



COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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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:	TIME:
	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 COMMUNITY HOSPITAL (15-0125) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(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		325,141	-15,962	-428,569		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		70,369	136			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		395,510	-15,826	-428,569		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: 901 MACARTHUR BOULEVARD	P.O. Box:							1
2	City: MUNSTER	State: IN	ZIP Code: 46321	County: LAKE					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	COMMUNITY HOSPITAL	15-0125	23844	1	10/03/1973	N	P	P
4	Subprovider - IPF								4
5	Subprovider - IRF	THE REHAB CENTER AT COMMUNITY	15-T125	23844	5	06/30/1996	N	P	P
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	COMMUNITY HOME HEALTH SERVICES	15-7487	23844		01/07/1997	N	P	N
13	Separately Certified ASC								13
14	Hospital-Based Hospice								14
15	Hospital-Based Health Clinic - RHC								15
16	Hospital-Based Health Clinic - FQHC								16
17	Hospital-Based (CMHC)								17
18	Renal Dialysis								18
19	Other								19
20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013	To: 06 / 30 / 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.						3	N	23
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
		1	2	3	4	5	6		
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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.	5,231	381	792	249	7,431		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.	220	57		25	13		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					
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			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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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.	Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, 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.	N			76
Long Term Care Hospital PPS					
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.		N		80
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

		V	XIX					
Title V and XIX Services		1	2					
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90				
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91				
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92				
93	Does this facility operate an ICF/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.	Physical	Occupational	Speech	Respiratory	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.	Y						117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1						118
		Premiums	Paid Losses	Self Insurance				
118.01	List amounts of malpractice premiums and paid losses:	1						118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N						118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N				120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y						121
Transplant Center Information								
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N						125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.							134



COMPU-MAX

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WORKSHEET S-2
PART I

All Providers								
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)				1	2	140	
					Y	158054		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141	Name: COMMUNITY FOUNDATION OF NW IN,		Contractor's Name: NGS		Contractor's Number: 00450		141	
142	Street: 10100 DON POWERS DRIVE		P.O. Box:				142	
143	City: MUNSTER		State: IN		ZIP Code: 46321		143	
144	Are provider based physicians' costs included in Worksheet A?				Y		144	
145	If costs for renal services are claimed on 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.				Y		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	
							3	
155	Hospital				N	N	N	155
156	Subprovider - IPF				N	N		156
157	Subprovider - IRF				N	N	N	157
158	Subprovider - Other							158
159	SNF				N	N		159
160	HHA				N	N	N	160
161	CMHC					N		161
161.10	CORF							161.10
Multicampus								
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.				N		165	
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.						166	
	Name	County	State	ZIP Code	CBSA	FTE/Campus		
	0	1	2	3	4	5		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.				Y		167	
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)						168	
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)				0.75		169	
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				10/01/2012	09/30/2013	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

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
		I	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	
		I	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 'T' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	Y			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		I	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		I	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	
				I	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		I	2	3	4
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	10/31/2013	Y	10/31/2013
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21



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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: CONNIE	LAST NAME: BIEGEL	TITLE: DIRECTOR OF REIMBURSEMENT
42	EMPLOYER: COMMUNITY HOSPITAL		
43	PHONE NUMBER: 12198366789	E-MAIL ADDRESS: CBIEGEL@COMHS.ORG	



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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	349	127,385			43,665	4,294	75,763	1
2	HMO AND OTHER (see instructions)						5,242	8,472		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER						438	38		4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		349	127,385			43,665	4,294	75,763	7
8	INTENSIVE CARE UNIT	31	34	12,410			5,752	476	9,836	8
9	CORONARY CARE UNIT	32								9
9.01	NEONATAL INTENSIVE CARE	32.01	25	9,125				447	4,697	9.01
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						308	3,694	13
14	TOTAL (see instructions)		408	148,920			49,417	5,525	93,990	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41	47	17,155			12,944	277	14,705	17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					34,058		42,925	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)		455							27
28	OBSERVATION BED DAYS								13,240	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							87	1,166	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES				
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					8,907	972	17,272	1
2	HMO AND OTHER (see instructions)					816	2,134		2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
9.01	NEONATAL INTENSIVE CARE								9.01
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		2,361.83			8,907	972	17,272	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF		72.99			1,262	31	1,434	17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY		41.73						22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		2,476.55						27
32.01	TOTAL ANCHLLARY 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	200	148,846,651		148,846,651	5,151,214.00	28.90	1
2							2
3		2,958,738		2,958,738	38,278.00	77.30	3
4							4
4.01							4.01
5		7,092,935		7,092,935	38,231.00	185.53	5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		8,344,887	42,562	8,387,449	353,289.00	23.74	10
OTHER WAGES & RELATED COSTS							
11		1,116,349		1,116,349	9,758.00	114.40	11
12							12
13		621,831		621,831	4,059.00	153.20	13
14		20,365,428		20,365,428	518,956.00	39.24	14
15							15
16							16
WAGE-RELATED COSTS							
17		40,279,018		40,279,018			17
18							18
19		2,708,858		2,708,858			19
20							20
21		720,337		720,337			21
22							22
22.01							22.01
23		1,313,399		1,313,399			23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		915,924		915,924	33,039.00	27.72	26
27		13,566,558	-34,771	13,531,787	528,888.00	25.59	27
28		3,319,815		3,319,815	23,750.00	139.78	28
29							29
30		4,757,170		4,757,170	177,291.00	26.83	30
31		106,528		106,528	7,495.00	14.21	31
32		3,248,453		3,248,453	213,811.00	15.19	32
33							33
34		3,562,860	-1,150,596	2,412,264	140,708.00	17.14	34
35							35
36			1,150,596	1,150,596	78,422.00	14.67	36
37							37
38		1,666,412		1,666,412	37,162.00	44.84	38
39			34,771	34,771	2,288.00	15.20	39
40		3,919,662		3,919,662	106,714.00	36.73	40
41		122,835		122,835	4,131.00	29.73	41
42		689,252		689,252	25,477.00	27.05	42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

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



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	2,084,915	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	13,070,049	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	250,000	6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	17,810,522	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	154,956	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	78,110	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	704,172	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	8,500,042	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	2,088,243	18
19	UNEMPLOYMENT INSURANCE	102,732	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	177,872	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	45,021,613	24

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

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

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



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

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



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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 15-7487

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: LAKE

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

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00	NUMBER OF EMPLOYEES (Full Time Equivalent)			
		STAFF	CONTRACT	TOTAL	
		1	2	3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)		1.56		1.56
5	OTHER ADMINISTRATIVE PERSONNEL		10.17		10.17
6	DIRECT NURSING SERVICE		7.15		7.15
7	NURSING SUPERVISOR				
8	PHYSICAL THERAPY SERVICE			6.50	6.50
9	PHYSICAL THERAPY SUPERVISOR				
10	OCCUPATIONAL THERAPY SERVICE			1.54	1.54
11	OCCUPATIONAL THERAPY SUPERVISOR				
12	SPEECH PATHOLOGY SERVICE		0.07		0.07
13	SPEECH PATHOLOGY SUPERVISOR				
14	MEDICAL SOCIAL SERVICE		0.01		0.01
15	MEDICAL SOCIAL SERVICE SUPERVISOR				
16	HOME HEALTH AIDE		1.73		1.73
17	HOME HEALTH AIDE SUPERVISOR				
18	PRIVATE DUTY		19.34		19.34

HOME HEALTH AGENCY - CBSA CODES

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

PPS ACTIVITY

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



COMPU-MAX

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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)		0.284287	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID		10,062,831	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID			5
6	MEDICAID CHARGES		118,683,365	6
7	MEDICAID COST (line 1 times line 6)		33,740,138	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.		23,677,307	8

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

9	NET REVENUE FROM STAND-ALONE SCHIP			9
10	STAND-ALONE SCHIP CHARGES			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		6,340	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)		23,677,307	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	22,706,684		22,706,684
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	6,455,215		6,455,215
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	146,043		146,043
23	COST OF CHARITY CARE (line 21 minus line 22)	6,309,172		6,309,172

