

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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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 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 06/30/2016 Time: 15:09
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY FIRST MEDICAL CENTER (14-0251) (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.

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL						1
2	SUBPROVIDER - IPF		-23,453	-270,323	-234,733		2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY			-1			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		-23,453	-270,324	-234,733		200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 5645 WEST ADDISON STREET	P.O. Box:								1
2	City: CHICAGO	State: IL	ZIP Code: 60634	County: COOK						2

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8		
3	Hospital	COMMUNITY FIRST MEDICAL CENTER	14-0251	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	CFMC SKILLED NURSING FACILITY	14-5548	16974		07 / 01 / 1985	N	P	N	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
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21	Type of control (see instructions)	1								21
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Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		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.	1	N		23

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
	1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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.	4,954	2,128			484	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 is in effect in the cost reporting period.						35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N					37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

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

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

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

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	1.84			62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

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

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
65	1	2	3	4	5		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))		
67	1	2	3	4	5		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.				109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, 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.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	742,500			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

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

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**WORKSHEET S-2
PART I**

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	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	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)	10 / 01 / 2014	09 / 30 / 2015		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	06/15/2016	Y	06/15/2016
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

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

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

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: DENNIS	Last name: FITZMAURICE	Title: VP PROFESSIONAL SERVICES
42	Employer: COMMUNITY FIRST MEDICAL CENTER		
43	Phone number: 7737947687	E-mail Address: DFITZMAURICE@CFMEDICALCENTER.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	193	70,445			11,682	3,942	25,469	1
2	HMO and other (see instructions)							2,612		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)		193	70,445			11,682	3,942	25,469	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34	20	7,300			2,566	1,012	5,912	11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		213	77,745			14,248	4,954	31,381	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	66	24,090			11,103		14,701	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)		279							27
28	Observation Bed Days							284	3,002	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									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)					2,845	1,146	6,571	1
2	HMO and other (see instructions)								2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	1.84	718.25			2,845	1,146	6,571	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		52.55						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)	1.84	770.80						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

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

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	Total salaries (see instructions)	200	46,420,538	40,000	46,460,538	1,603,260.35	28.98
2	Non-physician anesthetist Part A						
3	Non-physician anesthetest Part B						
4	Physician-Part A - Administrative						
4.01	Physician-Part A - Teaching						
5	Physician-Part B						
6	Non-physician-Part B						
7	Interns & residents (in an approved program)	21		54,442	54,442	3,827.00	14.23
7.01	Contracted interns & residents (in an approved program)						
8	Home office personnel						
9	SNF	44	2,817,650		2,817,650	109,297.18	25.78
10	Excluded area salaries (see instructions)		1,576,751		1,576,751	26,252.62	60.06
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		990,480		990,480	19,814.85	49.99
12	Contract management and administrative services						
13	Contract labor: Physician-Part A - Administrative		292,469		292,469	1,973.50	148.20
14	Home office salaries & wage-related costs						
15	Home office: Physician Part A - Administrative						
16	Home office & Contract Physicians Part A - Teaching						
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		8,647,412		8,647,412		
18	Wage-related costs (other)(see instructions)						
19	Excluded areas		304,149		304,149		
20	Non-physician anesthetist Part A						
21	Non-physician anesthetist Part B						
22	Physician Part A - Administrative						
22.01	Physician Part A - Teaching						
23	Physician Part B						
24	Wage-related costs (RHC/FOHC)						
25	Interns & residents (in an approved program)		10,502		10,502		
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		141,430		141,430	9,293.51	15.22
27	Administrative & General		2,881,007	40,000	2,921,007	125,873.68	23.21
28	Administrative & General under contract (see instructions)		293,978		293,978	3,783.00	77.71
29	Maintenance & Repairs						
30	Operation of Plant		1,581,999		1,581,999	73,289.53	21.59
31	Laundry & Linen Service		63,026		63,026	4,820.00	13.08
32	Housekeeping		1,079,661		1,079,661	83,204.84	12.98
33	Housekeeping under contract (see instructions)						
34	Dietary		1,157,379	-369,260	788,119	53,561.37	14.71
35	Dietary under contract (see instructions)						
36	Cafeteria			369,260	369,260	25,095.28	14.71
37	Maintenance of Personnel						
38	Nursing Administration		1,704,343		1,704,343	51,194.14	33.29
39	Central Services and Supply		647,000		647,000	35,432.08	18.26
40	Pharmacy		1,637,387		1,637,387	42,674.70	38.37
41	Medical Records & Medical Records Library		2,441,023		2,441,023	75,948.76	32.14
42	Social Service						
43	Other General Service						

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		46,714,516	-14,442	46,700,074	1,603,216.35	29.13
2	Excluded area salaries (see instructions)		4,394,401		4,394,401	135,549.80	32.42
3	Subtotal salaries (line 1 minus line 2)		42,320,115	-14,442	42,305,673	1,467,666.55	28.83
4	Subtotal other wages & related costs (see instructions)		1,282,949		1,282,949	21,788.35	58.88
5	Subtotal wage-related costs (see instructions)		8,647,412		8,647,412		20.44%
6	Total (sum of lines 3 through 5)		52,250,476	-14,442	52,236,034	1,489,454.90	35.07
7	Total overhead cost (see instructions)		13,628,233	40,000	13,668,233	584,170.89	23.40

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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
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)	3,956,057	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	356,812	10
11	Life Insurance (If employee is owner or beneficiary)	217,972	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	204,298	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	65,697	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	450,000	16
	TAXES		
17	FICA-Employers Portion Only	3,321,746	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	305,970	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	83,512	23
24	Total Wage Related cost (Sum of lines 1-23)	8,962,064	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)	CONTRIBUTION(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 MOonths in Provider Cost Reporting Period on Line 2		15
16	Average Pension Contributions (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)		17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)		18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor 1	Benefit Cost 2	
	0			
1	Total facility contract labor and benefit cost		9,977	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		9,977	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)						22

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE
		1	2
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N	
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N	/ /

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
	1	2	3	4
3	RUX			3
4	RUL	16		16
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL			8
9	RMX			9
10	RML			10
11	RLX			11
12	RUC	409		409
13	RUB	4,820		4,820
14	RUA	1,745		1,745
15	RVC	249		249
16	RVB	2,340		2,340
17	RVA	829		829
18	RHC	58		58
19	RHB	230		230
20	RHA	82		82
21	RMC	9		9
22	RMB	83		83
23	RMA	47		47
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2	5		5
28	ES1			28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1	5		5
35	HB2			35
36	HB1	14		14
37	LE2			37
38	LE1	5		5
39	LD2			39
40	LD1	1		1
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1	4		4
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1			48
49	CC2	4		4
50	CC1	65		65
51	CB2			51
52	CB1	30		30
53	CA2			53
54	CA1	7		7
55	SE3			55
56	SE2			56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA			60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1	5		5
67	BA2			67
68	BA1			68
69	PE2			69
70	PE1			70
71	PD2			71

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1	4		4	74
75	PB2				75
76	PB1	35		35	76
77	PA2				77
78	PA1	2		2	78
199	AAA				199
200	TOTAL	11,103		11,103	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).	16974		201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing	2,817,650	20.05%		202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	14,053,680			207

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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)		0.172374	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		26,637,771	2
3	Did you receive DSH or supplemental payments from Medicaid?		Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid			5
6	Medicaid charges		54,649,052	6
7	Medicaid cost (line 1 times line 6)		9,420,076	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.			8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care				17
18	Government grants, appropriations of transfers for support of hospital operations				18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	7,386,805	95,635	7,482,440	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,273,293	16,485	1,289,778	21
22	Partial payment by patients approved for charity care		6,008	6,008	22
23	Cost of charity care (line 21 minus line 22)	1,273,293	10,477	1,283,770	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)			25,873,568	26
27	Medicare bad debts for the entire hospital complex (see instructions)			468,348	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			25,405,220	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			4,379,199	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			5,662,969	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,662,969	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				2,239,733	2,239,733	-214	2,239,519	1
2	00200	Cap Rel Costs-Mvble Equip				2,001,834	2,001,834		2,001,834	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	141,430	9,183,426	9,324,856	-40,000	9,284,856	-5,319	9,279,537	4
5	00500	Administrative & General	2,881,007	28,553,527	31,434,534	-4,201,567	27,232,967	-4,320,349	22,912,618	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,581,999	2,213,701	3,795,700		3,795,700		3,795,700	7
8	00800	Laundry & Linen Service	63,026	556,965	619,991		619,991		619,991	8
9	00900	Housekeeping	1,079,661	489,242	1,568,903		1,568,903		1,568,903	9
10	01000	Dietary	1,157,379	1,796,329	2,953,708	-942,376	2,011,332		2,011,332	10
11	01100	Cafeteria				942,376	942,376	-362,180	580,196	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,704,343	107,933	1,812,276		1,812,276	-23,352	1,788,924	13
14	01400	Central Services & Supply	647,000	299,149	946,149		946,149		946,149	14
15	01500	Pharmacy	1,637,387	4,916,037	6,553,424	-4,841,548	1,711,876	-435	1,711,441	15
16	01600	Medical Records & Library	2,441,023	585,027	3,026,050		3,026,050	-33,677	2,992,373	16
17	01700	Social Service								17
17.01	01701	HOUSE STAFF PHYSICIANS		1,359,793	1,359,793		1,359,793	-1,359,793		17.01
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd				54,442	54,442		54,442	21
22	02200	I&R Services-Other Prgm Costs Apprvd				220,535	220,535		220,535	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	8,768,339	1,064,233	9,832,572	-576,395	9,256,177		9,256,177	30
34	03400	Surgical Intensive Care Unit	3,669,515	758,147	4,427,662	-480,148	3,947,514	-44,556	3,902,958	34
44	04400	Skilled Nursing Facility	2,817,650	386,181	3,203,831	-149,895	3,053,936	-12,548	3,041,388	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,179,223	5,868,206	8,047,429	-4,928,944	3,118,485	-243,334	2,875,151	50
51	05100	Recovery Room	436,202	36,071	472,273		472,273		472,273	51
53	05300	Anesthesiology	71,384	527,327	598,711		598,711	-438,137	160,574	53
54	05400	Radiology-Diagnostic	1,885,094	287,434	2,172,528	-20,403	2,152,125	-174,566	1,977,559	54
56	05600	Radioisotope	195,003	298,082	493,085		493,085		493,085	56
57	05700	CT Scan	553,683	321,329	875,012		875,012		875,012	57
58	05800	MRI	191,386	135,451	326,837		326,837		326,837	58
59	05900	Cardiac Catheterization	691,675	1,266,283	1,957,958	-1,168,816	789,142		789,142	59
60	06000	Laboratory		6,600,301	6,600,301		6,600,301	-1,886	6,598,415	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,258,307	376,733	1,635,040	-115,634	1,519,406	-1,884	1,517,522	65
66	06600	Physical Therapy	1,963,870	118,670	2,082,540		2,082,540		2,082,540	66
67	06700	Occupational Therapy	734,913	29,683	764,596		764,596		764,596	67
68	06800	Speech Pathology	169,403	451	169,854	-29	169,825		169,825	68
69	06900	Electrocardiology	500,149	46,752	546,901		546,901		546,901	69
69.01	03160	CARDIAC REHAB	225,186	7,991	233,177		233,177	-10,665	222,512	69.01
70	07000	Electroencephalography	39,909	651	40,560		40,560		40,560	70
71	07100	Medical Supplies Charged to Patients				4,616,105	4,616,105		4,616,105	71
72	07200	Impl. Dev. Charged to Patients				3,773,721	3,773,721		3,773,721	72
73	07300	Drugs Charged to Patients				4,841,548	4,841,548		4,841,548	73
74	07400	Renal Dialysis	227,114	41,985	269,099		269,099		269,099	74
75.01	03950	ACUTE DIALYSIS								75.01
76	03040	AUDIO-VESTIBULAR LAB								76
76.01	03480	ONCOLOGY								76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	1,255,960	528,039	1,783,999	-217,263	1,566,736	-3,280	1,563,456	90
91	09100	Emergency	3,675,567	3,042,307	6,717,874	-1,007,276	5,710,598	-1,717,733	3,992,865	91
91.01	04950	LITHOTRIPSY								91.01
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	44,843,787	71,803,436	116,647,223		116,647,223	-8,753,908	107,893,315	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		33,018	33,018		33,018		33,018	190
193.01	19301	NON EMPLOYEE DAY CARE								193.01
193.02	19302	RESURRECTION HOME CARE OFFICES								193.02

