Heal th Financi	al Systems	COMMUNITY HOSPT. OF NOB	SLE CTY, INC.	In I	Lieu of Form CMS-2552-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	re to report can res	ult in all inter	im FORM APPROVED
payments made	since the beginning of the cost	reporting period being d	leemed overpayments (	42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	T REPORT CERTIFICATION	Provi der CCN: 150146	Period: From 01/01/20 To 12/31/20	
PART I - COST	REPORT STATUS				
Provi der	1. [ X ] Electronically filed co	st report		Date: 5/16	/2016 Time: 4:42 pm
use only	2. [ ] Manually submitted cost 3. [ O ] If this is an amended r 4. [ F ] Medicare Utilization. E	eport enter the number of		resubmitted this	s cost report
Contractor use only	5. [ 1 ]Cost Report Status 6. (1) As Submitted 7. (2) Settled without Audit 8. (3) Settled with Audit	Contractor No.	this Provider CCN 12		

PART II - CERTIFICATION

(4) Reopened (5) Amended

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 HOSPT. OF NOBLE CTY, INC. (150146) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)						
_		Offi cer	or	Admi ni strator	of Provid	der(s)
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7	Title					
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Ī	)ate					

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	52, 704	62, 088	-9, 207	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	52, 704	62, 088	-9, 207	0	200. 00

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 and review the 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 the 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150146 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/16/2016 4:15 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 401 SAWYER ROAD P0 Box: 728 1.00 Zip Code: 46755-0728 County: NOBLE 2.00 City: KENDALLVILLE State: IN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPT. OF 150146 21140 1 05/30/2000 Ν 3.00 NOBLE CTY, INC. Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N 22.00 Υ share hospital adjustment, 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 Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 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) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 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 "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 Ν 23 00 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 enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 659 21 24.00 If this provider is an IPPS hospital, enter the 310 516 24.00 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. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the 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.

	Financial Systems COMMUNITY HO AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		NOBLE CTY, IN	CCN: 150146 P	eriod: rom 01/01,	/2015	u of For Workshe Part I	et S-2	
					o 12/31,		5/16/20	16 4:1	
26, 00	Enter your standard geographic classification (not wa	ge) sta	atus at the bed	innina of the	1. 00	) 2	2. 0	00	26. 00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	rural. ge) sta "2" fo	atus at the end or rural. If ap	of the cost		2		'2013	27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	number	r of periods SC	H status in		0			35. 00
					Begi nni 1. 00		Endi 2. 0		
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date	S.	•						36. 00
	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		·			0			37. 00
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 00
	enter subsequent dates.				Y/N		Y/		
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req	)? Ente uiremer	er in column 1 nts in accordan	"Y" for yes ice with 42	1. 00 Y	)	2. ( Y		39. 00
40. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	adjust er 1. [	tment? Enter "Y Enter "Y" for y	" for yes or	N		N		40. 00
						1. 00	XVIII 2. 00	XI X 3. 00	
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	it for a	di sproporti onat	e share in acc	cordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	N	46. 00
	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capils the facility electing full federal capital payment					N N	N N	N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" 1	for yes	N			56. 00
57. 00	or "N" for no.  If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or h of th ", comp	r "N" for no in his cost report plete Worksheet	column 1. If ing period? [	column 1 Enter "Y"	N			57. 00
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	ursemer	nt for physicia	ıns' services a	as	N			58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	, compl	lete Wkst. D-2,			N			59.00
60.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"				ctions)	N	Di rect	GME	60. 00
		1. 00	2. 00	3. 00	4.00	)	5. 0		
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00			61.00
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)		0.00	0. 00					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		0.00	0.00					61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00					61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61. 04
61. 05	current cost reporting period. (see instructions). 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		0.00	0.00					61. 05
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary		0.00	0.00					61. 06

