



COMPU-MAX

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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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: 08/26/2014	TIME: 16:01
		2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT			
		3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT			
		4. <input type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.			
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: ENTER NUMBER OF TIMES REOPENED = 0-9.	
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN			
	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 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 ROSELAND COMMUNITY HOSPITAL (14-0068) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 04/01/2013 AND ENDING 03/31/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-1,593,718	116			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-1,593,718	116			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.



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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: 45 W. 111TH STREET	P.O. Box:							1	
2	City: CHICAGO	State: IL	ZIP Code: 60628-	County: COOK					2	
Hospital and Hospital-Based Component Identification:										
							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ROSELAND COMMUNITY HOSPITAL	14-0068	16974	1	06/01/1966	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 04 / 01 / 2013	To: 03 / 31 / 2014							20
21	Type of control (see instructions)	2								21
Inpatient PPS Information								1	2	
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
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.							1	N	23
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1	2	3	4	5	6			
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	5,254	3,675	16		1,012	206		24	
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.								25	
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.				1				26	
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				1				27	
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								35	
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:		36	
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.								37	
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:		38	
							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



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
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 Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N	N		57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part 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 Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63



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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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 non-provider 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						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
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



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WORKSHEET S-2
PART I

Title V and XIX Services		V	XIX			
		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/MR 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	Column 1: 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. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			107		
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108		
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If 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'	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.	N		117		
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118		
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance	118.01	
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.	1,014,873			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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WORKSHEET S-2
PART I

All Providers		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140
If this facility is part of a chain organization, enter 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:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	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, section 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
			1	2
				Title XIX
				3
155	Hospital	N	N	N
156	Subprovider - IPF	N	N	
157	Subprovider - IRF	N	N	
158	Surpvodier - Other			
159	SNF	N	N	
160	HHA	N	N	
161	CMHC		N	
161.10	CORF			
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.			166
	Name	County	State	ZIP Code
	0	1	2	3
				CBSA
				FTE/Campus
				4
				5
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
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)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	N			4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT 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
BAD DEBTS				Y/N	
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	
PS&R REPORT DATA		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N	
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	08/13/2014	Y	08/13/2014
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 COSTS			
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 CAPITALIZED 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
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
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.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: RAJ	LAST NAME: SHAH	TITLE: SENIOR CONSULTANT
42	EMPLOYER: STRATEGIC REIMBURSEMENT, INC.		
43	PHONE NUMBER: 630 530-7100 X107	E-MAIL ADDRESS: RAJ.SHAH@SRGOUPLLC.COM	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	124	45,260			4,251	7,810	15,224	1
2	HMO AND OTHER (see instructions)							1,012		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		124	45,260			4,251	7,810	15,224	7
8	INTENSIVE CARE UNIT	31	10	3,650			933	986	2,449	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						355	665	13
14	TOTAL (see instructions)		134	48,910			5,184	9,151	18,338	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		134							27
28	OBSERVATION BED DAYS								247	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									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)					955	1,731	3,482	1
2	HMO AND OTHER (see instructions)								2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		445.14			955	1,731	3,482	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		445.14						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)		
	1	2	3	4	5	6		
SALARIES								
1	TOTAL SALARIES (see instructions)	200	22,504,899	803,690	23,308,589	925,891.00	25.17	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		369,804		369,804	5,850.00	63.21	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		116,499	412	116,911	448.00	260.96	10
OTHER WAGES & RELATED COSTS								
11	CONTRACT LABOR (see instructions)		241,553		241,553	1,929.00	125.22	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
WAGE-RELATED COSTS								
17	WAGE-RELATED COSTS (core)(see instructions)		3,970,410		3,970,410			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		1,145		1,145			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		64,027		64,027			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	EMPLOYEE BENEFITS DEPARTMENT							26
27	ADMINISTRATIVE & GENERAL		3,834,962	988,708	4,823,670	202,948.00	23.77	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		611,381	-27,442	583,939	26,691.00	21.88	30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		645,761	-8,978	636,783	52,524.00	12.12	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		611,841	-177,088	434,753	29,968.00	14.51	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			178,509	178,509	12,345.00	14.46	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,234,865	-20,180	1,214,685	32,121.00	37.82	38
39	CENTRAL SERVICES AND SUPPLY		92,716	1,962	94,678	6,171.00	15.34	39
40	PHARMACY		460,099	9,691	469,790	20,098.00	23.37	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		438,398	1,740	440,138	22,679.00	19.41	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		22,135,095	803,690	22,938,785	920,041.00	24.93	1
2	EXCLUDED AREA SALARIES (see instructions)		116,499	412	116,911	448.00	260.96	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		22,018,596	803,278	22,821,874	919,593.00	24.82	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		241,553		241,553	1,929.00	125.22	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		3,970,410		3,970,410		17.40%	5
6	TOTAL (sum of lines 3 through 5)		26,230,559	803,278	27,033,837	921,522.00	29.34	6
7	TOTAL OVERHEAD COST (see instructions)		7,930,023	946,922	8,876,945	405,545.00	21.89	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

PART IV - WAGE RELATED COST

PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	144,269	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	1,324,674	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	57,260	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	39,845	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	173,710	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	380,305	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	1,566,558	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	345,193	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	3,767	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	4,035,581	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		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		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		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)
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3

PART V - CONTRACT LABOR AND BENEFIT COST

PART V

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			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 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)	0.300443	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	28,520,424	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	51,250,538	6
7	MEDICAID COST (line 1 times line 6)	15,397,868	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.		8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		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	3,537,975		3,537,975	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	1,062,960		1,062,960	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	1,062,960		1,062,960	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?		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)	18,118,770	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	109,710	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	18,009,060	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	5,410,697	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	6,473,657	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	6,473,657	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		1,281,309	1,281,309	185,964	1,467,273	-44,128	1,423,145	1
2	00200	CAP REL COSTS-MVBLE EQUIP				4,880	4,880		4,880	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		4,022,200	4,022,200		4,022,200		4,022,200	4
5.01	00510	NONPATIENT TELEPHONES	79,486	549,569	629,055		629,055		629,055	5.01
5.02	00520	DATA PROCESSING	265,178	630,348	895,526		895,526		895,526	5.02
5.03	00530	PURCHASING RECEIVING AND STORES	476,066	247,469	723,535		723,535		723,535	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	677,257	91,420	768,677		768,677	-9,377	759,300	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	2,336,975	3,178,715	5,515,690	355,790	5,871,480	-192,453	5,679,027	5.05
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	611,381	1,385,900	1,997,281		1,997,281		1,997,281	7
8	00800	LAUNDRY & LINEN SERVICE								8
9	00900	HOUSEKEEPING	645,761	499,273	1,145,034		1,145,034		1,145,034	9
10	01000	DIETARY	611,841	554,694	1,166,535	-340,345	826,190	-3,293	822,897	10
11	01100	CAFETERIA				340,345	340,345	-83,750	256,595	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	1,234,865	69,145	1,304,010		1,304,010	-530	1,303,480	13
14	01400	CENTRAL SERVICES & SUPPLY	92,716	415,786	508,502	-405,144	103,358		103,358	14
15	01500	PHARMACY	460,099	1,384,085	1,844,184	-775,338	1,068,846		1,068,846	15
16	01600	MEDICAL RECORDS & LIBRARY	438,398	742,131	1,180,529		1,180,529	-143	1,180,386	16
17	01700	SOCIAL SERVICE								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 SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	6,507,658	1,054,022	7,561,680	-431,935	7,129,745	-1,010,265	6,119,480	30
31	03100	INTENSIVE CARE UNIT	1,513,865	53,247	1,567,112	-22,406	1,544,706		1,544,706	31
43	04300	NURSERY	378,225	29,983	408,208	-19,223	388,985		388,985	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	470,198	395,547	865,745	-233,365	632,380	-104,344	528,036	50
51	05100	RECOVERY ROOM		7,776	7,776	101,528	109,304		109,304	51
52	05200	DELIVERY ROOM & LABOR ROOM				337,910	337,910		337,910	52
53	05300	ANESTHESIOLOGY		756,093	756,093	-6,635	749,458	-723,916	25,542	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,221,506	1,096,315	2,317,821	-24,723	2,293,098		2,293,098	54
60	06000	LABORATORY	901,048	1,113,184	2,014,232	-210,327	1,803,905	-2,082	1,801,823	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.				210,327	210,327		210,327	63
66	06600	PHYSICAL THERAPY	42,646	216,462	259,108		259,108	-100,000	159,108	66
69.01	06901	CARDIOPULMONARY	907,737	576,750	1,484,487	-59,401	1,425,086	-183,000	1,242,086	69.01
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				799,352	799,352		799,352	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				67,638	67,638		67,638	72
73	07300	DRUGS CHARGED TO PATIENTS				775,338	775,338		775,338	73
74	07400	RENAL DIALYSIS		248,482	248,482	-6,928	241,554		241,554	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	26,372	12,597	38,969	-2,538	36,431		36,431	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	EMERGENCY	2,489,122	1,478,135	3,967,257	-94,130	3,873,127	-1,205,842	2,667,285	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
92.01	09201	23-HR OBSERVATION								92.01
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		546,634	546,634	-546,634				113
118		SUBTOTALS (sum of lines 1-117)	22,388,400	22,637,271	45,025,671		45,025,671	-3,663,123	41,362,548	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,718	4,150	10,868		10,868		10,868	190
192	19200	PHYSICIANS' PRIVATE OFFICES	109,781	9,895	119,676		119,676		119,676	192
200		TOTAL (sum of lines 118-199)	22,504,899	22,651,316	45,156,215		45,156,215	-3,663,123	41,493,092	200



