical Therapy				881,398		7
8	Occupational Therapy				192,175		8
9	Speech Pathology	29,595					9
10	Medical Social Services	698					10
11	Home Health Aide	99,264					11
12	Supplies (see instructions)					165,282	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing	411,172	2,715			11,353	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)	2,204,300	33,320	23,637	1,085,185	233,171	24

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	731,645	-51,207	680,438	26,989	707,427	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,054,316		1,054,316		1,054,316	6
7	Physical Therapy	881,398		881,398		881,398	7
8	Occupational Therapy	192,175		192,175		192,175	8
9	Speech Pathology	29,595		29,595		29,595	9
10	Medical Social Services	698		698		698	10
11	Home Health Aide	99,264		99,264		99,264	11
12	Supplies (see instructions)	165,282		165,282		165,282	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing	425,240		425,240		425,240	17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	3,579,613	-51,207	3,528,406	26,989	3,555,395	24

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

KPMG LLP Compu-Max 2552-10

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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	
GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	707,427				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,054,316				6
7	Physical Therapy	881,398				7
8	Occupational Therapy	192,175				8
9	Speech Pathology	29,595				9
10	Medical Social Services	698				10
11	Home Health Aide	99,264				11
12	Supplies (see instructions)	165,282				12
13	Drugs					13
14	DME					14
HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing	425,240				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)	3,555,395				24

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H-1
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		707,427	707,427		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		1,054,316	272,067	1,326,383	6
7	Physical Therapy		881,398	221,302	1,102,700	7
8	Occupational Therapy		192,175	51,913	244,088	8
9	Speech Pathology		29,595	3,840	33,435	9
10	Medical Social Services		698	278	976	10
11	Home Health Aide		99,264	28,601	127,865	11
12	Supplies (see instructions)		165,282	44,108	209,390	12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing		425,240	85,318	510,558	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)		3,555,395		3,555,395	24

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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	
GENERAL SERVICE COST CENTERS								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-707,427	5,452,854	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care					1,042,783	2,097,099	6
7	Physical Therapy					824,402	1,705,800	7
8	Occupational Therapy					207,973	400,148	8
9	Speech Pathology						29,595	9
10	Medical Social Services					1,445	2,143	10
11	Home Health Aide					121,191	220,455	11
12	Supplies (see instructions)					174,701	339,983	12
13	Drugs							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing					232,391	657,631	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)					1,897,459	5,452,854	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						707,427	25
26	Unit Cost Multiplier						0.129735	26

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General		41,459	591	665,123	707,173	133,840	1
2	Skilled Nursing Care	1,326,383				1,326,383	251,033	2
3	Physical Therapy	1,102,700				1,102,700	208,698	3
4	Occupational Therapy	244,088				244,088	46,196	4
5	Speech Pathology	33,435				33,435	6,328	5
6	Medical Social Services	976				976	185	6
7	Home Health Aide	127,865				127,865	24,200	7
8	Supplies	209,390				209,390	39,629	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing	510,558				510,558	96,629	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)	3,555,395	41,459	591	665,123	4,262,568	806,738	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

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

KPMG LLP Compu-Max 2552-10

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 14:11 Version: 2015.10 (11/17/2015)
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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		112,860		11,150			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		112,860		11,150			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

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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					28,313		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)					28,313		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.

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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						993,336	1
2	Skilled Nursing Care						1,577,416	2
3	Physical Therapy						1,311,398	3
4	Occupational Therapy						290,284	4
5	Speech Pathology						39,763	5
6	Medical Social Services						1,161	6
7	Home Health Aide						152,065	7
8	Supplies						249,019	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing						607,187	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)						5,221,629	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.

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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		993,336				1
2	Skilled Nursing Care		1,577,416	370,577	1,947,993		2
3	Physical Therapy		1,311,398	308,081	1,619,479		3
4	Occupational Therapy		290,284	68,195	358,479		4
5	Speech Pathology		39,763	9,341	49,104		5
6	Medical Social Services		1,161	273	1,434		6
7	Home Health Aide		152,065	35,724	187,789		7
8	Supplies		249,019	58,501	307,520		8
9	Drugs						9
10	DME						10
11	Home Dialysis Aide Services						11
12	Respiratory Therapy						12
13	Private Duty Nursing		607,187	142,644	749,831		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)		5,221,629	993,336	5,221,629		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.			0.234926			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.

