

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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: 05/19/2017 Time: 14:18
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 01/01/2016 and ending 12/31/2016, 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		499,428	-901	61,463		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		-1	-32			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		499,427	-933	61,463		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 / 2016	To: 12 / 31 / 2016								20
21	Type of control (see instructions)	1									21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	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.	2,732				3,321	2,630	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
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 OPSS 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)	0.25			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 / 2015	09 / 30 / 2016		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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		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.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	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	03/21/2017	Y	03/21/2017
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: IRENA	Last name: DUMANIS	Title: VP FINANCE
42	Employer: COMMUNITY FIRST MEDICAL CENTER		
43	Phone number: 7737948320	E-mail Address: IDUMANIS@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	70,638			10,969	4,804	26,677	1
2	HMO and other (see instructions)						3,857	3,321		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	70,638			10,969	4,804	26,677	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	7,320			2,326	558	4,786	11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		213	77,958			13,295	5,362	31,463	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	24,156			10,782		12,989	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							205	3,551	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)					2,614	982	6,102	1
2	HMO and other (see instructions)					681	658		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)	2.27	727.62			2,614	982	6,102	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		47.88						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)	2.27	775.50						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	Reclassification 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	50,139,392		50,139,392	1,619,249.20	30.96
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		62,409	62,409	1,233.80	50.58
7.01	Contracted interns & residents (in an approved program)						
8	Home office and/or related organization personnel						
9	SNF	44	2,613,085		2,613,085	99,968.75	26.14
10	Excluded area salaries (see instructions)		1,845,347		1,845,347	39,179.84	47.10
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		1,128,125		1,128,125	19,192.00	58.78
12	Contract management and administrative services						
13	Contract labor: Physician-Part A - Administrative		154,980		154,980	996.00	155.60
14	Home office salaries & wage-related costs						
14.01	Home office salaries						
14.02	Related organization salaries						
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)		9,932,005		9,932,005		
18	Wage-related costs (other)(see instructions)						
19	Excluded areas		379,999		379,999		
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/FQHC)						
25	Interns & residents (in an approved program)		12,851		12,851		
25.50	Home office wage-related						
25.51	Related organization wage-related						
25.52	Home office: Physician Part A - Administrative - wage-related						
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		277,207		277,207	8,890.63	31.18
27	Administrative & General		4,103,519		4,103,519	179,369.69	22.88
28	Administrative & General under contract (see instructions)		86,331		86,331	881.00	97.99
29	Maintenance & Repairs						
30	Operation of Plant		1,516,638		1,516,638	68,267.41	22.22
31	Laundry & Linen Service		78,579		78,579	5,995.70	13.11
32	Housekeeping		1,071,728		1,071,728	76,653.68	13.98
33	Housekeeping under contract (see instructions)						
34	Dietary		1,116,145	-399,308	716,837	49,301.20	14.54
35	Dietary under contract (see instructions)						
36	Cafeteria			399,308	399,308	27,462.83	14.54
37	Maintenance of Personnel						
38	Nursing Administration		1,851,597		1,851,597	48,536.37	38.15
39	Central Services and Supply		634,991		634,991	29,691.92	21.39
40	Pharmacy		1,644,396		1,644,396	42,397.65	38.79
41	Medical Records & Medical Records Library		2,303,749		2,303,749	69,599.27	33.10
42	Social Service		793,080		793,080	7,162.52	110.73
43	Other General Service						

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		50,225,723	-62,409	50,163,314	1,618,896.40	30.99
2	Excluded area salaries (see instructions)		4,458,432		4,458,432	139,148.59	32.04
3	Subtotal salaries (line 1 minus line 2)		45,767,291	-62,409	45,704,882	1,479,747.81	30.89
4	Subtotal other wages & related costs (see instructions)		1,283,105		1,283,105	20,188.00	63.56
5	Subtotal wage-related costs (see instructions)		9,932,005		9,932,005		21.73%
6	Total (sum of lines 3 through 5)		56,982,401	-62,409	56,919,992	1,499,935.81	37.95
7	Total overhead cost (see instructions)		15,477,960		15,477,960	614,209.87	25.20

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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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)	4,445,144	8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	195,599	10
11	Life Insurance (If employee is owner or beneficiary)	-93,591	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	417,019	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	910,000	16
	TAXES		
17	FICA-Employers Portion Only	3,809,921	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	533,549	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	107,256	23
24	Total Wage Related cost (Sum of lines 1-23)	10,324,897	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	209,170	25
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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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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	1
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	// 2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
	1	2	3	4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL			8
9	RMX			9
10	RML			10
11	RLX			11
12	RUC	285		285
13	RUB	6,103		6,103
14	RUA	2,149		2,149
15	RVC	175		175
16	RVB	1,287		1,287
17	RVA	332		332
18	RHC	4		4
19	RHB	152		152
20	RHA	99		99
21	RMC			21
22	RMB	35		35
23	RMA	22		22
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2	1		1
28	ES1			28
29	HE2	6		6
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1			34
35	HB2			35
36	HB1	1		1
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2			41
42	LC1	8		8
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1			48
49	CC2	3		3
50	CC1	63		63
51	CB2			51
52	CB1	28		28
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			66
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	14		14	74
75	PB2				75
76	PB1	8		8	76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL	10,782		10,782	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).			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				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)	13,065,483			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)		0.176078	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		34,473,650	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		45,938,494	6
7	Medicaid cost (line 1 times line 6)		8,088,758	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	13,535,065	323,904	13,858,969	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,383,227	57,032	2,440,259	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	2,383,227	57,032	2,440,259	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)			13,694,883	26
27	Medicare bad debts for the entire hospital complex (see instructions)			1,003,819	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			12,691,064	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,234,617	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			4,674,876	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,674,876	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				2,845,802	2,845,802		2,845,802	1
2	00200	Cap Rel Costs-Mvble Equip				2,181,521	2,181,521		2,181,521	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	277,207	10,877,991	11,155,198		11,155,198		11,155,198	4
5	00500	Administrative & General	4,103,519	27,580,644	31,684,163	-5,027,323	26,656,840	-5,625,170	21,031,670	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,516,638	2,562,548	4,079,186		4,079,186		4,079,186	7
8	00800	Laundry & Linen Service	78,579	435,301	513,880		513,880		513,880	8
9	00900	Housekeeping	1,071,728	458,987	1,530,715		1,530,715		1,530,715	9
10	01000	Dietary	1,116,145	1,713,467	2,829,612	-1,012,312	1,817,300		1,817,300	10
11	01100	Cafeteria				1,012,312	1,012,312	-395,106	617,206	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,851,597	49,820	1,901,417		1,901,417	-26,407	1,875,010	13
14	01400	Central Services & Supply	634,991	-833,688	-198,697		-198,697		-198,697	14
15	01500	Pharmacy	1,644,396	4,614,367	6,258,763	-4,758,329	1,500,434		1,500,434	15
16	01600	Medical Records & Library	2,303,749	498,441	2,802,190		2,802,190	-92,248	2,709,942	16
17	01700	Social Service								17
17.01	01701	HOUSE STAFF PHYSICIANS	793,080	392,173	1,185,253		1,185,253	-1,185,253		17.01
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd				62,409	62,409		62,409	21
22	02200	I&R Services-Other Prgm Costs Apprvd				315,217	315,217		315,217	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	8,627,670	1,560,398	10,188,068	-720,793	9,467,275		9,467,275	30
34	03400	Surgical Intensive Care Unit	3,535,941	1,254,567	4,790,508	-717,002	4,073,506	-54,787	4,018,719	34
44	04400	Skilled Nursing Facility	2,613,085	316,850	2,929,935	-209,672	2,720,263	-44,276	2,675,987	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,414,172	5,329,346	7,743,518	-4,131,259	3,612,259	-365,000	3,247,259	50
51	05100	Recovery Room	423,648	44,804	468,452		468,452		468,452	51
53	05300	Anesthesiology	69,536	633,791	703,327		703,327	-511,202	192,125	53
54	05400	Radiology-Diagnostic	1,669,831	288,226	1,958,057	-38,481	1,919,576	-3,261	1,916,315	54
56	05600	Radioisotope	194,892	286,684	481,576		481,576		481,576	56
57	05700	CT Scan	512,943	380,937	893,880		893,880		893,880	57
58	05800	MRI	188,758	155,707	344,465		344,465		344,465	58
59	05900	Cardiac Catheterization	686,786	1,332,489	2,019,275	-1,268,879	750,396		750,396	59
60	06000	Laboratory		6,353,719	6,353,719		6,353,719	-1,310	6,352,409	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,188,801	398,251	1,587,052	-174,692	1,412,360	-15,146	1,397,214	65
66	06600	Physical Therapy	1,845,109	37,330	1,882,439		1,882,439		1,882,439	66
67	06700	Occupational Therapy	731,009	1,513	732,522		732,522		732,522	67
68	06800	Speech Pathology	172,571	1,669	174,240	-1,164	173,076		173,076	68
69	06900	Electrocardiology	509,360	58,968	568,328		568,328	-160	568,168	69
69.01	03160	CARDIAC REHAB	220,740	11,675	232,415		232,415		232,415	69.01
70	07000	Electroencephalography	41,232	686	41,918		41,918		41,918	70
71	07100	Medical Supplies Charged to Patients				5,057,869	5,057,869		5,057,869	71
72	07200	Impl. Dev. Charged to Patients				3,191,827	3,191,827		3,191,827	72
73	07300	Drugs Charged to Patients				4,758,329	4,758,329		4,758,329	73
74	07400	Renal Dialysis	233,808	51,930	285,738		285,738		285,738	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	1,230,792	263,642	1,494,434	-171,426	1,323,008		1,323,008	90
91	09100	Emergency	5,791,732	4,547,797	10,339,529	-1,193,954	9,145,575	-2,945,921	6,199,654	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)	48,294,045	71,661,030	119,955,075		119,955,075	-11,265,247	108,689,828	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		26,538	26,538		26,538		26,538	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	1,845,347	1,916,916	3,762,263		3,762,263		3,762,263	194
200		TOTAL (sum of lines 118-199)	50,139,392	73,604,484	123,743,876		123,743,876	-11,265,247	112,478,629	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	399,308	613,004	1
500	Total reclassifications				399,308	613,004	500
	Code Letter - A						
1	CHARGEABLE MEDICAL SUPPLIES F	B	Medical Supplies Charged to P	71		5,057,869	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					5,057,869	500
	Code Letter - B						
1	DEPRECIATION	C	Cap Rel Costs-Bldg & Fixt	1		1,193,532	1
2			Cap Rel Costs-Mvble Equip	2		2,181,521	2
500	Total reclassifications					3,375,053	500
	Code Letter - C						
1	DRUGS	D	Drugs Charged to Patients	73		4,758,329	1
500	Total reclassifications					4,758,329	500
	Code Letter - D						
1	TEACHING COSTS	E	I&R Services-Other Prgm Costs	22		315,217	1
500	Total reclassifications					315,217	500
	Code Letter - E						
1	INSURANCE	F	Cap Rel Costs-Bldg & Fixt	1		144,000	1
500	Total reclassifications					144,000	500
	Code Letter - F						
1	RESIDENT SALARY	G	I&R Services-Salary & Fringes	21	62,409		1
500	Total reclassifications				62,409		500
	Code Letter - G						
1	IMPLANT RECLASS	H	Impl. Dev. Charged to Patient	72		3,191,827	1
2							2
3							3
4							4
500	Total reclassifications					3,191,827	500
	Code Letter - H						
1	INTEREST	I	Cap Rel Costs-Bldg & Fixt	1		1,508,270	1
500	Total reclassifications					1,508,270	500
	Code Letter - I						
	GRAND TOTAL (Increases)				461,717	18,963,569	