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
193.03	19303	OCCUPATIONAL HEALTH NON-REIM								193.03
194	07950	POB	1,576,751	1,866,402	3,443,153		3,443,153		3,443,153	194
200		TOTAL (sum of lines 118-199)	46,420,538	73,702,856	120,123,394		120,123,394	-8,753,908	111,369,486	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	SHARED FOOD COST F	A	Cafeteria	11	369,260	573,116	1
500	Total reclassifications				369,260	573,116	500
	Code Letter - A						
1	CHARGEABLE MEDICAL SUPPLIES F	B	Medical Supplies Charged to P	71		4,616,105	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					4,616,105	500
	Code Letter - B						
1	DEPRECIATION	C	Cap Rel Costs-Bldg & Fixt	1		1,199,462	1
2			Cap Rel Costs-Mvble Equip	2		2,001,834	2
500	Total reclassifications					3,201,296	500
	Code Letter - C						
1	DRUGS	D	Drugs Charged to Patients	73		4,841,548	1
500	Total reclassifications					4,841,548	500
	Code Letter - D						
1	TEACHING COSTS	E	I&R Services-Other Prgm Costs	22		220,535	1
500	Total reclassifications					220,535	500
	Code Letter - E						
1	INSURANCE	F	Cap Rel Costs-Bldg & Fixt	1		139,518	1
500	Total reclassifications					139,518	500
	Code Letter - F						
1	RESIDENT SALARIE	G	I&R Services-Salary & Fringes	21	54,442		1
500	Total reclassifications				54,442		500
	Code Letter - G						
1	IMPLANT RECLASS	H	Impl. Dev. Charged to Patient	72		3,773,721	1
2							2
3							3
4							4
500	Total reclassifications					3,773,721	500
	Code Letter - H						
1	INTEREST	I	Cap Rel Costs-Bldg & Fixt	1		900,753	1
500	Total reclassifications					900,753	500
	Code Letter - I						
1	RETENTION AWARD TO SALARIES	K	Administrative & General	5	40,000		1
500	Total reclassifications				40,000		500
	Code Letter - K						
	GRAND TOTAL (Increases)				463,702	18,266,592	

(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	SHARED FOOD COST F	A	Dietary	10	369,260	573,116	1	
500	Total reclassifications				369,260	573,116	500	
	Code letter - A							
1	CHARGEABLE MEDICAL SUPPLIES F	B	Adults & Pediatrics	30		576,395	1	
2			Surgical Intensive Care Unit	34		480,148	2	
3			Skilled Nursing Facility	44		149,895	3	
4			Operating Room	50		2,090,092	4	
5			Radiology-Diagnostic	54		20,403	5	
6			Cardiac Catheterization	59		337,723	6	
7			Respiratory Therapy	65		115,634	7	
8			Speech Pathology	68		29	8	
9			Clinic	90		113,594	9	
10			Emergency	91		732,192	10	
500	Total reclassifications					4,616,105	500	
	Code letter - B							
1	DEPRECIATION	C	Administrative & General	5		3,201,296	9	
2							9	
500	Total reclassifications					3,201,296	500	
	Code letter - C							
1	DRUGS	D	Pharmacy	15		4,841,548	9	
500	Total reclassifications					4,841,548	500	
	Code letter - D							
1	TEACHING COSTS	E	Emergency	91		220,535	1	
500	Total reclassifications					220,535	500	
	Code letter - E							
1	INSURANCE	F	Administrative & General	5		139,518	12	
500	Total reclassifications					139,518	500	
	Code letter - F							
1	RESIDENT SALARIE	G	Emergency	91	54,442		1	
500	Total reclassifications				54,442		500	
	Code letter - G							
1	IMPLANT RECLASS	H	Operating Room	50		2,838,852	1	
2			Cardiac Catheterization	59		831,093	2	
3			Clinic	90		103,669	3	
4			Emergency	91		107	4	
500	Total reclassifications					3,773,721	500	
	Code letter - H							
1	INTEREST	I	Administrative & General	5		900,753	11	
500	Total reclassifications					900,753	500	
	Code letter - I							
1	RETENTION AWARD TO SALARIES	K	Employee Benefits Department	4		40,000	1	
500	Total reclassifications					40,000	500	
	Code letter - K							
	GRAND TOTAL (Decreases)				423,702	18,306,592		

(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								1
2	Land Improvements								2
3	Buildings and Fixtures	17,902,905	193,507		193,507		18,096,412		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	5,254,193	105,834		105,834		5,360,027		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	23,157,098	299,341		299,341		23,456,439		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	23,157,098	299,341		299,341		23,456,439		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 line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see 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	49,980,436		49,980,436	1.000000					2
3	Total (sum of lines 1-2)	49,980,436		49,980,436	1.000000					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	1,199,462		900,539	139,518				2,239,519	1
2	Cap Rel Costs-Mvble Equip	2,001,834							2,001,834	2
3	Total (sum of lines 1-2)	3,201,296		900,539	139,518				4,241,353	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
				COST CENTER	LINE#	Wkst. A-7 Ref.	
1	Investment income-buildings & fixtures (chapter 2)	A	-214	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-10,256	Administrative & General	5	9	7
8	Television and radio service (chapter 21)	A	-4,307	Administrative & General	5	10	8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-2,512,190				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-362,180	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	-435	Pharmacy	15		17
18	Sale of medical records and abstracts	B	-1,448	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
33.03	HOUSE STAFF PHYSICIANS	A	-1,359,793	HOUSE STAFF PHYSICIANS	17.01		33.03
33.20	FITNESS CENTER REVENUE	B	-5,319	Employee Benefits Department	4		33.20
33.36	PATIENT TRANSPORTATION	B	-4,385	Administrative & General	5		33.36
33.42	MISC INCOME	B	-31,193	Administrative & General	5		33.42
33.43	CARDIAC REHAB MISC REVENUE	B	-10,665	CARDIAC REHAB	69.01		33.43
33.45	RADIOLOGY REVENUE	B	-172,020	Radiology-Diagnostic	54		33.45
34							34
35							35
36	OLR 5K	B	-20,032	Nursing Administration	13		36
37							37
38	EDUCATION	B	-3,320	Nursing Administration	13		38
39							39
40	AMB RENTAL	B	-3,280	Clinic	90		40
41							41
42	MEDICAID TAX ASSESSMENT	B	-4,252,871	Administrative & General	5		42
43							43
44							44
45							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)		-8,753,908				50