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)		16,804,053	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		943,552	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)		15,860,501	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)		4,508,934	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)		10,818,106	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)		34,495,413	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				10,742,441	10,742,441	328,423	11,070,864	1
2	00200	CAP REL COSTS-MVBLE EQUIP				9,431,996	9,431,996	5,425,925	14,857,921	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	915,924	366,703	1,282,627	43,841,352	45,123,979	115,502	45,239,481	4
5	00500	ADMINISTRATIVE & GENERAL	13,566,558	156,446,322	170,012,880	-64,870,506	105,142,374	-47,369,275	57,773,099	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	4,757,170	7,691,203	12,448,373	869,057	13,317,430	-19,908	13,297,522	7
8	00800	LAUNDRY & LINEN SERVICE	106,528	1,161,326	1,267,854		1,267,854		1,267,854	8
9	00900	HOUSEKEEPING	3,248,453	987,008	4,235,461	-72,725	4,162,736		4,162,736	9
10	01000	DIETARY	3,562,860	2,859,859	6,422,719	-2,491,384	3,931,335	-4,047	3,927,288	10
11	01100	CAFETERIA				2,489,059	2,489,059	-2,074,567	414,492	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	1,666,412	120,635	1,787,047	-6,393	1,780,654		1,780,654	13
14	01400	CENTRAL SERVICES & SUPPLY		17,670	17,670	34,771	52,441		52,441	14
15	01500	PHARMACY	3,919,662	11,909,539	15,829,201		15,829,201	-195	15,829,006	15
16	01600	MEDICAL RECORDS & LIBRARY	122,835	135,401	258,236		258,236	-110	258,126	16
17	01700	SOCIAL SERVICE	689,252	12,360	701,612		701,612	-268	701,344	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	32,593,427	4,660,880	37,254,307	-586,922	36,667,385	-56,159	36,611,226	30
31	03100	INTENSIVE CARE UNIT	7,743,164	1,028,114	8,771,278	-119,208	8,652,070		8,652,070	31
32.01	02060	NEONATAL INTENSIVE CARE	2,799,173	304,835	3,104,008	5,808	3,109,816	-41,760	3,068,056	32.01
41	04100	SUBPROVIDER - IRF	3,640,129	1,757,419	5,397,548	-6,771	5,390,777		5,390,777	41
43	04300	NURSERY	1,258,913	252,170	1,511,083	3,936	1,515,019		1,515,019	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	24,120,520	38,548,730	62,669,250	-25,486,821	37,182,429	-12,351,370	24,831,059	50
52	05200	DELIVERY ROOM & LABOR ROOM	1,902,706	328,821	2,231,527	-48,812	2,182,715		2,182,715	52
54	05400	RADIOLOGY-DIAGNOSTIC	7,821,563	7,055,424	14,876,987	-167,160	14,709,827	-102,544	14,607,283	54
60	06000	LABORATORY	5,712,782	6,114,657	11,827,439		11,827,439	6,418	11,833,857	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	401,036	2,560,174	2,961,210		2,961,210		2,961,210	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	3,401,362	634,196	4,035,558		4,035,558	-9,753	4,025,805	65
66	06600	PHYSICAL THERAPY	4,770,111	4,250,035	9,020,146	-180,572	8,839,574	-20,600	8,818,974	66
70	07000	ELECTROENCEPHALOGRAPHY	612,275	315,784	928,059	-3,141	924,918	-44,067	880,851	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				18,270,583	18,270,583		18,270,583	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				26,275,904	26,275,904		26,275,904	72
73	07300	DRUGS CHARGED TO PATIENTS								73
76	03140	CARDIOLOGY	6,676,458	22,072,152	28,748,610	-18,087,255	10,661,355	-845,889	9,815,466	76
76.97	07697	CARDIAC REHABILITATION	432,860	15,018	447,878	-69,509	378,369	-55,644	322,725	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	1,970,165	709,700	2,679,865	-180,666	2,499,199	-149,856	2,349,343	90
91	09100	EMERGENCY	5,729,595	1,516,856	7,246,451	-58,733	7,187,718	-85,056	7,102,662	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
101	10100	HOME HEALTH AGENCY	2,184,031	1,270,428	3,454,459	-585	3,453,874	12,396	3,466,270	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	146,325,924	275,103,419	421,429,343	-472,256	420,957,087	-57,342,404	363,614,683	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
191	19100	RESEARCH	205,325	110,347	315,672	-1,532	314,140		314,140	191
192	19200	PHYSICIANS' PRIVATE OFFICES								192
194	07950	ADVERTISING				1,175,554	1,175,554		1,175,554	194
194.01	07951	FITNESS POINTE	1,595,759	1,630,881	3,226,640	-698,924	2,527,716		2,527,716	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	301,766	164,162	465,928	-2,842	463,086		463,086	194.02
194.03	07953	RETAIL PHARMACY	417,877	3,981,332	4,399,209		4,399,209		4,399,209	194.03
194.04	07954	HOSPICE								194.04
194.05	07955	RUSH RESIDENTS								194.05
200		TOTAL (sum of lines 118-199)	148,846,651	280,990,141	429,836,792		429,836,792	-57,342,404	372,494,388	200



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RECLASSIFICATIONS

WORKSHEET A-6

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



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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
CODE LETTER - I					
GRAND TOTAL (INCREASES)				1,412,373	112,147,643

(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	6	7	8	9	10	
1	OPERATING RM/CARDIOLOGY SUPPLIES	A	OPERATING ROOM	50		25,483,991		
2			CARDIOLOGY	76		18,084,725		
3			RADIOLOGY-DIAGNOSTIC	54		178,973		
4			ADULTS & PEDIATRICS	30		358,421		
5			INTENSIVE CARE UNIT	31		185,985		
6			NEONATAL INTENSIVE CARE	32.01		15,786		
7			SUBPROVIDER - IRF	41		49,333		
8			NURSERY	43		1,476		
9			DELIVERY ROOM & LABOR ROOM	52		64,532		
10			EMERGENCY	91		123,265		
500	TOTAL RECLASSIFICATIONS					44,546,487	500	
	CODE LETTER - A							
1	NURSING FLOAT SALARIES	B	ADULTS & PEDIATRICS	30	227,006			
2								
3								
4								
5								
6								
500	TOTAL RECLASSIFICATIONS				227,006		500	
	CODE LETTER - B							
1	STOREROOM SALARY RECLASS	C	ADMINISTRATIVE & GENERAL	5	34,771			
500	TOTAL RECLASSIFICATIONS				34,771		500	
	CODE LETTER - C							
1	CAFETERIA EXPENSE	D	DIETARY	10	1,150,596	1,338,463		
500	TOTAL RECLASSIFICATIONS				1,150,596	1,338,463	500	
	CODE LETTER - D							
1	INTEREST EXPENSE	E	ADMINISTRATIVE & GENERAL	5		18,992	11	
500	TOTAL RECLASSIFICATIONS					18,992	500	
	CODE LETTER - E							
1	BUILDING INSURANCE	F	ADMINISTRATIVE & GENERAL	5		299,530	12	
2							12	
500	TOTAL RECLASSIFICATIONS					299,530	500	
	CODE LETTER - F							
1	UTILITY RECLASS	G						
2			ADMINISTRATIVE & GENERAL	5		487,680		
3			FITNESS POINTE	194.01		222,812		
4			CLINIC	90		11,201		
5			RESEARCH	191		1,532		
6			HOUSEKEEPING	9		72,725		
7			CARDIAC REHABILITATION	76.97		22,813		
8			PHYSICAL THERAPY	66		72,326		
500	TOTAL RECLASSIFICATIONS					891,089	500	
	CODE LETTER - G							
1	ADVERTISING NON-REIMBURSABLE	H	CLINIC	90		169,465		
2			HOME HEALTH AGENCY	101		6,970		
3			NURSING ADMINISTRATION	13		6,393		
4			ADMINISTRATIVE & GENERAL	5		953,708		
5			ADULTS & PEDIATRICS	30		1,495		
6			INTENSIVE CARE UNIT	31		1,556		
7			PHYSICAL THERAPY	66		10,065		
8			ELECTROENCEPHALOGRAPHY	70		3,141		
9			RADIOLOGY-DIAGNOSTIC	54		3,834		
10			DIETARY	10		2,325		
11			NURSERY	43		6,353		
12			DELIVERY ROOM & LABOR ROOM	52		1,250		
13			NEONATAL INTENSIVE CARE	32.01		1,250		
14			OPERATING ROOM	50		2,830		
15			EMPLOYEE BENEFITS DEPARTMENT	4		2,389		
16			CARDIOLOGY	76		2,530		
500	TOTAL RECLASSIFICATIONS					1,175,554	500	
	CODE LETTER - H							
1	DEPRECIATION AND BENEFIT RECLASS	I	EMPLOYEE BENEFITS DEPARTMENT	4		177,872	9	
2			ADMINISTRATIVE & GENERAL	5		63,075,825	9	
3			PHYSICAL THERAPY	66		98,181		
4			CARDIAC REHABILITATION	76.97		46,696		
5			FITNESS POINTE	194.01		476,112		
6			FITNESS POINTE SPA/PRO SHOP/D	194.02		2,842		



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
500	TOTAL RECLASSIFICATIONS					63,877,528		
	CODE LETTER - I							
	GRAND TOTAL (DECREASES)				1,412,373	112,147,643		

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



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

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

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

	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
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (sum of lines 1-2)									3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	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	347,804,765		347,804,765	0.727536					1
2	CAP REL COSTS-MVBLE EQU	130,253,640		130,253,640	0.272464					2
3	TOTAL (sum of lines 1-2)	478,058,405		478,058,405	1.000000					3

	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	10,779,114			291,750				11,070,864	1
2	CAP REL COSTS-MVBLE EQUIP	14,850,141			7,780				14,857,921	2
3	TOTAL (sum of lines 1-2)	25,629,255			299,530				25,928,785	3

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



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	WKST A-7 REF. 5
		1	2	3	4	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)	B	-18,992	CAP REL COSTS-MVBLE EQUIP	2	11 2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-803	ADMINISTRATIVE & GENERAL	5	4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)					7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-13,559,607			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-13,115,568			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS					14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-195	PHARMACY	15	17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-110	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33						33
34						34
35	A&G OTHER INCOME	B	-407,118	ADMINISTRATIVE & GENERAL	5	35
36	OFFSET RADIOLOGY DISCOUNTS	B	-1,575	CARDIOLOGY	76	36
37	OFFSET MAMMO FEES	A	-14,880	RADIOLOGY-DIAGNOSTIC	54	37
38	PHYSICIAN RENTAL/X RAY SALES-RA	B	-2,952	RADIOLOGY-DIAGNOSTIC	54	38
39	OFFSET PT OTHER INCOME	B	-20,600	PHYSICAL THERAPY	66	39
40	PHYSICIAN RENTAL-LAB	B	-932	LABORATORY	60	40
41	REMOVE MEDICAID ASSESSMENT FEES	A	-27,391,749	ADMINISTRATIVE & GENERAL	5	41
42	VARIOUS EH&W OFFSETS	B	-14,123	EMPLOYEE BENEFITS DEPARTMENT	4	42
43	OFFSET HEART SCAN COSTS	A	-2,611	RADIOLOGY-DIAGNOSTIC	54	43
43.02	OFFSET RESEARCH COSTS HEART CTR	A	-146,108	CARDIOLOGY	76	43.02
44	OFFSET BIOTERRORISM GRANT	B	-2,732	ADMINISTRATIVE & GENERAL	5	44
45	MEDICAL RESTRICTED COSTS	A	-4,484	ADMINISTRATIVE & GENERAL	5	45
45.01	EMPLOYEE CAFETERIA REVENUE	B	-2,074,567	CAFETERIA	11	45.01
45.03	GUEST TRAYS/CANDLELIGHT DINNERS	B	-347	DIETARY	10	45.03
45.04	TELEPHONE SERVICE	A	-146,863	ADMINISTRATIVE & GENERAL	5	45.04
45.06	TELEPHONE SERVICE	A	-16,107	CAP REL COSTS-MVBLE EQUIP	2	9 45.06
45.08	TELEVISION SERVICE	A	-9,611	OPERATION OF PLANT	7	45.08
45.09	TELEVISION SERVICE	A	-49,828	CAP REL COSTS-MVBLE EQUIP	2	9 45.09
45.10	PENSION CONTRIBUTN EXCESS OF EXP	A	129,951	EMPLOYEE BENEFITS DEPARTMENT	4	45.10
45.18	RENTAL INCOME	B	-295,578	ADMINISTRATIVE & GENERAL	5	45.18
45.19	CAPITALIZED INTEREST	A	1,589	CAP REL COSTS-BLDG & FIXT	1	9 45.19
45.21	PARETN ASSET DEP AJE	A	-2,672	CAP REL COSTS-BLDG & FIXT	1	9 45.21
45.28	1996 ASSET LIFE ADJUSTMENT	A	6,312	CAP REL COSTS-BLDG & FIXT	1	9 45.28
45.29	OFFSET RELEASED TEMP REST OP IN	B	-2,500	ADMINISTRATIVE & GENERAL	5	45.29
45.30	OFFSET RELEASED TEMP REST OP IN	B	-3,595	CARDIOLOGY	76	45.30
45.31	OFFSET RELEASED TEMP REST OP IN	B	-462	ADMINISTRATIVE & GENERAL	5	45.31
45.32	OFFSET RELEASED TEMP REST OP IN	B	-4,200	ADMINISTRATIVE & GENERAL	5	45.32
45.33	NON-PT CARE RELATED EXPENSES	A	-10,500	ADMINISTRATIVE & GENERAL	5	45.33
45.37	OTHER DIETARY INCOME	B	-3,700	DIETARY	10	45.37