(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	399,308	613,004	1	
500	Total reclassifications				399,308	613,004	500	
	Code letter - A							
1	CHARGEABLE MEDICAL SUPPLIES F	B	Adults & Pediatrics	30		720,793	1	
2			Surgical Intensive Care Unit	34		717,002	2	
3			Skilled Nursing Facility	44		209,672	3	
4			Operating Room	50		1,898,924	4	
5			Radiology-Diagnostic	54		38,481	5	
6			Cardiac Catheterization	59		381,615	6	
7			Respiratory Therapy	65		174,692	7	
8			Speech Pathology	68		1,164	8	
9			Clinic	90		99,424	9	
10			Emergency	91		816,102	10	
500	Total reclassifications					5,057,869	500	
	Code letter - B							
1	DEPRECIATION	C	Administrative & General	5		3,375,053	9	
2							9	
500	Total reclassifications					3,375,053	500	
	Code letter - C							
1	DRUGS	D	Pharmacy	15		4,758,329	9	
500	Total reclassifications					4,758,329	500	
	Code letter - D							
1	TEACHING COSTS	E	Emergency	91		315,217	1	
500	Total reclassifications					315,217	500	
	Code letter - E							
1	INSURANCE	F	Administrative & General	5		144,000	12	
500	Total reclassifications					144,000	500	
	Code letter - F							
1	RESIDENT SALARY	G	Emergency	91	62,409		1	
500	Total reclassifications				62,409		500	
	Code letter - G							
1	IMPLANT RECLASS	H	Operating Room	50		2,232,335	1	
2			Cardiac Catheterization	59		887,264	2	
3			Clinic	90		72,002	3	
4			Emergency	91		226	4	
500	Total reclassifications					3,191,827	500	
	Code letter - H							
1	INTEREST	I	Administrative & General	5		1,508,270	11	
500	Total reclassifications					1,508,270	500	
	Code letter - I							
	GRAND TOTAL (Decreases)				461,717	18,963,569		

(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	18,096,412					18,096,412		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	10,731,602	148,361		148,361		10,879,963		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	28,828,014	148,361		148,361		28,976,375		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	28,828,014	148,361		148,361		28,976,375		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	1,193,532		1,508,270	144,000				2,845,802	1
2	Cap Rel Costs-Mvble Equip	2,181,521							2,181,521	2
3	Total (sum of lines 1-2)	3,375,053		1,508,270	144,000				5,027,323	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						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	-10,769	Administrative & General	5	9	7
8	Television and radio service (chapter 21)	A	-4,522	Administrative & General	5	10	8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-4,035,948				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	-395,106	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	3,169	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	-1,185,253	HOUSE STAFF PHYSICIANS	17.01		33.03
33.42	MISC INCOME	B	-65,789	Administrative & General	5		33.42
33.46	ECU REVENUE	B	-372	Skilled Nursing Facility	44		33.46
33.47	CARDIOLOGY REVENUE	B	-160	Electrocardiology	69		33.47
34							34
35							35
36	OLR 5K	B	-26,407	Nursing Administration	13		36
37							37
38							38
39							39
40							40
41							41
42	MEDICAID TAX ASSESSMENT	A	-5,544,090	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)		-11,265,247				50

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

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
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	511,202	511,202						1
2	44	Skilled Nursing Faci AGGREGATE	43,904	43,904						2
3	65	Respiratory Therapy AGGREGATE	15,146	15,146						3
4	91	Emergency AGGREGATE	2,945,921	2,945,921						4
5										5
6	60	Laboratory AGGREGATE	1,310	1,310						6
7										7
8	34	Surgical Intensive C AGGREGATE	134,100	4,100	130,000	211,500	780	79,313	3,966	8
9	50	Operating Room AGGREGATE	365,000	365,000						9
10	54	Radiology-Diagnostic AGGREGATE	3,261	3,261						10
11										11
12										12
13	16	Medical Records & Li AGGREGATE	117,380	92,400	24,980	211,500	216	21,963	1,098	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	4,137,224	3,982,244	154,980		996	101,276	5,064	200

KPMG LLP Compu-Max 2552-10

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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							511,202	1
2	44	Skilled Nursing Faci AGGREGATE							43,904	2
3	65	Respiratory Therapy AGGREGATE							15,146	3
4	91	Emergency AGGREGATE							2,945,921	4
5										5
6	60	Laboratory AGGREGATE							1,310	6
7										7
8	34	Surgical Intensive C AGGREGATE					79,313	50,687	54,787	8
9	50	Operating Room AGGREGATE							365,000	9
10	54	Radiology-Diagnostic AGGREGATE							3,261	10
11										11
12										12
13	16	Medical Records & Li AGGREGATE					21,963	3,017	95,417	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					101,276	53,704	4,035,948	200