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

Health Financial Systems	COMMUNITY HO	SPT. OF NOBLE CT	Y, INC.	In Lie	eu of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP			ider CCN: 150146	Peri od:	Worksheet S-2	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	
		Program Name	e Program Code	Unweighted IME	5/16/2016 4:1	5 pm
			-   g	FTE Count	Direct GME FTE	
		1.00	2.00	3.00	4. 00	-
61.10 Of the FTEs in line 61.05, speci	fy each new program	1.00	2.00	0.00		61. 10
specialty, if any, and the number for each new program. (see instruction column 1, the program name, enter program code, enter in column 3, unweighted count and enter in column 3 (see instructions). The column 1 in the column 1 in the column 1, enter in column 2, the program column 2, the program of the column 2 in the column 2.	ructions) Enter in er in column 2, the the IME FTE column 4, direct GME fy each expanded the number of FTE gram. (see the program name,			0. 00	0. 00	61. 20
3, the IME FTE unweighted count						
4, direct GME FTE unweighted cou	ını.					
					1. 00	
ACA Provisions Affecting the Hea 62.00 Enter the number of FTE resident				iod for which	0.00	62.00
your hospital received HRSA PCRE 62.01 Enter the number of FTE resident	funding (see instruc	ctions)				62. 01
during in this cost reporting pe Teaching Hospitals that Claim Re	esidents in Nonprovide	er Settings				
63.00 Has your facility trained reside					N	63. 00
	, , , ,		Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	·		
Section 5504 of the ACA Base Yea	ar FTF Dasidants in No	onnrovider Settir	1.00	2.00	3.00	
period that begins on or after a	July 1, 2009 and befor	re June 30, 2010.		i is your cost i	eportring	
64.00 Enter in column 1, if line 63 is in the base year period, the num	s yes, or your facilit ber of unweighted nor	ty trained reside n-primary care	ents 0.0	0. 00	0. 000000	64. 00
resident FTEs attributable to ro	otations occurring in	al I nonprovi der				
settings. Enter in column 2 the resident FTEs that trained in yo						
of (column 1 divided by (column						
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			Si te			
65.00 Enter in column 1, if line 63	1. 00	2. 00	3.00	4.00	5. 00 0. 000000	65.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)					0. 000000	05.00

OSPITAL AND HOSPITAL HEALTH CARE COM	PLEX IDENTIFICATION DA	Provi de		Period: From 01/01/2015 To 12/31/2015	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 5/16/2016 4:1	pared:
		1	Unwei ghted FTEs Nonprovi der	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1.00	2.00	3.00	-
Section 5504 of the ACA Current		Nonprovider Setti				
6.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-primar occurring in all nonpr unweighted non-primar tal. Enter in column 3	ovider settings. y care resident the ratio of	0. (	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2. 00	3. 00	4.00	5. 00	
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. 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 + column 4)). (see instructions)			0. (	0.00	0. 000000	7 07. 60
(See Instructions)						
				1. 00	2.00 3.00	
Inpatient Psychiatric Facility 0.00 Is this facility an Inpatient P		DE) on door it or	ntain on LDE au	bprovider? N		70.00
Enter "Y" for yes or "N" for n  1.00 If line 70 yes: Column 1: Did t recent cost report filed on or 42 CFR 412.424(d)(1)(iii)(c)) C program in accordance with 42 C Column 3: If column 2 is Y, ind (see instructions) Inpatient Rehabilitation Facili	no.  The facility have an ap before November 15, 20 column 2: Did this facion FR 412.424 (d)(1)(iii) licate which program ye	proved GME teachin 04? Enter "Y" for Lity train residen (D)? Enter "Y" for	ng program in the yes or "N" for its in a new tead yes or "N" for	e most no. (see ching no.	0	71.00
5.00 Is this facility an Inpatient R	Rehabilitation Facility	(IRF), or does it	contain an IRF	N		75. 00
subprovider? Enter "Y" for yes 6.00 If line 75 yes: Column 1: Did t recent cost reporting period en no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ent indicate which program year beg	the facility have an ap ading on or before Nove of train residents in a cer "Y" for yes or "N"	mber 15, 2004? Ent new teaching progr for no. Column 3:	er "Y" for yes or am in accordance If column 2 is '	or "N" for e with 42 Y,	0	76. 00
					1.00	1
Long Term Care Hospital PPS  0.00 Is this a long term care hospit  1.00 Is this a LTCH co-located withi "Y" for yes and "N" for no.				g period? Enter	N N	80. 00 81. 00
TEFRA Providers 5.00 Is this a new hospital under 42 6.00 Did this facility establish a n §413.40(f)(1)(ii)? Enter "Y" f	new Other subprovider (				N	85. 00 86. 00
7.00 Is this hospital a "subclause (for yes or "N" for no.		nder section 1886(	(d) (1) (B) (i v) (II)	)? Enter "Y"	N XI X	87. 00
				1. 00	2.00	
Title V and XIX Services	I and/or VIV innationt	hoonital complete	Enton "V" far	NI NI		00.00
0.00 Does this facility have title V		nospi tal services?	Enter "Y" for	N	Y	90.00
yes or "N" for no in the applic		rough the cost ren	ort either in	N	N	91.00
1.00 Is this hospital reimbursed for						
	yes or "N" for no in t	he applicable colu	ımn.		N	92. 00
1.00 Is this hospital reimbursed for full or in part? Enter "Y" for	yes or "N" for no in t bying title XVIII SNF b s or "N" for no in the	he applicable colu eds (dual certific applicable column.	mn. cation)? (see	N	N N	92. 00