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

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

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

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

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



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

WORKSHEET A-8-1

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

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

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

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
				NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B		100.00	CFNI		PARENT	6
7							7
8							8
9							9
10							10

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

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



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

WORKSHEET A-8-1

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

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

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

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

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



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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	4	EMPLOYEE BENEFITS DE AGGREGATE							326	1
2	5	ADMINISTRATIVE & GEN AGGREGATE					98,720	16,579	97,179	2
3	17	SOCIAL SERVICE AGGREGATE							268	3
4	30	ADULTS & PEDIATRICS AGGREGATE					28,841	51,059	56,159	4
5	32.01	NEONATAL INTENSIVE C AGGREGATE					8,240	11,760	41,760	5
6	50	OPERATING ROOM AGGREGATE							100	6
7	54	RADIOLOGY-DIAGNOSTIC AGGREGATE					22,496	27,504	27,504	7
8	60	LABORATORY AGGREGATE					13,349	11,651	11,651	8
9	65	RESPIRATORY THERAPY AGGREGATE					19,447	782	9,753	9
10	70	ELECTROENCEPHALOGRAP AGGREGATE					5,933	6,667	44,067	10
11	76	CARDIOLOGY AGGREGATE					64,440	103,760	686,690	11
12	90	CLINIC AGGREGATE					10,960	2,340	147,824	12
13	91	EMERGENCY AGGREGATE					56,611	43,004	85,056	13
14	50	OPERATING ROOM CRNA ANESTHESIO	2,299,597						12,351,270	14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,299,597				329,037	275,106	13,559,607	200



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	11,070,864	11,070,864					1
2	CAP REL COSTS-MVBLE EQUIP	14,857,921		14,857,921				2
4	EMPLOYEE BENEFITS DEPARTMENT	45,239,481	36,188	13,654	45,289,323			4
5	ADMINISTRATIVE & GENERAL	57,773,099	2,777,927	527,152	4,142,784	65,220,962	65,220,962	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	13,297,522	1,349,399	794,065	1,456,417	16,897,403	3,586,592	7
8	LAUNDRY & LINEN SERVICE	1,267,854	14,103		32,614	1,314,571	279,027	8
9	HOUSEKEEPING	4,162,736	42,277	110,356	994,520	5,309,889	1,127,061	9
10	DIETARY	3,927,288	120,013	80,333	738,519	4,866,153	1,032,875	10
11	CAFETERIA	414,492	126,230	83,311	352,257	976,290	207,224	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,780,654	17,602	466,999	510,175	2,775,430	589,104	13
14	CENTRAL SERVICES & SUPPLY	52,441			10,645	63,086	13,390	14
15	PHARMACY	15,829,006	48,399	374,951	1,200,012	17,452,368	3,704,387	15
16	MEDICAL RECORDS & LIBRARY	258,126	76,161		37,606	371,893	78,937	16
17	SOCIAL SERVICE	701,344	20,541	1,800	211,016	934,701	198,397	17
19	NONPHYSICIAN ANESTHETISTS							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	36,611,226	1,713,583	762,429	9,909,081	48,996,319	10,399,840	30
31	INTENSIVE CARE UNIT	8,652,070	231,833	664,133	2,391,505	11,939,541	2,534,251	31
32.01	NEONATAL INTENSIVE CARE	3,068,056	63,041	209,868	863,966	4,204,931	892,526	32.01
41	SUBPROVIDER - IRF	5,390,777	270,833	39,201	1,127,463	6,828,274	1,449,349	41
43	NURSERY	1,515,019	24,178	7,012	389,021	1,935,230	410,766	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	24,831,059	704,729	3,094,653	7,384,545	36,014,986	7,644,433	50
52	DELIVERY ROOM & LABOR ROOM	2,182,715	132,160	147,805	587,713	3,050,393	647,467	52
54	RADIOLOGY-DIAGNOSTIC	14,607,283	471,627	3,922,276	2,394,587	21,395,773	4,541,403	54
60	LABORATORY	11,833,857	222,900	642,578	1,748,980	14,448,315	3,066,756	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,961,210	15,985	43,068	122,778	3,143,041	667,132	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,025,805	38,133	246,603	1,041,334	5,351,875	1,135,973	65
66	PHYSICAL THERAPY	8,818,974	382,865	140,221	1,460,379	10,802,439	2,292,893	66
70	ELECTROENCEPHALOGRAPHY	880,851	25,056	148,497	187,449	1,241,853	263,592	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,270,583				18,270,583	3,878,059	71
72	IMPL. DEV. CHARGED TO PATIENTS	26,275,904				26,275,904	5,577,245	72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY	9,815,466	397,370	1,404,054	2,044,011	13,660,901	2,899,622	76
76.97	CARDIAC REHABILITATION	322,725	25,214	32,820	132,521	513,280	108,947	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,349,343	79,227	16,382	603,170	3,048,122	646,985	90
91	EMERGENCY	7,102,662	277,314	679,813	1,773,884	9,833,673	2,087,266	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	3,466,270	37,795	689	668,645	4,173,399	885,833	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	363,614,683	9,742,683	14,654,723	44,517,597	361,311,578	62,847,332	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		23,893			23,893	5,071	190
191	RESEARCH	314,140		518	62,861	377,519	80,131	191
192	PHYSICIANS' PRIVATE OFFICES		692,645	15,221		707,866	150,250	192
194	ADVERTISING	1,175,554				1,175,554	249,520	194
194.01	FITNESS POINTE	2,527,716	503,988	143,131	488,545	3,663,380	777,578	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	463,086	17,402	6,048	92,386	578,922	122,880	194.02
194.03	RETAIL PHARMACY	4,399,209	15,583	38,280	127,934	4,581,006	972,351	194.03
194.04	HOSPICE		74,670			74,670	15,849	194.04
194.05	RUSH RESIDENTS							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	372,494,388	11,070,864	14,857,921	45,289,323	372,494,388	65,220,962	202



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	20,483,995						7
8	LAUNDRY & LINEN SERVICE	41,823	1,635,421					8
9	HOUSEKEEPING	125,375		6,562,325				9
10	DIETARY	355,904	504	8,850	6,264,286			10
11	CAFETERIA	374,338		30,657		1,588,509		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	52,200		1,825		16,277	3,434,836	13
14	CENTRAL SERVICES & SUPPLY					985		14
15	PHARMACY	143,528		17,153		45,579		15
16	MEDICAL RECORDS & LIBRARY	225,857		68,247		1,827		16
17	SOCIAL SERVICE	60,916		15,328		10,848		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	5,081,690	600,932	1,947,229	4,950,073	517,342	1,596,788	30
31	INTENSIVE CARE UNIT	687,510	93,531	357,258	401,217	103,905	320,705	31
32.01	NEONATAL INTENSIVE CARE	186,950	10,799	86,322		34,731	107,197	32.01
41	SUBPROVIDER - IRF	803,166	95,190	316,684	823,480	64,714	199,739	41
43	NURSERY	71,701	8,495	78,229		17,889	55,216	43
	ANCHLLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,089,900	251,407	1,382,181		232,016	716,119	50
52	DELIVERY ROOM & LABOR ROOM	391,927	83,030	256,931	89,516	25,799	79,630	52
54	RADIOLOGY-DIAGNOSTIC	1,398,628	107,030	196,950		75,875		54
60	LABORATORY	661,018		125,181		87,924		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	47,404				4,873		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	113,085	3,232	15,930		44,970		65
66	PHYSICAL THERAPY	1,135,399	55,521	82,052		40,070		66
70	ELECTROENCEPHALOGRAPHY	74,303	14,200	12,171		3,449		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY	1,178,414	141,372	415,077		85,210		76
76.97	CARDIAC REHABILITATION	74,774	1,352			5,921		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	234,949	31,183	28,312		24,250	56,599	90
91	EMERGENCY	822,385	134,134	848,411		98,127	302,843	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	112,082		10,949		37,418		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	16,545,226	1,631,912	6,301,927	6,264,286	1,579,999	3,434,836	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,855						190
191	RESEARCH					2,911		191
192	PHYSICIANS' PRIVATE OFFICES	2,054,065	3,011	260,398				192
194	ADVERTISING							194
194.01	FITNESS POINTE	1,494,595	498					194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	51,605						194.02
194.03	RETAIL PHARMACY	46,212				5,599		194.03
194.04	HOSPICE	221,437						194.04
194.05	RUSH RESIDENTS							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	20,483,995	1,635,421	6,562,325	6,264,286	1,588,509	3,434,836	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS
		14	15	16	17	24	25
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	77,461					14
15	PHARMACY		21,363,015				15
16	MEDICAL RECORDS & LIBRARY			746,761			16
17	SOCIAL SERVICE				1,220,190		17
19	NONPHYSICIAN ANESTHETISTS						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			65,230	1,079,803	75,235,246	30
31	INTENSIVE CARE UNIT			10,404	103,670	16,551,992	31
32.01	NEONATAL INTENSIVE CARE			12,141		5,535,597	32.01
41	SUBPROVIDER - IRF			7,166		10,587,762	41
43	NURSERY			2,734	14,687	2,594,947	43
	ANCHLLARY SERVICE COST CENTERS						
50	OPERATING ROOM			97,781	1,296	48,430,119	50
52	DELIVERY ROOM & LABOR ROOM			4,388		4,629,081	52
54	RADIOLOGY-DIAGNOSTIC			139,264		27,854,923	54
60	LABORATORY			97,899		18,487,093	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			6,165		3,868,615	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY			17,932		6,682,997	65
66	PHYSICAL THERAPY			28,258		14,436,632	66
70	ELECTROENCEPHALOGRAPHY			5,615		1,615,183	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,461		28,159		22,254,262	71
72	IMPL. DEV. CHARGED TO PATIENTS			33,718		31,886,867	72
73	DRUGS CHARGED TO PATIENTS		21,363,015	56,996		21,420,011	73
76	CARDIOLOGY			74,858		18,455,454	76
76.97	CARDIAC REHABILITATION			1,038		705,312	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC			3,611		4,074,011	90
91	EMERGENCY			49,493	20,734	14,197,066	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY			3,911		5,223,592	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	77,461	21,363,015	746,761	1,220,190	354,726,762	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					99,819	190
191	RESEARCH					460,561	191
192	PHYSICIANS' PRIVATE OFFICES					3,175,590	192
194	ADVERTISING					1,425,074	194
194.01	FITNESS POINTE					5,936,051	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY					753,407	194.02
194.03	RETAIL PHARMACY					5,605,168	194.03
194.04	HOSPICE					311,956	194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	77,461	21,363,015	746,761	1,220,190	372,494,388	202