KPMG LLP Compu-Max 2552-10

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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	2,845,802	2,845,802					1
2	Cap Rel Costs-Mvble Equip	2,181,521		2,181,521				2
4	Employee Benefits Department	11,155,198	30,285	23,216	11,208,699			4
5	Administrative & General	21,031,670	224,678	172,233	922,446	22,351,027	22,351,027	5
6	Maintenance & Repairs							6
7	Operation of Plant	4,079,186	329,549	252,624	340,931	5,002,290	1,240,533	7
8	Laundry & Linen Service	513,880			17,664	531,544	131,819	8
9	Housekeeping	1,530,715	68,222	52,298	240,918	1,892,153	469,241	9
10	Dietary	1,817,300	90,698	69,527	161,141	2,138,666	530,374	10
11	Cafeteria	617,206	88,961	68,196	89,762	864,125	214,297	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,875,010	28,660	21,970	416,228	2,341,868	580,767	13
14	Central Services & Supply	-198,697	86,833	66,564	142,742	97,442	24,165	14
15	Pharmacy	1,500,434	30,464	23,353	369,650	1,923,901	477,114	15
16	Medical Records & Library	2,709,942	84,267	64,597	517,869	3,376,675	837,392	16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS				178,280	178,280	44,212	17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	62,409			14,029	76,438	18,956	21
22	I&R Services-Other Prgm Costs Apprvd	315,217				315,217	78,172	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,467,275	614,071	470,731	1,939,428	12,491,505	3,097,819	30
34	Surgical Intensive Care Unit	4,018,719	81,992	62,853	794,858	4,958,422	1,229,654	34
44	Skilled Nursing Facility	2,675,987	223,087	171,013	587,406	3,657,493	907,033	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,247,259	234,661	179,885	542,691	4,204,496	1,042,686	50
51	Recovery Room	468,452	15,731	12,059	95,234	591,476	146,682	51
53	Anesthesiology	192,125	6,891	5,282	15,631	219,929	54,541	53
54	Radiology-Diagnostic	1,916,315	112,681	86,378	375,368	2,490,742	617,687	54
56	Radioisotope	481,576	6,891	5,282	43,811	537,560	133,311	56
57	CT Scan	893,880	12,526	9,602	115,307	1,031,315	255,759	57
58	MRI	344,465	3,350	2,568	42,432	392,815	97,415	58
59	Cardiac Catheterization	750,396	48,850	37,447	154,385	991,078	245,780	59
60	Laboratory	6,352,409	108,009	82,797		6,543,215	1,622,672	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,397,214	22,756	17,444	267,235	1,704,649	422,741	65
66	Physical Therapy	1,882,439	54,520	41,793	414,769	2,393,521	593,576	66
67	Occupational Therapy	732,522	13,781	10,564	164,326	921,193	228,449	67
68	Speech Pathology	173,076	9,075	6,957	38,793	227,901	56,518	68
69	Electrocardiology	568,168	16,515	12,660	114,501	711,844	176,532	69
69.01	CARDIAC REHAB	232,415	19,887	15,245	49,621	317,168	78,655	69.01
70	Electroencephalography	41,918			9,269	51,187	12,694	70
71	Medical Supplies Charged to Patients	5,057,869				5,057,869	1,254,316	71
72	Impl. Dev. Charged to Patients	3,191,827				3,191,827	791,551	72
73	Drugs Charged to Patients	4,758,329				4,758,329	1,180,032	73
74	Renal Dialysis	285,738	7,966	6,107	52,559	352,370	87,385	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	1,323,008	35,898	27,519	276,675	1,663,100	412,437	90
91	Emergency	6,199,654	117,969	90,432	1,287,917	7,695,972	1,908,547	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)	108,689,828	2,829,724	2,169,196	10,793,876	108,246,602	21,301,514	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	26,538	16,078	12,325		54,941	13,625	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	3,762,263			414,823	4,177,086	1,035,888	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)	112,478,629	2,845,802	2,181,521	11,208,699	112,478,629	22,351,027	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	6,242,823						7
8	Laundry & Linen Service		663,363					8
9	Housekeeping	188,344		2,549,738				9
10	Dietary	250,393		105,449	3,024,882			10
11	Cafeteria	245,599		103,430		1,427,451		11
12	Maintenance of Personnel							12
13	Nursing Administration	79,124		33,322		59,896	3,094,977	13
14	Central Services & Supply	239,722		100,955		36,633		14
15	Pharmacy	84,104		35,419		52,322		15
16	Medical Records & Library	232,639		97,972		85,863		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					1,520		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,695,281	276,441	713,936	1,815,323	355,510	867,564	30
34	Surgical Intensive Care Unit	226,359	65,316	95,327	325,688	115,257	307,795	34
44	Skilled Nursing Facility	615,884	72,467	259,369	883,871	123,347	264,024	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	647,837	51,678	272,825		81,226	1,164,941	50
51	Recovery Room	43,428		18,289		11,258	33,975	51
53	Anesthesiology	19,023		8,011		2,602		53
54	Radiology-Diagnostic	311,082	56,161	131,007		68,062	5,442	54
56	Radioisotope	19,023		8,011		5,307		56
57	CT Scan	34,582		14,564		17,415		57
58	MRI	9,249		3,895		5,127		58
59	Cardiac Catheterization	134,863	3,785	56,795		15,302	21,536	59
60	Laboratory	298,183		125,575				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	62,823		26,457		51,832		65
66	Physical Therapy	150,514	13,946	63,387		67,779		66
67	Occupational Therapy	38,046		16,022		24,499		67
68	Speech Pathology	25,055		10,551		5,204		68
69	Electrocardiology	45,594	3,687	19,201		22,722	14,616	69
69.01	CARDIAC REHAB	54,904		23,122		6,518	19,670	69.01
70	Electroencephalography		98			2,215		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	21,993	1,539	9,262		6,260	18,892	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	99,106	3,318	41,737		37,947	71,837	90
91	Emergency	325,682	112,017	137,155		165,828	304,685	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)	6,198,436	660,453	2,531,045	3,024,882	1,427,451	3,094,977	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	44,387	2,910	18,693				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

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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)	6,242,823	663,363	2,549,738	3,024,882	1,427,451	3,094,977	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES + SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	HOUSE STAFF PHYSICIANS	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	
		14	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	498,917						14
15	Pharmacy		2,572,860					15
16	Medical Records & Library			4,630,541				16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS				222,492			17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					96,914		21
22	I&R Services-Other Prgm Costs Apprvd						393,389	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			677,793	222,492			30
34	Surgical Intensive Care Unit			187,990				34
44	Skilled Nursing Facility			97,019				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			216,408				50
51	Recovery Room			38,731				51
53	Anesthesiology			51,582				53
54	Radiology-Diagnostic			206,487				54
56	Radioisotope			51,081				56
57	CT Scan			335,801				57
58	MRI			62,833				58
59	Cardiac Catheterization			124,600				59
60	Laboratory			549,001				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			158,862				65
66	Physical Therapy			104,354				66
67	Occupational Therapy			46,496				67
68	Speech Pathology			7,686				68
69	Electrocardiology			152,012				69
69.01	CARDIAC REHAB			3,725				69.01
70	Electroencephalography			2,570				70
71	Medical Supplies Charged to Patients	305,885		153,263				71
72	Impl. Dev. Charged to Patients	193,032		100,913				72
73	Drugs Charged to Patients		2,572,860	577,539				73
74	Renal Dialysis			21,394				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			96,341				90
91	Emergency			606,060		96,914	393,389	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)	498,917	2,572,860	4,630,541	222,492	96,914	393,389	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES + SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	HOUSE STAFF PHYSICIANS	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	
		14	15	16	17.01	21	22	
202	TOTAL (sum of lines 118-201)	498,917	2,572,860	4,630,541	222,492	96,914	393,389	202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		24	25	26		
	GENERAL SERVICE COST CENTERS					
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
4	Employee Benefits Department					4
5	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	22,213,664		22,213,664		30
34	Surgical Intensive Care Unit	7,511,808		7,511,808		34
44	Skilled Nursing Facility	6,880,507		6,880,507		44
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	7,682,097		7,682,097		50
51	Recovery Room	883,839		883,839		51
53	Anesthesiology	355,688		355,688		53
54	Radiology-Diagnostic	3,886,670		3,886,670		54
56	Radioisotope	754,293		754,293		56
57	CT Scan	1,689,436		1,689,436		57
58	MRI	571,334		571,334		58
59	Cardiac Catheterization	1,593,739		1,593,739		59
60	Laboratory	9,138,646		9,138,646		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	2,427,364		2,427,364		65
66	Physical Therapy	3,387,077		3,387,077		66
67	Occupational Therapy	1,274,705		1,274,705		67
68	Speech Pathology	332,915		332,915		68
69	Electrocardiology	1,146,208		1,146,208		69
69.01	CARDIAC REHAB	503,762		503,762		69.01
70	Electroencephalography	68,764		68,764		70
71	Medical Supplies Charged to Patients	6,771,333		6,771,333		71
72	Impl. Dev. Charged to Patients	4,277,323		4,277,323		72
73	Drugs Charged to Patients	9,088,760		9,088,760		73
74	Renal Dialysis	519,095		519,095		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	2,425,823		2,425,823		90
91	Emergency	11,746,249	-490,303	11,255,946		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)	107,131,099	-490,303	106,640,796		118
	NONREIMBURSABLE COST CENTERS					
190	Gift, Flower, Coffee Shop & Canteen	134,556		134,556		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	5,212,974		5,212,974		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	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		24	25	26				
202	TOTAL (sum of lines 118-201)	112,478,629	-490,303	111,988,326				202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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		30,285	23,216	53,501	53,501		4
5	Administrative & General	620,998	224,678	172,233	1,017,909	4,403	1,022,312	5
6	Maintenance & Repairs							6
7	Operation of Plant		329,549	252,624	582,173	1,627	56,741	7
8	Laundry & Linen Service					84	6,029	8
9	Housekeeping		68,222	52,298	120,520	1,150	21,463	9
10	Dietary	7,301	90,698	69,527	167,526	769	24,259	10
11	Cafeteria		88,961	68,196	157,157	428	9,802	11
12	Maintenance of Personnel							12
13	Nursing Administration		28,660	21,970	50,630	1,987	26,564	13
14	Central Services & Supply	50,331	86,833	66,564	203,728	681	1,105	14
15	Pharmacy		30,464	23,353	53,817	1,764	21,823	15
16	Medical Records & Library		84,267	64,597	148,864	2,472	38,302	16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS					851	2,022	17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					67	867	21
22	I&R Services-Other Prgm Costs Apprvd						3,576	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,093	614,071	470,731	1,093,895	9,256	141,683	30
34	Surgical Intensive Care Unit	842	81,992	62,853	145,687	3,794	56,243	34
44	Skilled Nursing Facility	4,000	223,087	171,013	398,100	2,804	41,487	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	153,809	234,661	179,885	568,355	2,590	47,692	50
51	Recovery Room		15,731	12,059	27,790	455	6,709	51
53	Anesthesiology		6,891	5,282	12,173	75	2,495	53
54	Radiology-Diagnostic	34,863	112,681	86,378	233,922	1,792	28,252	54
56	Radioisotope		6,891	5,282	12,173	209	6,098	56
57	CT Scan		12,526	9,602	22,128	550	11,698	57
58	MRI		3,350	2,568	5,918	203	4,456	58
59	Cardiac Catheterization		48,850	37,447	86,297	737	11,242	59
60	Laboratory		108,009	82,797	190,806		74,220	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	12,516	22,756	17,444	52,716	1,276	19,336	65
66	Physical Therapy		54,520	41,793	96,313	1,980	27,150	66
67	Occupational Therapy		13,781	10,564	24,345	784	10,449	67
68	Speech Pathology		9,075	6,957	16,032	185	2,585	68
69	Electrocardiology		16,515	12,660	29,175	547	8,074	69
69.01	CARDIAC REHAB		19,887	15,245	35,132	237	3,598	69.01
70	Electroencephalography					44	581	70
71	Medical Supplies Charged to Patients						57,371	71
72	Impl. Dev. Charged to Patients						36,205	72
73	Drugs Charged to Patients						53,974	73
74	Renal Dialysis		7,966	6,107	14,073	251	3,997	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	51,947	35,898	27,519	115,364	1,321	18,865	90
91	Emergency	9,318	117,969	90,432	217,719	6,148	87,295	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)	955,018	2,829,724	2,169,196	5,953,938	51,521	974,308	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		16,078	12,325	28,403		623	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					1,980	47,381	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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)	955,018	2,845,802	2,181,521	5,982,341	53,501	1,022,312	202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	
	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	640,541						7
8	Laundry & Linen Service		6,113					8
9	Housekeeping	19,325		162,458				9
10	Dietary	25,691		6,719	224,964			10
11	Cafeteria	25,200		6,590		199,177		11
12	Maintenance of Personnel							12
13	Nursing Administration	8,118		2,123		8,357	97,779	13
14	Central Services & Supply	24,597		6,432		5,112		14
15	Pharmacy	8,629		2,257		7,301		15
16	Medical Records & Library	23,870		6,242		11,981		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					212		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	173,944	2,546	45,491	135,007	49,609	27,409	30
34	Surgical Intensive Care Unit	23,225	602	6,074	24,222	16,082	9,724	34
44	Skilled Nursing Facility	63,192	668	16,526	65,735	17,211	8,341	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	66,471	476	17,383		11,334	36,804	50
51	Recovery Room	4,456		1,165		1,571	1,073	51
53	Anesthesiology	1,952		510		363		53
54	Radiology-Diagnostic	31,918	518	8,347		9,497	172	54
56	Radioisotope	1,952		510		740		56
57	CT Scan	3,548		928		2,430		57
58	MRI	949		248		715		58
59	Cardiac Catheterization	13,838	35	3,619		2,135	680	59
60	Laboratory	30,595		8,001				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,446		1,686		7,232		65
66	Physical Therapy	15,443	129	4,039		9,457		66
67	Occupational Therapy	3,904		1,021		3,418		67
68	Speech Pathology	2,571		672		726		68
69	Electrocardiology	4,678	34	1,223		3,170	462	69
69.01	CARDIAC REHAB	5,633		1,473		909	621	69.01
70	Electroencephalography		1			309		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	2,257	14	590		873	597	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	10,169	31	2,659		5,295	2,270	90
91	Emergency	33,416	1,032	8,739		23,138	9,626	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)	635,987	6,086	161,267	224,964	199,177	97,779	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	4,554	27	1,191				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)	640,541	6,113	162,458	224,964	199,177	97,779	202