Health Financial Systems COMMUNITY HOSPT. OF	NOBLE CTY, IN	NC.	l r	n Lieu	ı of For	m CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 01/01/		Workshe Part I	et S-2	
			o 12/31/		Date/Ti 5/16/20		
			V		XI	Χ	J piii
95.00 If line 94 is "Y", enter the reduction percentage in the ap	plicable colum	n.	1. 00	0. 00	2. (		95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.	s or "N" for n	o in the	N		N		96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the ap	plicable colum	n.		0. 00		0. 00	97. 00
105.00 Does this hospital qualify as a critical access hospital (C. 106.00 of this facility qualifies as a CAH, has it elected the all		hod of payment	N				105. 00 106. 00
for outpatient services? (see instructions) 107.00 f this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col	n 1. (see inst	ructions) If					107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the  CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N				108. 00
	Physi cal 1.00	Occupati onal 2.00	Speec 3. 00		Respir 4. (		
109.00 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 no for each therapy.	N N	2.00	3.00		4. (	<u> </u>	109. 00
				-	1. (	00	
110.00 Did this hospital participate in the Rural Community Hospit. the current cost reporting period? Enter "Y" for yes or "N"		on project (410	OA Demo)for	-	N		110. 00
the current cost reporting period: Enter 1 for yes of N	101 110.			1.00	0.00	0.00	
Miscellaneous Cost Reporting Information				1.00	2. 00	3.00	
115.00 s this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	. If column 2 nt for long te	is "E", enter i rm care (includ	n column des	N		0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu	-		'N" for	N Y			116. 00 117. 00
118.00 Is the mal practice insurance a claims-made or occurrence po	licy? Enter 1	if the policy i	s	1			118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	s	Insur	ance	
		1.00	2.00		2 (	20	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 98, 446	2.00	0	3. (		118. 01
			1. 00		2. (	00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.	center other dule listing c	than the ost centers	Y				118. 02
119. 00 DO NOT USE THIS LINE  120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hole  "N" for no. Is t	n column 1, "Y ualifies for t	" for yes or he Outpatient	N		Y		119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implementation patients? Enter "Y" for yes or "N" for no.  Transplant Center Information	antable device	s charged to	Y				121. 00
125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N	$\Box$			125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, e		fication date					126. 00
in column 1 and termination date, if applicable, in column 127.00 of this is a Medicare certified heart transplant center, en	ter the certif	cation date		ŀ			127. 00
in column 1 and termination date, if applicable, in column 128.00 f this is a Medicare certified liver transplant center, en	ter the certif	cation date					128. 00
in column 1 and termination date, if applicable, in column 1 129.00 If this is a Medicare certified lung transplant center, ent		cation date in					129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center,	enter the cer	tification					130. 00
date in column 1 and termination date, if applicable, in co 131.00 of this is a Medicare certified intestinal transplant cente	lumn 2.						131. 00
date in column 1 and termination date, if applicable, in co 132.00 f this is a Medicare certified islet transplant center, en	lumn 2.						132. 00
in column 1 and termination date, if applicable, in column	2.						
133.00 of this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column	2.						133. 00
134.00  f this is an organ procurement organization (0P0), enter the land termination date, if applicable, in column 2.	he OPO number	in column 1					134. 00