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

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

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	53	Anesthesiology AGGREGATE	438,137	438,137						1
2	44	Skilled Nursing Faci AGGREGATE	12,548	12,548						2
3	65	Respiratory Therapy AGGREGATE	13,781	1,548	12,233	211,500	117	11,897	595	3
4	91	Emergency AGGREGATE	1,739,290	1,702,860	36,430	211,500	212	21,557	1,078	4
5										5
6	60	Laboratory AGGREGATE	1,886	1,886						6
7										7
8	34	Surgical Intensive C AGGREGATE	110,650	3,550	107,100	211,500	650	66,094	3,305	8
9	50	Operating Room AGGREGATE	243,334	243,334						9
10	54	Radiology-Diagnostic AGGREGATE	2,546	2,546						10
11	5	Administrative & Gen AGGREGATE	19,167	17,084	2,083	211,500	18	1,830	92	11
12										12
13	16	Medical Records & Li AGGREGATE	112,050	467	111,583	211,500	785	79,821	3,991	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,693,389	2,423,960	269,429		1,782	181,199	9,061	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 Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	53	Anesthesiology AGGREGATE							438,137	1
2	44	Skilled Nursing Faci AGGREGATE							12,548	2
3	65	Respiratory Therapy AGGREGATE					11,897	336	1,884	3
4	91	Emergency AGGREGATE					21,557	14,873	1,717,733	4
5										5
6	60	Laboratory AGGREGATE							1,886	6
7										7
8	34	Surgical Intensive C AGGREGATE					66,094	41,006	44,556	8
9	50	Operating Room AGGREGATE							243,334	9
10	54	Radiology-Diagnostic AGGREGATE							2,546	10
11	5	Administrative & Gen AGGREGATE					1,830	253	17,337	11
12										12
13	16	Medical Records & Li AGGREGATE					79,821	31,762	32,229	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					181,199	88,230	2,512,190	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)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,239,519	2,239,519					1
2	Cap Rel Costs-Mvble Equip	2,001,834		2,001,834				2
4	Employee Benefits Department	9,279,537	23,833	21,303	9,324,673			4
5	Administrative & General	22,912,618	176,812	158,046	588,040	23,835,516	23,835,516	5
6	Maintenance & Repairs							6
7	Operation of Plant	3,795,700	259,341	231,816	318,479	4,605,336	1,254,033	7
8	Laundry & Linen Service	619,991			12,688	632,679	172,278	8
9	Housekeeping	1,568,903	53,688	47,990	217,351	1,887,932	514,084	9
10	Dietary	2,011,332	71,375	63,800	158,659	2,305,166	627,697	10
11	Cafeteria	580,196	70,009	62,578	74,337	787,120	214,333	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,788,924	22,554	20,161	343,108	2,174,747	592,184	13
14	Central Services & Supply	946,149	68,333	61,081	130,250	1,205,813	328,343	14
15	Pharmacy	1,711,441	23,974	21,430	329,629	2,086,474	568,147	15
16	Medical Records & Library	2,992,373	66,314	59,276	491,412	3,609,375	982,833	16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	54,442			10,960	65,402	17,809	21
22	I&R Services-Other Prgm Costs Apprvd	220,535				220,535	60,052	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,256,177	483,243	431,958	1,765,177	11,936,555	3,250,336	30
34	Surgical Intensive Care Unit	3,902,958	64,524	57,676	738,725	4,763,883	1,297,205	34
44	Skilled Nursing Facility	3,041,388	175,560	156,927	567,232	3,941,107	1,073,163	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,875,151	184,668	165,069	438,708	3,663,596	997,597	50
51	Recovery Room	472,273	12,379	11,066	87,814	583,532	158,896	51
53	Anesthesiology	160,574	5,423	4,847	14,371	185,215	50,434	53
54	Radiology-Diagnostic	1,977,559	88,675	79,263	379,496	2,524,993	687,556	54
56	Radioisotope	493,085	5,423	4,847	39,257	542,612	147,753	56
57	CT Scan	875,012	9,858	8,811	111,464	1,005,145	273,701	57
58	MRI	326,837	2,636	2,357	38,529	370,359	100,849	58
59	Cardiac Catheterization	789,142	38,443	34,363	139,244	1,001,192	272,625	59
60	Laboratory	6,598,415	84,998	75,977		6,759,390	1,840,582	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,517,522	17,908	16,007	253,315	1,804,752	491,434	65
66	Physical Therapy	2,082,540	42,905	38,351	395,355	2,559,151	696,857	66
67	Occupational Therapy	764,596	10,845	9,694	147,948	933,083	254,079	67
68	Speech Pathology	169,825	7,142	6,384	34,103	217,454	59,213	68
69	Electrocardiology	546,901	12,997	11,617	100,687	672,202	183,041	69
69.01	CARDIAC REHAB	222,512	15,651	13,990	45,333	297,486	81,005	69.01
70	Electroencephalography	40,560			8,034	48,594	13,232	70
71	Medical Supplies Charged to Patients	4,616,105				4,616,105	1,256,965	71
72	Impl. Dev. Charged to Patients	3,773,721				3,773,721	1,027,584	72
73	Drugs Charged to Patients	4,841,548				4,841,548	1,318,354	73
74	Renal Dialysis	269,099	6,269	5,604	45,721	326,693	88,959	74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,563,456	28,250	25,252	252,842	1,869,800	509,147	90
91	Emergency	3,992,865	92,836	82,983	728,983	4,897,667	1,333,635	91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	107,893,315	2,226,866	1,990,524	9,007,251	107,551,930	22,795,995	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	33,018	12,653	11,310		56,981	15,516	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
194	POB	3,443,153			317,422	3,760,575	1,024,005	194

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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)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINI- STRATIVE & GENERAL	
		0	1	2	4	4A	5	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	111,369,486	2,239,519	2,001,834	9,324,673	111,369,486	23,835,516	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	5,859,369						7
8	Laundry & Linen Service		804,957					8
9	Housekeeping	176,775		2,578,791				9
10	Dietary	235,013		106,650	3,274,526			10
11	Cafeteria	230,514		104,608		1,336,575		11
12	Maintenance of Personnel							12
13	Nursing Administration	74,264		33,701		56,925	2,931,821	13
14	Central Services & Supply	224,997		102,105		39,392		14
15	Pharmacy	78,938		35,822		47,465		15
16	Medical Records & Library	218,349		99,088		84,451	1,021	16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					4,256		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,591,151	335,449	722,076	1,809,799	342,499	1,256,187	30
34	Surgical Intensive Care Unit	212,456	79,257	96,414	420,096	117,228	487,327	34
44	Skilled Nursing Facility	578,055	87,935	262,324	1,044,631	121,553	397,089	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	608,045	62,708	275,934		61,991	187,928	50
51	Recovery Room	40,761		18,497		10,548	46,548	51
53	Anesthesiology	17,855		8,103		2,429		53
54	Radiology-Diagnostic	291,974	68,148	132,499		67,380	10,514	54
56	Radioisotope	17,855		8,103		4,696		56
57	CT Scan	32,458		14,729		16,215		57
58	MRI	8,681		3,939		4,742		58
59	Cardiac Catheterization	126,579	4,592	57,442		16,122	28,888	59
60	Laboratory	279,868		127,005				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	58,964		26,758		50,148		65
66	Physical Therapy	141,269	16,923	64,109		63,518		66
67	Occupational Therapy	35,709		16,205		22,136		67
68	Speech Pathology	23,516		10,672		4,788		68
69	Electrocardiology	42,793	4,474	19,420		19,222	18,681	69
69.01	CARDIAC REHAB	51,532		23,385		6,037	26,643	69.01
70	Electroencephalography		119			1,920		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	20,642	1,868	9,367		5,736	25,316	74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	93,018	4,027	42,212		42,422	97,384	90
91	Emergency	305,677	135,926	138,718		122,756	348,295	91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,817,708	801,426	2,559,885	3,274,526	1,336,575	2,931,821	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	41,661	3,531	18,906				190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
194	POB							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	
		7	8	9	10	11	13	
202	TOTAL (sum of lines 118-201)	5,859,369	804,957	2,578,791	3,274,526	1,336,575	2,931,821	202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES + SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
	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	1,900,650						14
15	Pharmacy		2,816,846					15
16	Medical Records & Library			4,995,117				16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				87,467			21
22	I&R Services-Other Prgm Costs Apprvd					280,587		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			696,516	21,867	70,147	22,032,582	30
34	Surgical Intensive Care Unit			195,657	21,867	70,147	7,761,537	34
44	Skilled Nursing Facility			110,604			7,616,461	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			232,429			6,090,228	50
51	Recovery Room			42,760			901,542	51
53	Anesthesiology			56,468			320,504	53
54	Radiology-Diagnostic			229,050			4,012,114	54
56	Radioisotope			54,102			775,121	56
57	CT Scan			361,024			1,703,272	57
58	MRI			76,086			564,656	58
59	Cardiac Catheterization			161,270			1,668,710	59
60	Laboratory			586,184			9,593,029	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			155,381			2,587,437	65
66	Physical Therapy			108,835			3,650,662	66
67	Occupational Therapy			50,132			1,311,344	67
68	Speech Pathology			7,990			323,633	68
69	Electrocardiology			175,039			1,134,872	69
69.01	CARDIAC REHAB			5,111			491,199	69.01
70	Electroencephalography			2,562			66,427	70
71	Medical Supplies Charged to Patients	1,045,744		183,648			7,102,462	71
72	Impl. Dev. Charged to Patients	854,906		109,468			5,765,679	72
73	Drugs Charged to Patients		2,816,846	601,219			9,577,967	73
74	Renal Dialysis			18,418			496,999	74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			102,008			2,760,018	90
91	Emergency			673,156	43,733	140,293	8,139,856	91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,900,650	2,816,846	4,995,117	87,467	280,587	106,448,311	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						136,595	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
194	POB						4,784,580	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES + SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
202	TOTAL (sum of lines 118-201)	1,900,650	2,816,846	4,995,117	87,467	280,587	111,369,486	202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	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
17.01	HOUSE STAFF PHYSICIANS						17.01
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	-92,014	21,940,568				30
34	Surgical Intensive Care Unit	-92,014	7,669,523				34
44	Skilled Nursing Facility		7,616,461				44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		6,090,228				50
51	Recovery Room		901,542				51
53	Anesthesiology		320,504				53
54	Radiology-Diagnostic		4,012,114				54
56	Radioisotope		775,121				56
57	CT Scan		1,703,272				57
58	MRI		564,656				58
59	Cardiac Catheterization		1,668,710				59
60	Laboratory		9,593,029				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		2,587,437				65
66	Physical Therapy		3,650,662				66
67	Occupational Therapy		1,311,344				67
68	Speech Pathology		323,633				68
69	Electrocardiology		1,134,872				69
69.01	CARDIAC REHAB		491,199				69.01
70	Electroencephalography		66,427				70
71	Medical Supplies Charged to Patients		7,102,462				71
72	Impl. Dev. Charged to Patients		5,765,679				72
73	Drugs Charged to Patients		9,577,967				73
74	Renal Dialysis		496,999				74
75.01	ACUTE DIALYSIS						75.01
76	AUDIO-VESTIBULAR LAB						76
76.01	ONCOLOGY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		2,760,018				90
91	Emergency	-184,026	7,955,830				91
91.01	LITHOTRIPSY						91.01
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	-368,054	106,080,257				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		136,595				190
193.01	NON EMPLOYEE DAY CARE						193.01
193.02	RESURRECTION HOME CARE OFFICES						193.02
193.03	OCCUPATIONAL HEALTH NON-REIM						193.03
194	POB		4,784,580				194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL					
		25	26					
202	TOTAL (sum of lines 118-201)	-368,054	111,001,432					202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINI- STRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		23,833	21,303	45,136	45,136		4
5	Administrative & General	462,476	176,812	158,046	797,334	2,845	800,179	5
6	Maintenance & Repairs							6
7	Operation of Plant	5,431	259,341	231,816	496,588	1,541	42,097	7
8	Laundry & Linen Service					61	5,783	8
9	Housekeeping		53,688	47,990	101,678	1,052	17,258	9
10	Dietary	5,943	71,375	63,800	141,118	768	21,072	10
11	Cafeteria		70,009	62,578	132,587	360	7,195	11
12	Maintenance of Personnel							12
13	Nursing Administration		22,554	20,161	42,715	1,660	19,879	13
14	Central Services & Supply	69,824	68,333	61,081	199,238	630	11,022	14
15	Pharmacy		23,974	21,430	45,404	1,595	19,072	15
16	Medical Records & Library	7	66,314	59,276	125,597	2,378	32,993	16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					53	598	21
22	I&R Services-Other Prgm Costs Apprvd						2,016	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		483,243	431,958	915,201	8,560	109,143	30
34	Surgical Intensive Care Unit		64,524	57,676	122,200	3,574	43,547	34
44	Skilled Nursing Facility		175,560	156,927	332,487	2,744	36,026	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	150,117	184,668	165,069	499,854	2,123	33,489	50
51	Recovery Room		12,379	11,066	23,445	425	5,334	51
53	Anesthesiology		5,423	4,847	10,270	70	1,693	53
54	Radiology-Diagnostic	18,036	88,675	79,263	185,974	1,836	23,081	54
56	Radioisotope		5,423	4,847	10,270	190	4,960	56
57	CT Scan		9,858	8,811	18,669	539	9,188	57
58	MRI		2,636	2,357	4,993	186	3,385	58
59	Cardiac Catheterization		38,443	34,363	72,806	674	9,152	59
60	Laboratory		84,998	75,977	160,975		61,788	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	19,330	17,908	16,007	53,245	1,226	16,497	65
66	Physical Therapy		42,905	38,351	81,256	1,913	23,393	66
67	Occupational Therapy		10,845	9,694	20,539	716	8,529	67
68	Speech Pathology		7,142	6,384	13,526	165	1,988	68
69	Electrocardiology		12,997	11,617	24,614	487	6,145	69
69.01	CARDIAC REHAB		15,651	13,990	29,641	219	2,719	69.01
70	Electroencephalography					39	444	70
71	Medical Supplies Charged to Patients						42,196	71
72	Impl. Dev. Charged to Patients						34,496	72
73	Drugs Charged to Patients						44,257	73
74	Renal Dialysis		6,269	5,604	11,873	221	2,986	74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		28,250	25,252	53,502	1,223	17,092	90
91	Emergency		92,836	82,983	175,819	3,527	44,770	91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	731,164	2,226,866	1,990,524	4,948,554	43,600	765,283	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		12,653	11,310	23,963		521	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
194	POB					1,536	34,375	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINI- STRATIVE & GENERAL	
		0	1	2	2A	4	5	
202	TOTAL (sum of lines 118-201)	731,164	2,239,519	2,001,834	4,972,517	45,136	800,179	202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	540,226						7
8	Laundry & Linen Service		5,844					8
9	Housekeeping	16,298		136,286				9
10	Dietary	21,668		5,636	190,262			10
11	Cafeteria	21,253		5,528		166,923		11
12	Maintenance of Personnel							12
13	Nursing Administration	6,847		1,781		7,109	79,991	13
14	Central Services & Supply	20,744		5,396		4,920		14
15	Pharmacy	7,278		1,893		5,928		15
16	Medical Records & Library	20,131		5,237		10,547		28 16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					532		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	146,706	2,436	38,163	105,156	42,774	34,273	30
34	Surgical Intensive Care Unit	19,588	575	5,095	24,409	14,640	13,296	34
44	Skilled Nursing Facility	53,296	638	13,864	60,697	15,181	10,834	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	56,061	455	14,583		7,742	5,127	50
51	Recovery Room	3,758		978		1,317	1,270	51
53	Anesthesiology	1,646		428		303		53
54	Radiology-Diagnostic	26,920	495	7,002		8,415	287	54
56	Radioisotope	1,646		428		586		56
57	CT Scan	2,993		778		2,025		57
58	MRI	800		208		592		58
59	Cardiac Catheterization	11,670	33	3,036		2,013	788	59
60	Laboratory	25,803		6,712				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,436		1,414		6,263		65
66	Physical Therapy	13,025	123	3,388		7,933		66
67	Occupational Therapy	3,292		856		2,765		67
68	Speech Pathology	2,168		564		598		68
69	Electrocardiology	3,945	32	1,026		2,401	510	69
69.01	CARDIAC REHAB	4,751		1,236		754	727	69.01
70	Electroencephalography		1			240		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	1,903	14	495		716	691	74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	8,576	29	2,231		5,298	2,657	90
91	Emergency	28,183	987	7,331		15,331	9,503	91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	536,385	5,818	135,287	190,262	166,923	79,991	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,841	26	999				190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
194	POB							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	
		7	8	9	10	11	13	
202	TOTAL (sum of lines 118-201)	540,226	5,844	136,286	190,262	166,923	79,991	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES + SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
	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	241,950						14
15	Pharmacy		81,170					15
16	Medical Records & Library			196,911				16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				1,183			21
22	I&R Services-Other Prgm Costs Apprvd					2,016		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			27,445			1,429,857	30
34	Surgical Intensive Care Unit			7,713			254,637	34
44	Skilled Nursing Facility			4,360			530,127	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			9,163			628,597	50
51	Recovery Room			1,686			38,213	51
53	Anesthesiology			2,226			16,636	53
54	Radiology-Diagnostic			9,030			263,040	54
56	Radioisotope			2,133			20,213	56
57	CT Scan			14,233			48,425	57
58	MRI			3,000			13,164	58
59	Cardiac Catheterization			6,358			106,530	59
60	Laboratory			23,109			278,387	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			6,126			90,207	65
66	Physical Therapy			4,291			135,322	66
67	Occupational Therapy			1,976			38,673	67
68	Speech Pathology			315			19,324	68
69	Electrocardiology			6,901			46,061	69
69.01	CARDIAC REHAB			202			40,249	69.01
70	Electroencephalography			101			825	70
71	Medical Supplies Charged to Patients	133,120		7,240			182,556	71
72	Impl. Dev. Charged to Patients	108,830		4,316			147,642	72
73	Drugs Charged to Patients		81,170	23,702			149,129	73
74	Renal Dialysis			726			19,625	74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			4,021			94,629	90
91	Emergency			26,538			311,989	91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	241,950	81,170	196,911			4,904,057	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						29,350	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
194	POB						35,911	194
200	Cross Foot Adjustments				1,183	2,016	3,199	200
201	Negative Cost Centers							201