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES + SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	HOUSE STAFF PHYSICIANS	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	
		14	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	172,826						14
15	Pharmacy		95,591					15
16	Medical Records & Library			231,731				16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS				2,873			17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					1,146		21
22	I&R Services-Other Prgm Costs Apprvd						3,576	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			33,732	2,873			30
34	Surgical Intensive Care Unit			9,417				34
44	Skilled Nursing Facility			4,860				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			10,840				50
51	Recovery Room			1,940				51
53	Anesthesiology			2,584				53
54	Radiology-Diagnostic			10,343				54
56	Radioisotope			2,559				56
57	CT Scan			16,821				57
58	MRI			3,147				58
59	Cardiac Catheterization			6,241				59
60	Laboratory			27,500				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			7,958				65
66	Physical Therapy			5,227				66
67	Occupational Therapy			2,329				67
68	Speech Pathology			385				68
69	Electrocardiology			7,614				69
69.01	CARDIAC REHAB			187				69.01
70	Electroencephalography			129				70
71	Medical Supplies Charged to Patients	105,960		7,677				71
72	Impl. Dev. Charged to Patients	66,866		5,055				72
73	Drugs Charged to Patients		95,591	28,930				73
74	Renal Dialysis			1,072				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			4,826				90
91	Emergency			30,358				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)	172,826	95,591	231,731	2,873			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					1,146	3,576	200
201	Negative Cost Centers	68,829						201

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	HOUSE STAFF PHYSICIANS	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	
		14	15	16	17.01	21	22	
202	TOTAL (sum of lines 118-201)	241,655	95,591	231,731	2,873	1,146	3,576	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		24	25	26			
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	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	1,715,445		1,715,445			30
34	Surgical Intensive Care Unit	295,070		295,070			34
44	Skilled Nursing Facility	618,924		618,924			44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	761,945		761,945			50
51	Recovery Room	45,159		45,159			51
53	Anesthesiology	20,152		20,152			53
54	Radiology-Diagnostic	324,761		324,761			54
56	Radioisotope	24,241		24,241			56
57	CT Scan	58,103		58,103			57
58	MRI	15,636		15,636			58
59	Cardiac Catheterization	124,824		124,824			59
60	Laboratory	331,122		331,122			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	96,650		96,650			65
66	Physical Therapy	159,738		159,738			66
67	Occupational Therapy	46,250		46,250			67
68	Speech Pathology	23,156		23,156			68
69	Electrocardiology	54,977		54,977			69
69.01	CARDIAC REHAB	47,790		47,790			69.01
70	Electroencephalography	1,064		1,064			70
71	Medical Supplies Charged to Patients	171,008		171,008			71
72	Impl. Dev. Charged to Patients	108,126		108,126			72
73	Drugs Charged to Patients	178,495		178,495			73
74	Renal Dialysis	23,724		23,724			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	160,800		160,800			90
91	Emergency	417,471		417,471			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)	5,824,631		5,824,631			118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	34,798		34,798			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	49,361		49,361			194
200	Cross Foot Adjustments	4,722		4,722			200
201	Negative Cost Centers	68,829		68,829			201

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		24	25	26				
202	TOTAL (sum of lines 118-201)	5,982,341		5,982,341				202

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	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	49,862,185				4
5	Administrative & General	20,053	20,053	4,103,519	-22,351,027	90,127,602		5
6	Maintenance & Repairs							6
7	Operation of Plant	29,413	29,413	1,516,638		5,002,290	201,825	7
8	Laundry & Linen Service			78,579		531,544		8
9	Housekeeping	6,089	6,089	1,071,728		1,892,153	6,089	9
10	Dietary	8,095	8,095	716,837		2,138,666	8,095	10
11	Cafeteria	7,940	7,940	399,308		864,125	7,940	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,558	2,558	1,851,597		2,341,868	2,558	13
14	Central Services & Supply	7,750	7,750	634,991		97,442	7,750	14
15	Pharmacy	2,719	2,719	1,644,396		1,923,901	2,719	15
16	Medical Records & Library	7,521	7,521	2,303,749		3,376,675	7,521	16
17	Social Service							17
17.01	HOUSE STAFF PHYSICIANS			793,080		178,280		17.01
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			62,409		76,438		21
22	I&R Services-Other Prgm Costs Apprvd					315,217		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	54,807	54,807	8,627,670		12,491,505	54,807	30
34	Surgical Intensive Care Unit	7,318	7,318	3,535,941		4,958,422	7,318	34
44	Skilled Nursing Facility	19,911	19,911	2,613,085		3,657,493	19,911	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	20,944	20,944	2,414,172		4,204,496	20,944	50
51	Recovery Room	1,404	1,404	423,648		591,476	1,404	51
53	Anesthesiology	615	615	69,536		219,929	615	53
54	Radiology-Diagnostic	10,057	10,057	1,669,831		2,490,742	10,057	54
56	Radioisotope	615	615	194,892		537,560	615	56
57	CT Scan	1,118	1,118	512,943		1,031,315	1,118	57
58	MRI	299	299	188,758		392,815	299	58
59	Cardiac Catheterization	4,360	4,360	686,786		991,078	4,360	59
60	Laboratory	9,640	9,640			6,543,215	9,640	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,031	2,031	1,188,801		1,704,649	2,031	65
66	Physical Therapy	4,866	4,866	1,845,109		2,393,521	4,866	66
67	Occupational Therapy	1,230	1,230	731,009		921,193	1,230	67
68	Speech Pathology	810	810	172,571		227,901	810	68
69	Electrocardiology	1,474	1,474	509,360		711,844	1,474	69
69.01	CARDIAC REHAB	1,775	1,775	220,740		317,168	1,775	69.01
70	Electroencephalography			41,232		51,187		70
71	Medical Supplies Charged to Patients					5,057,869		71
72	Impl. Dev. Charged to Patients					3,191,827		72
73	Drugs Charged to Patients					4,758,329		73
74	Renal Dialysis	711	711	233,808		352,370	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	1,230,792		1,663,100	3,204	90
91	Emergency	10,529	10,529	5,729,323		7,695,972	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	48,016,838	-22,351,027	85,895,575	200,390	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,435	1,435			54,941	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			1,845,347		4,177,086		194
200	Cross foot adjustments							200