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
1	INTEREST EXPENSES	A	CAP REL COSTS-BLDG & FIXT	1		163,092	1
2			OTHER ADMINISTRATIVE AND GENE	5.05		383,542	2
500	TOTAL RECLASSIFICATIONS					546,634	500
	CODE LETTER - A						
1	OB DELIVERY	B	DELIVERY ROOM & LABOR ROOM	52	352,442		1
2			ADULTS & PEDIATRICS	30		14,532	2
500	TOTAL RECLASSIFICATIONS				352,442	14,532	500
	CODE LETTER - B						
1	PROPERTY INSURANCE RECLASS	C	CAP REL COSTS-BLDG & FIXT	1		22,872	1
2			CAP REL COSTS-MVBLE EQUIP	2		4,880	2
500	TOTAL RECLASSIFICATIONS					27,752	500
	CODE LETTER - C						
1	CHARGEABEL MEDICAL SUPPLIES	D	MEDICAL SUPPLIES CHARGED TO P	71		799,352	1
2			IMPL. DEV. CHARGED TO PATIENT	72		67,638	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
500	TOTAL RECLASSIFICATIONS					866,990	500
	CODE LETTER - D						
1	DRUGS SOLD RECLASS	E	DRUGS CHARGED TO PATIENTS	73		775,338	1
500	TOTAL RECLASSIFICATIONS					775,338	500
	CODE LETTER - E						
1	DIETARY-CAFETERIA	F	CAFETERIA	11	178,509	161,836	1
500	TOTAL RECLASSIFICATIONS				178,509	161,836	500
	CODE LETTER - F						
1	RECOVERY ROOM	G	RECOVERY ROOM	51	103,704		1
500	TOTAL RECLASSIFICATIONS				103,704		500
	CODE LETTER - G						
1	BLOOD COST	H	BLOOD STORING, PROCESSING & T	63		210,327	1
500	TOTAL RECLASSIFICATIONS					210,327	500
	CODE LETTER - H						
1	VACATION EXP	I	NONPATIENT TELEPHONES	5.01	621		1
2			DATA PROCESSING	5.02		30,165	2
3			PURCHASING RECEIVING AND STOR	5.03	68,795		3
4			CASHIERING/ACCOUNTS RECEIVABL	5.04	984		4
5			OTHER ADMINISTRATIVE AND GENE	5.05	948,473		5
6			OPERATION OF PLANT	7		27,442	6
7			HOUSEKEEPING	9		8,978	7
8			DIETARY	10	1,421		8
9			NURSING ADMINISTRATION	13		20,180	9
10			CENTRAL SERVICES & SUPPLY	14	1,962		10
11			PHARMACY	15	9,691		11
12			MEDICAL RECORDS & LIBRARY	16	1,740		12
13			ADULTS & PEDIATRICS	30		102,307	13
14			INTENSIVE CARE UNIT	31	1,035		14
15			NURSERY	43		501	15
16			OPERATING ROOM	50		2,047	16
17			RADIOLOGY-DIAGNOSTIC	54	6,286		17
18			LABORATORY	60	3,381		18
19			PHYSICAL THERAPY	66		130	19
20			CARDIOPULMONARY	69.01		6,435	20
21			HYPERBARIC OXYGEN THERAPY	76.98		2,550	21
22			PHYSICIANS' PRIVATE OFFICES	192	516		22
23			EMERGENCY	91		40,376	23
24			GIFT, FLOWER, COFFEE SHOP & C	190		104	24
500	TOTAL RECLASSIFICATIONS				1,044,905	241,215	500
	CODE LETTER - I						
	GRAND TOTAL (INCREASES)				1,679,560	2,844,624	