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES + SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
202	TOTAL (sum of lines 118-201)	241,950	81,170	196,911	1,183	2,016	4,972,517	202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	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
17.01	HOUSE STAFF PHYSICIANS						17.01
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		1,429,857				30
34	Surgical Intensive Care Unit		254,637				34
44	Skilled Nursing Facility		530,127				44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		628,597				50
51	Recovery Room		38,213				51
53	Anesthesiology		16,636				53
54	Radiology-Diagnostic		263,040				54
56	Radioisotope		20,213				56
57	CT Scan		48,425				57
58	MRI		13,164				58
59	Cardiac Catheterization		106,530				59
60	Laboratory		278,387				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		90,207				65
66	Physical Therapy		135,322				66
67	Occupational Therapy		38,673				67
68	Speech Pathology		19,324				68
69	Electrocardiology		46,061				69
69.01	CARDIAC REHAB		40,249				69.01
70	Electroencephalography		825				70
71	Medical Supplies Charged to Patients		182,556				71
72	Impl. Dev. Charged to Patients		147,642				72
73	Drugs Charged to Patients		149,129				73
74	Renal Dialysis		19,625				74
75.01	ACUTE DIALYSIS						75.01
76	AUDIO-VESTIBULAR LAB						76
76.01	ONCOLOGY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		94,629				90
91	Emergency		311,989				91
91.01	LITHOTRIPSY						91.01
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)		4,904,057				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		29,350				190
193.01	NON EMPLOYEE DAY CARE						193.01
193.02	RESURRECTION HOME CARE OFFICES						193.02
193.03	OCCUPATIONAL HEALTH NON-REIM						193.03
194	POB		35,911				194
200	Cross Foot Adjustments		3,199				200
201	Negative Cost Centers						201

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL					
		25	26					
202	TOTAL (sum of lines 118-201)		4,972,517					202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT SQUARE FEET	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINI-STRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	253,994						1
2	Cap Rel Costs-Mvble Equip		253,994					2
4	Employee Benefits Department	2,703	2,703	46,319,108				4
5	Administrative & General	20,053	20,053	2,921,007	-23,835,516	87,533,970		5
6	Maintenance & Repairs							6
7	Operation of Plant	29,413	29,413	1,581,999		4,605,336	201,825	7
8	Laundry & Linen Service			63,026		632,679		8
9	Housekeeping	6,089	6,089	1,079,661		1,887,932	6,089	9
10	Dietary	8,095	8,095	788,119		2,305,166	8,095	10
11	Cafeteria	7,940	7,940	369,260		787,120	7,940	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,558	2,558	1,704,343		2,174,747	2,558	13
14	Central Services & Supply	7,750	7,750	647,000		1,205,813	7,750	14
15	Pharmacy	2,719	2,719	1,637,387		2,086,474	2,719	15
16	Medical Records & Library	7,521	7,521	2,441,023		3,609,375	7,521	16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			54,442		65,402		21
22	I&R Services-Other Prgm Costs Apprvd					220,535		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	54,807	54,807	8,768,339		11,936,555	54,807	30
34	Surgical Intensive Care Unit	7,318	7,318	3,669,515		4,763,883	7,318	34
44	Skilled Nursing Facility	19,911	19,911	2,817,650		3,941,107	19,911	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	20,944	20,944	2,179,223		3,663,596	20,944	50
51	Recovery Room	1,404	1,404	436,202		583,532	1,404	51
53	Anesthesiology	615	615	71,384		185,215	615	53
54	Radiology-Diagnostic	10,057	10,057	1,885,094		2,524,993	10,057	54
56	Radioisotope	615	615	195,003		542,612	615	56
57	CT Scan	1,118	1,118	553,683		1,005,145	1,118	57
58	MRI	299	299	191,386		370,359	299	58
59	Cardiac Catheterization	4,360	4,360	691,675		1,001,192	4,360	59
60	Laboratory	9,640	9,640			6,759,390	9,640	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,031	2,031	1,258,307		1,804,752	2,031	65
66	Physical Therapy	4,866	4,866	1,963,870		2,559,151	4,866	66
67	Occupational Therapy	1,230	1,230	734,913		933,083	1,230	67
68	Speech Pathology	810	810	169,403		217,454	810	68
69	Electrocardiology	1,474	1,474	500,149		672,202	1,474	69
69.01	CARDIAC REHAB	1,775	1,775	225,186		297,486	1,775	69.01
70	Electroencephalography			39,909		48,594		70
71	Medical Supplies Charged to Patients					4,616,105		71
72	Impl. Dev. Charged to Patients					3,773,721		72
73	Drugs Charged to Patients					4,841,548		73
74	Renal Dialysis	711	711	227,114		326,693	711	74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	3,204	3,204	1,255,960		1,869,800	3,204	90
91	Emergency	10,529	10,529	3,621,125		4,897,667	10,529	91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	252,559	252,559	44,742,357	-23,835,516	83,716,414	200,390	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,435	1,435			56,981	1,435	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
194	POB			1,576,751		3,760,575		194
200	Cross foot adjustments							200