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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	
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,845,802	2,181,521	11,208,699		22,351,027	6,242,823	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.204210	8.588868	0.224794		0.247993	30.931862	203
204	Cost to be allocated (Per Wkst. B, Part II)			53,501		1,022,312	640,541	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001073		0.011343	3.173745	205

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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		55,410			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,558		2,325	39,809		13
14	Central Services & Supply		7,750		1,422		8,249,696	14
15	Pharmacy		2,719		2,031			15
16	Medical Records & Library		7,521		3,333			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				59			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	83,897	13,800	11,159		30
34	Surgical Intensive Care Unit	89,693	7,318	15,052	4,474	3,959		34
44	Skilled Nursing Facility	99,513	19,911	40,849	4,788	3,396		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	70,965	20,944		3,153	14,984		50
51	Recovery Room		1,404		437	437		51
53	Anesthesiology		615		101			53
54	Radiology-Diagnostic	77,121	10,057		2,642	70		54
56	Radioisotope		615		206			56
57	CT Scan		1,118		676			57
58	MRI		299		199			58
59	Cardiac Catheterization	5,197	4,360		594	277		59
60	Laboratory		9,640					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,031		2,012			65
66	Physical Therapy	19,151	4,866		2,631			66
67	Occupational Therapy		1,230		951			67
68	Speech Pathology		810		202			68
69	Electrocardiology	5,063	1,474		882	188		69
69.01	CARDIAC REHAB		1,775		253	253		69.01
70	Electroencephalography	135			86			70
71	Medical Supplies Charged to Patients						5,057,869	71
72	Impl. Dev. Charged to Patients						3,191,827	72
73	Drugs Charged to Patients							73
74	Renal Dialysis	2,114	711		243	243		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		1,473	924		90
91	Emergency	153,823	10,529		6,437	3,919		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	55,410	39,809	8,249,696	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

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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)	663,363	2,549,738	3,024,882	1,427,451	3,094,977	498,917	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.728217	13.026413	21.637520	25.761613	77.745661	0.060477	203
204	Cost to be allocated (Per Wkst. B, Part II)	6,113	162,458	224,964	199,177	97,779	172,826	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.006711	0.829985	1.609208	3.594604	2.456203	0.020949	205

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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	4,758,329					15
16	Medical Records & Library		605,646,601				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				100		21
22	I&R Services-Other Prgm Costs Apprvd					100	22
23	Paramed Ed Prgm-(specify)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		88,677,405	100			30
34	Surgical Intensive Care Unit		24,586,710				34
44	Skilled Nursing Facility		12,688,816				44
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		28,303,371				50
51	Recovery Room		5,065,514				51
53	Anesthesiology		6,746,286				53
54	Radiology-Diagnostic		27,005,871				54
56	Radioisotope		6,680,778				56
57	CT Scan		43,918,485				57
58	MRI		8,217,707				58
59	Cardiac Catheterization		16,296,126				59
60	Laboratory		71,802,396				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		20,777,153				65
66	Physical Therapy		13,648,198				66
67	Occupational Therapy		6,081,062				67
68	Speech Pathology		1,005,199				68
69	Electrocardiology		19,881,199				69
69.01	CARDIAC REHAB		487,184				69.01
70	Electroencephalography		336,146				70
71	Medical Supplies Charged to Patients		20,044,861				71
72	Impl. Dev. Charged to Patients		13,198,094				72
73	Drugs Charged to Patients	4,758,329	75,534,844				73
74	Renal Dialysis		2,798,102				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		12,600,120				90
91	Emergency		79,264,974		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)	4,758,329	605,646,601	100	100	100	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

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		
194	POB							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,572,860	4,630,541	222,492	96,914	393,389		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.540707	0.007646	2,224.920000	969.140000	3,933.890000		203
204	Cost to be allocated (Per Wkst. B, Part II)	95,591	231,731	2,873	1,146	3,576		204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.020089	0.000383	28.730000	11.460000	35.760000		205