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RECLASSIFICATIONS

WORKSHEET A-6

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

(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.	
1	INTEREST EXPENSES	A	INTEREST EXPENSE	113		546,634	11	
2								
500	TOTAL RECLASSIFICATIONS CODE LETTER - A					546,634	500	
1	OB DELIVERY	B	ADULTS & PEDIATRICS	30	352,442			
2			DELIVERY ROOM & LABOR ROOM	52		14,532		
500	TOTAL RECLASSIFICATIONS CODE LETTER - B				352,442	14,532	500	
1	PROPERTY INSURANCE RECLASS	C	OTHER ADMINISTRATIVE AND GENE	5.05		27,752	12	
2							12	
500	TOTAL RECLASSIFICATIONS CODE LETTER - C					27,752	500	
1	CHARGEABEL MEDICAL SUPPLIES	D	ADULTS & PEDIATRICS	30		94,025		
2			INTENSIVE CARE UNIT	31		22,406		
3			NURSERY	43		19,223		
4			OPERATING ROOM	50		129,661		
5			RECOVERY ROOM	51		2,176		
6			ANESTHESIOLOGY	53		6,635		
7			RADIOLOGY-DIAGNOSTIC	54		24,723		
8			CARDIOPULMONARY	69.01		59,401		
9			RENAL DIALYSIS	74		6,928		
10			HYPERBARIC OXYGEN THERAPY	76.98		2,538		
11			EMERGENCY	91		94,130		
12			CENTRAL SERVICES & SUPPLY	14		405,144		
500	TOTAL RECLASSIFICATIONS CODE LETTER - D					866,990	500	
1	DRUGS SOLD RECLASS	E	PHARMACY	15		775,338		
500	TOTAL RECLASSIFICATIONS CODE LETTER - E					775,338	500	
1	DIETARY-CAFETERIA	F	DIETARY	10	178,509	161,836		
500	TOTAL RECLASSIFICATIONS CODE LETTER - F				178,509	161,836	500	
1	RECOVERY ROOM	G	OPERATING ROOM	50	103,704			
500	TOTAL RECLASSIFICATIONS CODE LETTER - G				103,704		500	
1	BLOOD COST	H	LABORATORY	60		210,327		
500	TOTAL RECLASSIFICATIONS CODE LETTER - H					210,327	500	
1	VACATION EXP	I	NONPATIENT TELEPHONES	5.01		621		
2			DATA PROCESSING	5.02	30,165			
3			PURCHASING RECEIVING AND STOR	5.03		68,795		
4			CASHIERING/ACCOUNTS RECEIVABL	5.04		984		
5			OTHER ADMINISTRATIVE AND GENE	5.05		948,473		
6			OPERATION OF PLANT	7	27,442			
7			HOUSEKEEPING	9	8,978			
8			DIETARY	10		1,421		
9			NURSING ADMINISTRATION	13	20,180			
10			CENTRAL SERVICES & SUPPLY	14		1,962		
11			PHARMACY	15		9,691		
12			MEDICAL RECORDS & LIBRARY	16		1,740		
13			ADULTS & PEDIATRICS	30	102,307			
14			INTENSIVE CARE UNIT	31		1,035		
15			NURSERY	43	501			
16			OPERATING ROOM	50	2,047			
17			RADIOLOGY-DIAGNOSTIC	54		6,286		
18			LABORATORY	60		3,381		
19			PHYSICAL THERAPY	66	130			
20			CARDIOPULMONARY	69.01	6,435			
21			HYPERBARIC OXYGEN THERAPY	76.98	2,550			
22			PHYSICIANS' PRIVATE OFFICES	192		516		
23			EMERGENCY	91	40,376			
24			GIFT, FLOWER, COFFEE SHOP & C	190	104			
500	TOTAL RECLASSIFICATIONS CODE LETTER - I				241,215	1,044,905	500	



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.		
	1	6	7	8	9	10		
GRAND TOTAL (DECREASES)				875,870	3,648,314			

(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	933,453					933,453		1
2	LAND IMPROVEMENTS	495,806					495,806		2
3	BUILDINGS AND FIXTURES	25,184,289	1,350,536		1,350,536		26,534,825		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	7,229,777					7,229,777		5
6	MOVABLE EQUIPMENT	19,148,430	407,378		407,378		19,555,808		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	52,991,755	1,757,914		1,757,914		54,749,669		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	52,991,755	1,757,914		1,757,914		54,749,669		10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of (cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	1,281,309							1,281,309	1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (sum of lines 1-2)	1,281,309							1,281,309	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	34,260,408		34,260,408	0.636619					1
2	CAP REL COSTS-MVBLE EQU	19,555,808		19,555,808	0.363381					2
3	TOTAL (sum of lines 1-2)	53,816,216		53,816,216	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of (cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	1,281,309	-13,314	132,278	22,872				1,423,145	1
2	CAP REL COSTS-MVBLE EQUIP				4,880				4,880	2
3	TOTAL (sum of lines 1-2)	1,281,309	-13,314	132,278	27,752				1,428,025	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

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)					7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,329,449			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1				12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-83,750	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-143	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES	B	-3,293	DIETARY	10	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 AND					32
33						33
34						34
35						35
36						36
37						37
38						38
39						39
40						40
41	RCH SUITE RENTAL	B	-13,314	CAP REL COSTS-BLDG & FIXT	1	10 41
42	CPR TRAINING	B	-530	NURSING ADMINISTRATION	13	42
43						43
44						44
45	INVESTMENT INCOME INTEREST FUND	B	-336	OTHER ADMINISTRATIVE AND GENERAL	5.05	45
45.04	MISC OTHER ADMIN REV-NEGATIVE INCO	B	113,321	OTHER ADMINISTRATIVE AND GENERAL	5.05	45.04
45.05	PATIENT ACCTG BILL COPIES	B	-9,377	CASHIERING/ACCOUNTS RECEIVABLE	5.04	45.05
45.07	MEDICARE ADJ-BOND AMORTIZATION	A	-30,814	CAP REL COSTS-BLDG & FIXT	1	11 45.07
45.08	MEDICARE ADJ-MEDICARE AFFAIRS C	A	-23,523	OTHER ADMINISTRATIVE AND GENERAL	5.05	45.08
46	MONTERERY SUITE -SUBLEASE INCOME	B	-108,178	OTHER ADMINISTRATIVE AND GENERAL	5.05	46
46.10	MOB RENTAL INCOME	B	-31,320	OTHER ADMINISTRATIVE AND GENERAL	5.05	46.10
46.20	TRUSTEE FEES	B	-2,143	OTHER ADMINISTRATIVE AND GENERAL	5.05	46.20
46.30	PHONE COMM. - NEGATIVIE INCOME	B	9,189	OTHER ADMINISTRATIVE AND GENERAL	5.05	46.30
46.40	FOUNDATION EXP GL CC 9503	A	-144,286	OTHER ADMINISTRATIVE AND GENERAL	5.05	46.40
46.50	RECONCILIATION TO INCOME STMT VARI	B	-5,177	OTHER ADMINISTRATIVE AND GENERAL	5.05	46.50
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,663,123			50



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
DESCRIPTION(1)		BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	

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

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



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

WORKSHEET A-8-1

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12							5

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

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
				NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS AGGREGATE	1,010,265	1,010,265						1
2	50	OPERATING ROOM AGGREGATE	104,344	104,344						2
3	53	ANESTHESIOLOGY AGGREGATE	723,916	723,916						3
4	60	LABORATORY AGGREGATE	2,082	2,082						4
6	66	PHYSICAL THERAPY AGGREGATE	100,000	100,000						6
7	69.01	CARDIOPULMONARY AGGREGATE	183,000	183,000						7
8	91	EMERGENCY AGGREGATE	1,205,842	1,205,842						8
200		TOTAL	3,329,449	3,329,449						200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS AGGREGATE							1,010,265	1
2	50	OPERATING ROOM AGGREGATE							104,344	2
3	53	ANESTHESIOLOGY AGGREGATE							723,916	3
4	60	LABORATORY AGGREGATE							2,082	4
6	66	PHYSICAL THERAPY AGGREGATE							100,000	6
7	69.01	CARDIOPULMONARY AGGREGATE							183,000	7
8	91	EMERGENCY AGGREGATE							1,205,842	8
200		TOTAL							3,329,449	200



