

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:38 Version: 2015.10 (05/05/2016)
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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: 05/31/2016 Time: 09:38	
	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 (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRIS HOSPITAL (14-0101) (Provider Name(s) and Number(s)) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 05/31/2016 09:38
yhKfrsAJ9ILgp2pmhAsxwRWNHzpDZ0
U9nUQ0N6z0YJvLP3Umxv0m6UnXyYUI
rCL50Vgyei0JcxoB

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

PI Encryption: 05/31/2016 09:38
Qe7n1WiNLtjHbCFM0UzfHTF0Hc3:r0
kyfM60w.cxgfZikxAViZcOILe:8ymr
s9qY0tbqUk03SWXq

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		231,638	298,110	966,090		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		231,638	298,110	966,090		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 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

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PARTS I, II & III**

for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 150 WEST HIGH STREET	P.O. Box:		1
2	City: MORRIS	State: IL	ZIP Code: 60450	County: GRUNDY

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	MORRIS HOSPITAL	14-0101	16974	1	07 / 01 / 1966	O	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	MORRIS HOSPITAL	14-U101	16974		10 / 07 / 1994	N	N	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01 / 01 / 2015	To: 12 / 31 / 2015	20
21	Type of control (see instructions)	2		21

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days
		1	2	3	4	5	6
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,878				160	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						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

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**WORKSHEET S-2
PART I**

37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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**WORKSHEET S-2
PART I**

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	Y			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1. (see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
65					65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
67					67
Inpatient Psychiatric Facility PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71
Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76
Long Term Care Hospital PPS					
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.		N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.		N		81
TEFRA Providers					
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.		N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.				86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.		N		87

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**WORKSHEET S-2
PART I**

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

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

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		981,005		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121

Transplant Center Information

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

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**WORKSHEET S-2
PART I**

All Providers

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

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

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

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y					167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)						168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)						168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	0.50					169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014		09/30/2014			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			Y			171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

Financial Data and Reports		Y/N	Type	Date	
		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	05/23/2016	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

Bad Debts		Y/N	
		1	2
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		Y/N	
		1	2
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/12/2016	Y	05/12/2016
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)	N		N	
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

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

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

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: THOMAS	Last name: CURTIS	Title: CPA
42	Employer: THE CURTIS GROUP, INC.		
43	Phone number: 217-483-9092	E-mail Address: TOM@THECURTISGROUP.NET	

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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	
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	81	29,565			8,055	1,046	11,297	1
2	HMO and other (see instructions)						769	137		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)		81	29,565			8,055	1,046	11,297	7
8	Intensive Care Unit	31	8	2,920			1,331	365	2,717	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						467	1,180	13
14	Total (see instructions)		89	32,485			9,386	1,878	15,194	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		89							27
28	Observation Bed Days								1,507	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								193	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,985	665	4,534	1
2	HMO and other (see instructions)					191	68		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		899.42			1,985	665	4,534	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		899.42						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

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

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassi- fication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	Total salaries (see instructions)	200	61,414,521		61,414,521	1,870,802.00	32.83
2	Non-physician anesthetist Part A						2
3	Non-physician anesthetest Part B						3
4	Physician-Part A - Administrative						4
4.01	Physician-Part A - Teaching						4.01
5	Physician-Part B		9,759,110		9,759,110	71,523.00	136.45
6	Non-physician-Part B						6
7	Interns & residents (in an approved program)	21					7
7.01	Contracted interns & residents (in an approved program)						7.01
8	Home office personnel						8
9	SNF	44					9
10	Excluded area salaries (see instructions)		195,912	279,958	475,870	9,401.00	50.62
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)						11
12	Contract management and administrative services						12
13	Contract labor: Physician-Part A - Administrative						13
14	Home office salaries & wage-related costs						14
15	Home office: Physician Part A - Administrative						15
16	Home office & Contract Physicians Part A - Teaching						16
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		12,488,636		12,488,636		17
18	Wage-related costs (other)(see instructions)						18
19	Excluded areas		47,545		47,545		19
20	Non-physician anesthetist Part A						20
21	Non-physician anesthetist Part B						21
22	Physician Part A - Administrative						22
22.01	Physician Part A - Teaching						22.01
23	Physician Part B		2,368,425		2,368,425		23
24	Wage-related costs (RHC/FQHC)						24
25	Interns & residents (in an approved program)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		428,804		428,804	14,233.00	30.13
27	Administrative & General		8,284,755	58,704	8,343,459	310,169.00	26.90
28	Administrative & General under contract (see instructions)						28
29	Maintenance & Repairs						29
30	Operation of Plant		985,537		985,537	35,609.00	27.68
31	Laundry & Linen Service		27,515		27,515	2,080.00	13.23
32	Housekeeping		1,274,219		1,274,219	89,356.00	14.26
33	Housekeeping under contract (see instructions)						33
34	Dietary		985,842	-706,541	279,301	18,200.00	15.35
35	Dietary under contract (see instructions)						35
36	Cafeteria			609,715	609,715	39,707.00	15.36
37	Maintenance of Personnel						37
38	Nursing Administration		708,326		708,326	22,443.00	31.56
39	Central Services and Supply		725,523	-626,295	99,228		39
40	Pharmacy		1,783,503		1,783,503	40,768.00	43.75
41	Medical Records & Medical Records Library		1,553,860	-99,228	1,454,632	71,052.00	20.47
42	Social Service						42
43	Other General Service						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		51,655,411		51,655,411	1,799,279.00	28.71
2	Excluded area salaries (see instructions)		195,912	279,958	475,870	9,401.00	50.62
3	Subtotal salaries (line 1 minus line 2)		51,459,499	-279,958	51,179,541	1,789,878.00	28.59
4	Subtotal other wages & related costs (see instructions)						4
5	Subtotal wage-related costs (see instructions)		12,488,636		12,488,636		24.40%
6	Total (sum of lines 3 through 5)		63,948,135	-279,958	63,668,177	1,789,878.00	35.57
7	Total overhead cost (see instructions)		16,757,884	-763,645	15,994,239	643,617.00	24.85

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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	1,366,389 1
2	Tax Sheltered Annuity (TSA) Employer Contribution	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	3
4	Qualified Defined Benefit Plan Cost (see instructions)	4
PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees	5
6	Legal/Accounting/Management Fees-Pension Plan	6
7	Employee Managed Care Program Administration Fees	7
HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	8,469,640 8
9	Prescription Drug Plan	9
10	Dental, Hearing and Vision Plan	196,196 10
11	Life Insurance (If employee is owner or beneficiary)	72,827 11
12	Accident Insurance (If employee is owner or beneficiary)	240,772 12
13	Disability Insurance (If employee is owner or beneficiary)	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)	14
15	Workers' Compensation Insurance	273,853 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	4,131,949 17
18	Medicare Taxes - Employers Portion Only	18
19	Unemployment Insurance	44,968 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	108,013 23
24	Total Wage Related cost (Sum of lines 1-23)	14,904,607 24

Part B - Other Than Core Related Cost

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

EXHIBIT 3

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

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

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD				
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable			9
10	Ending Date of Averaging Period from Line 5			10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	DEPOSIT DATE(S)	CONTRIB-UTION(S)	11
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	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

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

ESRD PPS

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

TRANSPLANT INFORMATION

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

EPOETIN

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

ARANESP

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

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

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

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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)	0.261516	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	15,149,853	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	59,383,667	6
7	Medicaid cost (line 1 times line 6)	15,529,779	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.	379,926	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 care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		17		
18	Government grants, appropriations of transfers for support of hospital operations		18		
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	379,926	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	4,972,097	2,130,899	7,102,996	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,300,283	557,264	1,857,547	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	1,300,283	557,264	1,857,547	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	5,735,314	26
27	Medicare bad debts for the entire hospital complex (see instructions)	434,362	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,300,952	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,386,284	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,243,831	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,623,757	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- FICATION S	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				2,517,990	2,517,990		2,517,990	1
2	00200								2
3	00300							-0-	3
4	00400	428,804	15,184,465	15,613,269		15,613,269	-8,413,803	7,199,466	4
5	00500	8,284,755	27,547,897	35,832,652	-1,820,862	34,011,790	-7,248,557	26,763,233	5
6	00600								6
7	00700	985,537	2,049,862	3,035,399		3,035,399		3,035,399	7
8	00800	27,515	353,662	381,177		381,177		381,177	8
9	00900	1,274,219	488,450	1,762,669		1,762,669		1,762,669	9
10	01000	985,842	505,168	1,491,010	-1,068,589	422,421	-19,594	402,827	10
11	01100				922,147	922,147	-419,307	502,840	11
12	01200								12
13	01300	708,326	54,840	763,166		763,166		763,166	13
14	01400	725,523	4,317,752	5,043,275	-4,833,282	209,993		209,993	14
15	01500	1,783,503	5,623,423	7,406,926		7,406,926	-67,939	7,338,987	15
16	01600	1,553,860	320,532	1,874,392	-209,993	1,664,399		1,664,399	16
17	01700								17
19	01900								19
20	02000								20
20.01	02002				376,807	376,807	-126,445	250,362	20.01
21	02100								21
22	02200								22
23	02300								23
INPATIENT ROUTINE SERVICE COST CENTERS									
30	03000	8,178,202	1,039,959	9,218,161	-1,133,173	8,084,988	-550,795	7,534,193	30
31	03100	3,054,216	417,490	3,471,706	-730,461	2,741,245		2,741,245	31
43	04300				671,541	671,541		671,541	43
ANCILLARY SERVICE COST CENTERS									
50	05000	3,300,562	7,969,317	11,269,879	-4,875,079	6,394,800		6,394,800	50
51	05100	433,457	49,751	483,208		483,208		483,208	51
52	05200				1,192,093	1,192,093		1,192,093	52
53	05300		128,214	128,214		128,214		128,214	53
54	05400	2,166,444	802,719	2,969,163		2,969,163		2,969,163	54
54.01	05401	311,789	336,513	648,302		648,302		648,302	54.01
54.02	05402	673,891	185,121	859,012		859,012		859,012	54.02
55	05500	445,338	1,088,399	1,533,737	-1,556	1,532,181		1,532,181	55
57	05700	712,520	762,602	1,475,122	-2,924	1,472,198		1,472,198	57
58	05800	339,448	457,191	796,639		796,639		796,639	58
59	05900	868,846	1,689,204	2,558,050	-890,125	1,667,925		1,667,925	59
59.97	05901	221,309	26,471	247,780		247,780		247,780	59.97
60	06000	3,260,784	3,380,451	6,641,235		6,641,235	-807,653	5,833,582	60
62.30	06250								62.30
65	06500	1,725,532	398,088	2,123,620		2,123,620		2,123,620	65
66	06600	876,766	88,105	964,871		964,871		964,871	66
67	06700	574,623	156,815	731,438		731,438		731,438	67
68	06800	115,722	14,404	130,126		130,126		130,126	68
71	07100				5,009,653	5,009,653		5,009,653	71
72	07200				5,798,826	5,798,826		5,798,826	72
73	07300								73
OUTPATIENT SERVICE COST CENTERS									
90	09000	14,203,703	4,303,751	18,507,454	-603,863	17,903,591	-8,400,662	9,502,929	90
91	09100	2,997,573	940,208	3,937,781	-376,807	3,560,974		3,560,974	91
92	09200								92
OTHER REIMBURSABLE COST CENTERS									
SPECIAL PURPOSE COST CENTERS									
118		61,218,609	80,680,824	141,899,433	-57,657	141,841,776	-26,054,755	115,787,021	118
NONREIMBURSABLE COST CENTERS									
190.01	19001				57,657	57,657		57,657	190.01
191.01	19101	195,912	171,690	367,602		367,602		367,602	191.01
200		61,414,521	80,852,514	142,267,035		142,267,035	-26,054,755	116,212,280	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	CAFETERIA FOOD SERVICE	A	Cafeteria	11	609,715	312,432	1
2			Administrative & General	5	58,704	30,081	2
3			MEALS ON WHEELS	190.01	38,122	19,535	3
500	Total reclassifications				706,541	362,048	500
	Code Letter - A						
1	EMS PARAMEDICAL EDUCATION COST	B	ALLIED HEALTH EMS	20.01	241,836	134,971	1
500	Total reclassifications				241,836	134,971	500
	Code Letter - B						
1	IMPLANTABLE DEVICES	C	Impl. Dev. Charged to Patient	72		890,125	1
2			Impl. Dev. Charged to Patient	72		4,875,079	2
3			Impl. Dev. Charged to Patient	72		33,622	3
500	Total reclassifications					5,798,826	500
	Code Letter - C						
1	CENTRAL SERVICES	D	Central Services & Supply	14	99,228	110,765	1
500	Total reclassifications				99,228	110,765	500
	Code Letter - D						
1	CHARGEABLE SUPPLY COST RECLASS	E	Medical Supplies Charged to P	71	725,523	4,317,752	1
500	Total reclassifications				725,523	4,317,752	500
	Code Letter - E						
1	ICU RECLASS	F	Adults & Pediatrics	30	642,619	87,842	1
500	Total reclassifications				642,619	87,842	500
	Code Letter - F						
1	BUILDING LAND FIXED RECLASS	G	Cap Rel Costs-Bldg & Fixt	1		2,517,990	1
2							2
3							3
4							4
500	Total reclassifications					2,517,990	500
	Code Letter - G						
1	LDR & NURSERY	I	Delivery Room & Labor Room	52	1,074,439	117,654	1
2			Nursery	43	605,263	66,278	2
500	Total reclassifications				1,679,702	183,932	500
	Code Letter - I						
	GRAND TOTAL (Increases)				4,095,449	13,514,126	