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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	22,213,664		22,213,664		22,213,664	30
34	Surgical Intensive Care Unit	7,511,808		7,511,808	50,687	7,562,495	34
44	Skilled Nursing Facility	6,880,507		6,880,507		6,880,507	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,682,097		7,682,097		7,682,097	50
51	Recovery Room	883,839		883,839		883,839	51
53	Anesthesiology	355,688		355,688		355,688	53
54	Radiology-Diagnostic	3,886,670		3,886,670		3,886,670	54
56	Radioisotope	754,293		754,293		754,293	56
57	CT Scan	1,689,436		1,689,436		1,689,436	57
58	MRI	571,334		571,334		571,334	58
59	Cardiac Catheterization	1,593,739		1,593,739		1,593,739	59
60	Laboratory	9,138,646		9,138,646		9,138,646	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,427,364		2,427,364		2,427,364	65
66	Physical Therapy	3,387,077		3,387,077		3,387,077	66
67	Occupational Therapy	1,274,705		1,274,705		1,274,705	67
68	Speech Pathology	332,915		332,915		332,915	68
69	Electrocardiology	1,146,208		1,146,208		1,146,208	69
69.01	CARDIAC REHAB	503,762		503,762		503,762	69.01
70	Electroencephalography	68,764		68,764		68,764	70
71	Medical Supplies Charged to Patients	6,771,333		6,771,333		6,771,333	71
72	Impl. Dev. Charged to Patients	4,277,323		4,277,323		4,277,323	72
73	Drugs Charged to Patients	9,088,760		9,088,760		9,088,760	73
74	Renal Dialysis	519,095		519,095		519,095	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	2,425,823		2,425,823		2,425,823	90
91	Emergency	11,255,946		11,255,946		11,255,946	91
91.01	LITHOTRIPSY						91.01
92	Observation Beds (Non-Distinct Part)	2,609,523		2,609,523		2,609,523	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)	109,250,319		109,250,319	50,687	109,301,006	200
201	Less Observation Beds	2,609,523		2,609,523		2,609,523	201
202	Total (line 200 minus line 201)	106,640,796		106,640,796		106,691,483	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	78,493,304		78,493,304				30
34	Surgical Intensive Care Unit	24,586,710		24,586,710				34
44	Skilled Nursing Facility	12,688,816		12,688,816				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,877,025	13,426,346	28,303,371	0.271420	0.271420	0.271420	50
51	Recovery Room	2,632,660	2,432,854	5,065,514	0.174482	0.174482	0.174482	51
53	Anesthesiology	3,446,907	3,299,379	6,746,286	0.052724	0.052724	0.052724	53
54	Radiology-Diagnostic	10,445,025	16,560,846	27,005,871	0.143919	0.143919	0.143919	54
56	Radioisotope	2,426,306	4,254,472	6,680,778	0.112905	0.112905	0.112905	56
57	CT Scan	17,004,595	26,913,890	43,918,485	0.038468	0.038468	0.038468	57
58	MRI	3,360,058	4,857,649	8,217,707	0.069525	0.069525	0.069525	58
59	Cardiac Catheterization	11,282,195	5,013,931	16,296,126	0.097799	0.097799	0.097799	59
60	Laboratory	47,870,950	23,931,446	71,802,396	0.127275	0.127275	0.127275	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	19,724,944	1,052,209	20,777,153	0.116829	0.116829	0.116829	65
66	Physical Therapy	10,443,636	3,204,562	13,648,198	0.248170	0.248170	0.248170	66
67	Occupational Therapy	5,033,648	1,047,414	6,081,062	0.209619	0.209619	0.209619	67
68	Speech Pathology	912,396	92,803	1,005,199	0.331193	0.331193	0.331193	68
69	Electrocardiology	11,124,854	8,756,345	19,881,199	0.057653	0.057653	0.057653	69
69.01	CARDIAC REHAB	188,417	298,767	487,184	1.034028	1.034028	1.034028	69.01
70	Electroencephalography	250,186	85,960	336,146	0.204566	0.204566	0.204566	70
71	Medical Supplies Charged to Patients	14,618,541	5,426,320	20,044,861	0.337809	0.337809	0.337809	71
72	Impl. Dev. Charged to Patients	7,189,002	6,009,092	13,198,094	0.324086	0.324086	0.324086	72
73	Drugs Charged to Patients	63,153,656	12,381,188	75,534,844	0.120325	0.120325	0.120325	73
74	Renal Dialysis	2,608,948	189,154	2,798,102	0.185517	0.185517	0.185517	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	2,855,843	9,744,277	12,600,120	0.192524	0.192524	0.192524	90
91	Emergency	20,264,153	59,000,821	79,264,974	0.142004	0.142004	0.142004	91
91.01	LITHOTRIPSY							91.01
92	Observation Beds (Non-Distinct Part)	1,480,372	8,703,729	10,184,101	0.256235	0.256235	0.256235	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)	388,963,147	216,683,454	605,646,601				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	388,963,147	216,683,454	605,646,601				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)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,715,445		1,715,445	30,228	56.75	10,969	622,491	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit	295,070		295,070	4,786	61.65	2,326	143,398	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	618,924		618,924	12,989	47.65	10,782	513,762	44
45	Nursing Facility								45
200	Total (lines 30-199)	2,629,439		2,629,439	48,003		24,077	1,279,651	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	761,945	28,303,371	0.026921	4,935,209	132,861	50
51	Recovery Room	45,159	5,065,514	0.008915	940,736	8,387	51
53	Anesthesiology	20,152	6,746,286	0.002987	1,300,718	3,885	53
54	Radiology-Diagnostic	324,761	27,005,871	0.012026	4,512,174	54,263	54
56	Radioisotope	24,241	6,680,778	0.003628	1,099,375	3,989	56
57	CT Scan	58,103	43,918,485	0.001323	6,824,237	9,028	57
58	MRI	15,636	8,217,707	0.001903	1,229,088	2,339	58
59	Cardiac Catheterization	124,824	16,296,126	0.007660	3,241,736	24,832	59
60	Laboratory	331,122	71,802,396	0.004612	18,890,572	87,123	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	96,650	20,777,153	0.004652	7,851,889	36,527	65
66	Physical Therapy	159,738	13,648,198	0.011704	1,164,744	13,632	66
67	Occupational Therapy	46,250	6,081,062	0.007606	363,769	2,767	67
68	Speech Pathology	23,156	1,005,199	0.023036	357,483	8,235	68
69	Electrocardiology	54,977	19,881,199	0.002765	5,714,064	15,799	69
69.01	CARDIAC REHAB	47,790	487,184	0.098094	79,219	7,771	69.01
70	Electroencephalography	1,064	336,146	0.003165	111,892	354	70
71	Medical Supplies Charged to Pat	171,008	20,044,861	0.008531	5,820,077	49,651	71
72	Impl. Dev. Charged to Patients	108,126	13,198,094	0.008193	2,571,845	21,071	72
73	Drugs Charged to Patients	178,495	75,534,844	0.002363	22,046,537	52,096	73
74	Renal Dialysis	23,724	2,798,102	0.008479	1,299,602	11,019	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	160,800	12,600,120	0.012762	1,223,230	15,611	90
91	Emergency	417,471	79,264,974	0.005267	8,512,774	44,837	91
91.01	LITHOTRIPSY						91.01
92	Observation Beds (Non-Distinct)	201,520	10,184,101	0.019788	653,410	12,930	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,396,712	489,877,771		100,744,380	619,007	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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)	30,228		10,969		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit	4,786		2,326		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	12,989		10,782		44
45	Nursing Facility					45
200	Total (lines 30-199)	48,003		24,077		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	2	3	4	5	6	
	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	28,303,371			4,935,209		4,577,742		50
51	Recovery Room	5,065,514			940,736		695,817		51
53	Anesthesiology	6,746,286			1,300,718		1,083,784		53
54	Radiology-Diagnostic	27,005,871			4,512,174		3,617,601		54
56	Radioisotope	6,680,778			1,099,375		1,730,503		56
57	CT Scan	43,918,485			6,824,237		6,177,115		57
58	MRI	8,217,707			1,229,088		1,817,770		58
59	Cardiac Catheterization	16,296,126			3,241,736		1,515,734		59
60	Laboratory	71,802,396			18,890,572		4,484,570		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,777,153			7,851,889		281,430		65
66	Physical Therapy	13,648,198			1,164,744		67,285		66
67	Occupational Therapy	6,081,062			363,769		27,502		67
68	Speech Pathology	1,005,199			357,483		12,728		68
69	Electrocardiology	19,881,199			5,714,064		3,538,038		69
69.01	CARDIAC REHAB	487,184			79,219		175,484		69.01
70	Electroencephalography	336,146			111,892		41,752		70
71	Medical Supplies Charged to Pat	20,044,861			5,820,077		1,865,293		71
72	Impl. Dev. Charged to Patients	13,198,094			2,571,845		3,344,262		72
73	Drugs Charged to Patients	75,534,844			22,046,537		3,759,242		73
74	Renal Dialysis	2,798,102			1,299,602		83,681		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	12,600,120			1,223,230		3,542,715		90
91	Emergency	79,264,974			8,512,774		7,277,552		91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct)	10,184,101			653,410		3,371,144		92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	489,877,771			100,744,380		53,088,744		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	0.271420	4,577,742			1,242,491			50
51	Recovery Room	0.174482	695,817			121,408			51
53	Anesthesiology	0.052724	1,083,784			57,141			53
54	Radiology-Diagnostic	0.143919	3,617,601			520,642			54
56	Radioisotope	0.112905	1,730,503			195,382			56
57	CT Scan	0.038468	6,177,115			237,621			57
58	MRI	0.069525	1,817,770			126,380			58
59	Cardiac Catheterization	0.097799	1,515,734			148,237			59
60	Laboratory	0.127275	4,484,570			570,774			60
62.30	BLOOD CLOTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.116829	281,430			32,879			65
66	Physical Therapy	0.248170	67,285			16,698			66
67	Occupational Therapy	0.209619	27,502			5,765			67
68	Speech Pathology	0.331193	12,728			4,215			68
69	Electrocardiology	0.057653	3,538,038			203,979			69
69.01	CARDIAC REHAB	1.034028	175,484			181,455			69.01
70	Electroencephalography	0.204566	41,752			8,541			70
71	Medical Supplies Charged to Pat	0.337809	1,865,293			630,113			71
72	Impl. Dev. Charged to Patients	0.324086	3,344,262	65,918		1,083,828	21,363		72
73	Drugs Charged to Patients	0.120325	3,759,242		91,219	452,331		10,976	73
74	Renal Dialysis	0.185517	83,681			15,524			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	0.192524	3,542,715			682,058			90
91	Emergency	0.142004	7,277,552			1,033,441			91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct	0.256235	3,371,144			863,805			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		53,088,744	65,918	91,219	8,434,708	21,363	10,976	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		53,088,744	65,918	91,219	8,434,708	21,363	10,976	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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 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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	28,303,371			54,292				50
51	Recovery Room	5,065,514							51
53	Anesthesiology	6,746,286							53
54	Radiology-Diagnostic	27,005,871			280,313				54
56	Radioisotope	6,680,778			3,627				56
57	CT Scan	43,918,485							57
58	MRI	8,217,707							58
59	Cardiac Catheterization	16,296,126			2,075				59
60	Laboratory	71,802,396			2,669,718				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,777,153			1,002,212				65
66	Physical Therapy	13,648,198			6,434,388				66
67	Occupational Therapy	6,081,062			3,486,672				67
68	Speech Pathology	1,005,199			157,358				68
69	Electrocardiology	19,881,199			46,211				69
69.01	CARDIAC REHAB	487,184							69.01
70	Electroencephalography	336,146			1,228				70
71	Medical Supplies Charged to Pat	20,044,861			350,674				71
72	Impl. Dev. Charged to Patients	13,198,094							72
73	Drugs Charged to Patients	75,534,844			6,153,557				73
74	Renal Dialysis	2,798,102							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	12,600,120			2,202				90
91	Emergency	79,264,974							91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct	10,184,101							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	489,877,771			20,644,527				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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	0.271420							50
51	Recovery Room	0.174482							51
53	Anesthesiology	0.052724							53
54	Radiology-Diagnostic	0.143919							54
56	Radioisotope	0.112905							56
57	CT Scan	0.038468							57
58	MRI	0.069525							58
59	Cardiac Catheterization	0.097799							59
60	Laboratory	0.127275							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.116829							65
66	Physical Therapy	0.248170							66
67	Occupational Therapy	0.209619							67
68	Speech Pathology	0.331193							68
69	Electrocardiology	0.057653							69
69.01	CARDIAC REHAB	1.034028							69.01
70	Electroencephalography	0.204566							70
71	Medical Supplies Charged to Pat	0.337809							71
72	Impl. Dev. Charged to Patients	0.324086							72
73	Drugs Charged to Patients	0.120325				3,358		404	73
74	Renal Dialysis	0.185517							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	0.192524							90
91	Emergency	0.142004							91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct	0.256235							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)					3,358		404	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)					3,358		404	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,715,445		1,715,445	30,228	56.75	4,804	272,627	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit	295,070		295,070	4,786	61.65	558	34,401	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	618,924		618,924	12,989	47.65			44
45	Nursing Facility								45
200	Total (lines 30-199)	2,629,439		2,629,439	48,003		5,362	307,028	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	761,945	28,303,371	0.026921		50
51	Recovery Room	45,159	5,065,514	0.008915		51
53	Anesthesiology	20,152	6,746,286	0.002987		53
54	Radiology-Diagnostic	324,761	27,005,871	0.012026		54
56	Radioisotope	24,241	6,680,778	0.003628		56
57	CT Scan	58,103	43,918,485	0.001323		57
58	MRI	15,636	8,217,707	0.001903		58
59	Cardiac Catheterization	124,824	16,296,126	0.007660		59
60	Laboratory	331,122	71,802,396	0.004612		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	96,650	20,777,153	0.004652		65
66	Physical Therapy	159,738	13,648,198	0.011704		66
67	Occupational Therapy	46,250	6,081,062	0.007606		67
68	Speech Pathology	23,156	1,005,199	0.023036		68
69	Electrocardiology	54,977	19,881,199	0.002765		69
69.01	CARDIAC REHAB	47,790	487,184	0.098094		69.01
70	Electroencephalography	1,064	336,146	0.003165		70
71	Medical Supplies Charged to Pat	171,008	20,044,861	0.008531		71
72	Impl. Dev. Charged to Patients	108,126	13,198,094	0.008193		72
73	Drugs Charged to Patients	178,495	75,534,844	0.002363		73
74	Renal Dialysis	23,724	2,798,102	0.008479		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	160,800	12,600,120	0.012762		90
91	Emergency	417,471	79,264,974	0.005267		91
91.01	LITHOTRIPSY					91.01
92	Observation Beds (Non-Distinct	201,520	10,184,101	0.019788		92
	OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-199)	3,396,712	489,877,771			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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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)	30,228		4,804		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit	4,786		558		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	12,989				44
45	Nursing Facility					45
200	Total (lines 30-199)	48,003		5,362		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	28,303,371							50
51	Recovery Room	5,065,514							51
53	Anesthesiology	6,746,286							53
54	Radiology-Diagnostic	27,005,871							54
56	Radioisotope	6,680,778							56
57	CT Scan	43,918,485							57
58	MRI	8,217,707							58
59	Cardiac Catheterization	16,296,126							59
60	Laboratory	71,802,396							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	20,777,153							65
66	Physical Therapy	13,648,198							66
67	Occupational Therapy	6,081,062							67
68	Speech Pathology	1,005,199							68
69	Electrocardiology	19,881,199							69
69.01	CARDIAC REHAB	487,184							69.01
70	Electroencephalography	336,146							70
71	Medical Supplies Charged to Pat	20,044,861							71
72	Impl. Dev. Charged to Patients	13,198,094							72
73	Drugs Charged to Patients	75,534,844							73
74	Renal Dialysis	2,798,102							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	12,600,120							90
91	Emergency	79,264,974							91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct	10,184,101							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	489,877,771							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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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 Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.271420							50
51	Recovery Room	0.174482							51
53	Anesthesiology	0.052724							53
54	Radiology-Diagnostic	0.143919							54
56	Radioisotope	0.112905							56
57	CT Scan	0.038468							57
58	MRI	0.069525							58
59	Cardiac Catheterization	0.097799							59
60	Laboratory	0.127275							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.116829							65
66	Physical Therapy	0.248170							66
67	Occupational Therapy	0.209619							67
68	Speech Pathology	0.331193							68
69	Electrocardiology	0.057653							69
69.01	CARDIAC REHAB	1.034028							69.01
70	Electroencephalography	0.204566							70
71	Medical Supplies Charged to Pat	0.337809							71
72	Impl. Dev. Charged to Patients	0.324086							72
73	Drugs Charged to Patients	0.120325							73
74	Renal Dialysis	0.185517							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	0.192524							90
91	Emergency	0.142004							91
91.01	LITHOTRIPSY								91.01
92	Observation Beds (Non-Distinct)	0.256235							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