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	75,235,246					30
31	INTENSIVE CARE UNIT	16,551,992					31
32.01	NEONATAL INTENSIVE CARE	5,535,597					32.01
41	SUBPROVIDER - IRF	10,587,762					41
43	NURSERY	2,594,947					43
	ANCHLLARY SERVICE COST CENTERS						
50	OPERATING ROOM	48,430,119					50
52	DELIVERY ROOM & LABOR ROOM	4,629,081					52
54	RADIOLOGY-DIAGNOSTIC	27,854,923					54
60	LABORATORY	18,487,093					60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,868,615					62
62.30	BLOOD CLOTTING FOR HEMOPHILLACS						62.30
65	RESPIRATORY THERAPY	6,682,997					65
66	PHYSICAL THERAPY	14,436,632					66
70	ELECTROENCEPHALOGRAPHY	1,615,183					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,254,262					71
72	IMPL. DEV. CHARGED TO PATIENTS	31,886,867					72
73	DRUGS CHARGED TO PATIENTS	21,420,011					73
76	CARDIOLOGY	18,455,454					76
76.97	CARDIAC REHABILITATION	705,312					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	4,074,011					90
91	EMERGENCY	14,197,066					91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	5,223,592					101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	354,726,762					118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	99,819					190
191	RESEARCH	460,561					191
192	PHYSICIANS' PRIVATE OFFICES	3,175,590					192
194	ADVERTISING	1,425,074					194
194.01	FITNESS POINTE	5,936,051					194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	753,407					194.02
194.03	RETAIL PHARMACY	5,605,168					194.03
194.04	HOSPICE	311,956					194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	372,494,388					202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT	21,600	36,188	13,654	71,442	71,442		4
5	ADMINISTRATIVE & GENERAL	403,666	2,777,927	527,152	3,708,745	6,536	3,715,281	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	6,018	1,349,399	794,065	2,149,482	2,298	204,306	7
8	LAUNDRY & LINEN SERVICE	18,070	14,103		32,173	51	15,894	8
9	HOUSEKEEPING	490	42,277	110,356	153,123	1,569	64,202	9
10	DIETARY	9,282	120,013	80,333	209,628	1,165	58,837	10
11	CAFETERIA		126,230	83,311	209,541	556	11,804	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		17,602	466,999	484,601	805	33,558	13
14	CENTRAL SERVICES & SUPPLY	17,094			17,094	17	763	14
15	PHARMACY	21,251	48,399	374,951	444,601	1,893	211,017	15
16	MEDICAL RECORDS & LIBRARY		76,161		76,161	59	4,497	16
17	SOCIAL SERVICE		20,541	1,800	22,341	333	11,301	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	70,099	1,713,583	762,429	2,546,111	15,622	592,449	30
31	INTENSIVE CARE UNIT	30,303	231,833	664,133	926,269	3,773	144,361	31
32.01	NEONATAL INTENSIVE CARE		63,041	209,868	272,909	1,363	50,842	32.01
41	SUBPROVIDER - IRF	6,049	270,833	39,201	316,083	1,779	82,561	41
43	NURSERY		24,178	7,012	31,190	614	23,399	43
	ANCHLLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,127,920	704,729	3,094,653	4,927,302	11,650	435,457	50
52	DELIVERY ROOM & LABOR ROOM		132,160	147,805	279,965	927	36,882	52
54	RADIOLOGY-DIAGNOSTIC	591,217	471,627	3,922,276	4,985,120	3,778	258,696	54
60	LABORATORY	5,106	222,900	642,578	870,584	2,759	174,695	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		15,985	43,068	59,053	194	38,003	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	47,100	38,133	246,603	331,836	1,643	64,710	65
66	PHYSICAL THERAPY	12,150	382,865	140,221	535,236	2,304	130,612	66
70	ELECTROENCEPHALOGRAPHY	201,567	25,056	148,497	375,120	296	15,015	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						220,910	71
72	IMPL. DEV. CHARGED TO PATIENTS						317,702	72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY	1,387,183	397,370	1,404,054	3,188,607	3,225	165,174	76
76.97	CARDIAC REHABILITATION		25,214	32,820	58,034	209	6,206	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	40,932	79,227	16,382	136,541	952	36,855	90
91	EMERGENCY	4,931	277,314	679,813	962,058	2,799	118,899	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		37,795	689	38,484	1,055	50,461	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,022,028	9,742,683	14,654,723	28,419,434	70,224	3,580,068	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		23,893		23,893		289	190
191	RESEARCH			518	518	99	4,565	191
192	PHYSICIANS' PRIVATE OFFICES		692,645	15,221	707,866		8,559	192
194	ADVERTISING						14,214	194
194.01	FITNESS POINTE		503,988	143,131	647,119	771	44,294	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		17,402	6,048	23,450	146	7,000	194.02
194.03	RETAIL PHARMACY		15,583	38,280	53,863	202	55,389	194.03
194.04	HOSPICE		74,670		74,670		903	194.04
194.05	RUSH RESIDENTS							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,022,028	11,070,864	14,857,921	29,950,813	71,442	3,715,281	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,356,086						7
8	LAUNDRY & LINEN SERVICE	4,811	52,929					8
9	HOUSEKEEPING	14,421		233,315				9
10	DIETARY	40,936	16	315	310,897			10
11	CAFETERIA	43,057		1,090		266,048		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	6,004		65		2,726	527,759	13
14	CENTRAL SERVICES & SUPPLY					165		14
15	PHARMACY	16,509		610		7,634		15
16	MEDICAL RECORDS & LIBRARY	25,978		2,426		306		16
17	SOCIAL SERVICE	7,007		545		1,817		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	584,499	19,449	69,231	245,673	86,644	245,344	30
31	INTENSIVE CARE UNIT	79,078	3,027	12,702	19,912	17,402	49,276	31
32.01	NEONATAL INTENSIVE CARE	21,503	349	3,069		5,817	16,471	32.01
41	SUBPROVIDER - IRF	92,381	3,081	11,259	40,869	10,838	30,690	41
43	NURSERY	8,247	275	2,781		2,996	8,484	43
	ANCHLLARY SERVICE COST CENTERS							
50	OPERATING ROOM	240,382	8,137	49,142		38,859	110,031	50
52	DELIVERY ROOM & LABOR ROOM	45,080	2,687	9,135	4,443	4,321	12,235	52
54	RADIOLOGY-DIAGNOSTIC	160,871	3,464	7,002		12,708		54
60	LABORATORY	76,031		4,451		14,726		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,452				816		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	13,007	105	566		7,532		65
66	PHYSICAL THERAPY	130,595	1,797	2,917		6,711		66
70	ELECTROENCEPHALOGRAPHY	8,546	460	433		578		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY	135,542	4,575	14,758		14,271		76
76.97	CARDIAC REHABILITATION	8,601	44			992		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	27,024	1,009	1,007		4,061	8,696	90
91	EMERGENCY	94,591	4,341	30,164		16,435	46,532	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	12,892		389		6,267		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,903,045	52,816	224,057	310,897	264,622	527,759	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,150						190
191	RESEARCH					488		191
192	PHYSICIANS' PRIVATE OFFICES	236,260	97	9,258				192
194	ADVERTISING							194
194.01	FITNESS POINTE	171,910	16					194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	5,936						194.02
194.03	RETAIL PHARMACY	5,315				938		194.03
194.04	HOSPICE	25,470						194.04
194.05	RUSH RESIDENTS							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,356,086	52,929	233,315	310,897	266,048	527,759	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	18,039						14
15	PHARMACY		682,264					15
16	MEDICAL RECORDS & LIBRARY			109,427				16
17	SOCIAL SERVICE				43,344			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS			9,599	38,356	4,452,977		30
31	INTENSIVE CARE UNIT			1,531	3,683	1,261,014		31
32.01	NEONATAL INTENSIVE CARE			1,787		374,110		32.01
41	SUBPROVIDER - IRF			1,054		590,595		41
43	NURSERY			402	522	78,910		43
	ANCHLLARY SERVICE COST CENTERS							
50	OPERATING ROOM			14,389	46	5,835,395		50
52	DELIVERY ROOM & LABOR ROOM			646		396,321		52
54	RADIOLOGY-DIAGNOSTIC			20,030		5,451,669		54
60	LABORATORY			14,407		1,157,653		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			907		104,425		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			2,639		422,038		65
66	PHYSICAL THERAPY			4,158		814,330		66
70	ELECTROENCEPHALOGRAPHY			826		401,274		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,039		4,144		243,093		71
72	IMPL. DEV. CHARGED TO PATIENTS			4,962		322,664		72
73	DRUGS CHARGED TO PATIENTS		682,264	8,387		690,651		73
76	CARDIOLOGY			11,016		3,537,168		76
76.97	CARDIAC REHABILITATION			153		74,239		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC			531		216,676		90
91	EMERGENCY			7,283	737	1,283,839		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY			576		110,124		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	18,039	682,264	109,427	43,344	27,819,165		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					32,332		190
191	RESEARCH					5,670		191
192	PHYSICIANS' PRIVATE OFFICES					962,040		192
194	ADVERTISING					14,214		194
194.01	FITNESS POINTE					864,110		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY					36,532		194.02
194.03	RETAIL PHARMACY					115,707		194.03
194.04	HOSPICE					101,043		194.04
194.05	RUSH RESIDENTS							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	18,039	682,264	109,427	43,344	29,950,813		202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	TOTAL				
		26				
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS DEPARTMENT					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	4,452,977				30
31	INTENSIVE CARE UNIT	1,261,014				31
32.01	NEONATAL INTENSIVE CARE	374,110				32.01
41	SUBPROVIDER - IRF	590,595				41
43	NURSERY	78,910				43
	ANCHLLARY SERVICE COST CENTERS					
50	OPERATING ROOM	5,835,395				50
52	DELIVERY ROOM & LABOR ROOM	396,321				52
54	RADIOLOGY-DIAGNOSTIC	5,451,669				54
60	LABORATORY	1,157,653				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	104,425				62
62.30	BLOOD CLOTTING FOR HEMOPHILLACS					62.30
65	RESPIRATORY THERAPY	422,038				65
66	PHYSICAL THERAPY	814,330				66
70	ELECTROENCEPHALOGRAPHY	401,274				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,093				71
72	IMPL. DEV. CHARGED TO PATIENTS	322,664				72
73	DRUGS CHARGED TO PATIENTS	690,651				73
76	CARDIOLOGY	3,537,168				76
76.97	CARDIAC REHABILITATION	74,239				76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	CLINIC	216,676				90
91	EMERGENCY	1,283,839				91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
101	HOME HEALTH AGENCY	110,124				101
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (sum of lines 1-117)	27,819,165				118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,332				190
191	RESEARCH	5,670				191
192	PHYSICIANS' PRIVATE OFFICES	962,040				192
194	ADVERTISING	14,214				194
194.01	FITNESS POINTE	864,110				194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	36,532				194.02
194.03	RETAIL PHARMACY	115,707				194.03
194.04	HOSPICE	101,043				194.04
194.05	RUSH RESIDENTS					194.05
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (sum of lines 118-201)	29,950,813				202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT NEW- SQ FT	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,047,188						1
2	CAP REL COSTS-MVBLE EQUIP		9,386,408					2
4	EMPLOYEE BENEFITS DEPARTMENT	3,423	8,626	147,930,727				4
5	ADMINISTRATIVE & GENERAL	262,763	333,025	13,531,787	-65,220,962	307,273,426		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	127,639	501,646	4,757,170		16,897,403	653,363	7
8	LAUNDRY & LINEN SERVICE	1,334		106,528		1,314,571	1,334	8
9	HOUSEKEEPING	3,999	69,717	3,248,453		5,309,889	3,999	9
10	DIETARY	11,352	50,750	2,412,264		4,866,153	11,352	10
11	CAFETERIA	11,940	52,631	1,150,596		976,290	11,940	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,665	295,024	1,666,412		2,775,430	1,665	13
14	CENTRAL SERVICES & SUPPLY			34,771		63,086		14
15	PHARMACY	4,578	236,873	3,919,662		17,452,368	4,578	15
16	MEDICAL RECORDS & LIBRARY	7,204		122,835		371,893	7,204	16
17	SOCIAL SERVICE	1,943	1,137	689,252		934,701	1,943	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	162,087	481,660	32,366,421		48,996,319	162,087	30
31	INTENSIVE CARE UNIT	21,929	419,562	7,811,497		11,939,541	21,929	31
32.01	NEONATAL INTENSIVE CARE	5,963	132,583	2,822,017		4,204,931	5,963	32.01
41	SUBPROVIDER - IRF	25,618	24,765	3,682,691		6,828,274	25,618	41
43	NURSERY	2,287	4,430	1,270,678		1,935,230	2,287	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	66,660	1,955,029	24,120,520		36,014,986	66,660	50
52	DELIVERY ROOM & LABOR ROOM	12,501	93,375	1,919,676		3,050,393	12,501	52
54	RADIOLOGY-DIAGNOSTIC	44,611	2,477,878	7,821,563		21,395,773	44,611	54
60	LABORATORY	21,084	405,945	5,712,782		14,448,315	21,084	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,512	27,208	401,036		3,143,041	1,512	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,607	155,790	3,401,362		5,351,875	3,607	65
66	PHYSICAL THERAPY	36,215	88,584	4,770,111		10,802,439	36,215	66
70	ELECTROENCEPHALOGRAPHY	2,370	93,812	612,275		1,241,853	2,370	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					18,270,583		71
72	IMPL. DEV. CHARGED TO PATIENTS					26,275,904		72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY	37,587	887,003	6,676,458		13,660,901	37,587	76
76.97	CARDIAC REHABILITATION	2,385	20,734	432,860		513,280	2,385	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	7,494	10,349	1,970,165		3,048,122	7,494	90
91	EMERGENCY	26,231	429,468	5,794,127		9,833,673	26,231	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	3,575	435	2,184,031		4,173,399	3,575	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	921,556	9,258,039	145,410,000	-65,220,962	296,090,616	527,731	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,260				23,893	2,260	190
191	RESEARCH		327	205,325		377,519		191
192	PHYSICIANS' PRIVATE OFFICES	65,517	9,616			707,866	65,517	192
194	ADVERTISING					1,175,554		194
194.01	FITNESS POINTE	47,672	90,422	1,595,759		3,663,380	47,672	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	1,646	3,821	301,766		578,922	1,646	194.02
194.03	RETAIL PHARMACY	1,474	24,183	417,877		4,581,006	1,474	194.03
194.04	HOSPICE	7,063				74,670	7,063	194.04
194.05	RUSH RESIDENTS							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	11,070,864	14,857,921	45,289,323		65,220,962	20,483,995	202
203	UNIT COST MULT-WS B PT I	10.571993	1.582919	0.306152		0.212257	31.351630	203
204	COST TO BE ALLOC PER B PT II			71,442		3,715,281	2,356,086	204
205	UNIT COST MULT-WS B PT II			0.000483		0.012091	3.606090	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE POUNDS	HOUSE-KEEPING TIME SPENT	DIETARY PATIENT MEALS	CAFETERIA FTES	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY COSTED REQ	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	3,460,106						8
9	HOUSEKEEPING		719,240					9
10	DIETARY	1,066	970	337,230				10
11	CAFETERIA		3,360		177,326			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		200		1,817	2,583,950		13
14	CENTRAL SERVICES & SUPPLY				110		100	14
15	PHARMACY		1,880		5,088			15
16	MEDICAL RECORDS & LIBRARY		7,480		204			16
17	SOCIAL SERVICE		1,680		1,211			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	1,271,413	213,419	266,481	57,751	1,201,228		30
31	INTENSIVE CARE UNIT	197,886	39,156	21,599	11,599	241,259		31
32.01	NEONATAL INTENSIVE CARE	22,847	9,461		3,877	80,642		32.01
41	SUBPROVIDER - IRF	201,396	34,709	44,331	7,224	150,259		41
43	NURSERY	17,973	8,574		1,997	41,538		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	531,908	151,489		25,900	538,720		50
52	DELIVERY ROOM & LABOR ROOM	175,669	28,160	4,819	2,880	59,904		52
54	RADIOLOGY-DIAGNOSTIC	226,447	21,586		8,470			54
60	LABORATORY		13,720		9,815			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS				544			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	6,838	1,746		5,020			65
66	PHYSICAL THERAPY	117,468	8,993		4,473			66
70	ELECTROENCEPHALOGRAPHY	30,043	1,334		385			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						100	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY	299,104	45,493		9,512			76
76.97	CARDIAC REHABILITATION	2,860			661			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	65,975	3,103		2,707	42,578		90
91	EMERGENCY	283,790	92,987		10,954	227,822		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		1,200		4,177			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,452,683	690,700	337,230	176,376	2,583,950	100	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
191	RESEARCH				325			191
192	PHYSICIANS' PRIVATE OFFICES	6,370	28,540					192
194	ADVERTISING							194
194.01	FITNESS POINTE	1,053						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY				625			194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,635,421	6,562,325	6,264,286	1,588,509	3,434,836	77,461	202
203	UNIT COST MULT-WS B PT I	0.472651	9.123971	18.575708	8.958128	1.329297	774.610000	203
204	COST TO BE ALLOC PER B PT II	52,929	233,315	310,897	266,048	527,759	18,039	204
205	UNIT COST MULT-WS B PT II	0.015297	0.324391	0.921914	1.500333	0.204245	180.390000	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQ	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE GROSS REVENUE				
	15	16	17				

GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	10,000					15
16	MEDICAL RECORDS & LIBRARY		1,247,775,458				16
17	SOCIAL SERVICE			141,240			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		109,079,807	124,990			30
31	INTENSIVE CARE UNIT		17,397,741	12,000			31
32.01	NEONATAL INTENSIVE CARE		20,303,194				32.01
41	SUBPROVIDER - IRF		11,982,793				41
43	NURSERY		4,571,357	1,700			43
ANCHLLARY SERVICE COST CENTERS							
50	OPERATING ROOM		163,512,868	150			50
52	DELIVERY ROOM & LABOR ROOM		7,337,260				52
54	RADIOLOGY-DIAGNOSTIC		231,895,918				54
60	LABORATORY		163,711,142				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		10,308,845				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		29,986,203				65
66	PHYSICAL THERAPY		47,254,923				66
70	ELECTROENCEPHALOGRAPHY		9,389,312				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		47,089,434				71
72	IMPL. DEV. CHARGED TO PATIENTS		56,384,882				72
73	DRUGS CHARGED TO PATIENTS	10,000	95,311,081				73
76	CARDIOLOGY		125,180,338				76
76.97	CARDIAC REHABILITATION		1,735,577				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		6,038,117				90
91	EMERGENCY		82,763,966	2,400			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY		6,540,700				101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,000	1,247,775,458	141,240			118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191	RESEARCH						191
192	PHYSICIANS' PRIVATE OFFICES						192
194	ADVERTISING						194
194.01	FITNESS POINTE						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03	RETAIL PHARMACY						194.03
194.04	HOSPICE						194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	21,363,015	746,761	1,220,190			202
203	UNIT COST MULT-WS B PT I	2,136,301,500	0.000598	8.639125			203
204	COST TO BE ALLOC PER B PT II	682,264	109,427	43,344			204



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQ	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE GROSS REVENUE				
		15	16	17				
205	UNIT COST MULT-WS B PT II	68.226400	0.000088	0.306882				205