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT SQUARE FEET	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,239,519	2,001,834	9,324,673		23,835,516	5,859,369	202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.817212	7.881422	0.201314		0.272300	29.031929	203
204	Cost to be allocated (Per Wkst. B, Part II)			45,136		800,179	540,226	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000974		0.009141	2.676705	205

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY AND LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY (MEALS SERVED)	CAFETERIA FTES SERVED	NURSING ADMINISTRATION (DIRECT NRSG HRS)	CENTRAL SERVICES + SUPPLY (COSTED RE UIS)	
		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	910,942						8
9	Housekeeping		195,736					9
10	Dietary		8,095	139,798				10
11	Cafeteria		7,940		57,783			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,558		2,461	28,721		13
14	Central Services & Supply		7,750		1,703		8,389,826	14
15	Pharmacy		2,719		2,052			15
16	Medical Records & Library		7,521		3,651	10		16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				184			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	379,614	54,807	77,265	14,807	12,306		30
34	Surgical Intensive Care Unit	89,693	7,318	17,935	5,068	4,774		34
44	Skilled Nursing Facility	99,513	19,911	44,598	5,255	3,890		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	70,965	20,944		2,680	1,841		50
51	Recovery Room		1,404		456	456		51
53	Anesthesiology		615		105			53
54	Radiology-Diagnostic	77,121	10,057		2,913	103		54
56	Radioisotope		615		203			56
57	CT Scan		1,118		701			57
58	MRI		299		205			58
59	Cardiac Catheterization	5,197	4,360		697	283		59
60	Laboratory		9,640					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,031		2,168			65
66	Physical Therapy	19,151	4,866		2,746			66
67	Occupational Therapy		1,230		957			67
68	Speech Pathology		810		207			68
69	Electrocardiology	5,063	1,474		831	183		69
69.01	CARDIAC REHAB		1,775		261	261		69.01
70	Electroencephalography	135			83			70
71	Medical Supplies Charged to Patients						4,616,105	71
72	Impl. Dev. Charged to Patients						3,773,721	72
73	Drugs Charged to Patients							73
74	Renal Dialysis	2,114	711		248	248		74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,557	3,204		1,834	954		90
91	Emergency	153,823	10,529		5,307	3,412		91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	906,946	194,301	139,798	57,783	28,721	8,389,826	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,996	1,435					190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
194	POB							194
200	Cross foot adjustments							200

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY AND LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY (MEALS SERVED)	CAFETERIA FTES SERVED	NURSING ADMINISTRATION (DIRECT NRSG HRS)	CENTRAL SERVICES + SUPPLY (COSTED RE UIS)	
		8	9	10	11	13	14	
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	804,957	2,578,791	3,274,526	1,336,575	2,931,821	1,900,650	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.883653	13.174843	23.423268	23.130938	102.079350	0.226542	203
204	Cost to be allocated (Per Wkst. B, Part II)	5,844	136,286	190,262	166,923	79,991	241,950	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.006415	0.696275	1.360978	2.888791	2.785105	0.028839	205

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	HOUSE STAFF PHYSICIANS ASSIGNED TIME	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)		
	15	16	17.01	21	22		

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	4,841,548					15
16	Medical Records & Library		615,408,673				16
17	Social Service						17
17.01	HOUSE STAFF PHYSICIANS			100			17.01
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd				200		21
22	I&R Services-Other Prgm Costs Apprvd					200	22
23	Paramed Ed Prgm-(specify)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		85,828,523	100	50	50	30
34	Surgical Intensive Care Unit		24,104,623		50	50	34
44	Skilled Nursing Facility		13,626,251				44
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		28,634,879				50
51	Recovery Room		5,267,958				51
53	Anesthesiology		6,956,737				53
54	Radiology-Diagnostic		28,218,555				54
56	Radioisotope		6,665,318				56
57	CT Scan		44,477,568				57
58	MRI		9,373,641				58
59	Cardiac Catheterization		19,868,158				59
60	Laboratory		72,216,855				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		19,142,642				65
66	Physical Therapy		13,408,320				66
67	Occupational Therapy		6,176,215				67
68	Speech Pathology		984,336				68
69	Electrocardiology		21,564,447				69
69.01	CARDIAC REHAB		629,718				69.01
70	Electroencephalography		315,582				70
71	Medical Supplies Charged to Patients		22,625,129				71
72	Impl. Dev. Charged to Patients		13,486,223				72
73	Drugs Charged to Patients	4,841,548	74,069,077				73
74	Renal Dialysis		2,269,094				74
75.01	ACUTE DIALYSIS						75.01
76	AUDIO-VESTIBULAR LAB						76
76.01	ONCOLOGY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	Clinic		12,567,166				90
91	Emergency		82,931,658		100	100	91
91.01	LITHOTRIPSY						91.01
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,841,548	615,408,673	100	200	200	118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
193.01	NON EMPLOYEE DAY CARE						193.01
193.02	RESURRECTION HOME CARE OFFICES						193.02
193.03	OCCUPATIONAL HEALTH NON-REIM						193.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	HOUSE STAFF PHYSICIANS ASSIGNED TIME	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)		
		15	16	17.01	21	22		
194	POB							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,816,846	4,995,117		87,467	280,587		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.581807	0.008117		437.335000	1,402.935000		203
204	Cost to be allocated (Per Wkst. B, Part II)	81,170	196,911		1,183	2,016		204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.016765	0.000320		5.915000	10.080000		205

KPMG LLP Compu-Max 2552-10

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POST STEPDOWN ADJUSTMENTS**WORKSHEET B-2**

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	21,940,568		21,940,568		21,940,568	30
34	Surgical Intensive Care Unit	7,669,523		7,669,523	41,006	7,710,529	34
44	Skilled Nursing Facility	7,616,461		7,616,461		7,616,461	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,090,228		6,090,228		6,090,228	50
51	Recovery Room	901,542		901,542		901,542	51
53	Anesthesiology	320,504		320,504		320,504	53
54	Radiology-Diagnostic	4,012,114		4,012,114		4,012,114	54
56	Radioisotope	775,121		775,121		775,121	56
57	CT Scan	1,703,272		1,703,272		1,703,272	57
58	MRI	564,656		564,656		564,656	58
59	Cardiac Catheterization	1,668,710		1,668,710		1,668,710	59
60	Laboratory	9,593,029		9,593,029		9,593,029	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,587,437		2,587,437	336	2,587,773	65
66	Physical Therapy	3,650,662		3,650,662		3,650,662	66
67	Occupational Therapy	1,311,344		1,311,344		1,311,344	67
68	Speech Pathology	323,633		323,633		323,633	68
69	Electrocardiology	1,134,872		1,134,872		1,134,872	69
69.01	CARDIAC REHAB	491,199		491,199		491,199	69.01
70	Electroencephalography	66,427		66,427		66,427	70
71	Medical Supplies Charged to Patients	7,102,462		7,102,462		7,102,462	71
72	Impl. Dev. Charged to Patients	5,765,679		5,765,679		5,765,679	72
73	Drugs Charged to Patients	9,577,967		9,577,967		9,577,967	73
74	Renal Dialysis	496,999		496,999		496,999	74
75.01	ACUTE DIALYSIS						75.01
76	AUDIO-VESTIBULAR LAB						76
76.01	ONCOLOGY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,760,018		2,760,018		2,760,018	90
91	Emergency	7,955,830		7,955,830	14,873	7,970,703	91
91.01	LITHOTRIPSY						91.01
92	Observation Beds (Non-Distinct Part)	2,313,431		2,313,431		2,313,431	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	108,393,688		108,393,688	56,215	108,449,903	200
201	Less Observation Beds	2,313,431		2,313,431		2,313,431	201
202	Total (line 200 minus line 201)	106,080,257		106,080,257		106,136,472	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	76,679,056		76,679,056				30
34	Surgical Intensive Care Unit	24,104,623		24,104,623				34
44	Skilled Nursing Facility	13,626,251		13,626,251				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	13,826,226	14,808,653	28,634,879	0.212686	0.212686	0.212686	50
51	Recovery Room	2,801,980	2,465,978	5,267,958	0.171137	0.171137	0.171137	51
53	Anesthesiology	3,488,447	3,468,290	6,956,737	0.046071	0.046071	0.046071	53
54	Radiology-Diagnostic	10,505,495	17,713,060	28,218,555	0.142180	0.142180	0.142180	54
56	Radioisotope	2,216,660	4,448,658	6,665,318	0.116292	0.116292	0.116292	56
57	CT Scan	17,051,291	27,426,277	44,477,568	0.038295	0.038295	0.038295	57
58	MRI	3,551,326	5,822,315	9,373,641	0.060239	0.060239	0.060239	58
59	Cardiac Catheterization	14,266,602	5,601,556	19,868,158	0.083989	0.083989	0.083989	59
60	Laboratory	47,728,528	24,488,327	72,216,855	0.132836	0.132836	0.132836	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,269,027	873,615	19,142,642	0.135166	0.135166	0.135184	65
66	Physical Therapy	9,809,919	3,598,401	13,408,320	0.272268	0.272268	0.272268	66
67	Occupational Therapy	5,147,936	1,028,279	6,176,215	0.212322	0.212322	0.212322	67
68	Speech Pathology	857,427	126,909	984,336	0.328783	0.328783	0.328783	68
69	Electrocardiology	11,787,816	9,776,631	21,564,447	0.052627	0.052627	0.052627	69
69.01	CARDIAC REHAB	258,890	370,828	629,718	0.780030	0.780030	0.780030	69.01
70	Electroencephalography	227,166	88,416	315,582	0.210490	0.210490	0.210490	70
71	Medical Supplies Charged to Patients	16,867,601	5,757,528	22,625,129	0.313919	0.313919	0.313919	71
72	Impl. Dev. Charged to Patients	6,869,260	6,616,963	13,486,223	0.427524	0.427524	0.427524	72
73	Drugs Charged to Patients	61,947,632	12,121,445	74,069,077	0.129311	0.129311	0.129311	73
74	Renal Dialysis	2,132,054	137,040	2,269,094	0.219030	0.219030	0.219030	74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,567,767	9,999,399	12,567,166	0.219621	0.219621	0.219621	90
91	Emergency	22,278,434	60,653,224	82,931,658	0.095932	0.095932	0.096112	91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)	1,307,374	7,842,093	9,149,467	0.252849	0.252849	0.252849	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	390,174,788	225,233,885	615,408,673				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	390,174,788	225,233,885	615,408,673				202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed 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)	1,429,857		1,429,857	28,471	50.22	11,682	586,670	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit	254,637		254,637	5,912	43.07	2,566	110,518	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	530,127		530,127	14,701	36.06	11,103	400,374	44
45	Nursing Facility								45
200	Total (lines 30-199)	2,214,621		2,214,621	49,084		25,351	1,097,562	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0251