(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	CAFETERIA FOOD SERVICE	A	Dietary	10	609,715	312,432	1	
2			Dietary	10	58,704	30,081	2	
3			Dietary	10	38,122	19,535	3	
500	Total reclassifications				706,541	362,048	500	
	Code letter - A							
1	EMS PARAMEDICAL EDUCATION COST	B	Emergency	91	241,836	134,971	1	
500	Total reclassifications				241,836	134,971	500	
	Code letter - B							
1	IMPLANTABLE DEVICES	C	Cardiac Catheterization	59		890,125	1	
2			Operating Room	50		4,875,079	2	
3			Medical Supplies Charged to P	71		33,622	3	
500	Total reclassifications					5,798,826	500	
	Code letter - C							
1	CENTRAL SERVICES	D	Medical Records & Library	16	99,228	110,765	1	
500	Total reclassifications				99,228	110,765	500	
	Code letter - D							
1	CHARGEABLE SUPPLY COST RECLASS	E	Central Services & Supply	14	725,523	4,317,752	1	
500	Total reclassifications				725,523	4,317,752	500	
	Code letter - E							
1	ICU RECLASS	F	Intensive Care Unit	31	642,619	87,842	1	
500	Total reclassifications				642,619	87,842	500	
	Code letter - F							
1	BUILDING LAND FIXED RECLASS	G	Administrative & General	5		1,909,647	9	
2			Radiology-Therapeutic	55		1,556	9	
3			CT Scan	57		2,924	9	
4			Clinic	90		603,863	9	
500	Total reclassifications					2,517,990	500	
	Code letter - G							
1	LDR & NURSERY	I	Adults & Pediatrics	30	1,074,439	117,654	1	
2			Adults & Pediatrics	30	605,263	66,278	2	
500	Total reclassifications				1,679,702	183,932	500	
	Code letter - I							
	GRAND TOTAL (Decreases)				4,095,449	13,514,126		

(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	6,841,711	700,418		700,418		7,542,129		1
2	Land Improvements	6,192,337	393,878		393,878		6,586,215		2
3	Buildings and Fixtures	69,988,240	1,596,910		1,596,910		71,585,150		3
4	Building Improvements								4
5	Fixed Equipment	22,025,614	104,642		104,642		22,130,256		5
6	Movable Equipment	67,726,830	3,591,417		3,591,417		71,318,247		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	172,774,732	6,387,265		6,387,265		179,161,997		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	172,774,732	6,387,265		6,387,265		179,161,997		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 instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		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 lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				0.000000					1
2	Cap Rel Costs-Mvble Equip				0.000000					2
3	Total (sum of lines 1-2)				0.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	2,517,990							2,517,990	1
2	Cap Rel Costs-Mvble Equip									2
3	Total (sum of lines 1-2)	2,517,990							2,517,990	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			Wkst. A-7 Ref.
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)	B	-93,101	Administrative & General	5		3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)	B	-25,927	Administrative & General	5		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	-9,759,110				10
11	Sale of scrap, waste, etc. (chapter 23)	B	-1,843	Administrative & General	5		11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-419,307	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients	B	-67,939	Pharmacy	15		17
18	Sale of medical records and abstracts	B	-1,361	Administrative & General	5		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-8,087	Administrative & General	5		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	EMPLOYEE SELF INSURANCE	A	-8,413,803	Employee Benefits Department	4		33
34	LIFELINE	A	-71,422	Administrative & General	5		34
35	LOBBYING COSTS	A	-28,033	Administrative & General	5		35
36	MEALS ON WHEELS	B	-19,594	Dietary	10		36
37	LEASED EE FEES	B	-40,025	Administrative & General	5		37
38	INTEREST-NET SETTLEMENT DERIVATIVE	A	-581,800	Administrative & General	5		38
39	PHYSICIAN RECRUITMENT	A	-462,680	Administrative & General	5		39
40	BAD DEBT EXPENSE	A	-5,735,314	Administrative & General	5		40
41	MISC INCOME	B	-154,709	Administrative & General	5		41
42	FUND RAISING	B	-27,418	Administrative & General	5		42
43	EMS EDUCATION	B	-126,445	ALLIED HEALTH EMS	20.01		43
44							44
45	CPR CLASS	B	-16,837	Administrative & General	5		45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-26,054,755				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

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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		LINE#	Wkst. A-7 Ref.
				COST CENTER			
		1	2	3		4	5