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,423,145	1,423,145					1
2	CAP REL COSTS-MVBLE EQUIP	4,880		4,880				2
4	EMPLOYEE BENEFITS DEPARTMENT	4,022,200	11,074	12	4,033,286			4
5.01	NONPATIENT TELEPHONES	629,055			13,862	642,917		5.01
5.02	DATA PROCESSING	895,526	6,947	1,546	40,666	70,780	1,015,465	5.02
5.03	PURCHASING RECEIVING AND STORES	723,535	20,267	6	94,282	17,695	27,821	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	759,300		63	117,362	33,424	90,418	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	5,679,027	406,577	120	568,511	184,815	326,898	5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,997,281	25,031	33	101,044	25,559	13,910	7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	1,145,034	12,369	32	110,188	3,932		9
10	DIETARY	822,897	41,788	57	75,229	19,661	13,910	10
11	CAFETERIA	256,595			30,889			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,303,480		37	210,188	7,864		13
14	CENTRAL SERVICES & SUPPLY	103,358	25,156	42	16,383		6,955	14
15	PHARMACY	1,068,846	7,188		81,292	17,695	27,821	15
16	MEDICAL RECORDS & LIBRARY	1,180,386	16,485	67	76,161	29,492	76,508	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	6,119,480	370,765	1,248	1,047,381	53,085	187,791	30
31	INTENSIVE CARE UNIT	1,544,706	29,252	123	262,137	3,932	6,955	31
43	NURSERY	388,985	34,371	28	65,361			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	528,036	76,138	437	63,064	55,051	13,910	50
51	RECOVERY ROOM	109,304	6,937	73	17,945			51
52	DELIVERY ROOM & LABOR ROOM	337,910	43,313	53	60,986			52
53	ANESTHESIOLOGY	25,542		84				53
54	RADIOLOGY-DIAGNOSTIC	2,293,098	45,236	599	212,456	31,458		54
60	LABORATORY	1,801,823	34,475		156,501	41,288	118,239	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	210,327						63
66	PHYSICAL THERAPY	159,108		41	7,357	17,695		66
69.01	CARDIOPULMONARY	1,242,086	11,617	99	155,960	21,627	55,642	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	799,352						71
72	IMPL. DEV. CHARGED TO PATIENTS	67,638						72
73	DRUGS CHARGED TO PATIENTS	775,338						73
74	RENAL DIALYSIS	241,554						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	36,431			4,122	1,966		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	2,667,285	156,705	80	423,729		48,687	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	41,362,548	1,381,691	4,880	4,013,056	637,019	1,015,465	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,868	3,636		1,144	5,898		190
192	PHYSICIANS' PRIVATE OFFICES	119,676	37,818		19,086			192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	41,493,092	1,423,145	4,880	4,033,286	642,917	1,015,465	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORE 5.03	CASHIERING /ACCOUNTS RECEIVABLE 5.04	SUBTOTAL (cols.0-4) 4A	OTHER ADMINISTRATIVE AND GENER 5.05	OPERATION OF PLANT 7	HOUSE-KEEPING 9	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES	883,606						5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE		1,000,567					5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL			7,165,948	7,165,948			5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT			2,162,858	451,507	2,614,365		7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING			1,271,555	265,443	33,924	1,570,922	9
10	DIETARY			973,542	203,232	114,607	27,128	10
11	CAFETERIA			287,484	60,014		27,128	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			1,521,569	317,635		13,564	13
14	CENTRAL SERVICES & SUPPLY			151,894	31,709	68,994	32,941	14
15	PHARMACY			1,202,842	251,099	19,712	13,564	15
16	MEDICAL RECORDS & LIBRARY			1,379,099	287,894	45,213	23,253	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	242,437	274,500	8,296,687	1,731,959	1,016,853	996,772	30
31	INTENSIVE CARE UNIT	46,526	52,687	1,946,318	406,304	80,225	23,253	31
43	NURSERY	3,051	3,455	495,251	103,386	94,265	13,564	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	14,376	16,279	767,291	160,176	208,815	70,727	50
51	RECOVERY ROOM	3,963	4,488	142,710	29,791	19,025	6,782	51
52	DELIVERY ROOM & LABOR ROOM	8,619	9,761	460,642	96,161	118,790	20,346	52
53	ANESTHESIOLOGY	11,626	13,166	50,418	10,525		2,907	53
54	RADIOLOGY-DIAGNOSTIC	68,555	77,632	2,729,034	569,699	124,062	52,319	54
60	LABORATORY	87,392	98,964	2,338,682	488,212	94,551	36,817	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	8,959	10,145	229,431	47,895			63
66	PHYSICAL THERAPY	1,343	1,520	187,064	39,051		9,689	66
69.01	CARDIOPULMONARY	89,085	100,881	1,676,997	350,082	31,861	16,858	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,224	34,226	863,802	180,323			71
72	IMPL. DEV. CHARGED TO PATIENTS	1,310	1,484	70,432	14,703			72
73	DRUGS CHARGED TO PATIENTS	87,067	98,596	961,001	200,614		2,907	73
74	RENAL DIALYSIS	5,481	6,206	253,241	52,865			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	876	991	44,386	9,266			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	172,716	195,586	3,664,788	765,043	429,777	155,019	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	883,606	1,000,567	41,294,966	7,124,588	2,500,674	1,545,538	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			21,546	4,498	9,971		190
192	PHYSICIANS' PRIVATE OFFICES			176,580	36,862	103,720	25,384	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	883,606	1,000,567	41,493,092	7,165,948	2,614,365	1,570,922	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY	1,318,509						10
11	CAFETERIA		374,626					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		20,205	1,872,973				13
14	CENTRAL SERVICES & SUPPLY		3,887		289,425			14
15	PHARMACY		12,641			1,499,858		15
16	MEDICAL RECORDS & LIBRARY		14,264				1,749,723	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	1,220,341	128,255	1,004,214	3,958	4,150	480,097	30
31	INTENSIVE CARE UNIT	98,168	24,863	194,674	1,112		92,129	31
43	NURSERY		6,464	50,615	954		6,041	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		15,533	121,620	6,437		28,466	50
51	RECOVERY ROOM		4,397	34,427	108		7,848	51
52	DELIVERY ROOM & LABOR ROOM		7,852	61,476	709		17,068	52
53	ANESTHESIOLOGY				329		23,022	53
54	RADIOLOGY-DIAGNOSTIC		32,322		1,227	80,245	135,751	54
60	LABORATORY		27,821				173,052	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.						17,741	63
66	PHYSICAL THERAPY		249				2,659	66
69.01	CARDIOPULMONARY		23,489		2,949	155	176,404	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				264,635		59,849	71
72	IMPL. DEV. CHARGED TO PATIENTS				1,513		2,594	72
73	DRUGS CHARGED TO PATIENTS					1,415,308	172,407	73
74	RENAL DIALYSIS				344		10,852	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		249		126		1,734	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		51,847	405,947	4,673		342,009	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,318,509	374,338	1,872,973	289,074	1,499,858	1,749,723	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		288					190
192	PHYSICIANS' PRIVATE OFFICES				351			192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,318,509	374,626	1,872,973	289,425	1,499,858	1,749,723	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		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
5.01	NONPATIENT TELEPHONES						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING RECEIVING AND STORES						5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	14,883,286		14,883,286			30
31	INTENSIVE CARE UNIT	2,867,046		2,867,046			31
43	NURSERY	770,540		770,540			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,379,065		1,379,065			50
51	RECOVERY ROOM	245,088		245,088			51
52	DELIVERY ROOM & LABOR ROOM	783,044		783,044			52
53	ANESTHESIOLOGY	87,201		87,201			53
54	RADIOLOGY-DIAGNOSTIC	3,724,659		3,724,659			54
60	LABORATORY	3,159,135		3,159,135			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	295,067		295,067			63
66	PHYSICAL THERAPY	238,712		238,712			66
69.01	CARDIOPULMONARY	2,278,795		2,278,795			69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,368,609		1,368,609			71
72	IMPL. DEV. CHARGED TO PATIENTS	89,242		89,242			72
73	DRUGS CHARGED TO PATIENTS	2,752,237		2,752,237			73
74	RENAL DIALYSIS	317,302		317,302			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	55,761		55,761			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	5,819,103		5,819,103			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	23-HR OBSERVATION						92.01
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	41,113,892		41,113,892			118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,303		36,303			190
192	PHYSICIANS' PRIVATE OFFICES	342,897		342,897			192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	41,493,092		41,493,092			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 MOVEABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		11,074	12	11,086	11,086		4
5.01	NONPATIENT TELEPHONES					38	38	5.01
5.02	DATA PROCESSING		6,947	1,546	8,493	112	4	5.02
5.03	PURCHASING RECEIVING AND STORES		20,267	6	20,273	259	1	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE			63	63	323	2	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL		406,577	120	406,697	1,564	13	5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		25,031	33	25,064	278	2	7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING		12,369	32	12,401	303		9
10	DIETARY		41,788	57	41,845	207	1	10
11	CAFETERIA					85		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			37	37	578		13
14	CENTRAL SERVICES & SUPPLY		25,156	42	25,198	45		14
15	PHARMACY		7,188		7,188	224	1	15
16	MEDICAL RECORDS & LIBRARY		16,485	67	16,552	210	2	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		370,765	1,248	372,013	2,872	3	30
31	INTENSIVE CARE UNIT		29,252	123	29,375	721		31
43	NURSERY		34,371	28	34,399	180		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		76,138	437	76,575	173	3	50
51	RECOVERY ROOM		6,937	73	7,010	49		51
52	DELIVERY ROOM & LABOR ROOM		43,313	53	43,366	168		52
53	ANESTHESIOLOGY			84	84			53
54	RADIOLOGY-DIAGNOSTIC		45,236	599	45,835	584	2	54
60	LABORATORY		34,475		34,475	431	2	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
66	PHYSICAL THERAPY			41	41	20	1	66
69.01	CARDIOPULMONARY		11,617	99	11,716	429	1	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY					11		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		156,705	80	156,785	1,166		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		1,381,691	4,880	1,386,571	11,030	38	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,636		3,636	3		190
192	PHYSICIANS' PRIVATE OFFICES		37,818		37,818	53		192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		1,423,145	4,880	1,428,025	11,086	38	202