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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	3,575	372	2,204,300		707,173		1
2	Skilled Nursing Care					1,326,383		2
3	Physical Therapy					1,102,700		3
4	Occupational Therapy					244,088		4
5	Speech Pathology					33,435		5
6	Medical Social Services					976		6
7	Home Health Aide					127,865		7
8	Supplies					209,390		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing					510,558		13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	3,575	372	2,204,300		4,262,568		20
21	Total cost to be allocated	41,459	591	665,123		806,738		21
22	Unit Cost Multiplier	11.596923		0.301739		0.189261		22
22	Unit Cost Multiplier		1.588710					22

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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 NEW- SQ FT	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	3,575		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)	3,575		1,200				20
21	Total cost to be allocated	112,860		11,150				21
22	Unit Cost Multiplier	31.569231		9.291667				22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

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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				6,850,456			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)				6,850,456			20
21	Total cost to be allocated				28,313			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				0.004133			22

KPMG LLP Compu-Max 2552-10

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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

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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	1,947,993		1,947,993	20,633	94.41	1
2	Physical Therapy	3	1,619,479		1,619,479	14,608	110.86	2
3	Occupational Therapy	4	358,479		358,479	3,492	102.66	3
4	Speech Pathology	5	49,104		49,104	478	102.73	4
5	Medical Social Services	6	1,434		1,434	13	110.31	5
6	Home Health Aide	7	187,789		187,789	5,190	36.18	6
7	Total (sum of lines 1-6)		4,164,278		4,164,278	44,414		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		16,854		8
9	Physical Therapy	23844		12,277		9
10	Occupational Therapy	23844		3,243		10
11	Speech Pathology	23844		421		11
12	Medical Social Services	23844		11		12
13	Home Health Aide	23844		4,892		13
14	Total (sum of lines 8-13)			37,698		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	307,520		307,520	423,024	0.726956	15
16	Cost of Drugs	9						16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.305990			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.452022			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.220691			col. 2, line 16	5

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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7487

WORKSHEET H-3
PARTS I & II

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
		Part B			Part B			Total Program Cost (sum of cols 9-10)	
Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6	7	8	9	10	11	12		
1 Skilled Nursing Care		16,854			1,591,186		1,591,186	1	
2 Physical Therapy		12,277			1,361,028		1,361,028	2	
3 Occupational Therapy		3,243			332,926		332,926	3	
4 Speech Pathology		421			43,249		43,249	4	
5 Medical Social Services		11			1,213		1,213	5	
6 Home Health Aide		4,892			176,993		176,993	6	
7 Total (sum of lines 1-6)		37,698			3,506,595		3,506,595	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			
15 Cost of Medical Supplies								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

	Description	Part A 1	Part B		
			Not Subject to Deductibles & Coinsurance 2	Subject to Deductibles & Coinsurance 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				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		4,767,020	11
12	Total PPS Reimbursement - Full Episodes with Outliers		311,739	12
13	Total PPS Reimbursement - LUPA Episodes		52,532	13
14	Total PPS Reimbursement - PEP Episodes		23,932	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		44,548	15
16	Total PPS Outlier Reimbursement - PSP Episodes		3,408	16
17	Total Other Payments		25	17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		5,203,204	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		5,203,204	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		5,203,204	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		5,203,204	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		5,203,204	31
31.01	Sequestration adjustment (see instructions)		104,063	31.01
32	Interim payments (see instructions)		5,099,141	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

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

WORKSHEET H-5

	DESCRIPTION	Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1	2	3	4	
1	Total interim payments paid to provider				5,099,141	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				5,099,141	4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				5,099,141	7
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

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

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0125

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	6,491,861	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	156,749	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)	254.96	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)	0.0300	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1567	8
9	Sum of lines 7 and 8	0.1867	9
10	Allowable disproportionate share percentage (see instructions)	0.0385	10
11	Disproportionate share adjustment (see instructions)	249,937	11
12	Total prospective capital payments (see instructions)	6,898,547	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

KPMG LLP Compu-Max 2552-10

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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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
32.01	NEONATAL INTENSIVE CARE							32.01
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY							194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
194.06	EINSTEIN BAGELS							194.06
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202