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

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

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

WORKSHEET A-8-1

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

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12					5

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics GROUP A	550,795	550,795						1
2	60	Laboratory GROUP B	807,653	807,653						2
3	90	Clinic GROUP C	8,400,662	8,400,662						3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	9,759,110	9,759,110						200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowanc e	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics GROUP A							550,795	1
2	60	Laboratory GROUP B							807,653	2
3	90	Clinic GROUP C							8,400,662	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							9,759,110	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	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	4	4A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,517,990	2,517,990					1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	7,199,466	8,195	7,207,661				4
5	Administrative & General	26,763,233	574,974	986,080	28,324,287	28,324,287		5
6	Maintenance & Repairs							6
7	Operation of Plant	3,035,399	245,494	116,477	3,397,370	1,094,894	4,492,264	7
8	Laundry & Linen Service	381,177	23,877	3,252	408,306	131,588	63,494	8
9	Housekeeping	1,762,669	18,463	150,595	1,931,727	622,551	49,098	9
10	Dietary	402,827	74,399	33,009	510,235	164,437	197,843	10
11	Cafeteria	502,840	38,086	72,060	612,986	197,551	101,279	11
12	Maintenance of Personnel							12
13	Nursing Administration	763,166	20,795	83,714	867,675	279,632	55,299	13
14	Central Services & Supply	209,993	90,940	11,727	312,660	100,763	241,828	14
15	Pharmacy	7,338,987	14,809	210,785	7,564,581	2,437,890	39,380	15
16	Medical Records & Library	1,664,399	58,554	171,917	1,894,870	610,673	155,707	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
20.01	ALLIED HEALTH EMS	250,362		28,582	278,944	89,897		20.01
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	7,534,193	454,660	843,980	8,832,833	2,846,619	1,209,034	30
31	Intensive Care Unit	2,741,245	41,222	285,017	3,067,484	988,580	109,619	31
43	Nursery	671,541	7,773	71,534	750,848	241,981	20,669	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,394,800	78,899	390,080	6,863,779	2,212,038	209,809	50
51	Recovery Room	483,208	82,881	51,229	617,318	198,947	220,398	51
52	Delivery Room & Labor Room	1,192,093	5,836	126,984	1,324,913	426,989	15,520	52
53	Anesthesiology	128,214	7,091		135,305	43,606	18,856	53
54	Radiology-Diagnostic	2,969,163	142,540	256,043	3,367,746	1,085,347	379,042	54
54.01	NUCLEAR MEDICINE	648,302	5,891	36,849	691,042	222,707	15,665	54.01
54.02	ULTRASOUND	859,012	10,691	79,644	949,347	305,953	28,429	54.02
55	Radiology-Therapeutic	1,532,181		52,633	1,584,814	510,749		55
57	CT Scan	1,472,198	16,718	84,210	1,573,126	506,982	44,457	57
58	MRI	796,639	94,963	40,118	931,720	300,272	252,526	58
59	Cardiac Catheterization	1,667,925	21,327	102,685	1,791,937	577,500	56,713	59
59.97	CARDIAC REHAB	247,780		26,156	273,936	88,283		59.97
60	Laboratory	5,833,582	74,045	385,379	6,293,006	2,028,091	196,900	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,123,620	73,418	203,934	2,400,972	773,778	195,232	65
66	Physical Therapy	964,871	54,395	103,621	1,122,887	361,881	144,647	66
67	Occupational Therapy	731,438	14,577	67,912	813,927	262,310	38,764	67
68	Speech Pathology	130,126	3,205	13,677	147,008	47,377	8,521	68
71	Medical Supplies Charged to Patients	5,009,653		85,747	5,095,400	1,642,130		71
72	Impl. Dev. Charged to Patients	5,798,826			5,798,826	1,868,828		72
73	Drugs Charged to Patients							73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	9,502,929	8,850	1,678,682	11,190,461	3,606,438	23,534	90
91	Emergency	3,560,974	150,422	325,690	4,037,086	1,301,060	400,001	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	115,787,021	2,517,990	7,180,002	115,759,362	28,178,322	4,492,264	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS	57,657		4,505	62,162	20,033		190.01
191.01	PATIENT TRANSPORTATION	367,602		23,154	390,756	125,932		191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	116,212,280	2,517,990	7,207,661	116,212,280	28,324,287	4,492,264	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		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	603,388						8
9	Housekeeping		2,603,376					9
10	Dietary		117,602	990,117				10
11	Cafeteria		60,202		972,018			11
12	Maintenance of Personnel							12
13	Nursing Administration		32,871		19,300	1,254,777		13
14	Central Services & Supply		143,748		35,091		834,090	14
15	Pharmacy		23,408		33,336			15
16	Medical Records & Library		92,556		59,655			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
20.01	ALLIED HEALTH EMS							20.01
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	448,630	718,679	736,169	185,982	513,416		30
31	Intensive Care Unit	107,898	65,160	177,053	59,655	163,709		31
43	Nursery	46,860	12,286	76,895	14,036	43,994		43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room		124,715		78,955	217,406		50
51	Recovery Room		131,009		10,527	26,945		51
52	Delivery Room & Labor Room		9,225		24,564	69,912		52
53	Anesthesiology		11,208					53
54	Radiology-Diagnostic		225,311		71,936			54
54.01	NUCLEAR MEDICINE		9,312		5,264			54.01
54.02	ULTRASOUND		16,899		14,036			54.02
55	Radiology-Therapeutic							55
57	CT Scan		26,426		15,791			57
58	MRI		150,107		7,018			58
59	Cardiac Catheterization		33,712		17,545	48,354		59
59.97	CARDIAC REHAB				5,264			59.97
60	Laboratory		117,042		91,236			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		116,050		61,409	171,041		65
66	Physical Therapy		85,982		22,809			66
67	Occupational Therapy		23,042		10,527			67
68	Speech Pathology		5,065		1,755			68
71	Medical Supplies Charged to Patients				35,091		386,595	71
72	Impl. Dev. Charged to Patients						447,495	72
73	Drugs Charged to Patients							73
OUTPATIENT SERVICE COST CENTERS								
90	Clinic		13,989		17,545			90
91	Emergency		237,770		64,918			91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	603,388	2,603,376	990,117	963,245	1,254,777	834,090	118
NONREIMBURSABLE COST CENTERS								
190.0	MEALS ON WHEELS							190.0
191.0	PATIENT TRANSPORTATION				8,773			191.0
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	603,388	2,603,376	990,117	972,018	1,254,777	834,090	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	EMS ALLIED HEALTH 20.01	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	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	10,098,595						15
16	Medical Records & Library		2,813,461					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
20.01	ALLIED HEALTH EMS			368,841				20.01
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		96,958		15,588,320		15,588,320	30
31	Intensive Care Unit		40,044		4,779,202		4,779,202	31
43	Nursery		6,310		1,213,879		1,213,879	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room		357,002		10,063,704		10,063,704	50
51	Recovery Room		36,740		1,241,884		1,241,884	51
52	Delivery Room & Labor Room		11,233		1,882,356		1,882,356	52
53	Anesthesiology		34,465		243,440		243,440	53
54	Radiology-Diagnostic		129,011		5,258,393		5,258,393	54
54.01	NUCLEAR MEDICINE		38,000		981,990		981,990	54.01
54.02	ULTRASOUND		83,212		1,397,876		1,397,876	54.02
55	Radiology-Therapeutic		43,078		2,138,641		2,138,641	55
57	CT Scan		342,226		2,509,008		2,509,008	57
58	MRI		92,914		1,734,557		1,734,557	58
59	Cardiac Catheterization		78,074		2,603,835		2,603,835	59
59.97	CARDIAC REHAB		4,156		371,639		371,639	59.97
60	Laboratory		493,242		9,219,517		9,219,517	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		131,484		3,849,966		3,849,966	65
66	Physical Therapy		35,821		1,774,027		1,774,027	66
67	Occupational Therapy		11,386		1,159,956		1,159,956	67
68	Speech Pathology		2,916		212,642		212,642	68
71	Medical Supplies Charged to Patients		88,165		7,247,381		7,247,381	71
72	Impl. Dev. Charged to Patients		94,085		8,209,234		8,209,234	72
73	Drugs Charged to Patients	10,098,595	167,671		10,266,266		10,266,266	73
OUTPATIENT SERVICE COST CENTERS								
90	Clinic		163,213		15,015,180		15,015,180	90
91	Emergency		232,055	368,841	6,641,731		6,641,731	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	10,098,595	2,813,461	368,841	115,604,624		115,604,624	118
NONREIMBURSABLE COST CENTERS								
190.0	MEALS ON WHEELS				82,195		82,195	190.0
191.0	PATIENT TRANSPORTATION				525,461		525,461	191.0
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,098,595	2,813,461	368,841	116,212,280		116,212,280	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	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMEN T	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2A	4	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		8,195	8,195	8,195			4
5	Administrative & General		574,974	574,974	1,118	576,092		5
6	Maintenance & Repairs							6
7	Operation of Plant		245,494	245,494	132	22,270	267,896	7
8	Laundry & Linen Service		23,877	23,877	4	2,676	3,786	8
9	Housekeeping		18,463	18,463	171	12,662	2,928	9
10	Dietary		74,399	74,399	37	3,345	11,798	10
11	Cafeteria		38,086	38,086	82	4,018	6,040	11
12	Maintenance of Personnel							12
13	Nursing Administration		20,795	20,795	95	5,688	3,298	13
14	Central Services & Supply		90,940	90,940	13	2,049	14,421	14
15	Pharmacy		14,809	14,809	239	49,586	2,348	15
16	Medical Records & Library		58,554	58,554	195	12,421	9,286	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
20.01	ALLIED HEALTH EMS				32	1,828		20.01
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		454,660	454,660	957	57,899	72,103	30
31	Intensive Care Unit		41,222	41,222	323	20,107	6,537	31
43	Nursery		7,773	7,773	81	4,922	1,233	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		78,899	78,899	442	44,992	12,512	50
51	Recovery Room		82,881	82,881	58	4,047	13,143	51
52	Delivery Room & Labor Room		5,836	5,836	144	8,685	926	52
53	Anesthesiology		7,091	7,091		887	1,124	53
54	Radiology-Diagnostic		142,540	142,540	290	22,076	22,604	54
54.01	NUCLEAR MEDICINE		5,891	5,891	42	4,530	934	54.01
54.02	ULTRASOUND		10,691	10,691	90	6,223	1,695	54.02
55	Radiology-Therapeutic				60	10,388		55
57	CT Scan		16,718	16,718	95	10,312	2,651	57
58	MRI		94,963	94,963	45	6,107	15,059	58
59	Cardiac Catheterization		21,327	21,327	116	11,746	3,382	59
59.97	CARDIAC REHAB				30	1,796		59.97
60	Laboratory		74,045	74,045	437	41,251	11,742	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		73,418	73,418	231	15,738	11,643	65
66	Physical Therapy		54,395	54,395	117	7,361	8,626	66
67	Occupational Therapy		14,577	14,577	77	5,335	2,312	67
68	Speech Pathology		3,205	3,205	16	964	508	68
71	Medical Supplies Charged to Patients				97	33,400		71
72	Impl. Dev. Charged to Patients					38,011		72
73	Drugs Charged to Patients							73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		8,850	8,850	1,929	73,341	1,403	90
91	Emergency		150,422	150,422	369	26,463	23,854	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		2,517,990	2,517,990	8,164	573,124	267,896	118
	NONREIMBURSABLE COST CENTERS							
190.0	MEALS ON WHEELS				5	407		190.0
1								1
191.0	PATIENT TRANSPORTATION				26	2,561		191.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,517,990	2,517,990	8,195	576,092	267,896	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		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	30,343						8
9	Housekeeping		34,224					9
10	Dietary		1,546	91,125				10
11	Cafeteria		791		49,017			11
12	Maintenance of Personnel							12
13	Nursing Administration		432		973	31,281		13
14	Central Services & Supply		1,890		1,770		111,083	14
15	Pharmacy		308		1,681			15
16	Medical Records & Library		1,217		3,008			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
20.01	ALLIED HEALTH EMS							20.01
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	22,560	9,447	67,753	9,378	12,799		30
31	Intensive Care Unit	5,426	857	16,295	3,008	4,081		31
43	Nursery	2,357	162	7,077	708	1,097		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,640		3,982	5,420		50
51	Recovery Room		1,722		531	672		51
52	Delivery Room & Labor Room		121		1,239	1,743		52
53	Anesthesiology		147					53
54	Radiology-Diagnostic		2,962		3,628			54
54.01	NUCLEAR MEDICINE		122		265			54.01
54.02	ULTRASOUND		222		708			54.02
55	Radiology-Therapeutic							55
57	CT Scan		347		796			57
58	MRI		1,973		354			58
59	Cardiac Catheterization		443		885	1,205		59
59.97	CARDIAC REHAB				265			59.97
60	Laboratory		1,539		4,601			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,526		3,097	4,264		65
66	Physical Therapy		1,130		1,150			66
67	Occupational Therapy		303		531			67
68	Speech Pathology		67		88			68
71	Medical Supplies Charged to Patients				1,770		51,484	71
72	Impl. Dev. Charged to Patients						59,599	72
73	Drugs Charged to Patients							73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		184		885			90
91	Emergency		3,126		3,274			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	30,343	34,224	91,125	48,575	31,281	111,083	118
	NONREIMBURSABLE COST CENTERS							
190.0	MEALS ON WHEELS							190.0
1								1
191.0	PATIENT TRANSPORTATION				442			191.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	30,343	34,224	91,125	49,017	31,281	111,083	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	EMS ALLIED HEALTH	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	20.01	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	68,971						15
16	Medical Records & Library		84,681					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
20.01	ALLIED HEALTH EMS			1,860				20.01
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		2,925		710,481		710,481	30
31	Intensive Care Unit		1,208		99,064		99,064	31
43	Nursery		190		25,600		25,600	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		10,771		158,658		158,658	50
51	Recovery Room		1,108		104,162		104,162	51
52	Delivery Room & Labor Room		339		19,033		19,033	52
53	Anesthesiology		1,040		10,289		10,289	53
54	Radiology-Diagnostic		3,892		197,992		197,992	54
54.01	NUCLEAR MEDICINE		1,146		12,930		12,930	54.01
54.02	ULTRASOUND		2,510		22,139		22,139	54.02
55	Radiology-Therapeutic		1,300		11,748		11,748	55
57	CT Scan		10,325		41,244		41,244	57
58	MRI		2,803		121,304		121,304	58
59	Cardiac Catheterization		2,355		41,459		41,459	59
59.97	CARDIAC REHAB		125		2,216		2,216	59.97
60	Laboratory		14,681		148,296		148,296	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,967		113,884		113,884	65
66	Physical Therapy		1,081		73,860		73,860	66
67	Occupational Therapy		344		23,479		23,479	67
68	Speech Pathology		88		4,936		4,936	68
71	Medical Supplies Charged to Patients		2,660		89,411		89,411	71
72	impl. Dev. Charged to Patients		2,839		100,449		100,449	72
73	Drugs Charged to Patients	68,971	5,059		74,030		74,030	73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		4,924		91,516		91,516	90
91	Emergency		7,001		214,509		214,509	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	68,971	84,681		2,512,689		2,512,689	118
	NONREIMBURSABLE COST CENTERS							
190.0	MEALS ON WHEELS				412		412	190.0
191.0	PATIENT TRANSPORTATION				3,029		3,029	191.0
200	Cross Foot Adjustments			1,860	1,860		1,860	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	68,971	84,681	1,860	2,517,990		2,517,990	202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	EMPLOYEE BENEFITS DEPARTMEN T GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		1	4	5A	5	6	7	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	184,654						1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	601	60,985,717					4
5	Administrative & General	42,165	8,343,459	-28,324,287	87,887,993			5
6	Maintenance & Repairs					22,357		6
7	Operation of Plant	18,003	985,537		3,397,370		123,885	7
8	Laundry & Linen Service	1,751	27,515		408,306		1,751	8
9	Housekeeping	1,354	1,274,219		1,931,727		1,354	9
10	Dietary	5,456	279,301		510,235		5,456	10
11	Cafeteria	2,793	609,715		612,986		2,793	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,525	708,326		867,675		1,525	13
14	Central Services & Supply	6,669	99,228		312,660		6,669	14
15	Pharmacy	1,086	1,783,503		7,564,581		1,086	15
16	Medical Records & Library	4,294	1,454,632		1,894,870		4,294	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
20.01	ALLIED HEALTH EMS		241,836		278,944			20.01
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	33,342	7,141,119		8,832,833		33,342	30
31	Intensive Care Unit	3,023	2,411,597		3,067,484		3,023	31
43	Nursery	570	605,263		750,848		570	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	5,786	3,300,562		6,863,779		5,786	50
51	Recovery Room	6,078	433,457		617,318		6,078	51
52	Delivery Room & Labor Room	428	1,074,439		1,324,913		428	52
53	Anesthesiology	520			135,305		520	53
54	Radiology-Diagnostic	10,453	2,166,444		3,367,746		10,453	54
54.01	NUCLEAR MEDICINE	432	311,789		691,042		432	54.01
54.02	ULTRASOUND	784	673,891		949,347		784	54.02
55	Radiology-Therapeutic		445,338		1,584,814			55
57	CT Scan	1,226	712,520		1,573,126		1,226	57
58	MRI	6,964	339,448		931,720		6,964	58
59	Cardiac Catheterization	1,564	868,846		1,791,937		1,564	59
59.97	CARDIAC REHAB		221,309		273,936			59.97
60	Laboratory	5,430	3,260,784		6,293,006		5,430	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,384	1,725,532		2,400,972	5,384	5,384	65
66	Physical Therapy	3,989	876,766		1,122,887	3,989	3,989	66
67	Occupational Therapy	1,069	574,623		813,927	1,069	1,069	67
68	Speech Pathology	235	115,722		147,008	235	235	68
71	Medical Supplies Charged to Patients		725,523		5,095,400			71
72	Impl. Dev. Charged to Patients				5,798,826			72
73	Drugs Charged to Patients							73
OUTPATIENT SERVICE COST CENTERS								
90	Clinic	649	14,203,703		11,190,461	649	649	90
91	Emergency	11,031	2,755,737		4,037,086	11,031	11,031	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	184,654	60,751,683	-28,324,287	87,435,075	22,357	123,885	118
NONREIMBURSABLE COST CENTERS								
190.0	MEALS ON WHEELS		38,122		62,162			190.0
191.0	PATIENT TRANSPORTATION		195,912		390,756			191.0
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,517,990	7,207,661		28,324,287		4,492,264	202
203	Unit Cost Multiplier (Wkst. B, Part I)	13.636260	0.118186		0.322277		36.261565	203
204	Cost to be allocated (Per Wkst. B, Part II)		8,195		576,092		267,896	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.000134		0.006555		2.162457	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA FTE'S	MAINTENANCE OF PERSONNEL SQUARE FEET	NURSING ADMINISTRATION DIRECT NRSING HRS	
		8	9	10	11	12	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							7
8	Laundry & Linen Service	15,194						8
9	Housekeeping		120,780					9
10	Dietary		5,456	15,194				10
11	Cafeteria		2,793		554			11
12	Maintenance of Personnel					112,531		12
13	Nursing Administration		1,525			1,525	537,577	13
14	Central Services & Supply		6,669		20	6,669		14
15	Pharmacy		1,086		19	1,086		15
16	Medical Records & Library		4,294		34	4,294		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
20.01	ALLIED HEALTH EMS							20.01
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	11,297	33,342	11,297	106	33,342	219,960	30
31	Intensive Care Unit	2,717	3,023	2,717	34	3,023	70,137	31
43	Nursery	1,180	570	1,180	8	570	18,848	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,786		45	5,786	93,142	50
51	Recovery Room		6,078		6	6,078	11,544	51
52	Delivery Room & Labor Room		428		14	428	29,952	52
53	Anesthesiology		520			520		53
54	Radiology-Diagnostic		10,453		41	10,453		54
54.01	NUCLEAR MEDICINE		432		3	432		54.01
54.02	ULTRASOUND		784		8	784		54.02
55	Radiology-Therapeutic							55
57	CT Scan		1,226		9	1,226		57
58	MRI		6,964		4	6,964		58
59	Cardiac Catheterization		1,564		10	1,564	20,716	59
59.97	CARDIAC REHAB				3			59.97
60	Laboratory		5,430		52	5,430		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,384		35	5,384	73,278	65
66	Physical Therapy		3,989		13	3,989		66
67	Occupational Therapy		1,069		6	1,069		67
68	Speech Pathology		235		1	235		68
71	Medical Supplies Charged to Patients				20			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		649		10	649		90
91	Emergency		11,031		37	11,031		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	15,194	120,780	15,194	549	112,531	537,577	118
	NONREIMBURSABLE COST CENTERS							
190.0	MEALS ON WHEELS							190.0
1								1
191.0	PATIENT TRANSPORTATION				5			191.0
1								1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	603,388	2,603,376	990,117	972,018		1,254,777	202
203	Unit Cost Multiplier (Wkst. B, Part I)	39.712255	21.554694	65.164999	1,754.545126		2,334,134	203
204	Cost to be allocated (Per Wkst. B, Part II)	30,343	34,224	91,125	49,017		31,281	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.997038	0.283358	5.997433	88.478339		0.058189	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	EMS ALLIED HEALTH TIME SPENT	PARAMED EDUCATION EMS ASSIGNED TIME		
	14	15	16	20.01	23		