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	628,597	28,634,879	0.021952	5,351,951	117,486	50
51	Recovery Room	38,213	5,267,958	0.007254	1,089,464	7,903	51
53	Anesthesiology	16,636	6,956,737	0.002391	1,355,017	3,240	53
54	Radiology-Diagnostic	263,040	28,218,555	0.009322	4,790,770	44,660	54
56	Radioisotope	20,213	6,665,318	0.003033	1,035,147	3,140	56
57	CT Scan	48,425	44,477,568	0.001089	7,130,249	7,765	57
58	MRI	13,164	9,373,641	0.001404	1,383,557	1,943	58
59	Cardiac Catheterization	106,530	19,868,158	0.005362	5,312,268	28,484	59
60	Laboratory	278,387	72,216,855	0.003855	19,976,174	77,008	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	90,207	19,142,642	0.004712	7,515,490	35,413	65
66	Physical Therapy	135,322	13,408,320	0.010092	1,133,387	11,438	66
67	Occupational Therapy	38,673	6,176,215	0.006262	346,715	2,171	67
68	Speech Pathology	19,324	984,336	0.019632	348,538	6,842	68
69	Electrocardiology	46,061	21,564,447	0.002136	6,233,622	13,315	69
69.01	CARDIAC REHAB	40,249	629,718	0.063916	102,412	6,546	69.01
70	Electroencephalography	825	315,582	0.002614	107,666	281	70
71	Medical Supplies Charged to Pat	182,556	22,625,129	0.008069	6,778,403	54,695	71
72	Impl. Dev. Charged to Patients	147,642	13,486,223	0.010948	3,008,647	32,939	72
73	Drugs Charged to Patients	149,129	74,069,077	0.002013	23,361,277	47,026	73
74	Renal Dialysis	19,625	2,269,094	0.008649	1,185,669	10,255	74
75.01	ACUTE DIALYSIS						75.01
76	AUDIO-VESTIBULAR LAB						76
76.01	ONCOLOGY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	94,629	12,567,166	0.007530	1,261,289	9,498	90
91	Emergency	311,989	82,931,658	0.003762	9,635,755	36,250	91
91.01	LITHOTRIPSY						91.01
92	Observation Beds (Non-Distinct)	150,766	9,149,467	0.016478	632,180	10,417	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,840,202	500,998,743		109,075,647	568,715	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	28,471		11,682		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit	5,912		2,566		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	14,701		11,103		44
45	Nursing Facility					45
200	Total (lines 30-199)	49,084		25,351		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0251

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
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
69	Electrocardiology							69
69.01	CARDIAC REHAB							69.01
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0251

**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	28,634,879			5,351,951		5,203,315		50
51	Recovery Room	5,267,958			1,089,464		694,729		51
53	Anesthesiology	6,956,737			1,355,017		1,130,190		53
54	Radiology-Diagnostic	28,218,555			4,790,770		3,991,526		54
56	Radioisotope	6,665,318			1,035,147		1,679,976		56
57	CT Scan	44,477,568			7,130,249		6,413,494		57
58	MRI	9,373,641			1,383,557		2,114,621		58
59	Cardiac Catheterization	19,868,158			5,312,268		1,392,738		59
60	Laboratory	72,216,855			19,976,174		4,967,601		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,142,642			7,515,490		263,233		65
66	Physical Therapy	13,408,320			1,133,387		763		66
67	Occupational Therapy	6,176,215			346,715		2,248		67
68	Speech Pathology	984,336			348,538				68
69	Electrocardiology	21,564,447			6,233,622		4,000,465		69
69.01	CARDIAC REHAB	629,718			102,412		167,295		69.01
70	Electroencephalography	315,582			107,666		39,296		70
71	Medical Supplies Charged to Pat	22,625,129			6,778,403		1,963,240		71
72	Impl. Dev. Charged to Patients	13,486,223			3,008,647		3,312,391		72
73	Drugs Charged to Patients	74,069,077			23,361,277		3,828,989		73
74	Renal Dialysis	2,269,094			1,185,669		105,291		74
75.01	ACUTE DIALYSIS								75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	12,567,166			1,261,289		3,557,435		90
91	Emergency	82,931,658			9,635,755		7,941,628		91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct)	9,149,467			632,180		3,276,251		92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	500,998,743			109,075,647		56,046,715		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0251

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.212686	5,203,315			1,106,672			50
51	Recovery Room	0.171137	694,729			118,894			51
53	Anesthesiology	0.046071	1,130,190			52,069			53
54	Radiology-Diagnostic	0.142180	3,991,526			567,515			54
56	Radioisotope	0.116292	1,679,976			195,368			56
57	CT Scan	0.038295	6,413,494			245,605			57
58	MRI	0.060239	2,114,621			127,383			58
59	Cardiac Catheterization	0.083989	1,392,738			116,975			59
60	Laboratory	0.132836	4,967,601	2,051		659,876	272		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.135166	263,233			35,580			65
66	Physical Therapy	0.272268	763			208			66
67	Occupational Therapy	0.212322	2,248			477			67
68	Speech Pathology	0.328783							68
69	Electrocardiology	0.052627	4,000,465			210,532			69
69.01	CARDIAC REHAB	0.780030	167,295			130,495			69.01
70	Electroencephalography	0.210490	39,296			8,271			70
71	Medical Supplies Charged to Pat	0.313919	1,963,240			616,298			71
72	Impl. Dev. Charged to Patients	0.427524	3,312,391	58,900		1,416,127	25,181		72
73	Drugs Charged to Patients	0.129311	3,828,989		141,771	495,130		18,333	73
74	Renal Dialysis	0.219030	105,291			23,062			74
75.01	ACUTE DIALYSIS								75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.219621	3,557,435			781,287			90
91	Emergency	0.095932	7,941,628			761,856			91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct	0.252849	3,276,251			828,397			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		56,046,715	60,951	141,771	8,498,077	25,453	18,333	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		56,046,715	60,951	141,771	8,498,077	25,453	18,333	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-5548

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
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
69	Electrocardiology							69
69.01	CARDIAC REHAB							69.01
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-5548

**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	28,634,879			49,118				50
51	Recovery Room	5,267,958							51
53	Anesthesiology	6,956,737							53
54	Radiology-Diagnostic	28,218,555			376,714				54
56	Radioisotope	6,665,318			20,730				56
57	CT Scan	44,477,568			9,736				57
58	MRI	9,373,641							58
59	Cardiac Catheterization	19,868,158			3,170				59
60	Laboratory	72,216,855			3,221,862				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,142,642			1,431,110				65
66	Physical Therapy	13,408,320			5,883,776				66
67	Occupational Therapy	6,176,215			3,524,725				67
68	Speech Pathology	984,336			164,566				68
69	Electrocardiology	21,564,447			107,368				69
69.01	CARDIAC REHAB	629,718							69.01
70	Electroencephalography	315,582							70
71	Medical Supplies Charged to Pat	22,625,129			1,492,879				71
72	Impl. Dev. Charged to Patients	13,486,223							72
73	Drugs Charged to Patients	74,069,077			6,769,218				73
74	Renal Dialysis	2,269,094							74
75.01	ACUTE DIALYSIS								75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	12,567,166			579				90
91	Emergency	82,931,658							91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct)	9,149,467							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	500,998,743			23,055,551				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5548

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.212686							50
51	Recovery Room	0.171137							51
53	Anesthesiology	0.046071							53
54	Radiology-Diagnostic	0.142180							54
56	Radioisotope	0.116292							56
57	CT Scan	0.038295							57
58	MRI	0.060239							58
59	Cardiac Catheterization	0.083989							59
60	Laboratory	0.132836							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.135166							65
66	Physical Therapy	0.272268							66
67	Occupational Therapy	0.212322							67
68	Speech Pathology	0.328783							68
69	Electrocardiology	0.052627							69
69.01	CARDIAC REHAB	0.780030							69.01
70	Electroencephalography	0.210490							70
71	Medical Supplies Charged to Pat	0.313919							71
72	Impl. Dev. Charged to Patients	0.427524							72
73	Drugs Charged to Patients	0.129311			1,661			215	73
74	Renal Dialysis	0.219030							74
75.01	ACUTE DIALYSIS								75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.219621							90
91	Emergency	0.095932							91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct	0.252849							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)				1,661			215	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)				1,661			215	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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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)	1,429,857		1,429,857	28,471	50.22	3,942	197,967	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit	254,637		254,637	5,912	43.07	1,012	43,587	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	530,127		530,127	14,701	36.06			44
45	Nursing Facility								45
200	Total (lines 30-199)	2,214,621		2,214,621	49,084		4,954	241,554	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0251