Health Financial Systems	COMMUNITY HOSPT. (	OF NOBLE CTY, INC	· .		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi der C	CN: 150146		1/01/2015 2/31/2015	Worksheet S- Part I Date/Time Pr 5/16/2016 4:	epared:
					1. 00	2.00	-
All Providers  140.00 Are there any related organization or chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the ho	for no in column 1. I	f yes, and home o	office cost	ts	Υ	15H032	140. 00
1.00		00	UIIS)		3. 00		
If this facility is part of a chain of home office and enter the home office	•	,	•	name and	d address	of the	
141. 00 Name: PARKVI EW HEALTH SYSTEM, INC.	Contractor's Name: W			tor's Nu	mber: 0810	1	141. 00
142.00 Street: 10501 CORPORATE DRIVE	•	ERVI CES 600					142. 00
143. 00 Ci ty: FORT WAYNE		N	Zi p Coo	le:	4684	5	143. 00
						1 00	
144.00 Are provider based physicians' costs	included in Worksheet	A?				1. 00 Y	144. 00
145.00  f costs for renal services are claim	ned on Wkst A line 7	1 are the costs	for		1. 00 N	2.00	145. 00
inpatient services only? Enter "Y" for no, does the dialysis facility include period? Enter "Y" for yes or "N" for 146.00 Has the cost allocation methodology of the cost allocation methodolog	or yes or "N" for no in de Medicare utilization no in column 2.	n column 1. If con for this cost m	olumn 1 is reporting		N		145. 00
Enter "Y" for yes or "N" for no in co yes, enter the approval date (mm/dd/y	•	15-2, chapter 40	), §4020) I	f			
						1.00	
147.00 Was there a change in the statistical 148.00 Was there a change in the order of al 149.00 Was there a change to the simplified	location? Enter "Y" fo	or yes or "N" for	no.	or no.		N N N	147. 00 148. 00 149. 00
		Part A	Part B	Т	itle V	Title XIX	
Does this facility contain a provider	that qualifies for a	1.00	2.00	cation of	3.00 the Lowe	4.00	
or charges? Enter "Y" for yes or "N"		nent for Part A	and Part B		2 CFR §413	. 13)	
155.00 Hospi tal 156.00 Subprovi der - TPF		N N	N N		N N	N N	155. 00 156. 00
157.00 Subprovi der - IRF 158.00 SUBPROVI DER		N	N		N	N	157. 00 158. 00
159. 00 SNF 160. 00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 00 160. 00
161. 00 CMHC			N		N	N	161. 00
						1.00	
Multicampus 165.00 s this hospital part of a Multicampu	ıs hospital that has o	ne or more campus	ses in dif1	erent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Nama	County	C+o+o -	7in Codo	CDCA	ETE /Compute	
	Name O	County 1.00	2. 00	Zip Code 3.00	4. 00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	166. 00
						1.00	+
Health Information Technology (HIT) i 167.00 Is this provider a meaningful user ur	nder §1886(n)? Enter '	"Y" for yes or "N	N" for no.			Y	167. 00
168.00 If this provider is a CAH (line 105 i reasonable cost incurred for the HIT 168.01 If this provider is a CAH and is not	assets (see instruction	ons)					0168. 00
exception under §413.70(a)(6)(ii)? Er 169.00 If this provider is a meaningful user transition factor. (see instructions)	nter "Y" for yes or "N' ~ (line 167 is "Y") and	' for no. (see ir	nstructi ons	s)	•	0. 2	25169. 00
The state of the s					gi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR begi	nning date and ending	date for the ren	oorti na		1. 00 ′01/2014	2.00 09/30/2015	170. 00
period respectively (mm/dd/yyyy)	J 22 231.119						

Health Financial Systems	COMMUNITY HOSPT. OF	NOBLE CTY, INC.	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 150146	From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/16/2016 4:1	
				07 107 2010 11 1	<u>р</u>
				1. 00	
171.00 If line 167 is "Y", does this provide	der have any days for ind	ividuals enrolled in sect	i on 1876	N	171. 00
Medicare cost plans reported on Wkst	t. S-3, Pt. I, line 2, co	I. 6? Enter "Y" for yes a	nd "N" for no.		
(see instructions)					