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	10,808,479					14
15	Pharmacy		100				15
16	Medical Records & Library			442,056,238			16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
20.01	ALLIED HEALTH EMS				100		20.01
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)					100	23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			15,235,463			30
31	Intensive Care Unit			6,292,345			31
43	Nursery			991,477			43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room			56,097,094			50
51	Recovery Room			5,773,044			51
52	Delivery Room & Labor Room			1,765,057			52
53	Anesthesiology			5,415,597			53
54	Radiology-Diagnostic			20,272,017			54
54.01	NUCLEAR MEDICINE			5,971,122			54.01
54.02	ULTRASOUND			13,075,398			54.02
55	Radiology-Therapeutic			6,768,937			55
57	CT Scan			53,775,338			57
58	MRI			14,599,954			58
59	Cardiac Catheterization			12,268,041			59
59.97	CARDIAC REHAB			653,081			59.97
60	Laboratory			77,471,101			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy			20,660,589			65
66	Physical Therapy			5,628,649			66
67	Occupational Therapy			1,789,116			67
68	Speech Pathology			458,271			68
71	Medical Supplies Charged to Patients	5,009,653		13,853,690			71
72	Impl. Dev. Charged to Patients	5,798,826		14,783,929			72
73	Drugs Charged to Patients		100	26,346,854			73
OUTPATIENT SERVICE COST CENTERS							
90	Clinic			25,646,321			90
91	Emergency			36,463,753	100	100	91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,808,479	100	442,056,238	100	100	118
NONREIMBURSABLE COST CENTERS							
190.0	MEALS ON WHEELS						190.0
1							1
191.0	PATIENT TRANSPORTATION						191.0
1							1
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	834,090	10,098,595	2,813,461	368,841		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.077170	100,985.950000	0.006364	3,688.410000		203
204	Cost to be allocated (Per Wkst. B, Part II)	111,083	68,971	84,681	1,860		204

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	EMS ALLIED HEALTH TIME SPENT	PARAMED EDUCATION EMS ASSIGNED TIME		
		14	15	16	20.01	23		
205	Unit Cost Multiplier (Wkst. B, Part II)	0.010277	689.710000	0.000192	18.600000			205

KPMG LLP Compu-Max 2552-10

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT
		PART	LINE NO.	
	1	2	3	4

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
				1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	15,588,320		15,588,320		15,588,320	30
31	Intensive Care Unit	4,779,202		4,779,202		4,779,202	31
43	Nursery	1,213,879		1,213,879		1,213,879	43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,063,704		10,063,704		10,063,704	50
51	Recovery Room	1,241,884		1,241,884		1,241,884	51
52	Delivery Room & Labor Room	1,882,356		1,882,356		1,882,356	52
53	Anesthesiology	243,440		243,440		243,440	53
54	Radiology-Diagnostic	5,258,393		5,258,393		5,258,393	54
54.01	NUCLEAR MEDICINE	981,990		981,990		981,990	54.01
54.02	ULTRASOUND	1,397,876		1,397,876		1,397,876	54.02
55	Radiology-Therapeutic	2,138,641		2,138,641		2,138,641	55
57	CT Scan	2,509,008		2,509,008		2,509,008	57
58	MRI	1,734,557		1,734,557		1,734,557	58
59	Cardiac Catheterization	2,603,835		2,603,835		2,603,835	59
59.97	CARDIAC REHAB	371,639		371,639		371,639	59.97
60	Laboratory	9,219,517		9,219,517		9,219,517	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	3,849,966		3,849,966		3,849,966	65
66	Physical Therapy	1,774,027		1,774,027		1,774,027	66
67	Occupational Therapy	1,159,956		1,159,956		1,159,956	67
68	Speech Pathology	212,642		212,642		212,642	68
71	Medical Supplies Charged to Patients	7,247,381		7,247,381		7,247,381	71
72	Impl. Dev. Charged to Patients	8,209,234		8,209,234		8,209,234	72
73	Drugs Charged to Patients	10,266,266		10,266,266		10,266,266	73
OUTPATIENT SERVICE COST CENTERS							
90	Clinic	15,015,180		15,015,180		15,015,180	90
91	Emergency	6,641,731		6,641,731		6,641,731	91
92	Observation Beds (Non-Distinct Part)	1,834,712		1,834,712		1,834,712	92
OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	117,439,336		117,439,336		117,439,336	200
201	Less Observation Beds	1,834,712		1,834,712		1,834,712	201
202	Total (line 200 minus line 201)	115,604,624		115,604,624		115,604,624	202