COMPU-MAX

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DATA PROCES- SSING	PURCHASING RECEIVING AND STORE	CASHIERING /ACCOUNTS RECEIVABLE	OTHER ADMI- NISTRATIVE AND GENER	OPERATION OF PLANT	HOUSE- KEEPING	
		5.02	5.03	5.04	5.05	7	9	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING	8,609						5.02
5.03	PURCHASING RECEIVING AND STORES	236	20,769					5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	767		1,155				5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	2,770			411,044			5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	118			25,898	51,360		7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING				15,226	666	28,596	9
10	DIETARY	118			11,657	2,251	494	10
11	CAFETERIA				3,442		494	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION				18,219		247	13
14	CENTRAL SERVICES & SUPPLY	59			1,819	1,355	600	14
15	PHARMACY	236			14,403	387	247	15
16	MEDICAL RECORDS & LIBRARY	649			16,513	888	423	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	1,592	5,675	360	99,358	19,978	18,146	30
31	INTENSIVE CARE UNIT	59	1,095	58	23,305	1,576	423	31
43	NURSERY		72	4	5,930	1,852	247	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	118	338	18	9,188	4,102	1,287	50
51	RECOVERY ROOM		93	5	1,709	374	123	51
52	DELIVERY ROOM & LABOR ROOM		203	11	5,516	2,334	370	52
53	ANESTHESIOLOGY		274	14	604		53	53
54	RADIOLOGY-DIAGNOSTIC		1,614	85	32,677	2,437	952	54
60	LABORATORY	1,002	2,057	108	28,003	1,857	670	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		211	11	2,747			63
66	PHYSICAL THERAPY		32	2	2,240		176	66
69.01	CARDIOPULMONARY	472	2,097	110	20,080	626	307	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		711	37	10,343			71
72	IMPL. DEV. CHARGED TO PATIENTS		31	2	843			72
73	DRUGS CHARGED TO PATIENTS		2,050	108	11,507		53	73
74	RENAL DIALYSIS		129	7	3,032			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		21	1	531			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	413	4,066	214	43,882	8,443	2,822	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	8,609	20,769	1,155	408,672	49,126	28,134	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				258	196		190
192	PHYSICIANS' PRIVATE OFFICES				2,114	2,038	462	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	8,609	20,769	1,155	411,044	51,360	28,596	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY	56,573						10
11	CAFETERIA		4,021					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		217	19,298				13
14	CENTRAL SERVICES & SUPPLY		42		29,118			14
15	PHARMACY		136			22,822		15
16	MEDICAL RECORDS & LIBRARY		153				35,390	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	52,361	1,376	10,346	398	63	9,673	30
31	INTENSIVE CARE UNIT	4,212	267	2,006	112		1,866	31
43	NURSERY		69	522	96		122	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		167	1,253	648		577	50
51	RECOVERY ROOM		47	355	11		159	51
52	DELIVERY ROOM & LABOR ROOM		84	633	71		346	52
53	ANESTHESIOLOGY				33		466	53
54	RADIOLOGY-DIAGNOSTIC		347		123	1,221	2,750	54
60	LABORATORY		299				3,505	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.						359	63
66	PHYSICAL THERAPY		3				54	66
69.01	CARDIOPULMONARY		252		297	2	3,573	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				26,624		1,212	71
72	IMPL. DEV. CHARGED TO PATIENTS				152		53	72
73	DRUGS CHARGED TO PATIENTS					21,536	3,492	73
74	RENAL DIALYSIS				35		220	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY		3		13		35	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		556	4,183	470		6,928	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	56,573	4,018	19,298	29,083	22,822	35,390	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3					190
192	PHYSICIANS' PRIVATE OFFICES				35			192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	56,573	4,021	19,298	29,118	22,822	35,390	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		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
5.01	NONPATIENT TELEPHONES						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING RECEIVING AND STORES						5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	594,214		594,214			30
31	INTENSIVE CARE UNIT	65,075		65,075			31
43	NURSERY	43,493		43,493			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	94,447		94,447			50
51	RECOVERY ROOM	9,935		9,935			51
52	DELIVERY ROOM & LABOR ROOM	53,102		53,102			52
53	ANESTHESIOLOGY	1,528		1,528			53
54	RADIOLOGY-DIAGNOSTIC	88,627		88,627			54
60	LABORATORY	72,409		72,409			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	3,328		3,328			63
66	PHYSICAL THERAPY	2,569		2,569			66
69.01	CARDIOPULMONARY	39,962		39,962			69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,927		38,927			71
72	IMPL. DEV. CHARGED TO PATIENTS	1,081		1,081			72
73	DRUGS CHARGED TO PATIENTS	38,746		38,746			73
74	RENAL DIALYSIS	3,423		3,423			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	615		615			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	229,928		229,928			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	23-HR OBSERVATION						92.01
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	1,381,409		1,381,409			118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,096		4,096			190
192	PHYSICIANS' PRIVATE OFFICES	42,520		42,520			192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	1,428,025		1,428,025			202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NONPATIENT TELEPHONE S PHONES	DATA PROCESSING MACH	PURCHASING RECEIVING AND STORE GROSS REVENUE	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	136,225						1
2	CAP REL COSTS-MVBLE EQUIP		101,982					2
4	EMPLOYEE BENEFITS DEPARTMENT	1,060	252	23,308,589				4
5.01	NONPATIENT TELEPHONES			80,107	327			5.01
5.02	DATA PROCESSING	665	32,286	235,013	36	146		5.02
5.03	PURCHASING RECEIVING AND STORES	1,940	133	544,861	9	4	136,844,439	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE		1,319	678,241	17	13		5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	38,918	2,502	3,285,448	94	47		5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,396	694	583,939	13	2		7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	1,184	664	636,783	2			9
10	DIETARY	4,000	1,188	434,753	10	2		10
11	CAFETERIA			178,509				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		775	1,214,685	4			13
14	CENTRAL SERVICES & SUPPLY	2,408	871	94,678		1		14
15	PHARMACY	688		469,790	9	4		15
16	MEDICAL RECORDS & LIBRARY	1,578	1,399	440,138	15	11		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	35,490	26,083	6,052,909	27	27	37,546,249	30
31	INTENSIVE CARE UNIT	2,800	2,575	1,514,900	2	1	7,205,496	31
43	NURSERY	3,290	585	377,724			472,508	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	7,288	9,141	364,447	28	2	2,226,376	50
51	RECOVERY ROOM	664	1,534	103,704			613,788	51
52	DELIVERY ROOM & LABOR ROOM	4,146	1,114	352,442			1,334,882	52
53	ANESTHESIOLOGY		1,749				1,800,564	53
54	RADIOLOGY-DIAGNOSTIC	4,330	12,509	1,227,792	16		10,617,132	54
60	LABORATORY	3,300		904,429	21	17	13,534,515	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.						1,387,497	63
66	PHYSICAL THERAPY		863	42,516	9		207,927	66
69.01	CARDIOPULMONARY	1,112	2,066	901,302	11	8	13,796,641	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						4,680,804	71
72	IMPL. DEV. CHARGED TO PATIENTS						202,915	72
73	DRUGS CHARGED TO PATIENTS		10				13,484,083	73
74	RENAL DIALYSIS						848,771	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY			23,822	1		135,595	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	15,000	1,670	2,448,746		7	26,748,696	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	132,257	101,982	23,191,678	324	146	136,844,439	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	348		6,614	3			190
192	PHYSICIANS' PRIVATE OFFICES	3,620		110,297				192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,423,145	4,880	4,033,286	642,917	1,015,465	883,606	202
203	UNIT COST MULT-WS B PT I	10.447018	0.047852	0.173039	1,966.107034	6,955.239726	0.006457	203
204	COST TO BE ALLOC PER B PT II			11,086	38	8,609	20,769	204
205	UNIT COST MULT-WS B PT II			0.000476	0.116208	58.965753	0.000152	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON-CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	
		5.04	5A.05	5.05	7	9	10	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	136,844,439						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL		-7,165,948	34,327,144				5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT			2,162,858	91,246			7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING			1,271,555	1,184	8,107		9
10	DIETARY			973,542	4,000	140	49,346	10
11	CAFETERIA			287,484		140		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			1,521,569		70		13
14	CENTRAL SERVICES & SUPPLY			151,894	2,408	170		14
15	PHARMACY			1,202,842	688	70		15
16	MEDICAL RECORDS & LIBRARY			1,379,099	1,578	120		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	37,546,249		8,296,687	35,490	5,144	45,672	30
31	INTENSIVE CARE UNIT	7,205,496		1,946,318	2,800	120	3,674	31
43	NURSERY	472,508		495,251	3,290	70		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,226,376		767,291	7,288	365		50
51	RECOVERY ROOM	613,788		142,710	664	35		51
52	DELIVERY ROOM & LABOR ROOM	1,334,882		460,642	4,146	105		52
53	ANESTHESIOLOGY	1,800,564		50,418		15		53
54	RADIOLOGY-DIAGNOSTIC	10,617,132		2,729,034	4,330	270		54
60	LABORATORY	13,534,515		2,338,682	3,300	190		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,387,497		229,431				63
66	PHYSICAL THERAPY	207,927		187,064		50		66
69.01	CARDIOPULMONARY	13,796,641		1,676,997	1,112	87		69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,680,804		863,802				71
72	IMPL. DEV. CHARGED TO PATIENTS	202,915		70,432				72
73	DRUGS CHARGED TO PATIENTS	13,484,083		961,001		15		73
74	RENAL DIALYSIS	848,771		253,241				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	135,595		44,386				76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	26,748,696		3,664,788	15,000	800		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	136,844,439	-7,165,948	34,129,018	87,278	7,976	49,346	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			21,546	348			190
192	PHYSICIANS' PRIVATE OFFICES			176,580	3,620	131		192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,000,567		7,165,948	2,614,365	1,570,922	1,318,509	202
203	UNIT COST MULT-WS B PT I	0.007312		0.208755	28.651831	193.773529	26.719673	203
204	COST TO BE ALLOC PER B PT II	1,155		411,044	51,360	28,596	56,573	204
205	UNIT COST MULT-WS B PT II	0.000008		0.011974	0.562874	3.527322	1.146456	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINISTRATION DIRECT NRSNG	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE		
	MEALS SERVED					11	13
	11	13	14	15	16		

GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONES						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING RECEIVING AND STORES						5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	28,628					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,544	18,280				13
14	CENTRAL SERVICES & SUPPLY	297		5,830,391			14
15	PHARMACY	966			820,315		15
16	MEDICAL RECORDS & LIBRARY	1,090				136,844,439	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	9,801	9,801	79,741	2,270	37,546,249	30
31	INTENSIVE CARE UNIT	1,900	1,900	22,406		7,205,496	31
43	NURSERY	494	494	19,223		472,508	43
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,187	1,187	129,662		2,226,376	50
51	RECOVERY ROOM	336	336	2,176		613,788	51
52	DELIVERY ROOM & LABOR ROOM	600	600	14,284		1,334,882	52
53	ANESTHESIOLOGY			6,635		1,800,564	53
54	RADIOLOGY-DIAGNOSTIC	2,470		24,723	43,888	10,617,132	54
60	LABORATORY	2,126				13,534,515	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.					1,387,497	63
66	PHYSICAL THERAPY	19				207,927	66
69.01	CARDIOPULMONARY	1,795		59,401	85	13,796,641	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			5,330,986		4,680,804	71
72	IMPL. DEV. CHARGED TO PATIENTS			30,484		202,915	72
73	DRUGS CHARGED TO PATIENTS				774,072	13,484,083	73
74	RENAL DIALYSIS			6,928		848,771	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	19		2,538		135,595	76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	3,962	3,962	94,130		26,748,696	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	28,606	18,280	5,823,317	820,315	136,844,439	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22					190
192	PHYSICIANS' PRIVATE OFFICES			7,074			192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	374,626	1,872,973	289,425	1,499,858	1,749,723	202
203	UNIT COST MULT-WS B PT I	13.086000	102.460230	0.049641	1.828393	0.012786	203
204	COST TO BE ALLOC PER B PT II	4,021	19,298	29,118	22,822	35,390	204
205	UNIT COST MULT-WS B PT II	0.140457	1.055689	0.004994	0.027821	0.000259	205



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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		PART	LINE NO.		
	1	2	3	4	