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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	75,235,246		75,235,246	51,059	75,286,305	30
31	INTENSIVE CARE UNIT	16,551,992		16,551,992		16,551,992	31
32.01	NEONATAL INTENSIVE CARE	5,535,597		5,535,597	11,760	5,547,357	32.01
41	SUBPROVIDER - IRF	10,587,762		10,587,762		10,587,762	41
43	NURSERY	2,594,947		2,594,947		2,594,947	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	48,430,119		48,430,119		48,430,119	50
52	DELIVERY ROOM & LABOR ROOM	4,629,081		4,629,081		4,629,081	52
54	RADIOLOGY-DIAGNOSTIC	27,854,923		27,854,923	27,504	27,882,427	54
60	LABORATORY	18,487,093		18,487,093	11,651	18,498,744	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,868,615		3,868,615		3,868,615	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	6,682,997		6,682,997	782	6,683,779	65
66	PHYSICAL THERAPY	14,436,632		14,436,632		14,436,632	66
70	ELECTROENCEPHALOGRAPHY	1,615,183		1,615,183	6,667	1,621,850	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,254,262		22,254,262		22,254,262	71
72	IMPL. DEV. CHARGED TO PATIENTS	31,886,867		31,886,867		31,886,867	72
73	DRUGS CHARGED TO PATIENTS	21,420,011		21,420,011		21,420,011	73
76	CARDIOLOGY	18,455,454		18,455,454	103,760	18,559,214	76
76.97	CARDIAC REHABILITATION	705,312		705,312		705,312	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	4,074,011		4,074,011	2,340	4,076,351	90
91	EMERGENCY	14,197,066		14,197,066	43,004	14,240,070	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	11,199,584		11,199,584		11,199,584	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	5,223,592		5,223,592		5,223,592	101
200	SUBTOTAL (SEE INSTRUCTIONS)	365,926,346		365,926,346	258,527	366,184,873	200
201	LESS OBSERVATION BEDS	11,199,584		11,199,584		11,199,584	201
202	TOTAL (SEE INSTRUCTIONS)	354,726,762		354,726,762		354,985,289	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	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	84,537,023		84,537,023				30
31	INTENSIVE CARE UNIT	17,397,741		17,397,741				31
32.01	NEONATAL INTENSIVE CARE	20,303,194		20,303,194				32.01
41	SUBPROVIDER - IRF	11,982,793		11,982,793				41
43	NURSERY	4,571,357		4,571,357				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	70,095,091	93,417,777	163,512,868	0.296185	0.296185	0.296185	50
52	DELIVERY ROOM & LABOR ROOM	5,206,463	2,130,797	7,337,260	0.630900	0.630900	0.630900	52
54	RADIOLOGY-DIAGNOSTIC	56,569,991	175,325,927	231,895,918	0.120118	0.120118	0.120237	54
60	LABORATORY	65,758,022	97,953,120	163,711,142	0.112925	0.112925	0.112996	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,323,220	2,985,625	10,308,845	0.375271	0.375271	0.375271	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	27,648,148	2,338,055	29,986,203	0.222869	0.222869	0.222895	65
66	PHYSICAL THERAPY	27,175,028	20,079,895	47,254,923	0.305505	0.305505	0.305505	66
70	ELECTROENCEPHALOGRAPHY	1,697,500	7,691,812	9,389,312	0.172024	0.172024	0.172734	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,311,631	24,777,803	47,089,434	0.472596	0.472596	0.472596	71
72	IMPL. DEV. CHARGED TO PATIENTS	36,298,112	20,086,770	56,384,882	0.565522	0.565522	0.565522	72
73	DRUGS CHARGED TO PATIENTS	69,931,111	25,379,970	95,311,081	0.224738	0.224738	0.224738	73
76	CARDIOLOGY	46,379,863	78,800,475	125,180,338	0.147431	0.147431	0.148260	76
76.97	CARDIAC REHABILITATION	338,874	1,396,703	1,735,577	0.406385	0.406385	0.406385	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	240,740	5,797,377	6,038,117	0.674715	0.674715	0.675103	90
91	EMERGENCY	26,531,592	56,232,374	82,763,966	0.171537	0.171537	0.172056	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,204,416	21,338,368	24,542,784	0.456329	0.456329	0.456329	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		6,540,700	6,540,700				101
200	SUBTOTAL (SEE INSTRUCTIONS)	605,501,910	642,273,548	1,247,775,458				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	605,501,910	642,273,548	1,247,775,458				202



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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 ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	4,452,977		4,452,977	89,003	50.03	43,665	2,184,560	30
31	INTENSIVE CARE UNIT	1,261,014		1,261,014	9,836	128.20	5,752	737,406	31
32	CORONARY CARE UNIT								32
32.01	NEONATAL INTENSIVE CARE	374,110		374,110	4,697	79.65			32.01
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	590,595		590,595	14,705	40.16	12,944	519,831	41
42	SUBPROVIDER I								42
43	NURSERY	78,910		78,910	3,694	21.36			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	6,757,606		6,757,606	121,935		62,361	3,441,797	200

(A) Worksheet A line numbers



COMPU-MAX

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

COMPONENT CCN: 15-0125

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

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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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
32.01	NEONATAL INTENSIVE CARE					32.01
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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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)	89,003		43,665		30
31	INTENSIVE CARE UNIT	9,836		5,752		31
32	CORONARY CARE UNIT					32
32.01	NEONATAL INTENSIVE CARE	4,697				32.01
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	14,705		12,944		41
42	SUBPROVIDER I					42
43	NURSERY	3,694				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	121,935		62,361		200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART IV

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

(A) Worksheet A line numbers



COMPU-MAX

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

COMPONENT CCN: 15-0125

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.296185	28,455,385			8,428,058			50
52	DELIVERY ROOM & LABOR ROOM	0.630900							52
54	RADIOLOGY-DIAGNOSTIC	0.120118	63,665,485			7,647,371			54
60	LABORATORY	0.112925	10,577,321			1,194,444			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271	994,562			373,230			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.222869	1,025,824			228,624			65
66	PHYSICAL THERAPY	0.305505	126,928			38,777			66
70	ELECTROENCEPHALOGRAPHY	0.172024	2,633,728			453,064			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596	13,182,224			6,229,866			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522	10,859,869			6,141,495			72
73	DRUGS CHARGED TO PATIENTS	0.224738	10,741,547		84,799	2,414,034		19,058	73
76	CARDIOLOGY	0.147431	45,922,439			6,770,391			76
76.97	CARDIAC REHABILITATION	0.406385	827,673			336,354			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.674715	3,102,038			2,092,992			90
91	EMERGENCY	0.171537	11,844,400			2,031,753			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329	7,974,121			3,638,823			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		211,933,544		84,799	48,019,276		19,058	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		211,933,544		84,799	48,019,276		19,058	202

(A) Worksheet A line numbers



COMPU-MAX

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

COMPONENT CCN: 15-T125

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,835,395	163,512,868	0.035688	274,347	9,791	50
52	DELIVERY ROOM & LABOR ROOM	396,321	7,337,260	0.054015			52
54	RADIOLOGY-DIAGNOSTIC	5,451,669	231,895,918	0.023509	1,190,860	27,996	54
60	LABORATORY	1,157,653	163,711,142	0.007071	2,588,612	18,304	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	104,425	10,308,845	0.010130	228,031	2,310	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	422,038	29,986,203	0.014074	1,180,719	16,617	65
66	PHYSICAL THERAPY	814,330	47,254,923	0.017233	12,878,520	221,936	66
70	ELECTROENCEPHALOGRAPHY	401,274	9,389,312	0.042737	161,700	6,911	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,093	47,089,434	0.005162	1,352,280	6,980	71
72	IMPL. DEV. CHARGED TO PATIENTS	322,664	56,384,882	0.005723	81,338	465	72
73	DRUGS CHARGED TO PATIENTS	690,651	95,311,081	0.007246	4,927,031	35,701	73
76	CARDIOLOGY	3,537,168	125,180,338	0.028257	598,824	16,921	76
76.97	CARDIAC REHABILITATION	74,239	1,735,577	0.042775			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	216,676	6,038,117	0.035885	12,444	447	90
91	EMERGENCY	1,283,839	82,763,966	0.015512	1,303	20	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		24,542,784				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	20,951,435	1,102,442,650		25,476,009	364,399	200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [XX] 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	163,512,868			274,347			50
52	DELIVERY ROOM & LABOR ROOM	7,337,260						52
54	RADIOLOGY-DIAGNOSTIC	231,895,918			1,190,860		308	54
60	LABORATORY	163,711,142			2,588,612			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,308,845			228,031			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	29,986,203			1,180,719		97	65
66	PHYSICAL THERAPY	47,254,923			12,878,520			66
70	ELECTROENCEPHALOGRAPHY	9,389,312			161,700		339	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,089,434			1,352,280		2,496	71
72	IMPL. DEV. CHARGED TO PATIENTS	56,384,882			81,338			72
73	DRUGS CHARGED TO PATIENTS	95,311,081			4,927,031		6,118	73
76	CARDIOLOGY	125,180,338			598,824			76
76.97	CARDIAC REHABILITATION	1,735,577						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	6,038,117			12,444			90
91	EMERGENCY	82,763,966			1,303			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	24,542,784						92
OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,102,442,650			25,476,009		9,358	200

(A) Worksheet A line numbers



COMPU-MAX

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

COMPONENT CCN: 15-T125

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.296185							50
52	DELIVERY ROOM & LABOR ROOM	0.630900							52
54	RADIOLOGY-DIAGNOSTIC	0.120118	308			37			54
60	LABORATORY	0.112925							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.222869	97			22			65
66	PHYSICAL THERAPY	0.305505							66
70	ELECTROENCEPHALOGRAPHY	0.172024	339			58			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596	2,496			1,180			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522							72
73	DRUGS CHARGED TO PATIENTS	0.224738	6,118		5,551	1,375		1,248	73
76	CARDIOLOGY	0.147431							76
76.97	CARDIAC REHABILITATION	0.406385							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.674715							90
91	EMERGENCY	0.171537							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		9,358		5,551	2,672		1,248	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		9,358		5,551	2,672		1,248	202

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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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 ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	4,452,977		4,452,977	89,003	50.03	4,294	214,829	30
31	INTENSIVE CARE UNIT	1,261,014		1,261,014	9,836	128.20	476	61,023	31
32	CORONARY CARE UNIT								32
32.01	NEONATAL INTENSIVE CARE	374,110		374,110	4,697	79.65	447	35,604	32.01
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	590,595		590,595	14,705	40.16	277	11,124	41
42	SUBPROVIDER I								42
43	NURSERY	78,910		78,910	3,694	21.36	308	6,579	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	6,757,606		6,757,606	121,935		5,802	329,159	200

(A) Worksheet A line numbers



COMPU-MAX

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

COMPONENT CCN: 15-0125

WORKSHEET D
PART II

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

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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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
32.01	NEONATAL INTENSIVE CARE					32.01
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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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)	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	89,003		4,294		30
31	INTENSIVE CARE UNIT	9,836		476		31
32	CORONARY CARE UNIT					32
32.01	NEONATAL INTENSIVE CARE	4,697		447		32.01
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	14,705		277		41
42	SUBPROVIDER I					42
43	NURSERY	3,694		308		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	121,935		5,802		200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0125