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	11,921,990		11,921,990				30
31	Intensive Care Unit	6,292,345		6,292,345				31
43	Nursery	991,477		991,477				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,625,696	39,471,398	56,097,094	0.179398	0.179398	0.179398	50
51	Recovery Room	1,803,698	3,969,346	5,773,044	0.215118	0.215118	0.215118	51
52	Delivery Room & Labor Room	1,765,057		1,765,057	1.066456	1.066456	1.066456	52
53	Anesthesiology	1,865,493	3,550,104	5,415,597	0.044952	0.044952	0.044952	53
54	Radiology-Diagnostic	4,079,000	16,193,017	20,272,017	0.259392	0.259392	0.259392	54
54.01	NUCLEAR MEDICINE	833,813	5,137,309	5,971,122	0.164457	0.164457	0.164457	54.01
54.02	ULTRASOUND	1,747,350	11,328,048	13,075,398	0.106909	0.106909	0.106909	54.02
55	Radiology-Therapeutic	2,003	6,766,934	6,768,937	0.315949	0.315949	0.315949	55
57	CT Scan	8,818,074	44,957,264	53,775,338	0.046657	0.046657	0.046657	57
58	MRI	1,860,979	12,738,975	14,599,954	0.118806	0.118806	0.118806	58
59	Cardiac Catheterization	4,469,221	7,798,820	12,268,041	0.212245	0.212245	0.212245	59
59.97	CARDIAC REHAB	774	652,307	653,081	0.569055	0.569055	0.569055	59.97
60	Laboratory	20,063,705	57,407,396	77,471,101	0.119006	0.119006	0.119006	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	10,224,807	10,435,782	20,660,589	0.186343	0.186343	0.186343	65
66	Physical Therapy	2,323,691	3,304,958	5,628,649	0.315178	0.315178	0.315178	66
67	Occupational Therapy	829,943	959,173	1,789,116	0.648340	0.648340	0.648340	67
68	Speech Pathology	322,506	135,765	458,271	0.464009	0.464009	0.464009	68
71	Medical Supplies Charged to Patients	7,242,945	6,610,745	13,853,690	0.523137	0.523137	0.523137	71
72	Impl. Dev. Charged to Patients	11,048,324	3,735,605	14,783,929	0.555281	0.555281	0.555281	72
73	Drugs Charged to Patients	13,108,839	13,238,015	26,346,854	0.389658	0.389658	0.389658	73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	32,777	25,613,544	25,646,321	0.585471	0.585471	0.585471	90
91	Emergency	7,874,898	28,588,855	36,463,753	0.182146	0.182146	0.182146	91
92	Observation Beds (Non-Distinct Part)	1,700,507	1,612,966	3,313,473	0.553713	0.553713	0.553713	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	137,849,912	304,206,326	442,056,238				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	137,849,912	304,206,326	442,056,238				202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	710,481		710,481	12,804	55.49			30
31	Intensive Care Unit	99,064		99,064	2,717	36.46			31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	25,600		25,600	1,180	21.69			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	835,145		835,145	16,701				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0101

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other)
 Applicable Title XVIII, Part A IPF
 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	158,658	56,097,094	0.002828		50
51	Recovery Room	104,162	5,773,044	0.018043		51
52	Delivery Room & Labor Room	19,033	1,765,057	0.010783		52
53	Anesthesiology	10,289	5,415,597	0.001900		53
54	Radiology-Diagnostic	197,992	20,272,017	0.009767		54
54.01	NUCLEAR MEDICINE	12,930	5,971,122	0.002165		54.01
54.02	ULTRASOUND	22,139	13,075,398	0.001693		54.02
55	Radiology-Therapeutic	11,748	6,768,937	0.001736		55
57	CT Scan	41,244	53,775,338	0.000767		57
58	MRI	121,304	14,599,954	0.008309		58
59	Cardiac Catheterization	41,459	12,268,041	0.003379		59
59.97	CARDIAC REHAB	2,216	653,081	0.003393		59.97
60	Laboratory	148,296	77,471,101	0.001914		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	113,884	20,660,589	0.005512		65
66	Physical Therapy	73,860	5,628,649	0.013122		66
67	Occupational Therapy	23,479	1,789,116	0.013123		67
68	Speech Pathology	4,936	458,271	0.010771		68
71	Medical Supplies Charged to Pat	89,411	13,853,690	0.006454		71
72	Impl. Dev. Charged to Patients	100,449	14,783,929	0.006794		72
73	Drugs Charged to Patients	74,030	26,346,854	0.002810		73
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	91,516	25,646,321	0.003568		90
91	Emergency	214,509	36,463,753	0.005883		91
92	Observation Beds (Non-Distinct	83,623	3,313,473	0.025237		92
	OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-199)	1,761,167	422,850,426			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5+ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	12,804				30
31	Intensive Care Unit	2,717				31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,180				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	16,701				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0101

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	NUCLEAR MEDICINE							54.01
54.02	ULTRASOUND							54.02
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
59.97	CARDIAC REHAB							59.97
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency		368,841			368,841	368,841	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)		368,841			368,841	368,841	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

COMPONENT CCN: 14-0101

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7		8	9	10	11	12	13		
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	56,097,094							50
51	Recovery Room	5,773,044							51
52	Delivery Room & Labor Room	1,765,057							52
53	Anesthesiology	5,415,597							53
54	Radiology-Diagnostic	20,272,017							54
54.01	NUCLEAR MEDICINE	5,971,122							54.01
54.02	ULTRASOUND	13,075,398							54.02
55	Radiology-Therapeutic	6,768,937							55
57	CT Scan	53,775,338							57
58	MRI	14,599,954							58
59	Cardiac Catheterization	12,268,041							59
59.97	CARDIAC REHAB	653,081							59.97
60	Laboratory	77,471,101							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,660,589							65
66	Physical Therapy	5,628,649							66
67	Occupational Therapy	1,789,116							67
68	Speech Pathology	458,271							68
71	Medical Supplies Charged to Pat	13,853,690							71
72	Impl. Dev. Charged to Patients	14,783,929							72
73	Drugs Charged to Patients	26,346,854							73
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	25,646,321							90
91	Emergency	36,463,753	0.010115	0.010115					91
92	Observation Beds (Non-Distinct	3,313,473							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	422,850,426							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0101

WORKSHEET D
PART V

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

(A)	Cost Center Description	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.)
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.179398						50
51	Recovery Room	0.215118						51
52	Delivery Room & Labor Room	1.066456						52
53	Anesthesiology	0.044952						53
54	Radiology-Diagnostic	0.259392						54
54.01	NUCLEAR MEDICINE	0.164457						54.01
54.02	ULTRASOUND	0.106909						54.02
55	Radiology-Therapeutic	0.315949						55
57	CT Scan	0.046657						57
58	MRI	0.118806						58
59	Cardiac Catheterization	0.212245						59
59.97	CARDIAC REHAB	0.569055						59.97
60	Laboratory	0.119006						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.186343						65
66	Physical Therapy	0.315178						66
67	Occupational Therapy	0.648340						67
68	Speech Pathology	0.464009						68
71	Medical Supplies Charged to Pat	0.523137						71
72	Impl. Dev. Charged to Patients	0.555281						72
73	Drugs Charged to Patients	0.389658						73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	0.585471						90
91	Emergency	0.182146						91
92	Observation Beds (Non-Distinct	0.553713						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 + col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	710,481		710,481	12,804	55.49	8,055	446,972	30
31	Intensive Care Unit	99,064		99,064	2,717	36.46	1,331	48,528	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	25,600		25,600	1,180	21.69			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	835,145		835,145	16,701		9,386	495,500	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0101

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	158,658	56,097,094	0.002828	7,153,789	20,231	50
51	Recovery Room	104,162	5,773,044	0.018043	967,087	17,449	51
52	Delivery Room & Labor Room	19,033	1,765,057	0.010783			52
53	Anesthesiology	10,289	5,415,597	0.001900	829,355	1,576	53
54	Radiology-Diagnostic	197,992	20,272,017	0.009767	2,479,487	24,217	54
54.01	NUCLEAR MEDICINE	12,930	5,971,122	0.002165	528,312	1,144	54.01
54.02	ULTRASOUND	22,139	13,075,398	0.001693	486,324	823	54.02
55	Radiology-Therapeutic	11,748	6,768,937	0.001736			55
57	CT Scan	41,244	53,775,338	0.000767	6,222,751	4,773	57
58	MRI	121,304	14,599,954	0.008309	1,171,169	9,731	58
59	Cardiac Catheterization	41,459	12,268,041	0.003379	1,458,099	4,927	59
59.97	CARDIAC REHAB	2,216	653,081	0.003393			59.97
60	Laboratory	148,296	77,471,101	0.001914	13,412,158	25,671	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	113,884	20,660,589	0.005512	7,693,751	42,408	65
66	Physical Therapy	73,860	5,628,649	0.013122	1,598,540	20,976	66
67	Occupational Therapy	23,479	1,789,116	0.013123	591,528	7,763	67
68	Speech Pathology	4,936	458,271	0.010771	258,616	2,786	68
71	Medical Supplies Charged to Pat	89,411	13,853,690	0.006454	5,828,107	37,615	71
72	Impl. Dev. Charged to Patients	100,449	14,783,929	0.006794	5,129,049	34,847	72
73	Drugs Charged to Patients	74,030	26,346,854	0.002810	7,575,394	21,287	73
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	91,516	25,646,321	0.003568			90
91	Emergency	214,509	36,463,753	0.005883	4,625,024	27,209	91
92	Observation Beds (Non-Distinct	83,623	3,313,473	0.025237	271,750	6,858	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,761,167	422,850,426		68,280,290	312,291	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	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 SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

		Total Patient Days	Per Diem (col. 5+ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	12,804		8,055		30
31	Intensive Care Unit	2,717		1,331		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,180				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	16,701		9,386		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0101

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	NUCLEAR MEDICINE							54.01
54.02	ULTRASOUND							54.02
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
59.97	CARDIAC REHAB							59.97
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency		368,841			368,841	368,841	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)		368,841			368,841	368,841	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0101