WORKSHEET D
PART II

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	628,597	28,634,879	0.021952		50
51	Recovery Room	38,213	5,267,958	0.007254		51
53	Anesthesiology	16,636	6,956,737	0.002391		53
54	Radiology-Diagnostic	263,040	28,218,555	0.009322		54
56	Radioisotope	20,213	6,665,318	0.003033		56
57	CT Scan	48,425	44,477,568	0.001089		57
58	MRI	13,164	9,373,641	0.001404		58
59	Cardiac Catheterization	106,530	19,868,158	0.005362		59
60	Laboratory	278,387	72,216,855	0.003855		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	90,207	19,142,642	0.004712		65
66	Physical Therapy	135,322	13,408,320	0.010092		66
67	Occupational Therapy	38,673	6,176,215	0.006262		67
68	Speech Pathology	19,324	984,336	0.019632		68
69	Electrocardiology	46,061	21,564,447	0.002136		69
69.01	CARDIAC REHAB	40,249	629,718	0.063916		69.01
70	Electroencephalography	825	315,582	0.002614		70
71	Medical Supplies Charged to Pat	182,556	22,625,129	0.008069		71
72	Impl. Dev. Charged to Patients	147,642	13,486,223	0.010948		72
73	Drugs Charged to Patients	149,129	74,069,077	0.002013		73
74	Renal Dialysis	19,625	2,269,094	0.008649		74
75.01	ACUTE DIALYSIS					75.01
76	AUDIO-VESTIBULAR LAB					76
76.01	ONCOLOGY					76.01
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	94,629	12,567,166	0.007530		90
91	Emergency	311,989	82,931,658	0.003762		91
91.01	LITHOTRIPSY					91.01
92	Observation Beds (Non-Distinct)	150,766	9,149,467	0.016478		92
	OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-199)	2,840,202	500,998,743			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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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	1 Nursing School	2 Allied Health Cost	3 All Other Medical Education Cost	4 Swing-Bed Adjustment Amount (see instructions)	5 Total Costs (sum of cols. 1 through 3 minus col 4.)	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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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)	28,471		3,942		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit	5,912		1,012		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	14,701				44
45	Nursing Facility					45
200	Total (lines 30-199)	49,084		4,954		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0251

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
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
69	Electrocardiology							69
69.01	CARDIAC REHAB							69.01
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0251

**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	28,634,879							50
51	Recovery Room	5,267,958							51
53	Anesthesiology	6,956,737							53
54	Radiology-Diagnostic	28,218,555							54
56	Radioisotope	6,665,318							56
57	CT Scan	44,477,568							57
58	MRI	9,373,641							58
59	Cardiac Catheterization	19,868,158							59
60	Laboratory	72,216,855							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,142,642							65
66	Physical Therapy	13,408,320							66
67	Occupational Therapy	6,176,215							67
68	Speech Pathology	984,336							68
69	Electrocardiology	21,564,447							69
69.01	CARDIAC REHAB	629,718							69.01
70	Electroencephalography	315,582							70
71	Medical Supplies Charged to Pat	22,625,129							71
72	Impl. Dev. Charged to Patients	13,486,223							72
73	Drugs Charged to Patients	74,069,077							73
74	Renal Dialysis	2,269,094							74
75.01	ACUTE DIALYSIS								75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	12,567,166							90
91	Emergency	82,931,658							91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct)	9,149,467							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	500,998,743							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0251

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.212686							50
51	Recovery Room	0.171137							51
53	Anesthesiology	0.046071							53
54	Radiology-Diagnostic	0.142180							54
56	Radioisotope	0.116292							56
57	CT Scan	0.038295							57
58	MRI	0.060239							58
59	Cardiac Catheterization	0.083989							59
60	Laboratory	0.132836							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.135166							65
66	Physical Therapy	0.272268							66
67	Occupational Therapy	0.212322							67
68	Speech Pathology	0.328783							68
69	Electrocardiology	0.052627							69
69.01	CARDIAC REHAB	0.780030							69.01
70	Electroencephalography	0.210490							70
71	Medical Supplies Charged to Pat	0.313919							71
72	Impl. Dev. Charged to Patients	0.427524							72
73	Drugs Charged to Patients	0.129311							73
74	Renal Dialysis	0.219030							74
75.01	ACUTE DIALYSIS								75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.219621							90
91	Emergency	0.095932							91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct	0.252849							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,471	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,471	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	25,469	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)	11,682	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)	21,940,568	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)	21,940,568	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)	21,940,568	37

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1					
38	Adjusted general inpatient routine service cost per diem (see instructions)						770.63	38				
39	Program general inpatient routine service cost (line 9 x line 38)						9,002,500	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)						9,002,500	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							43				
44	Coronary Care Unit							44				
45	Burn Intensive Care Unit							45				
46	Surgical Intensive Care Unit						7,710,529	5,912	1,304.22	2,566	3,346,629	46
47	Other Special Care (specify)											47
							1					
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						15,645,855	48				
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						27,994,984	49				
	PASS THROUGH COST ADJUSTMENTS											
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						697,188	50				
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						568,715	51				
52	Total Program excludable cost (sum of lines 50 and 51)						1,265,903	52				
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						26,729,081	53				
	TARGET AMOUNT AND LIMIT COMPUTATION											
54	Program discharges							54				
55	Target amount per discharge							55				
56	Target amount (line 54 x line 55)							56				
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57				
58	Bonus payment (see instructions)							58				
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59				
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60				
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61				
62	Relief payment (see instructions)							62				
63	Allowable Inpatient cost plus incentive payment (see instructions)							63				
	PROGRAM INPATIENT ROUTINE SWING BED COST											
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64				
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65				
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66				
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67				
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68				
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69				

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

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)					3,002	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					770.63	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,313,431	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,429,857	21,940,568	0.065170	2,313,431	150,766	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5548

**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)	14,701	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,701	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)	14,701	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)	11,103	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)	7,616,461	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)	7,616,461	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)	7,616,461	37

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5548

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 III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	7,616,461	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	518.09	71
72	Program routine service cost (line 9 x line 71)	5,752,353	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	5,752,353	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	5,752,353	83
84	Program inpatient ancillary services (see instructions)	4,442,676	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	10,195,029	86

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,471	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,471	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	25,469	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,942	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)	21,940,568	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)	21,940,568	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)	21,940,568	37

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						770.63	38
39	Program general inpatient routine service cost (line 9 x line 38)						3,037,823	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						3,037,823	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							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit						7,669,523	46
47	Other Special Care (specify)						5,912	47
				1,297.28	1,012	1,312,847		

							1	
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)						4,350,670	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						241,554	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)						241,554	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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

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)					3,002	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0251

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		33,696,896		30
34	Surgical Intensive Care Unit		10,697,014		34
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.212686	5,351,951	1,138,285	50
51	Recovery Room	0.171137	1,089,464	186,448	51
53	Anesthesiology	0.046071	1,355,017	62,427	53
54	Radiology-Diagnostic	0.142180	4,790,770	681,152	54
56	Radioisotope	0.116292	1,035,147	120,379	56
57	CT Scan	0.038295	7,130,249	273,053	57
58	MRI	0.060239	1,383,557	83,344	58
59	Cardiac Catheterization	0.083989	5,312,268	446,172	59
60	Laboratory	0.132836	19,976,174	2,653,555	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.135184	7,515,490	1,015,974	65
66	Physical Therapy	0.272268	1,133,387	308,585	66
67	Occupational Therapy	0.212322	346,715	73,615	67
68	Speech Pathology	0.328783	348,538	114,593	68
69	Electrocardiology	0.052627	6,233,622	328,057	69
69.01	CARDIAC REHAB	0.780030	102,412	79,884	69.01
70	Electroencephalography	0.210490	107,666	22,663	70
71	Medical Supplies Charged to Patients	0.313919	6,778,403	2,127,869	71
72	Impl. Dev. Charged to Patients	0.427524	3,008,647	1,286,269	72
73	Drugs Charged to Patients	0.129311	23,361,277	3,020,870	73
74	Renal Dialysis	0.219030	1,185,669	259,697	74
75.01	ACUTE DIALYSIS				75.01
76	AUDIO-VESTIBULAR LAB				76
76.01	ONCOLOGY				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.219621	1,261,289	277,006	90
91	Emergency	0.096112	9,635,755	926,112	91
91.01	LITHOTRIPSY				91.01
92	Observation Beds (Non-Distinct Part)	0.252849	632,180	159,846	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		109,075,647	15,645,855	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		109,075,647		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-5548

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
34	Surgical Intensive Care Unit				34
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.212686	49,118	10,447	50
51	Recovery Room	0.171137			51
53	Anesthesiology	0.046071			53
54	Radiology-Diagnostic	0.142180	376,714	53,561	54
56	Radioisotope	0.116292	20,730	2,411	56
57	CT Scan	0.038295	9,736	373	57
58	MRI	0.060239			58
59	Cardiac Catheterization	0.083989	3,170	266	59
60	Laboratory	0.132836	3,221,862	427,979	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.135166	1,431,110	193,437	65
66	Physical Therapy	0.272268	5,883,776	1,601,964	66
67	Occupational Therapy	0.212322	3,524,725	748,377	67
68	Speech Pathology	0.328783	164,566	54,107	68
69	Electrocardiology	0.052627	107,368	5,650	69
69.01	CARDIAC REHAB	0.780030			69.01
70	Electroencephalography	0.210490			70
71	Medical Supplies Charged to Patients	0.313919	1,492,879	468,643	71
72	Impl. Dev. Charged to Patients	0.427524			72
73	Drugs Charged to Patients	0.129311	6,769,218	875,334	73
74	Renal Dialysis	0.219030			74
75.01	ACUTE DIALYSIS				75.01
76	AUDIO-VESTIBULAR LAB				76
76.01	ONCOLOGY				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.219621	579	127	90
91	Emergency	0.095932			91
91.01	LITHOTRIPSY				91.01
92	Observation Beds (Non-Distinct Part)	0.252849			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		23,055,551	4,442,676	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		23,055,551		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0251

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
34	Surgical Intensive Care Unit				34
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.212686			50
51	Recovery Room	0.171137			51
53	Anesthesiology	0.046071			53
54	Radiology-Diagnostic	0.142180			54
56	Radioisotope	0.116292			56
57	CT Scan	0.038295			57
58	MRI	0.060239			58
59	Cardiac Catheterization	0.083989			59
60	Laboratory	0.132836			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.135166			65
66	Physical Therapy	0.272268			66
67	Occupational Therapy	0.212322			67
68	Speech Pathology	0.328783			68
69	Electrocardiology	0.052627			69
69.01	CARDIAC REHAB	0.780030			69.01
70	Electroencephalography	0.210490			70
71	Medical Supplies Charged to Patients	0.313919			71
72	Impl. Dev. Charged to Patients	0.427524			72
73	Drugs Charged to Patients	0.129311			73
74	Renal Dialysis	0.219030			74
75.01	ACUTE DIALYSIS				75.01
76	AUDIO-VESTIBULAR LAB				76
76.01	ONCOLOGY				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.219621			90
91	Emergency	0.095932			91
91.01	LITHOTRIPSY				91.01
92	Observation Beds (Non-Distinct Part)	0.252849			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