WORKSHEET D
PART IV

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

(A) Worksheet A line numbers



COMPU-MAX

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

COMPONENT CCN: 15-0125

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.296185							50
52	DELIVERY ROOM & LABOR ROOM	0.630900							52
54	RADIOLOGY-DIAGNOSTIC	0.120118							54
60	LABORATORY	0.112925							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.222869							65
66	PHYSICAL THERAPY	0.305505							66
70	ELECTROENCEPHALOGRAPHY	0.172024							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522							72
73	DRUGS CHARGED TO PATIENTS	0.224738							73
76	CARDIOLOGY	0.147431							76
76.97	CARDIAC REHABILITATION	0.406385							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.674715							90
91	EMERGENCY	0.171537							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers



COMPU-MAX

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

COMPONENT CCN: 15-T125

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,835,395	163,512,868	0.035688	5,338	191	50
52	DELIVERY ROOM & LABOR ROOM	396,321	7,337,260	0.054015			52
54	RADIOLOGY-DIAGNOSTIC	5,451,669	231,895,918	0.023509	28,196	663	54
60	LABORATORY	1,157,653	163,711,142	0.007071	46,121	326	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	104,425	10,308,845	0.010130	3,019	31	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	422,038	29,986,203	0.014074	32,046	451	65
66	PHYSICAL THERAPY	814,330	47,254,923	0.017233	248,850	4,288	66
70	ELECTROENCEPHALOGRAPHY	401,274	9,389,312	0.042737	1,539	66	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,093	47,089,434	0.005162	21,609	112	71
72	IMPL. DEV. CHARGED TO PATIENTS	322,664	56,384,882	0.005723			72
73	DRUGS CHARGED TO PATIENTS	690,651	95,311,081	0.007246	143,588	1,040	73
76	CARDIOLOGY	3,537,168	125,180,338	0.028257	8,605	243	76
76.97	CARDIAC REHABILITATION	74,239	1,735,577	0.042775			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	216,676	6,038,117	0.035885	122	4	90
91	EMERGENCY	1,283,839	82,763,966	0.015512			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		24,542,784				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	20,951,435	1,102,442,650		539,033	7,415	200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE 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	163,512,868			5,338				50
52	DELIVERY ROOM & LABOR ROOM	7,337,260							52
54	RADIOLOGY-DIAGNOSTIC	231,895,918			28,196				54
60	LABORATORY	163,711,142			46,121				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,308,845			3,019				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	29,986,203			32,046				65
66	PHYSICAL THERAPY	47,254,923			248,850				66
70	ELECTROENCEPHALOGRAPHY	9,389,312			1,539				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,089,434			21,609				71
72	IMPL. DEV. CHARGED TO PATIENTS	56,384,882							72
73	DRUGS CHARGED TO PATIENTS	95,311,081			143,588				73
76	CARDIOLOGY	125,180,338			8,605				76
76.97	CARDIAC REHABILITATION	1,735,577							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	6,038,117			122				90
91	EMERGENCY	82,763,966							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	24,542,784							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,102,442,650			539,033				200

(A) Worksheet A line numbers



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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T125

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.296185							50
52	DELIVERY ROOM & LABOR ROOM	0.630900							52
54	RADIOLOGY-DIAGNOSTIC	0.120118							54
60	LABORATORY	0.112925							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.375271							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.222869							65
66	PHYSICAL THERAPY	0.305505							66
70	ELECTROENCEPHALOGRAPHY	0.172024							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472596							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.565522							72
73	DRUGS CHARGED TO PATIENTS	0.224738							73
76	CARDIOLOGY	0.147431							76
76.97	CARDIAC REHABILITATION	0.406385							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.674715							90
91	EMERGENCY	0.171537							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.456329							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/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)	89,003	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	89,003	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	25,218	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	50,545	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)	43,665	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)	75,286,305	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	75,286,305	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					845.89	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					36,935,787	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					36,935,787	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	16,551,992	9,836	1,682.80	5,752	9,679,466	43
44	CORONARY CARE UNIT						44
44.01	NEONATAL INTENSIVE CARE	5,547,357	4,697	1,181.04			44.01
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

1

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					58,376,002	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					104,991,255	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					2,921,966	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					4,135,328	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					7,057,294	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					97,933,961	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: 15-0125

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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	14,705	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	14,705	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	1,524	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	13,181	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)	12,944	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)	1,317	14
15	TOTAL NURSERY DAYS (Title V or 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)	10,587,762	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		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	10,587,762	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	5,447,659	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	646,362	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	4,801,297	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.943543	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	424.12	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	364.26	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	59.86	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	116.34	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	177,302	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	10,410,460	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	720.01	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	9,319,809	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	9,319,809	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	6,717,855	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	16,037,664	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	519,831	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	364,399	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	884,230	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	15,153,434	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	89,003	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	89,003	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	25,218	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	50,545	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)	4,294	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)	3,694	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	308	16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
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)	75,286,305	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	75,286,305	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0125

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					845.89	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					3,632,252	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)					3,632,252	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)	2,594,947	3,694	702.48	308	216,364	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	16,551,992	9,836	1,682.80	476	801,013	43
44	CORONARY CARE UNIT						44
44.01	NEONATAL INTENSIVE CARE	5,547,357	4,697	1,181.04	447	527,925	44.01
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

1

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					4,284,018	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					9,461,572	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					318,035	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					298,527	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					616,562	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					8,845,010	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: 15-0125

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)					13,240	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	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						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	14,705	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	14,705	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	1,524	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	13,181	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)	277	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
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)	10,587,762	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		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	10,587,762	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	5,447,659	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	646,362	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	4,801,297	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.943543	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	424.12	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	364.26	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	59.86	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	116.34	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	177,302	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	10,410,460	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T125

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	720.01	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	199,443	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	199,443	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	138,589	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	338,032	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	11,124	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	7,415	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	18,539	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	319,493	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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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0125

WORKSHEET D-3

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

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

(A) Worksheet A line numbers



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T125

WORKSHEET D-3

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

(A) Worksheet A line numbers



COMPU-MAX

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

COMPONENT CCN: 15-0125

WORKSHEET D-3

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

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

(A) Worksheet A line numbers



COMPU-MAX

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T125

WORKSHEET D-3

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

(A) Worksheet A line numbers



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
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)	21,445,610			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	58,291,500			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)	1,833,169			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)	371.73			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)	0.0307			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1480			31
32	SUM OF LINES 30 AND 31	0.1787			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0437			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	1,574,008			34
	UNCOMPENSATED CARE ADJUSTMENT				
		PRIOR TO	ON OR AFTER		
		OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
35.01	FACTOR 3 (see instructions)		0.000472800		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		4,277,129		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		3,199,057		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	3,199,057			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	86,343,344			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	86,343,344			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	6,723,697			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES	1,705			54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	93,068,746			59
60	PRIMARY PAYER PAYMENTS	66,726			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	93,002,020			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	7,199,360			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	460,248			63
64	ALLOWABLE BAD DEBTS (see instructions)	629,581			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	409,228			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	215,595			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	85,751,640			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (OTHER ADJUSTMENTS)	39,139			70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	134,943			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-634,168			70.94
71	AMOUNT DUE PROVIDER (see instructions)	85,291,554			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	1,705,831			71.01
72	INTERIM PAYMENTS	83,260,582			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	325,141			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	372,186			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: 15-0125

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	19,058			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	48,019,276			2
3	PPS PAYMENTS	45,962,718			3
4	OUTLIER PAYMENT (see instructions)	132,404			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				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)	19,058			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	84,799			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)	84,799			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)	84,799			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	65,741			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)	19,058			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)	46,095,122			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	9,482,322			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	36,631,858			27
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)	36,631,858			30
31	PRIMARY PAYER PAYMENTS	7,324			31
32	SUBTOTAL (line 30 minus line 31)	36,624,534			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)	808,062			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	525,240			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	447,922			36
37	SUBTOTAL (see instructions)	37,149,774			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	233			38
39	OTHER ADJUSTMENTS (FDO LOSS)				39
40	SUBTOTAL (see instructions)	37,149,541			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	742,991			40.01
41	INTERIM PAYMENTS	36,422,512			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-15,962			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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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	1,248			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	2,672			2
3	PPS PAYMENTS	1,336			3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 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)	1,248			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	5,551			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)	5,551			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)	5,551			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	4,303			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)	1,248			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)	1,336			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	52			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	2,532			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	2,532			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	2,532			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)	2,532			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS ()				39
40	SUBTOTAL (see instructions)	2,532			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	51			40.01
41	INTERIM PAYMENTS	2,345			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	136			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



COMPU-MAX

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

COMPONENT CCN: 15-0125

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		82,721,994		35,885,338	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		444,588		537,174	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	.01	02/12/2014	94,000		3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.02				3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM				3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO				3.04
		PROVIDER				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		94,000		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)			83,260,582	36,422,512	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	.01				5.01
		.02				5.02
		PROGRAM				5.03
		TO				5.04
		PROVIDER				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		PROVIDER				5.52
		TO				5.53
		PROGRAM				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		2,030,972	727,029	6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			85,291,554	37,149,541	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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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-T125

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		19,940,571		2,345	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					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03			3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					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)		19,940,571		2,345	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03			5.03
		TO	.04			5.04
		PROVIDER	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		PROVIDER	.52			5.52
		TO	.53			5.53
		PROGRAM	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		478,756		187	6.01
						6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		20,419,327		2,532	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	17,272	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	49,417	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	5,242	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	90,296	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,247,775,458	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	22,706,684	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	2,416,116	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	48,322	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	2,367,794	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T125

WORKSHEET E-3
PART III

CHECK [] HOSPITAL
 APPLICABLE [XX] SUBPROVIDER IRF
 BOX:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	4,605,998	15,467,559	1
2	MEDICARE SSI RATIO (see instructions)	0.019400		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	85,672	197,985	3
4	OUTLIER PAYMENTS	270,037		4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (see instructions)			5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)			9
10	AVERAGE DAILY CENSUS (see instructions)	40.287671		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	20,627,251		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	20,627,251		17
18	PRIMARY PAYER PAYMENTS	3,816		18
19	SUBTOTAL (line 17 less line 18)	20,623,435		19
20	DEDUCTIBLES	155,488		20
21	SUBTOTAL (line 19 minus line 20)	20,467,947		21
22	COINSURANCE	57,704		22
23	SUBTOTAL (line 21 minus line 22)	20,410,243		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	13,976		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	9,084		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	8,134		26
27	SUBTOTAL (sum of lines 23 and 25)	20,419,327		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	20,419,327		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	408,387		32.01
33	INTERIM PAYMENTS	19,940,571		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	70,369		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	416,646		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (see instructions)			50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)			51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)			52
53	TIME VALUE OF MONEY (see instructions)			53