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7		8		9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	56,097,094			7,153,789		11,793,284		50
51	Recovery Room	5,773,044			967,087		1,993,761		51
52	Delivery Room & Labor Room	1,765,057							52
53	Anesthesiology	5,415,597			829,355		800,594		53
54	Radiology-Diagnostic	20,272,017			2,479,487		4,721,441		54
54.01	NUCLEAR MEDICINE	5,971,122			528,312		2,172,748		54.01
54.02	ULTRASOUND	13,075,398			486,324		1,054,620		54.02
55	Radiology-Therapeutic	6,768,937							55
57	CT Scan	53,775,338			6,222,751		13,566,216		57
58	MRI	14,599,954			1,171,169		3,583,992		58
59	Cardiac Catheterization	12,268,041			1,458,099		1,411,755		59
59.97	CARDIAC REHAB	653,081					370,856		59.97
60	Laboratory	77,471,101			13,412,158		7,478,947		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,660,589			7,693,751		3,410,112		65
66	Physical Therapy	5,628,649			1,598,540		8,434		66
67	Occupational Therapy	1,789,116			591,528		576		67
68	Speech Pathology	458,271			258,616				68
71	Medical Supplies Charged to Pat	13,853,690			5,828,107		3,123,936		71
72	Impl. Dev. Charged to Patients	14,783,929			5,129,049		1,827,203		72
73	Drugs Charged to Patients	26,346,854			7,575,394		5,857,086		73
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	25,646,321					1,582,409		90
91	Emergency	36,463,753	0.010115	0.010115	4,625,024	46,782	5,864,391	59,318	91
92	Observation Beds (Non-Distinct	3,313,473			271,750		1,263,326		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	422,850,426			68,280,290	46,782	71,885,687	59,318	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0101

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.179398	11,793,284			2,115,692			50
51	Recovery Room	0.215118	1,993,761			428,894			51
52	Delivery Room & Labor Room	1.066456							52
53	Anesthesiology	0.044952	800,594			35,988			53
54	Radiology-Diagnostic	0.259392	4,721,441			1,224,704			54
54.01	NUCLEAR MEDICINE	0.164457	2,172,748			357,324			54.01
54.02	ULTRASOUND	0.106909	1,054,620			112,748			54.02
55	Radiology-Therapeutic	0.315949							55
57	CT Scan	0.046657	13,566,216			632,959			57
58	MRI	0.118806	3,583,992			425,800			58
59	Cardiac Catheterization	0.212245	1,411,755			299,638			59
59.97	CARDIAC REHAB	0.569055	370,856			211,037			59.97
60	Laboratory	0.119006	7,478,947			890,040			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.186343	3,410,112			635,451			65
66	Physical Therapy	0.315178	8,434			2,658			66
67	Occupational Therapy	0.648340	576			373			67
68	Speech Pathology	0.464009							68
71	Medical Supplies Charged to Pat	0.523137	3,123,936			1,634,247			71
72	Impl. Dev. Charged to Patients	0.555281	1,827,203			1,014,611			72
73	Drugs Charged to Patients	0.389658	5,857,086			2,282,260			73
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.585471	1,582,409			926,455			90
91	Emergency	0.182146	5,864,391			1,068,175			91
92	Observation Beds (Non-Distinct	0.553713	1,263,326			699,520			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		71,885,687			14,998,574			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		71,885,687			14,998,574			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 + col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	710,481		710,481	12,804	55.49	1,046	58,043	30
31	Intensive Care Unit	99,064		99,064	2,717	36.46	365	13,308	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	25,600		25,600	1,180	21.69	467	10,129	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	835,145		835,145	16,701		1,878	81,480	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0101

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	158,658	56,097,094	0.002828		50
51	Recovery Room	104,162	5,773,044	0.018043		51
52	Delivery Room & Labor Room	19,033	1,765,057	0.010783		52
53	Anesthesiology	10,289	5,415,597	0.001900		53
54	Radiology-Diagnostic	197,992	20,272,017	0.009767		54
54.01	NUCLEAR MEDICINE	12,930	5,971,122	0.002165		54.01
54.02	ULTRASOUND	22,139	13,075,398	0.001693		54.02
55	Radiology-Therapeutic	11,748	6,768,937	0.001736		55
57	CT Scan	41,244	53,775,338	0.000767		57
58	MRI	121,304	14,599,954	0.008309		58
59	Cardiac Catheterization	41,459	12,268,041	0.003379		59
59.97	CARDIAC REHAB	2,216	653,081	0.003393		59.97
60	Laboratory	148,296	77,471,101	0.001914		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	113,884	20,660,589	0.005512		65
66	Physical Therapy	73,860	5,628,649	0.013122		66
67	Occupational Therapy	23,479	1,789,116	0.013123		67
68	Speech Pathology	4,936	458,271	0.010771		68
71	Medical Supplies Charged to Pat	89,411	13,853,690	0.006454		71
72	Impl. Dev. Charged to Patients	100,449	14,783,929	0.006794		72
73	Drugs Charged to Patients	74,030	26,346,854	0.002810		73
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	91,516	25,646,321	0.003568		90
91	Emergency	214,509	36,463,753	0.005883		91
92	Observation Beds (Non-Distinct	83,623	3,313,473	0.025237		92
	OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-199)	1,761,167	422,850,426			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	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 SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

		Total Patient Days	Per Diem (col. 5+ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	12,804		1,046		30
31	Intensive Care Unit	2,717		365		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,180		467		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	16,701		1,878		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0101

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	NUCLEAR MEDICINE							54.01
54.02	ULTRASOUND							54.02
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
59.97	CARDIAC REHAB							59.97
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency		368,841			368,841	368,841	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)		368,841			368,841	368,841	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0101

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	56,097,094							50
51	Recovery Room	5,773,044							51
52	Delivery Room & Labor Room	1,765,057							52
53	Anesthesiology	5,415,597							53
54	Radiology-Diagnostic	20,272,017							54
54.01	NUCLEAR MEDICINE	5,971,122							54.01
54.02	ULTRASOUND	13,075,398							54.02
55	Radiology-Therapeutic	6,768,937							55
57	CT Scan	53,775,338							57
58	MRI	14,599,954							58
59	Cardiac Catheterization	12,268,041							59
59.97	CARDIAC REHAB	653,081							59.97
60	Laboratory	77,471,101							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,660,589							65
66	Physical Therapy	5,628,649							66
67	Occupational Therapy	1,789,116							67
68	Speech Pathology	458,271							68
71	Medical Supplies Charged to Pat	13,853,690							71
72	Impl. Dev. Charged to Patients	14,783,929							72
73	Drugs Charged to Patients	26,346,854							73
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	25,646,321							90
91	Emergency	36,463,753	0.010115	0.010115					91
92	Observation Beds (Non-Distinct	3,313,473							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	422,850,426							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0101

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	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	0.179398						50	
51	Recovery Room	0.215118						51	
52	Delivery Room & Labor Room	1.066456						52	
53	Anesthesiology	0.044952						53	
54	Radiology-Diagnostic	0.259392						54	
54.01	NUCLEAR MEDICINE	0.164457						54.01	
54.02	ULTRASOUND	0.106909						54.02	
55	Radiology-Therapeutic	0.315949						55	
57	CT Scan	0.046657						57	
58	MRI	0.118806						58	
59	Cardiac Catheterization	0.212245						59	
59.97	CARDIAC REHAB	0.569055						59.97	
60	Laboratory	0.119006						60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
65	Respiratory Therapy	0.186343						65	
66	Physical Therapy	0.315178						66	
67	Occupational Therapy	0.648340						67	
68	Speech Pathology	0.464009						68	
71	Medical Supplies Charged to Pat	0.523137						71	
72	Impl. Dev. Charged to Patients	0.555281						72	
73	Drugs Charged to Patients	0.389658						73	
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.585471						90	
91	Emergency	0.182146						91	
92	Observation Beds (Non-Distinct	0.553713						92	
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)							200	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)							202	

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0101

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,804	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,804	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	11,297	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,180	15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	15,588,320	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,588,320	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,588,320	37

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0101

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,217.46	38
39	Program general inpatient routine service cost (line 9 x line 38)						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)						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)	1,213,879	1,180	1,028.71			42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,779,202	2,717	1,759.00			43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

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

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0101

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/LID 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)					1,507	87
88	Adjusted general inpatient routine cost per diem (line 27 + line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0101

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,804	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,804	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	11,297	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,055	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	15,588,320	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,588,320	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,588,320	37

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0101

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,217.46	38
39	Program general inpatient routine service cost (line 9 x line 38)					9,806,640	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)					9,806,640	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	4,779,202	2,717	1,759.00	1,331	2,341,229	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					16,928,497	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					29,076,366	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					495,500	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					359,073	51
52	Total Program excludable cost (sum of lines 50 and 51)					854,573	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					28,221,793	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0101

**WORKSHEET D-1
PARTS III & IV**

Check Title V - I/P Hospital SUB (Other) ICF/IID PFS
 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)					1,507	87
88	Adjusted general inpatient routine cost per diem (line 27 + line 2)					1,217.46	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,834,712	89
		Cost	Routine Cost (from line 27)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	710,481	15,588,320	0.045578	1,834,712	83,623	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0101

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,804	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,804	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	11,297	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,046	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,180	15
16	Nursery days (title V or XIX only)	467	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)	15,588,320	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,588,320	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,588,320	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0101

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,217.46	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,273,463	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)					1,273,463	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)	1,213,879	1,180	1,028.71	467	480,408	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,779,202	2,717	1,759.00	365	642,035	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,395,906	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					81,480	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					81,480	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					2,314,426	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0101

**WORKSHEET D-1
PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,507	87
88	Adjusted general inpatient routine cost per diem (line 27 + line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0101

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
1	2	3		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30	Adults & Pediatrics			30
31	Intensive Care Unit			31
43	Nursery			43
	ANCILLARY SERVICE COST CENTERS			
50	Operating Room	0.179398		50
51	Recovery Room	0.215118		51
52	Delivery Room & Labor Room	1.066456		52
53	Anesthesiology	0.044952		53
54	Radiology-Diagnostic	0.259392		54
54.01	NUCLEAR MEDICINE	0.164457		54.01
54.02	ULTRASOUND	0.106909		54.02
55	Radiology-Therapeutic	0.315949		55
57	CT Scan	0.046657		57
58	MRI	0.118806		58
59	Cardiac Catheterization	0.212245		59
59.97	CARDIAC REHAB	0.569055		59.97
60	Laboratory	0.119006		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65	Respiratory Therapy	0.186343		65
66	Physical Therapy	0.315178		66
67	Occupational Therapy	0.648340		67
68	Speech Pathology	0.464009		68
71	Medical Supplies Charged to Patients	0.523137		71
72	Impl. Dev. Charged to Patients	0.555281		72
73	Drugs Charged to Patients	0.389658		73
	OUTPATIENT SERVICE COST CENTERS			
90	Clinic	0.585471		90
91	Emergency	0.182146		91
92	Observation Beds (Non-Distinct Part)	0.553713		92
	OTHER REIMBURSABLE COST CENTERS			
200	Total (sum of lines 50-94, and 96-98)			200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)			201
202	Net Charges (line 200 minus line 201)			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0101