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

**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)	30,228	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	30,228	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)	26,677	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)	10,969	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)	22,213,664	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)	22,213,664	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)	22,213,664	37

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
38	Adjusted general inpatient routine service cost per diem (see instructions)					734.87	38	
39	Program general inpatient routine service cost (line 9 x line 38)					8,060,789	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)					8,060,789	41	
42	Nursery (Titles V and XIX only)	1	2	3	4	5	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	7,562,495	4,786	1,580.13	2,326	3,675,382	46	
47	Other Special Care (specify)						47	

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					14,555,517	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					26,291,688	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					765,889	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					619,007	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,384,896	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					24,906,792	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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)					3,551	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					734.87	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,609,523	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	1,715,445	22,213,664	0.077225	2,609,523	201,520	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

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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)	12,989	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,989	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)	12,989	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)	10,782	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)	6,880,507	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)	6,880,507	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)	6,880,507	37

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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)	6,880,507	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	529.72	71
72	Program routine service cost (line 9 x line 71)	5,711,441	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)	5,711,441	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)	5,711,441	83
84	Program inpatient ancillary services (see instructions)	3,754,604	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	9,466,045	86

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0251

**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)	30,228	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	30,228	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)	26,677	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)	4,804	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)	22,213,664	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)	22,213,664	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)	22,213,664	37

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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

38	Adjusted general inpatient routine service cost per diem (see instructions)					734.87	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,530,315	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)					3,530,315	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	7,511,808	4,786	1,569.54	558	875,803	46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					4,406,118	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					307,028	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)					307,028	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

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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)					3,551	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

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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/ID 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		31,371,971		30
34	Surgical Intensive Care Unit		9,731,262		34
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.271420	4,935,209	1,339,514	50
51	Recovery Room	0.174482	940,736	164,141	51
53	Anesthesiology	0.052724	1,300,718	68,579	53
54	Radiology-Diagnostic	0.143919	4,512,174	649,388	54
56	Radioisotope	0.112905	1,099,375	124,125	56
57	CT Scan	0.038468	6,824,237	262,515	57
58	MRI	0.069525	1,229,088	85,452	58
59	Cardiac Catheterization	0.097799	3,241,736	317,039	59
60	Laboratory	0.127275	18,890,572	2,404,298	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.116829	7,851,889	917,328	65
66	Physical Therapy	0.248170	1,164,744	289,055	66
67	Occupational Therapy	0.209619	363,769	76,253	67
68	Speech Pathology	0.331193	357,483	118,396	68
69	Electrocardiology	0.057653	5,714,064	329,433	69
69.01	CARDIAC REHAB				69.01
70	Electroencephalography	1.034028	79,219	81,915	70
71	Medical Supplies Charged to Patients	0.204566	111,892	22,889	71
72	Impl. Dev. Charged to Patients	0.337809	5,820,077	1,966,074	72
73	Drugs Charged to Patients	0.324086	2,571,845	833,499	73
74	Renal Dialysis	0.120325	22,046,537	2,652,750	74
75.01	ACUTE DIALYSIS				75.01
76	Renal Dialysis	0.185517	1,299,602	241,098	76
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	0.192524	1,223,230	235,501	90
91	Emergency	0.142004	8,512,774	1,208,848	91
91.01	LITHOTRIPSY				91.01
92	Observation Beds (Non-Distinct Part)	0.256235	653,410	167,427	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		100,744,380	14,555,517	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		100,744,380		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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 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	0.271420	54,292	14,736	50
51	Recovery Room	0.174482			51
53	Anesthesiology	0.052724			53
54	Radiology-Diagnostic	0.143919	280,313	40,342	54
56	Radioisotope	0.112905	3,627	410	56
57	CT Scan	0.038468			57
58	MRI	0.069525			58
59	Cardiac Catheterization	0.097799	2,075	203	59
60	Laboratory	0.127275	2,669,718	339,788	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.116829	1,002,212	117,087	65
66	Physical Therapy	0.248170	6,434,388	1,596,822	66
67	Occupational Therapy	0.209619	3,486,672	730,873	67
68	Speech Pathology	0.331193	157,358	52,116	68
69	Electrocardiology	0.057653	46,211	2,664	69
69.01	CARDIAC REHAB	1.034028			69.01
70	Electroencephalography	0.204566	1,228	251	70
71	Medical Supplies Charged to Patients	0.337809	350,674	118,461	71
72	Impl. Dev. Charged to Patients	0.324086			72
73	Drugs Charged to Patients	0.120325	6,153,557	740,427	73
74	Renal Dialysis	0.185517			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	0.192524	2,202	424	90
91	Emergency	0.142004			91
91.01	LITHOTRIPSY				91.01
92	Observation Beds (Non-Distinct Part)	0.256235			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		20,644,527	3,754,604	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		20,644,527		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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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	0.271420			50
51	Recovery Room	0.174482			51
53	Anesthesiology	0.052724			53
54	Radiology-Diagnostic	0.143919			54
56	Radioisotope	0.112905			56
57	CT Scan	0.038468			57
58	MRI	0.069525			58
59	Cardiac Catheterization	0.097799			59
60	Laboratory	0.127275			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.116829			65
66	Physical Therapy	0.248170			66
67	Occupational Therapy	0.209619			67
68	Speech Pathology	0.331193			68
69	Electrocardiology	0.057653			69
69.01	CARDIAC REHAB	1.034028			69.01
70	Electroencephalography	0.204566			70
71	Medical Supplies Charged to Patients	0.337809			71
72	Impl. Dev. Charged to Patients	0.324086			72
73	Drugs Charged to Patients	0.120325			73
74	Renal Dialysis	0.185517			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	0.192524			90
91	Emergency	0.142004			91
91.01	LITHOTRIPSY				91.01
92	Observation Beds (Non-Distinct Part)	0.256235			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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	16,492,656			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,497,552			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)	104,041			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	5,518,554			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	203.30			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	2.27			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	2.27			12
13	Total allowable FTE count for the prior year	1.84			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	2.57			14
15	Sum of lines 12 through 14 divided by 3	2.23			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	2.23			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.010969			19
20	Prior year resident to bed ratio (see instructions)	0.008985			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.008985			21
22	IME payment adjustment (see instructions)	107,730			22
22.01	IME payment adjustment - Managed Care (see instructions)	27,035			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)	-0.68			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)	107,730			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	27,035			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0861			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2760			31
32	Sum of lines 30 and 31	0.3621			32
33	Allowable disproportionate share percentage (see instructions)	0.1908			33
34	Disproportionate share adjustment (see instructions)	1,048,933			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)	1,667,078		1,239,060	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,248,031		312,311	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,560,342			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	24,811,254			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)	24,838,289			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,922,490			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)	63,203			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	26,823,982			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	26,823,982			61
62	Deductibles billed to program beneficiaries	2,278,864			62
63	Coinsurance billed to program beneficiaries	109,480			63
64	Allowable bad debts (see instructions)	831,675			64
65	Adjusted reimbursable bad debts (see instructions)	540,589			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	644,330			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	24,976,227			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)	-126,730			70.93
71	Amount due provider (see instructions)	24,849,497			71
71.01	Sequestration adjustment (see instructions)	496,990			71.01
72	Interim payments	23,853,079			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	499,428			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,695,858			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