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0125

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	6,037,234		8
9	ANCILLARY SERVICE CHARGES	18,718,771		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	24,756,005		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	24,756,005		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	24,756,005		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 + line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



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

COMPONENT CCN: 15-T125

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX SUBPROVIDER IRF ICF/MR TEFRA
 BOXES: SNF OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	201,770		8
9	ANCILLARY SERVICE CHARGES	539,033		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	740,803		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	740,803		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	740,803		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 + line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	12,655,029				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	101,901,551				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-44,071,437				6
7	INVENTORY	9,873,456				7
8	PREPAID EXPENSES	3,070,432				8
9	OTHER CURRENT ASSETS	1,538,066				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	84,967,097				11
FIXED ASSETS						
12	LAND	3,403,554				12
13	LAND IMPROVEMENTS	6,747,854				13
14	ACCUMULATED DEPRECIATION	-5,513,914				14
15	BUILDINGS	272,818,361				15
16	ACCUMULATED DEPRECIATION	-196,158,572				16
17	LEASEHOLD IMPROVEMENTS	984,452				17
18	ACCUMULATED AMORTIZATION	-974,875				18
19	FIXED EQUIPMENT	60,277,569				19
20	ACCUMULATED DEPRECIATION	-20,508,729				20
21	AUTOMOBILES AND TRUCKS	563,089				21
22	ACCUMULATED DEPRECIATION	-411,522				22
23	MAJOR MOVABLE EQUIPMENT	132,244,871				23
24	ACCUMULATED DEPRECIATION	-96,782,776				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE	39,792,777				29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	196,482,139				30
OTHER ASSETS						
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	8,400,334				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	8,400,334				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	289,849,570				36
LIABILITIES AND FUND BALANCES						
	(Omit Cents)	1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	15,570,170				37
38	SALARIES, WAGES & FEES PAYABLE	17,538,516				38
39	PAYROLL TAXES PAYABLE	2,176,016				39
40	NOTES & LOANS PAYABLE (short term)	536,273				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	34,025,957				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	69,846,932				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	42,648,621				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	42,648,621				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	112,495,553				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	177,354,017				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)	177,354,017				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	289,849,570				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		101,037,483			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		36,297,404			2
3	TOTAL (sum of line 1 and line 2)		137,334,887			3
4	ADDITIONS (credit adjustments)					4
5	NET ASSETS TRANSFERRED TO AFFILITES	-13,587,870				5
6	PENSION-RELATED CHGS-NOT NET COST	53,625,000				6
7	RELEASED ASSETS	5,000				7
8	OTHER					8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		40,042,130			10
11	SUBTOTAL (line 3 plus line 10)		177,377,017			11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS RELEASED FROM RESTRCTN	-70,000				13
14	RESTRICTED CONTRIBUITIONS	88,000				14
15	NET ASSETS TRANSFERRED					15
16	OTHER	5,000				16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		23,000			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		177,354,017			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	NET ASSETS TRANSFERRED TO AFFILITES					5
6	PENSION-RELATED CHGS-NOT NET COST					6
7	RELEASED ASSETS					7
8	OTHER					8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS RELEASED FROM RESTRCTN					13
14	RESTRICTED CONTRIBUITIONS					14
15	NET ASSETS TRANSFERRED					15
16	OTHER					16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



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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	89,203,896		89,203,896	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	12,224,069		12,224,069	3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	101,427,965		101,427,965	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	18,149,237		18,149,237	11
12	CORONARY CARE UNIT				12
12.01	NEONATAL INTENSIVE CARE	20,362,820		20,362,820	12.01
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	38,512,057		38,512,057	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	139,940,022		139,940,022	17
18	ANCILLARY SERVICES	489,955,807		489,955,807	18
19	OUTPATIENT SERVICES		611,355,972	611,355,972	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		6,540,700	6,540,700	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		44,209,617	44,209,617	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	629,895,829	662,106,289	1,292,002,118	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		429,836,792	29
30	ADD (SPECIFY)			30
31	BAD DEBTS			31
32	CHARITY CARE			32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		429,836,792	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	1,292,002,118	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	840,740,541	2
3	NET PATIENT REVENUES (line 1 minus line 2)	451,261,577	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	429,836,792	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	21,424,785	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	252,000	6
7	INCOME FROM INVESTMENTS	489,212	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	4,835	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	2,074,913	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	5,199,761	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	15,037	21
22	RENTAL OF HOSPITAL SPACE	1,965,655	22
23	GOVERNMENTAL APPROPRIATIONS	139,684	23
24	OTHER (OTHER REVENUE)	436,338	24
24.01	OTHER (REVENUE-CLASSES)	64,166	24.01
24.02	OTHER (ASSETS RELEASED FROM RESTRICTION)	32,859	24.02
24.03	OTHER (FITNESS REVENUE)	4,193,107	24.03
24.04	OTHER (SALE OF XRAY SCRAP)	2,952	24.04
24.05	OTHER (GAIN ON FIXED ASSETS)	2,100	24.05
25	TOTAL OTHER INCOME (sum of lines 6-24)	14,872,619	25
26	TOTAL (line 5 plus line 25)	36,297,404	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	36,297,404	29



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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H

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



COMPU-MAX

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H

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

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



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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H-1
PART I

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



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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7487

WORKSHEET H-1
PART I

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



COMPU-MAX

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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
GENERAL SERVICE COST CENTER								
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL					-717,693	21,413,852	5
HHA REIMBURSABLE SERVICES								
6	SKILLED NURSING CARE					7,305,655	8,350,496	6
7	PHYSICAL THERAPY					5,747,360	6,563,944	7
8	OCCUPATIONAL THERAPY					1,412,596	1,606,164	8
9	SPEECH PATHOLOGY					36,150	48,200	9
10	MEDICAL SOCIAL SERVICES					9,320	10,500	10
11	HOME HEALTH AIDE					716,901	794,280	11
12	SUPPLIES (see instructions)					1,204,874	1,373,564	12
13	DRUGS							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING					2,232,419	2,666,704	17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)					17,947,582	21,413,852	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						717,693	25
26	UNIT COST MULTIPLIER						0.033515	26



COMPU-MAX

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

WORKSHEET H-2
PART I

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

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL		112,082		10,949		37,418	1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)		112,082		10,949		37,418	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL					3,911		1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)					3,911		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

WORKSHEET H-2
PART I

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

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 15-7487

WORKSHEET H-2
PART I

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

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-2
PART II

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



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-2
PART II

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



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COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-2
PART II

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



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COMMUNITY HOSPITAL Provider CCN: 15-0125	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 01/05/2015 Run Time: 13:42 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7487

WORKSHEET H-2
PART II

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



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

HHA CCN: 15-7487

WORKSHEET H-3
PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

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

LIMITATION COST COMPUTATION					PROGRAM VISITS		
	PATIENT SERVICES	CBSA NO.	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
		1	2	3	4		
8	SKILLED NURSING CARE	23844	3,869	14,041		8	
9	PHYSICAL THERAPY	23844	2,534	8,739		9	
10	OCCUPATIONAL THERAPY	23844	714	2,138		10	
11	SPEECH PATHOLOGY	23844	66	218		11	
12	MEDICAL SOCIAL SERVICES	23844	5	14		12	
13	HOME HEALTH AIDE	23844	615	3,149		13	
14	TOTAL (sum of lines 8-13)		7,803	28,299		14	

SUPPLIES AND DRUGS COSTS COMPUTATIONS								
	OTHER PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL CHARGES (from HHA Record)	RATIO (col. 3 ÷ col. 4)	
		1	2	3	4	5		
15	COST OF MEDICAL SUPPLIES	8	323,586		323,586	462,751	0.699266	15
16	COST OF DRUGS	9						16

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

		FROM WKST. C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records)	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED
		1	2	3	4	
1	PHYSICAL THERAPY	66	0.305505			col. 2, line 2
2	OCCUPATIONAL THERAPY	67				col. 2, line 3
3	SPEECH PATHOLOGY	68				col. 2, line 4
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.472596			col. 2, line 15
5	DRUGS CHARGED TO PATIENTS	73	0.224738			col. 2, line 16



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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7487

WORKSHEET H-3
PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

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

SUPPLIES AND DRUGS COSTS COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES				
		PART B			PART B				
	OTHER PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
		6	7	8	9	10	11		
15	COST OF MEDICAL SUPPLIES								15
16	COST OF DRUGS								16



COMPU-MAX

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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 15-7487

WORKSHEET H-4
PARTS I & II

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

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

	DESCRIPTION	PART A 1	PART B		
			NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)				1
2	TOTAL CHARGES				2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (from your records)				3
4	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(b)				4
5	RATIO OF LINE 3 TO LINE 4 (not to exceed 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (see instructions)				6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)				7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)				8
9	PRIMARY PAYER PAYMENTS	5,000			9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST (see instructions)	-5,000		10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	926,018	3,321,880	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	92,472	233,505	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	7,429	51,312	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	3,128	10,533	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	12,250	58,940	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES		271	16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)	1,036,297	3,676,441	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	1,036,297	3,676,441	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	1,036,297	3,676,441	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	1,036,297	3,676,441	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	324	-191	30
31	SUBTOTAL (line 29 plus/minus line 30)	1,036,621	3,676,250	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	20,732	73,525	31.01
32	INTERIM PAYMENTS (see instructions)	1,015,889	3,602,725	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35



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

WORKSHEET H-5

	DESCRIPTION	PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,015,889		3,602,725	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					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM				3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		1,015,889		3,602,725	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				5.03
		TO				5.04
		PROVIDER				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		PROVIDER				5.52
		TO				5.53
		PROGRAM				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		20,732		73,525	6.01
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		1,036,621		3,676,250	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0125

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is 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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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0125

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (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)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		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	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
32.01	NEONATAL INTENSIVE CARE							32.01
41	SUBPROVIDER - IRF							41
43	NURSERY							43
	ANCHLLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILLACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
191	RESEARCH							191
192	PHYSICIANS' PRIVATE OFFICES							192
194	ADVERTISING							194
194.01	FITNESS POINTE							194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY							194.02
194.03	RETAIL PHARMACY							194.03
194.04	HOSPICE							194.04
194.05	RUSH RESIDENTS							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202