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
1	2	3			
INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics		7,673,192		30
31	Intensive Care Unit		1,073,640		31
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.179398	7,153,789	1,283,375	50
51	Recovery Room	0.215118	967,087	208,038	51
52	Delivery Room & Labor Room	1.066456			52
53	Anesthesiology	0.044952	829,355	37,281	53
54	Radiology-Diagnostic	0.259392	2,479,487	643,159	54
54.01	NUCLEAR MEDICINE	0.164457	528,312	86,885	54.01
54.02	ULTRASOUND	0.106909	486,324	51,992	54.02
55	Radiology-Therapeutic	0.315949			55
57	CT Scan	0.046657	6,222,751	290,335	57
58	MRI	0.118806	1,171,169	139,142	58
59	Cardiac Catheterization	0.212245	1,458,099	309,474	59
59.97	CARDIAC REHAB	0.569055			59.97
60	Laboratory	0.119006	13,412,158	1,596,127	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.186343	7,693,751	1,433,677	65
66	Physical Therapy	0.315178	1,598,540	503,825	66
67	Occupational Therapy	0.648340	591,528	383,511	67
68	Speech Pathology	0.464009	258,616	120,000	68
71	Medical Supplies Charged to Patients	0.523137	5,828,107	3,048,898	71
72	Impl. Dev. Charged to Patients	0.555281	5,129,049	2,848,063	72
73	Drugs Charged to Patients	0.389658	7,575,394	2,951,813	73
OUTPATIENT SERVICE COST CENTERS					
90	Clinic	0.585471			90
91	Emergency	0.182146	4,625,024	842,430	91
92	Observation Beds (Non-Distinct Part)	0.553713	271,750	150,472	92
OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-94, and 96-98)		68,280,290	16,928,497	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		68,280,290		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0101

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
43	Nursery				43
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.179398			50
51	Recovery Room	0.215118			51
52	Delivery Room & Labor Room	1.066456			52
53	Anesthesiology	0.044952			53
54	Radiology-Diagnostic	0.259392			54
54.01	NUCLEAR MEDICINE	0.164457			54.01
54.02	ULTRASOUND	0.106909			54.02
55	Radiology-Therapeutic	0.315949			55
57	CT Scan	0.046657			57
58	MRI	0.118806			58
59	Cardiac Catheterization	0.212245			59
59.97	CARDIAC REHAB	0.569055			59.97
60	Laboratory	0.119006			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.186343			65
66	Physical Therapy	0.315178			66
67	Occupational Therapy	0.648340			67
68	Speech Pathology	0.464009			68
71	Medical Supplies Charged to Patients	0.523137			71
72	Impl. Dev. Charged to Patients	0.555281			72
73	Drugs Charged to Patients	0.389658			73
OUTPATIENT SERVICE COST CENTERS					
90	Clinic	0.585471			90
91	Emergency	0.182146			91
92	Observation Beds (Non-Distinct Part)	0.553713			92
OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/31/2016 Run Time: 09:37 Version: 2015.10 (05/05/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	1	1.01	1.02	
1	DRG amounts other than outlier payments			1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	16,520,285		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,036		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			1.04
2	Outlier payments for discharges (see instructions)	709,641		2
2.01	Outlier reconciliation amount			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			2.02
3	Managed care simulated payments	1,605,183		3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	84.87		4
	Indirect Medical Education Adjustment Calculation for Hospitals			
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.			7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)			8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)			9
10	FTE count for allopathic and osteopathic programs in the current year from your records			10
11	FTE count for residents in dental and podiatric programs			11
12	Current year allowable FTE (see instructions)			12
13	Total allowable FTE count for the prior year			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero			14
15	Sum of lines 12 through 14 divided by 3			15
16	Adjustment for residents in initial years of the program			16
17	Adjustment for residents displaced by program or hospital closure			17
18	Adjusted rolling average FTE count			18
19	Current year resident to bed ratio (line 18 divided by line 4)			19
20	Prior year resident to bed ratio (see instructions)			20
21	Enter the lesser of lines 19 or 20 (see instructions)			21
22	IME payment adjustment (see instructions)			22
22.01	IME payment adjustment - Managed Care (see instructions)			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)			23
24	IME FTE resident count over cap (see instructions)			24
25	If the amount on line 24 is greater than 0-, then enter the lower of line 23 or line 24 (see instructions)			25
26	Resident to bed ratio (divide line 25 by line 4)			26
27	IME payments adjustment factor (see instructions)			27
28	IME add-on adjustment amount (see instructions)			28
28.01	IME add-on adjustment amount - Managed Care (see instructions)			28.01
29	Total IME payment (sum of lines 22 and 28)			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			29.01
	Disproportionate Share Adjustment			
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			30
31	Percentage of Medicaid patient days to total patient days (see instructions)			31
32	Sum of lines 30 and 31			32
33	Allowable disproportionate share percentage (see instructions)			33
34	Disproportionate share adjustment (see instructions)			34
		Prior to October 1	On or after October 1	
	Uncompensated Care Adjustment			
35	Total uncompensated care amount (see instructions)			35
35.01	Factor 3 (see instructions)			35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)			
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			40

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

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)	17,230,962			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	17,230,962			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,453,161			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35)				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	46,782			58
59	Total (sum of amounts on lines 49 through 58)	18,730,905			59
60	Primary payer payments	3,740			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	18,727,165			61
62	Deductibles billed to program beneficiaries	1,822,516			62
63	Coinurance billed to program beneficiaries	43,155			63
64	Allowable bad debts (see instructions)	291,667			64
65	Adjusted reimbursable bad debts (see instructions)	189,584			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	163,041			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	17,051,078			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.01	NEW TECHNOLOGY				70.01
70.93	HVBP payment adjustment amount (see instructions)	164,587			70.93
70.94	HRR adjustment amount (see instructions)	-102,357			70.94
71	Amount due provider (see instructions)	17,113,308			71
71.01	Sequestration adjustment (see instructions)	342,266			71.01
72	Interim payments	16,539,404			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	231,638			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	350,000			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

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

HSP Bonus Payment Amount

Prior to 10/1

On or After
10/1

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

Prior to 10/1

On or After
10/1

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

HRR Adjustment for HSP Bonus Payment

Prior to 10/1

On or After
10/1

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0101

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	1.01	1.02	
1	Medical and other services (see instructions)			1
2	Medical and other services reimbursed under OPPS (see instructions)	14,939,256		2
3	PPS payments	11,808,442		3
4	Outlier payment (see instructions)	54,599		4
5	Enter the hospital specific payment to cost ratio (see instructions)			5
6	Line 2 times line 5			6
7	Sum of line 3 and line 4 divided by line 6			7
8	Transitional corridor payment (see instructions)			8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	59,318		9
10	Organ acquisition			10
11	Total cost (sum of lines 1 and 10) (see instructions)			11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
12	Ancillary service charges			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)			13
14	Total reasonable charges (sum of lines 12 and 13)			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)			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)			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)			21
22	Interns and residents (see instructions)			22
23	Cost of physicians' services in a teaching hospital (see instructions)			23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	11,922,359		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	Deductibles and coinsurance (see instructions)	2,483,089		25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)			26
27	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	9,439,270		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)	9,439,270		30
31	Primary payer payments			31
32	Subtotal (line 30 minus line 31)	9,439,270		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)	376,582		34
35	Adjusted reimbursable bad debts (see instructions)	244,778		35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	258,249		36
37	Subtotal (see instructions)	9,684,048		37
38	MSP-LCC reconciliation amount from PS&R			38
39	Other adjustments (specify) (see instructions)			39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
40	Subtotal (see instructions)	9,684,048		40
40.01	Sequestration adjustment (see instructions)	193,681		40.01
41	Interim payments	9,192,257		41
42	Tentative settlement (for contractors use only)			42
43	Balance due provider/program (see instructions)	298,110		43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			44

TO BE COMPLETED BY CONTRACTOR

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0101

**WORKSHEET E-1
PART I**

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

		INPATIENT PART A		PART B		
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	Total interim payments paid to provider		16,539,404		9,192,257	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16,539,404		9,192,257	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	231,638		298,110	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		16,771,042		9,490,367	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 applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	4,534	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	9,386	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	769	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	14,014	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	442,056,238	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	7,102,996	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	985,806	8
9	Sequestration adjustment amount (see instructions)	19,716	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	966,090	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	966,090	32

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

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0101

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
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			8
9	Ancillary service charges			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)			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)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			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 physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			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	Titles V or XIX (sum of lines 21 and 27)			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 Wkst. 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 line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0101

**WORKSHEET E-3
PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
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			8
9	Ancillary service charges			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)			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)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			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 physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			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	Titles V or XIX (sum of lines 21 and 27)			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 Wkst. 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 line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	33,093,032				1
2	Temporary investments	25,707				2
3	Notes receivable					3
4	Accounts receivable	31,339,673				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	5,970,799				7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	70,429,211				11
FIXED ASSETS						
12	Land	7,542,129				12
13	Land improvements	6,586,215				13
14	Accumulated depreciation	-4,684,973				14
15	Buildings	70,528,025				15
16	Accumulated depreciation	-36,413,518				16
17	Leasehold improvements	1,584,302				17
18	Accumulated depreciation	-95,431				18
19	Fixed equipment	22,130,256				19
20	Accumulated depreciation	-17,061,164				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	71,318,247				23
24	Accumulated depreciation	-56,199,499				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	65,234,589				30
OTHER ASSETS						
31	Investments	1,346,146				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	61,036,720				34
35	Total other assets (sum of lines 31-34)	62,382,866				35
36	Total assets (sum of lines 11, 30 and 35)	198,046,666				36
Liabilities and Fund Balances (Omit Cents)						
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	10,803,389				37
38	Salaries, wages and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	1,795,000				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	144,061				43
44	Other current liabilities	11,568,818				44
45	Total current liabilities (sum of lines 37 thru 44)	24,311,268				45
LONG TERM LIABILITIES						
46	Mortgage payable	35,135,000				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	9,531,007				49
50	Total long term liabilities (sum of lines 46 thru 49)	44,666,007				50
51	Total liabilities (sum of lines 45 and 50)	68,977,275				51
CAPITAL ACCOUNTS						
52	General fund balance	129,069,391				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets		1	2	3	4	
(Omit Cents)						
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	129,069,391				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	198,046,666				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		117,915,972			1
2 Net income (loss) (from Worksheet G-3, line 29)		11,120,005			2
3 Total (sum of line 1 and line 2)		129,035,977			3
4 Additions (credit adjustments) (specify)					4
5					5
6					6
7					7
8					8
9					9
10 Total additions (sum of lines 4-9)					10
11 Subtotal (line 3 plus line 10)		129,035,977			11
12 Deductions (debit adjustments) (specify)					12
13					13
14					14
15					15
16					16
17					17
18 Total deductions (sum of lines 12-17)					18
19 Fund balance at end of period per balance sheet (line 11 minus line 18)		129,035,977			19