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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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)	17,711,764			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,903,921			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)	190,370			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	204.78			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)	1.56			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.	0.11			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).	1.50			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)	2.95			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	1.84			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	1.84			12
13	Total allowable FTE count for the prior year	2.57			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	3.11			14
15	Sum of lines 12 through 14 divided by 3	2.51			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	2.51			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.012257			19
20	Prior year resident to bed ratio (see instructions)	0.014405			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.012257			21
22	IME payment adjustment (see instructions)	157,682			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)	-1.11			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)	157,682			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0983			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2411			31
32	Sum of lines 30 and 31	0.3394			32
33	Allowable disproportionate share percentage (see instructions)	0.1721			33
34	Disproportionate share adjustment (see instructions)	1,016,065			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
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)	1,935,355		1,667,078	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,447,539		419,047	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,866,586			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	26,846,388			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)	26,846,388			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	2,046,536			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)	78,186			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	1,705			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	28,972,815			59
60	Primary payer payments	6,594			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	28,966,221			61
62	Deductibles billed to program beneficiaries	2,401,368			62
63	Coinsurance billed to program beneficiaries	77,772			63
64	Allowable bad debts (see instructions)	409,687			64
65	Adjusted reimbursable bad debts (see instructions)	266,297			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	399,613			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	26,753,378			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
70.93	HVBP payment adjustment amount (see instructions)	-135,576			70.93
70.94	HRR adjustment amount (see instructions)	-17,831			70.94
71	Amount due provider (see instructions)	26,599,971			71
71.01	Sequestration adjustment (see instructions)	531,999			71.01
72	Interim payments	26,091,425			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-23,453			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	149,302			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

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

HSP Bonus Payment Amount

Prior to 10/1 On or After 10/1

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

Prior to 10/1 On or After 10/1

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

HRR Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

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

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0251

**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)	43,786			1
2	Medical and other services reimbursed under OPPTS (see instructions)	8,498,077			2
3	PPS payments	8,589,590			3
4	Outlier payment (see instructions)	4,513			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	43,786			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	202,722			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)	202,722			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)	202,722			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	158,936			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)	43,786			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)	8,594,103			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,736,685			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)	6,901,204			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	16,854			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	6,918,058			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	6,918,058			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)	310,848			34
35	Adjusted reimbursable bad debts (see instructions)	202,051			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	307,428			36
37	Subtotal (see instructions)	7,120,109			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)	7,120,109			40
40.01	Sequestration adjustment (see instructions)	142,402			40.01
41	Interim payments	7,248,030			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-270,323			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-5548

**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)	215			1
2	Medical and other services reimbursed under OPPTS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	215			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,661			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	1,661			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	1,661			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	1,446			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)	215			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)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	215			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)	215			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	215			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	215			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)	215			40
40.01	Sequestration adjustment (see instructions)	4			40.01
41	Interim payments	212			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-1			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0251

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4		
1	Total interim payments paid to provider		26,005,140		7,222,457	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	08/05/2015	14,300	08/05/2015	23,030	3.01
		.02	12/15/2015	71,985	12/15/2015	2,543	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		86,285		25,573	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)			26,091,425		7,248,030	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					6.01
		.02		-23,453		-270,323	6.02
7	Total Medicare program liability (see instructions)			26,067,972		6,977,707	7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)		8

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

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-5548

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		5,460,990		212 1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	Program to Provider	.01 .02 .03 .04 .05 .06 .07 .08 .09 .10 .50 .51 .52 to .53 Program .54 .55 .56 .57 .58 .59		3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.10 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.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)		5,460,990		212 4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	Program to Provider	.01 .02 .03 .04 .05 .06 .07 .08 .09 .10 .50 .51 .52 to .53 Program .54 .55 .56 .57 .58 .59		5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.10 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99		5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		.01 .02		6.01 -1 6.02
7	Total Medicare program liability (see instructions)		5,460,990		211 7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)	
					8

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

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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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)	6,571	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	14,248	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	31,381	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	615,408,673	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	7,482,440	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)	708,795	8
9	Sequestration adjustment amount (see instructions)	14,176	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	694,619	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	929,352	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-234,733	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

**WORKSHEET E-3
PART VI**

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

PROSPECTIVE PAYMENT AMOUNT (see instructions)			
1	Resource Utilization Group (RUGS) payment	5,886,389	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	5,886,389	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	313,950	7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	5,572,439	12
13	Inpatient primary payer payments		13
14	Other adjustments (ADJ. PENDING CORRECT SNF PS & R)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	5,572,439	15
15.01	Sequestration adjustment (see instructions)	111,449	15.01
16	Interim payments	5,460,990	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0251

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	4,350,670	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	4,350,670	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	4,350,670	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 cahрге 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(c)		14
15	Ratio of line 13 to line 14 (not to exceed 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)	4,350,670	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)	4,350,670	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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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check [] Title V
Applicable [XX] Title XVIII
Box: [] Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			1.56	2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			0.13	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			1.25	4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			2.68	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			1.84	6
7	Enter the lesser of line 5 or line 6			1.84	7
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	1.21	1.21	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	1.21	1.21	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.00	1.21		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.12		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.11		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	2.15		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	0.00	2.15		17
18	Per resident amount	97,359.78	97,359.78		18
19	Approved amount for resident costs		209,324	209,324	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			209,324	25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	14,248			26
27	Total inpatient days (see instructions)	31,381			27
28	Ratio of inpatient days to total inpatient days	0.454033	0.000000		28
29	Program direct GME amount	95,040			29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount			95,040	31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			2,269,094	33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
Part A Reasonable Cost					
37	Reasonable cost (see instructions)			39,633,726	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col I, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			6,594	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			39,627,132	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			8,542,078	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			8,542,078	44
45	Total reasonable cost (sum of lines 41 and 44)			48,169,210	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.822665	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.177335	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			95,040	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			78,186	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			16,854	50

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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	1,283,376				1
2	Temporary investments					2
3	Notes receivable	79,579,932				3
4	Accounts receivable					4
5	Other receivables	1,748,207				5
6	Allowances for uncollectible notes and accounts receivable	-49,120,786				6
7	Inventory	2,304,721				7
8	Prepaid expenses					8
9	Other current assets	1,078,409				9
10	Due from other funds	359,962				10
11	Total current assets (sum of lines 1-10)	37,233,821				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	27,865,782				19
20	Accumulated depreciation	-3,294,353				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	24,571,429				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)					35
36	Total assets (sum of lines 11, 30 and 35)	61,805,250				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	15,726,693				37
38	Salaries, wages and fees payable	6,010,741				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	21,737,434				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	10,702,139				49
50	Total long term liabilities (sum of lines 46 thru 49)	10,702,139				50
51	Total liabilities (sum of lines 45 and 50)	32,439,573				51
CAPITAL ACCOUNTS						
52	General fund balance	29,365,677				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	29,365,677				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	61,805,250				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		33,211,046			1
2	Net income (loss) (from Worksheet G-3, line 29)		-4,031,416			2
3	Total (sum of line 1 and line 2)		29,179,630			3
4	Additions (credit adjustments) (specify)	186,047				4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		186,047			10
11	Subtotal (line 3 plus line 10)		29,365,677			11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFERS TO AFFILIATES					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)		29,365,677			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	TRANSFERS TO AFFILIATES					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

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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	73,719,261		73,719,261	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	14,053,680		14,053,680	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	87,772,941		87,772,941	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	25,144,038		25,144,038	14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	25,144,038		25,144,038	16
17	Total inpatient routine care services (sum of lines 10 and 16)	112,916,979		112,916,979	17
18	Ancillary services	272,205,530	230,305,060	502,510,590	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)	385,122,509	230,305,060	615,427,569	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		120,123,394	29
30	TRIAL BALANCE VARIANCE WITH KPMG			30
31				31
32				32
33				33
34				34
35	IMMATERIAL VARIANCE			35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		120,123,394	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)	615,427,569	1
2	Less contractual allowances and discounts on patients' accounts	504,057,503	2
3	Net patient revenues (line 1 minus line 2)	111,370,066	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	120,123,394	4
5	Net income from service to patients (line 3 minus line 4)	-8,753,328	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		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 other 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 hospital space		22
23	Governmental appropriations		23
24	Other (specify)		24
24.01	Other (NET ASSETS RELEASED FROM RESTRICTIO)		24.01
24.02	Other (RECONCILIATION)	4,721,912	24.02
24.03	Other (MISCELLANEOUS - CARDIAC REHAB, ETC.)		24.03
25	Total other income (sum of lines 6-24)	4,721,912	25
26	Total (line 5 plus line 25)	-4,031,416	26
29	Net income (or loss) for the period (line 26 minus line 28)	-4,031,416	29

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0251

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	1,889,596	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	6,906	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)	85.98	3
4	Number of interns & residents (see instructions)	2.51	4
5	Indirect medical education percentage (see instructions)	0.83	5
6	Indirect medical education adjustment (see instructions)	15,684	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0983	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.2411	8
9	Sum of lines 7 and 8	0.3394	9
10	Allowable disproportionate share percentage (see instructions)	0.0711	10
11	Disproportionate share adjustment (see instructions)	134,350	11
12	Total prospective capital payments (see instructions)	2,046,536	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
17.01	HOUSE STAFF PHYSICIANS						17.01
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
34	Surgical Intensive Care Unit						34
44	Skilled Nursing Facility						44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
53	Anesthesiology						53
54	Radiology-Diagnostic						54
56	Radioisotope						56
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
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
69	Electrocardiology						69
69.01	CARDIAC REHAB						69.01
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75.01	ACUTE DIALYSIS						75.01
76	AUDIO-VESTIBULAR LAB						76
76.01	ONCOLOGY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency						91
91.01	LITHOTRIPSY						91.01
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
193.01	NON EMPLOYEE DAY CARE						193.01
193.02	RESURRECTION HOME CARE OFFICES						193.02
193.03	OCCUPATIONAL HEALTH NON-REIM						193.03
194	POB						194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 06/30/2016 Run Time: 15:09 Version: 2016.05 (06/29/2016)
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
202	TOTAL (sum of lines 118-201)							202