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS			
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	14,883,286		14,883,286		14,883,286	30
31	INTENSIVE CARE UNIT	2,867,046		2,867,046		2,867,046	31
43	NURSERY	770,540		770,540		770,540	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,379,065		1,379,065		1,379,065	50
51	RECOVERY ROOM	245,088		245,088		245,088	51
52	DELIVERY ROOM & LABOR ROOM	783,044		783,044		783,044	52
53	ANESTHESIOLOGY	87,201		87,201		87,201	53
54	RADIOLOGY-DIAGNOSTIC	3,724,659		3,724,659		3,724,659	54
60	LABORATORY	3,159,135		3,159,135		3,159,135	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	295,067		295,067		295,067	63
66	PHYSICAL THERAPY	238,712		238,712		238,712	66
69.01	CARDIOPULMONARY	2,278,795		2,278,795		2,278,795	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,368,609		1,368,609		1,368,609	71
72	IMPL. DEV. CHARGED TO PATIENTS	89,242		89,242		89,242	72
73	DRUGS CHARGED TO PATIENTS	2,752,237		2,752,237		2,752,237	73
74	RENAL DIALYSIS	317,302		317,302		317,302	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	55,761		55,761		55,761	76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	5,819,103		5,819,103		5,819,103	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	237,616		237,616		237,616	92
92.01	23-HR OBSERVATION						92.01
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	41,351,508		41,351,508		41,351,508	200
201	LESS OBSERVATION BEDS	237,616		237,616		237,616	201
202	TOTAL (SEE INSTRUCTIONS)	41,113,892		41,113,892		41,113,892	202



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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				
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	36,950,639		36,950,639				30
31	INTENSIVE CARE UNIT	7,205,496		7,205,496				31
43	NURSERY	472,508		472,508				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,475,167	751,209	2,226,376	0.619421	0.619421	0.619421	50
51	RECOVERY ROOM	248,204	365,584	613,788	0.399304	0.399304	0.399304	51
52	DELIVERY ROOM & LABOR ROOM	1,005,042	329,840	1,334,882	0.586602	0.586602	0.586602	52
53	ANESTHESIOLOGY	1,298,209	502,355	1,800,564	0.048430	0.048430	0.048430	53
54	RADIOLOGY-DIAGNOSTIC	3,234,741	7,382,391	10,617,132	0.350816	0.350816	0.350816	54
60	LABORATORY	6,716,194	6,818,321	13,534,515	0.233413	0.233413	0.233413	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,092,870	294,627	1,387,497	0.212661	0.212661	0.212661	63
66	PHYSICAL THERAPY	163,498	44,429	207,927	1.148057	1.148057	1.148057	66
69.01	CARDIOPULMONARY	11,089,027	2,707,614	13,796,641	0.165170	0.165170	0.165170	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,404,812	1,275,992	4,680,804	0.292388	0.292388	0.292388	71
72	IMPL. DEV. CHARGED TO PATIENTS	152,915	50,000	202,915	0.439800	0.439800	0.439800	72
73	DRUGS CHARGED TO PATIENTS	10,797,286	2,686,797	13,484,083	0.204110	0.204110	0.204110	73
74	RENAL DIALYSIS	799,841	48,930	848,771	0.373837	0.373837	0.373837	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	780	134,815	135,595	0.411232	0.411232	0.411232	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	5,419,367	21,329,329	26,748,696	0.217547	0.217547	0.217547	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		595,610	595,610	0.398946	0.398946	0.398946	92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	91,526,596	45,317,843	136,844,439				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	91,526,596	45,317,843	136,844,439				202



COMPU-MAX

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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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	8	9	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	594,214		594,214	15,471	38.41	4,251	163,281	30
31	INTENSIVE CARE UNIT	65,075		65,075	2,449	26.57	933	24,790	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	43,493		43,493	665	65.40			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	702,782		702,782	18,585		5,184	188,071	200

(A) Worksheet A line numbers



COMPU-MAX

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0068

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] 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	94,447	2,226,376	0.042422	193,088	8,191	50
51	RECOVERY ROOM	9,935	613,788	0.016186	82,403	1,334	51
52	DELIVERY ROOM & LABOR ROOM	53,102	1,334,882	0.039780	5,462	217	52
53	ANESTHESIOLOGY	1,528	1,800,564	0.000849	205,778	175	53
54	RADIOLOGY-DIAGNOSTIC	88,627	10,617,132	0.008348	1,245,248	10,395	54
60	LABORATORY	72,409	13,534,515	0.005350	2,306,661	12,341	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	3,328	1,387,497	0.002399	307,770	738	63
66	PHYSICAL THERAPY	2,569	207,927	0.012355	64,258	794	66
69.01	CARDIOPULMONARY	39,962	13,796,641	0.002897	2,164,171	6,270	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,927	4,680,804	0.008316	2,969,235	24,692	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,081	202,915	0.005327	18,701	100	72
73	DRUGS CHARGED TO PATIENTS	38,746	13,484,083	0.002873	3,476,810	9,989	73
74	RENAL DIALYSIS	3,423	848,771	0.004033	318,744	1,285	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	615	135,595	0.004536			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	229,928	26,748,696	0.008596	1,496,117	12,861	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	9,487	595,610	0.015928			92
92.01	23-HR OBSERVATION						92.01
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	688,114	92,215,796		14,854,446	89,382	200

(A) Worksheet A line numbers



COMPU-MAX

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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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

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)					30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers



COMPU-MAX

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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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

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
		6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	15,471		4,251		30
31	INTENSIVE CARE UNIT	2,449		933		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	665				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	18,585		5,184		200

(A) Worksheet A line numbers



COMPU-MAX

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0068

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
66	PHYSICAL THERAPY							66
69.01	CARDIOPULMONARY							69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0068

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,226,376			193,088		43,891	50
51	RECOVERY ROOM	613,788			82,403		22,057	51
52	DELIVERY ROOM & LABOR ROOM	1,334,882			5,462		1,178	52
53	ANESTHESIOLOGY	1,800,564			205,778		48,918	53
54	RADIOLOGY-DIAGNOSTIC	10,617,132			1,245,248		804,087	54
60	LABORATORY	13,534,515			2,306,661		205,301	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,387,497			307,770		18,673	63
66	PHYSICAL THERAPY	207,927			64,258		594	66
69.01	CARDIOPULMONARY	13,796,641			2,164,171		273,198	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,680,804			2,969,235		852,719	71
72	IMPL. DEV. CHARGED TO PATIENTS	202,915			18,701		2,041	72
73	DRUGS CHARGED TO PATIENTS	13,484,083			3,476,810		226,929	73
74	RENAL DIALYSIS	848,771			318,744			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	135,595					4,244	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	26,748,696			1,496,117		1,770,965	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	595,610					39,468	92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	92,215,796			14,854,446		4,314,263	200

(A) Worksheet A line numbers



COMPU-MAX

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0068

WORKSHEET D
PART V

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

(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	0.619421	43,891			27,187		50
51	RECOVERY ROOM	0.399304	22,057			8,807		51
52	DELIVERY ROOM & LABOR ROOM	0.586602	1,178			691		52
53	ANESTHESIOLOGY	0.048430	48,918			2,369		53
54	RADIOLOGY-DIAGNOSTIC	0.350816	804,087			282,087		54
60	LABORATORY	0.233413	205,301			47,920		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.212661	18,673			3,971		63
66	PHYSICAL THERAPY	1.148057	594			682		66
69.01	CARDIOPULMONARY	0.165170	273,198			45,124		69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.292388	852,719	763		249,325	223	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.439800	2,041			898		72
73	DRUGS CHARGED TO PATIENTS	0.204110	226,929			46,318		73
74	RENAL DIALYSIS	0.373837						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.411232	4,244			1,745		76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.217547	1,770,965			385,268		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.398946	39,468			15,746		92
92.01	23-HR OBSERVATION							92.01
OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		4,314,263	763		1,118,138	223	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)		4,314,263	763		1,118,138	223	202

(A) Worksheet A line numbers



COMPU-MAX

ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0068

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [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)	15,471	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	15,471	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	15,224	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	4,251	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
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)	14,883,286	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	14,883,286	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	14,883,286	37