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

HSP Bonus Payment Amount

Prior to 10/1

On or After 10/1

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

Prior to 10/1

On or After 10/1

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

HRR Adjustment for HSP Bonus Payment

Prior to 10/1

On or After 10/1

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0251

**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)	32,339			1
2	Medical and other services reimbursed under OPPTS (see instructions)	8,434,708			2
3	PPS payments	7,787,537			3
4	Outlier payment (see instructions)	33,585			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)	32,339			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	157,137			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)	157,137			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)	157,137			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	124,798			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)	32,339			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)	7,821,122			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,575,041			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)	6,278,420			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	14,063			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	6,292,483			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	6,292,483			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)	712,662			34
35	Adjusted reimbursable bad debts (see instructions)	463,230			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	604,465			36
37	Subtotal (see instructions)	6,755,713			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)	6,755,713			40
40.01	Sequestration adjustment (see instructions)	135,114			40.01
41	Interim payments	6,621,500			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-901			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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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)	404			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)	404			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	3,358			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)	3,358			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)	3,358			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	2,954			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)	404			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)	404			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)	404			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	404			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)	404			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)	404			40
40.01	Sequestration adjustment (see instructions)	8			40.01
41	Interim payments	428			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-32			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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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		23,960,805		6,548,143	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	12/29/2016	219,135	12/26/2016	272,215	3.01
		.02					3.02
		.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50	09/01/2016	326,861	09/01/2016	198,858	3.50
		.51					3.51
		.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		-107,726		73,357	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)			23,853,079		6,621,500	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
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		499,428			6.01
		.02				-901	6.02
7	Total Medicare program liability (see instructions)			24,352,507		6,620,599	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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		5,584,216		428 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	.01			3.01
	amount based on subsequent revision of the interim	.02			3.02
	rate for the cost reporting period. Also show date of	Program .03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to .04			3.04
		Provider .05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
		Provider .52			3.52
		to .53			3.53
		Program .54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.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)		5,584,216		428 4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment	.01			5.01
	after desk review. Also show date of each payment.	.02			5.02
	If none, write 'NONE' or enter a zero. (1)	Program .03			5.03
		to .04			5.04
		Provider .05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		Provider .52			5.52
		to .53			5.53
		Program .54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02		-1	-32 6.02
7	Total Medicare program liability (see instructions)		5,584,215		396 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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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)	6,102	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	13,295	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	3,857	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	31,463	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	605,646,601	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	13,858,969	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)	417,114	8
9	Sequestration adjustment amount (see instructions)	8,342	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	408,772	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	347,309	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	61,463	32

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

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	6,051,595	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	6,051,595	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	353,416	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)	5,698,179	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)	5,698,179	15
15.01	Sequestration adjustment (see instructions)	113,964	15.01
16	Interim payments	5,584,216	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)	-1	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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	4,406,118	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	4,406,118	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	4,406,118	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)	4,406,118	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)	4,406,118	30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		31
32	Deductibles		32
33	Coinsurance		33
34	Allowable bad debts (see instructions)		34
35	Utilization review		35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)		38
39	Direct graduate medical education payments (from Wkst. E-4)		39
40	Total amount payable to the provider (sum of lines 38 and 39)		40
41	Interim payments		41
42	Balance due provider/program (line 40 minus line 41)		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		43

KPMG LLP Compu-Max 2552-10

COMMUNITY FIRST MEDICAL CENTER Provider CCN: 14-0251	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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)		2.27	6
7	Enter the lesser of line 5 or line 6		2.27	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	1.14	1.14
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	1.14	1.14
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			
11	Total weighted FTE count	0.00	1.14	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	1.21	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.12	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	1.49	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
15.01	Unweighted adjustment for residents in initial years of new programs			
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure			
17	Adjusted rolling average FTE count	0.00	1.49	
18	Per resident amount	98,245.75	98,245.75	
19	Approved amount for resident costs		146,386	146,386
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			146,386
COMPUTATION OF PROGRAM PATIENT LOAD				
26	Inpatient days (see instructions)	13,295	3,857	
27	Total inpatient days (see instructions)	31,463	31,463	
28	Ratio of inpatient days to total inpatient days	0.422560	0.122588	
29	Program direct GME amount	61,857	17,945	
30	Reduction for direct GME payments for Medicare Advantage		2,536	
31	Net Program direct GME amount			77,266
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)			
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			2,798,102
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			
35	Medicare outpatient ESRD charges (see instructions)			
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
Part A Reasonable Cost				
37	Reasonable cost (see instructions)			38,054,724
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			
39	Cost of physicians' services in a teaching hospital (see instructions)			
40	Primary payer payments (see instructions)			
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			38,054,724
Part B Reasonable Cost				
42	Reasonable cost (see instructions)			8,467,451
43	Primary payer payments (see instructions)			
44	Total Part B reasonable cost (line 42 minus line 43)			8,467,451
45	Total reasonable cost (sum of lines 41 and 44)			46,522,175
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.817991
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.182009
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			77,266
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			63,203
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			14,063

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check Title V
 Applicable 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)			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)			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))			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)			5	
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6	
7	Enter the lesser of line 5 or line 6			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	0.00	0.00	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	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				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)				25
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	5,362	3,321		26
27	Total inpatient days (see instructions)	31,463	31,463		27
28	Ratio of inpatient days to total inpatient days	0.170422	0.105553		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				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)				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)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				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)

Assets (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
CURRENT ASSETS					
1	Cash on hand and in banks	1,021,809			1
2	Temporary investments				2
3	Notes receivable				3
4	Accounts receivable	73,952,097			4
5	Other receivables				5
6	Allowances for uncollectible notes and accounts receivable	-37,190,233			6
7	Inventory	3,204,111			7
8	Prepaid expenses	75,464			8
9	Other current assets	8,613,117			9
10	Due from other funds				10
11	Total current assets (sum of lines 1-10)	49,676,365			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	28,976,383			19
20	Accumulated depreciation	-6,722,379			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)	22,254,004			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)	71,930,369			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	17,703,335			37
38	Salaries, wages and fees payable	6,537,520			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	1,295,536			43
44	Other current liabilities	14,547,861			44
45	Total current liabilities (sum of lines 37 thru 44)	40,084,252			45
LONG TERM LIABILITIES					
46	Mortgage payable				46
47	Notes payable				47
48	Unsecured loans				48
49	Other long term liabilities	2,099,005			49
50	Total long term liabilities (sum of lines 46 thru 49)	2,099,005			50
51	Total liabilities (sum of lines 45 and 50)	42,183,257			51
CAPITAL ACCOUNTS					
52	General fund balance	29,747,112			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)	29,747,112			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	71,930,369			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		29,365,677			1
2	Net income (loss) (from Worksheet G-3, line 29)		380,018			2
3	Total (sum of line 1 and line 2)		29,745,695			3
4	Additions (credit adjustments) (specify)	1,417				4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		1,417			10
11	Subtotal (line 3 plus line 10)		29,747,112			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)		29,747,112			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	75,188,043		75,188,043	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	13,065,483		13,065,483	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	88,253,526		88,253,526	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	25,681,360		25,681,360	14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	25,681,360		25,681,360	16
17	Total inpatient routine care services (sum of lines 10 and 16)	113,934,886		113,934,886	17
18	Ancillary services	269,347,342		269,347,342	18
19	Outpatient services		222,367,118	222,367,118	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
27.01	PRO FEES		7,845,575	7,845,575	27.01
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	383,282,228	230,212,693	613,494,921	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		123,743,876	29
30	TRIAL BALANCE VARIANCE WITH KPMG	30,837		30
31				31
32				32
33				33
34				34
35	IMMATERIAL VARIANCE			35
36	Total additions (sum of lines 30-35)		30,837	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)		123,774,713	43

KPMG LLP Compu-Max 2552-10

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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	613,494,921	1
2	Less contractual allowances and discounts on patients' accounts	491,902,925	2
3	Net patient revenues (line 1 minus line 2)	121,591,996	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	123,774,713	4
5	Net income from service to patients (line 3 minus line 4)	-2,182,717	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 otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER INCOME)	2,562,735	24
24.01	Other (NET ASSETS RELEASED FROM RESTRICTIO)		24.01
24.02	Other (RECONCILIATION)		24.02
24.03	Other (MISCELLANEOUS - CARDIAC REHAB, ETC.)		24.03
25	Total other income (sum of lines 6-24)	2,562,735	25
26	Total (line 5 plus line 25)	380,018	26
29	Net income (or loss) for the period (line 26 minus line 28)	380,018	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	1,767,869	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	7,181	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)	85.96	3
4	Number of interns & residents (see instructions)	2.23	4
5	Indirect medical education percentage (see instructions)	0.73	5
6	Indirect medical education adjustment (see instructions)	12,905	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0861	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.2760	8
9	Sum of lines 7 and 8	0.3621	9
10	Allowable disproportionate share percentage (see instructions)	0.0761	10
11	Disproportionate share adjustment (see instructions)	134,535	11
12	Total prospective capital payments (see instructions)	1,922,490	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 14:18 Version: 2017.01 (05/18/2017)
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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