	ENDOWMENT FUND		PLANT FUND		
	5	6	7	8	
1 Fund balances at beginning of period					1
2 Net income (loss) (from Worksheet G-3, line 29)					2
3 Total (sum of line 1 and line 2)					3
4 Additions (credit adjustments) (specify)					4
5					5
6					6
7					7
8					8
9					9
10 Total additions (sum of lines 4-9)					10
11 Subtotal (line 3 plus line 10)					11
12 Deductions (debit adjustments) (specify)					12
13					13
14					14
15					15
16					16
17					17
18 Total deductions (sum of lines 12-17)					18
19 Fund balance at end of period per balance sheet (line 11 minus line 18)					19

KPMG LLP Compu-Max 2552-10

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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	22,903,845		22,903,845	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	22,903,845		22,903,845	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	22,903,845		22,903,845	17
18	Ancillary services	116,599,312	312,534,127	429,133,439	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	139,503,157	312,534,127	452,037,284	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		142,267,035	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38	BAD DEBT ALLOWANCE	-5,735,314		38
39	NET SETTLEMENT DERIVATIVE	-581,800		39
40	CHANGE IN FAIR MARKET DERIVATIVE	-469,953		40
41	GAIN ON DISPOSAL OF ASSET	-6,194		41
42	Total deductions (sum of lines 37-41)		-6,793,261	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		135,473,774	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)	452,037,284	1
2	Less contractual allowances and discounts on patients' accounts	308,868,223	2
3	Net patient revenues (line 1 minus line 2)	143,169,061	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	135,473,774	4
5	Net income from service to patients (line 3 minus line 4)	7,695,287	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	402,002	6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER)	2,748,714	24
24.0	Other (UNRESTRICTED DONATIONS)		24.0
1			1
24.0	Other (NET ASSETS RELEASED FROM RESTRICTIO	274,002	24.0
2			2
25	Total other income (sum of lines 6-24)	3,424,718	25
26	Total (line 5 plus line 25)	11,120,005	26
29	Net income (or loss) for the period (line 26 minus line 28)	11,120,005	29

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0101

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	1,453,161	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)	38.92	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)	1,453,161	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: 14-0101

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	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
20.01	ALLIED HEALTH EMS							20.01
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	NUCLEAR MEDICINE							54.01
54.02	ULTRASOUND							54.02
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
59.97	CARDIAC REHAB							59.97
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
OUTPATIENT SERVICE COST CENTERS								
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)							118
NONREIMBURSABLE COST CENTERS								
190.0	MEALS ON WHEELS							190.0
1								1
191.0	PATIENT TRANSPORTATION							191.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6		
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	Adults & Pediatrics	62.91		8.17				71.08	30
31	Intensive Care Unit	48.99		13.43				62.42	31
43	Nursery			39.58				39.58	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	12.75	21.02					33.77	50
51	Recovery Room	16.75	34.54					51.29	51
53	Anesthesiology	15.31	14.78					30.09	53
54	Radiology-Diagnostic	12.23	23.29					35.52	54
54.01	NUCLEAR MEDICINE	8.85	36.39					45.24	54.01
54.02	ULTRASOUND	3.72	8.07					11.79	54.02
57	CT Scan	11.57	25.23					36.80	57
58	MRI	8.02	24.55					32.57	58
59	Cardiac Catheterization	11.89	11.51					23.40	59
59.97	CARDIAC REHAB		56.79					56.79	59.97
60	Laboratory	17.31	9.65					26.96	60
65	Respiratory Therapy	37.24	16.51					53.75	65
66	Physical Therapy	28.40	0.15					28.55	66
67	Occupational Therapy	33.06	0.03					33.09	67
68	Speech Pathology	56.43						56.43	68
71	Medical Supplies Charged to Pat	42.07	22.55					64.62	71
72	Impl. Dev. Charged to Patients	34.69	12.36					47.05	72
73	Drugs Charged to Patients	28.75	22.23					50.98	73
90	Clinic		6.17					6.17	90
91	Emergency	12.68	16.08					28.76	91
92	Observation Beds (Non-Distinct	8.20	38.13					46.33	92
200	TOTAL CHARGES	16.15	17.00					33.15	200

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REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	2,517,990	2.17	-2,517,990	-4.77			1
2	Cap Rel Costs-Mvble Equip							2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	7,199,466	6.20	-7,199,466	-13.64			4
5	Administrative & General	26,763,233	23.03	-26,763,233	-50.70			5
6	Maintenance & Repairs							6
7	Operation of Plant	3,035,399	2.61	-3,035,399	-5.75			7
8	Laundry & Linen Service	381,177	0.33	-381,177	-0.72			8
9	Housekeeping	1,762,669	1.52	-1,762,669	-3.34			9
10	Dietary	402,827	0.35	-402,827	-0.76			10
11	Cafeteria	502,840	0.43	-502,840	-0.95			11
12	Maintenance of Personnel							12
13	Nursing Administration	763,166	0.66	-763,166	-1.45			13
14	Central Services & Supply	209,993	0.18	-209,993	-0.40			14
15	Pharmacy	7,338,987	6.32	-7,338,987	-13.90			15
16	Medical Records & Library	1,664,399	1.43	-1,664,399	-3.15			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
20.01	ALLIED HEALTH EMS	250,362	0.22	-250,362	-0.47			20.01
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	7,534,193	6.48	8,054,127	15.26	15,588,320	13.41	30
31	Intensive Care Unit	2,741,245	2.36	2,037,957	3.86	4,779,202	4.11	31
43	Nursery	671,541	0.58	542,338	1.03	1,213,879	1.04	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	6,394,800	5.50	3,668,904	6.95	10,063,704	8.66	50
51	Recovery Room	483,208	0.42	758,676	1.44	1,241,884	1.07	51
52	Delivery Room & Labor Room	1,192,093	1.03	690,263	1.31	1,882,356	1.62	52
53	Anesthesiology	128,214	0.11	115,226	0.22	243,440	0.21	53
54	Radiology-Diagnostic	2,969,163	2.55	2,289,230	4.34	5,258,393	4.52	54
54.01	NUCLEAR MEDICINE	648,302	0.56	333,688	0.63	981,990	0.84	54.01
54.02	ULTRASOUND	859,012	0.74	538,864	1.02	1,397,876	1.20	54.02
55	Radiology-Therapeutic	1,532,181	1.32	606,460	1.15	2,138,641	1.84	55
57	CT Scan	1,472,198	1.27	1,036,810	1.96	2,509,008	2.16	57
58	MRI	796,639	0.69	937,918	1.78	1,734,557	1.49	58
59	Cardiac Catheterization	1,667,925	1.44	935,910	1.77	2,603,835	2.24	59
59.97	CARDIAC REHAB	247,780	0.21	123,859	0.23	371,639	0.32	59.97
60	Laboratory	5,833,582	5.02	3,385,935	6.41	9,219,517	7.93	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,123,620	1.83	1,726,346	3.27	3,849,966	3.31	65
66	Physical Therapy	964,871	0.83	809,156	1.53	1,774,027	1.53	66
67	Occupational Therapy	731,438	0.63	428,518	0.81	1,159,956	1.00	67
68	Speech Pathology	130,126	0.11	82,516	0.16	212,642	0.18	68
71	Medical Supplies Charged to Patients	5,009,653	4.31	2,237,728	4.24	7,247,381	6.24	71
72	Impl. Dev. Charged to Patients	5,798,826	4.99	2,410,408	4.57	8,209,234	7.06	72
73	Drugs Charged to Patients			10,266,266	19.45	10,266,266	8.83	73
OUTPATIENT SERVICE COST CENTERS								
90	Clinic	9,502,929	8.18	5,512,251	10.44	15,015,180	12.92	90
91	Emergency	3,560,974	3.06	3,080,757	5.84	6,641,731	5.72	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
190.01	MEALS ON WHEELS	57,657	0.05	24,538	0.05	82,195	0.07	190.01
191.01	PATIENT TRANSPORTATION	367,602	0.32	157,859	0.30	525,461	0.45	191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	116,212,280	100.00			116,212,280	100.00	202

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	158,658	56,097,094	0.002828	7,153,789	20,231	50
51	Recovery Room	104,162	5,773,044	0.018043	967,087	17,449	51
52	Delivery Room & Labor Room	19,033	1,765,057	0.010783			52
53	Anesthesiology	10,289	5,415,597	0.001900	829,355	1,576	53
54	Radiology-Diagnostic	197,992	20,272,017	0.009767	2,479,487	24,217	54
54.01	NUCLEAR MEDICINE	12,930	5,971,122	0.002165	528,312	1,144	54.01
54.02	ULTRASOUND	22,139	13,075,398	0.001693	486,324	823	54.02
55	Radiology-Therapeutic	11,748	6,768,937	0.001736			55
57	CT Scan	41,244	53,775,338	0.000767	6,222,751	4,773	57
58	MRI	121,304	14,599,954	0.008309	1,171,169	9,731	58
59	Cardiac Catheterization	41,459	12,268,041	0.003379	1,458,099	4,927	59
59.97	CARDIAC REHAB	2,216	653,081	0.003393			59.97
60	Laboratory	148,296	77,471,101	0.001914	13,412,158	25,671	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	113,884	20,660,589	0.005512	7,693,751	42,408	65
66	Physical Therapy	73,860	5,628,649	0.013122	1,598,540	20,976	66
67	Occupational Therapy	23,479	1,789,116	0.013123	591,528	7,763	67
68	Speech Pathology	4,936	458,271	0.010771	258,616	2,786	68
71	Medical Supplies Charged to Pat	89,411	13,853,690	0.006454	5,828,107	37,615	71
72	Impl. Dev. Charged to Patients	100,449	14,783,929	0.006794	5,129,049	34,847	72
73	Drugs Charged to Patients	74,030	26,346,854	0.002810	7,575,394	21,287	73
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	91,516	25,646,321	0.003568			90
91	Emergency	214,509	36,463,753	0.005883	4,625,024	27,209	91
92	Observation Beds (Non-Distinct	83,623	3,313,473	0.025237	271,750	6,858	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	1,761,167	422,850,426		68,280,290	312,291	200

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUSTMENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	710,481		710,481	12,804	55.49	8,055	446,972	30
31	Intensive Care Unit	99,064		99,064	2,717	36.46	1,331	48,528	31
200	TOTAL	809,545		809,545	15,521		9,386	495,500	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	495,500
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	312,291
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	807,791
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	1,985
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	9,386
PER DISCHARGE CAPITAL COSTS	406.95

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I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-I, Part II, line 53)	28,221,793
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	77,027,122
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.366

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	807,791
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.010

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, columns 2, 2.01 & 2.02 x Worksheet B, Part I, column 26 - columns 20 & 23 / Worksheet C, Part I, column 8) less lines 61, 66-68, 74, 94, 95 & 96) (see CR 5999)	14,936,225
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	71,876,677
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.208