COMPU-MAX

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0068

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					962.01	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					4,089,505	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)					4,089,505	41

		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43	INTENSIVE CARE UNIT	2,867,046	2,449	1,170.70	933	1,092,263	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					3,668,294	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					8,850,062	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					188,071	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					89,382	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					277,453	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					8,572,609	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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0068

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR 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)					247	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					962.01	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					237,616	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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	594,214	14,883,286	0.039925	237,616	9,487	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0068

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/MR 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		10,657,102		30
31	INTENSIVE CARE UNIT		2,743,020		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.619421	193,088	119,603	50
51	RECOVERY ROOM	0.399304	82,403	32,904	51
52	DELIVERY ROOM & LABOR ROOM	0.586602	5,462	3,204	52
53	ANESTHESIOLOGY	0.048430	205,778	9,966	53
54	RADIOLOGY-DIAGNOSTIC	0.350816	1,245,248	436,853	54
60	LABORATORY	0.233413	2,306,661	538,405	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.212661	307,770	65,451	63
66	PHYSICAL THERAPY	1.148057	64,258	73,772	66
69.01	CARDIOPULMONARY	0.165170	2,164,171	357,456	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.292388	2,969,235	868,169	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.439800	18,701	8,225	72
73	DRUGS CHARGED TO PATIENTS	0.204110	3,476,810	709,652	73
74	RENAL DIALYSIS	0.373837	318,744	119,158	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.411232			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.217547	1,496,117	325,476	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.398946			92
92.01	23-HR OBSERVATION				92.01
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		14,854,446	3,668,294	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		14,854,446		202

(A) Worksheet A line numbers



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK

APPLICABLE BOX:

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, 2013 (see instructions)	2,982,798			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	2,818,767			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	236,331			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	133.32			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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 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 LINES (8, 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 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
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
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 (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.2345			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.5542			31
32	SUM OF LINES 30 AND 31	0.7887			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.5428			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	2,001,570			34
		PRIOR TO	ON OR AFTER		
		OCTOBER 1	OCTOBER 1		
	UNCOMPENSATED CARE ADJUSTMENT				
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
35.01	FACTOR 3 (see instructions)		0.000353777		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		3,200,401		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		1,595,816		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	1,595,816			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I 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
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 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)				46
47	SUBTOTAL (see instructions)	9,635,282			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	9,635,282			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	543,356			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	10,178,638			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	10,178,638			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	697,614			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	94,624			63
64	ALLOWABLE BAD DEBTS (see instructions)	168,618			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	109,602			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	168,618			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	9,496,002			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-44,216			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-53,507			70.94
71	AMOUNT DUE PROVIDER (see instructions)	9,398,279			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	187,966			71.01
72	INTERIM PAYMENTS	10,804,031			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	-1,593,718			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	178,106			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0068

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)	223			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	1,118,138			2
3	PPS PAYMENTS	848,859			3
4	OUTLIER PAYMENT (see instructions)	9,319			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	223			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	763			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	763			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)	763			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	540			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)	223			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	858,178			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	153			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	213,177			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	645,071			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)	645,071			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	645,071			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)	166			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	108			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	166			36
37	SUBTOTAL (see instructions)	645,179			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	645,179			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	12,904			40.01
41	INTERIM PAYMENTS	632,159			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	116			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0068

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		12,295,662		641,207	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)					
	PROGRAM					3.01
	TO					3.02
	PROVIDER					3.03
						3.04
						3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
		03/27/2014	1,491,631	11/12/2013	9,048	3.51
	PROVIDER					3.52
	TO					3.53
	PROGRAM					3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-1,491,631		-9,048	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)		10,804,031		632,159	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)					
	PROGRAM					5.01
	TO					5.02
	PROVIDER					5.03
						5.04
						5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
	PROVIDER					5.52
	TO					5.53
	PROGRAM					5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)				13,020	6.01
			-1,405,752			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		9,398,279		645,179	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL CAH
 APPLICABLE BOX:

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 FROM WKST S-3, PART I, COLUMN 15, LINE 14	3,482	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	5,184	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	17,673	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	136,844,439	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	3,537,975	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)		8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32



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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	234,737				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	112,884,751				4
5	OTHER RECEIVABLES	912,741				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-112,171,112				6
7	INVENTORY	280,941				7
8	PREPAID EXPENSES	20,626				8
9	OTHER CURRENT ASSETS	1,295,932				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	3,458,616				11
FIXED ASSETS						
12	LAND	933,453				12
13	LAND IMPROVEMENTS	495,806				13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	33,757,264				15
16	ACCUMULATED DEPRECIATION	-27,983,772				16
17	LEASEHOLD IMPROVEMENTS	779,926				17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	18,783,220				23
24	ACCUMULATED DEPRECIATION					24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	26,765,897				30
OTHER ASSETS						
31	INVESTMENTS	605,090				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS					34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	605,090				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	30,829,603				36
LIABILITIES AND FUND BALANCES						
	(Omit Cents)	1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	8,631,722				37
38	SALARIES, WAGES & FEES PAYABLE	874,403				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	2,835,815				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	6,043,199				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	18,385,139				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	11,269,446				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	11,269,446				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	29,654,585				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	1,175,018				52
53	SPECIFIC PURPOSE FUND BALANCE					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 52-58)	1,175,018				59



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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	30,829,603				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		1,761,342			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-586,324			2
3	TOTAL (sum of line 1 and line 2)		1,175,018			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		1,175,018			11
12	DEDUCTIONS (debit adjustments)					12
13	NET EQUITY ADJUSTMENTS					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		1,175,018			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)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	NET EQUITY ADJUSTMENTS					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



ROSELAND COMMUNITY HOSPITAL Provider CCN: 14-0068	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/26/2014 Run Time: 16:01 Version: 2014.03
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	37,240,765		37,240,765	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				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)	37,240,765		37,240,765	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	7,274,969		7,274,969	11
12	CORONARY CARE UNIT				12
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)	7,274,969		7,274,969	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	44,515,734		44,515,734	17
18	ANCILLARY SERVICES	46,571,168		46,571,168	18
19	OUTPATIENT SERVICES		45,858,816	45,858,816	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	91,086,902	45,858,816	136,945,718	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		45,156,215	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		45,156,215	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	136,945,718	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	113,837,175	2
3	NET PATIENT REVENUES (line 1 minus line 2)	23,108,543	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	45,156,215	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-22,047,672	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	422	6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	83,750	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		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	143	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	3,293	21
22	RENTAL OF HOSPITAL SPACE	44,634	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER OPERATING REVENUE)	24,101	24
24.01	OTHER (CHAP/HARDSHIP PAYMENTS)	11,498,009	24.01
24.02	OTHER (PROVIDER TAX REVENUE - NET)	6,553,468	24.02
24.03	OTHER (ENHANCED PAYMENTS)	2,314,078	24.03
24.04	OTHER (GRANT INCOME)	939,450	24.04
25	TOTAL OTHER INCOME (sum of lines 6-24)	21,461,348	25
26	TOTAL (line 5 plus line 25)	-586,324	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-586,324	29



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0068

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	462,437	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	825	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)	48.42	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.2345	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.5542	8
9	SUM OF LINES 7 AND 8	0.7887	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1732	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	80,094	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	543,356	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	EXTRAORDINARY 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
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL							5.05
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							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
66	PHYSICAL THERAPY							66
69.01	CARDIOPULMONARY							69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
92.01	23-HR OBSERVATION							92.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202