		INITY HOSPT. OF NO				u of Form CMS	
HOSPI <sup>-</sup>	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der	CCN: 150146	Peri od: From 01/01/2015 To 12/31/2015	Worksheet S- Part II Date/Time Pr 5/16/2016 4:	epared:
					Y/N	Date	13 pili
					1. 00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	onses. Enter N foi	all NO re	esponses. Ente	er all dates in t	the	
	Provider Organization and Operation						
1.00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t					V/I	1.00
				1.00	2.00	3. 00	
2. 00	Has the provider terminated participation in yes, enter in column 2 the date of terminatio voluntary or "I" for involuntary.			N			2. 00
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	, chain home office to the provider , or members of t	ces, drug or its ne board	N			3. 00
				Y/N	Type	Date	
	Financial Data and Reports			1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for enter date availa	Compiled,	Y	А		4. 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If y	revenues di fferen		N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				1.00	2.00	
6. 00	Column 1: Are costs claimed for nursing scho the legal operator of the program? Are costs claimed for Allied Health Programs?			ne provider is	S N		6. 00 7. 00
7. 00 8. 00	Were nursing school and/or allied health programs? cost reporting period? If yes, see instruction	rams approved and		d during the	N N		8. 00
9. 00	Are costs claimed for Interns and Residents i program in the current cost report? If yes, s	n an approved gra ee instructions.			N		9. 00
10. 00	cost reporting period? If yes, see instruction	ns.			N		10. 00
11. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see	s other than I & instructions.	R in an App	oroved	N		11. 00
	Dad Daha					Y/N 1. 00	
	Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad deb	<b>J</b> .			ost roporting	Y N	12.00
	period? If yes, submit copy.  If line 12 is yes, were patient deductibles a	·	, ,	3	. 3	N	14. 00
45.00	Bed Complement		. 10.1.6			N.	45.00
15.00	Did total beds available change from the prio	r cost reporting	period? If	7	ructions. art A	N Part B	15. 00
		Descripti O	on	Y/N 1.00	Date 2.00	Y/N 3. 00	
	PS&R Data			1			
16. 00	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			N		N	16. 00
17. 00	instructions) 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			Y	04/08/2016	Y	17. 00
	2 and 4. (see instructions)						

yes, enter the paid-through date in columns
2 and 4. (see instructions)

18.00 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
this cost report? If yes, see instructions.

19.00 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.

20.00 If line 16 or 17 is yes, were adjustments
made to PS&R Report data for Other? Describe
the other adjustments:

Health Financial Systems	COMMUNITY HOSPT. OF NOE	LE CTY, INC.	In Lie	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REI	MBURSEMENT QUESTIONNAIRE	Provider CCN: 150146	From 01/01/2015	Worksheet S-2 Part II Date/Time Prepared:

Receiption Provider to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  The structions.  The provider to Beneric Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  The structions.  The structions.  The structions.  The structions are structions are structions.  The structions are structions.  The structions are structions.  The structions are structions.  The structio						From 01/01/2015 To 12/31/2015	Part II Date/Time Pr 5/16/2016 4:	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.    Complete By Cost Relimbussed AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)   Capital Related Cost				<del></del>	Pa	art A		
N   21.00			Descr	ription	Y/N	Date	Y/N	
provider's records? If yes, see    Instructions				0	1. 00	2. 00	3. 00	
COUPLETED BY COST RELIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Related Cost Capital Related Cost 2.00 lave assets been relifed for Nedicare purposes? If yes, see instructions 2.30 blave changes occurred in the Nedicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions 2.40 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 2.50 New three one new capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one new capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one new capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one one capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one one capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one one capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New Loans on the New Loans of	21. 00	provider's records? If yes, see			N		N	21. 00
COUPLETED BY COST RELIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Related Cost Capital Related Cost 2.00 lave assets been relifed for Nedicare purposes? If yes, see instructions 2.30 blave changes occurred in the Nedicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions 2.40 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 2.50 New three one new capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one new capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one new capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one one capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one one capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three one one capital lazed leases entered into during the cost reporting period? If yes, see 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New three New Loans, mortgage agreements or letters of credit entered into during the cost reporting 2.50 New Loans on the New Loans of							1 00	
22.00 Allow assets been relifed for Medicare purposes? If yes, see instructions 23.00 Allow assets been relifed for Medicare purposes? If yes, see instructions 23.00 Allow changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions 25.00 Allow there been new capitalized leases entered into during the cost reporting period? If yes, see 26.00 Instructions. 27.00 Allow there been new capitalized leases entered into during the cost reporting period? If yes, see 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 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. 30.00 Also skiting debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31.00 Also debt been recalled before scheduled maturity with new debt? If yes, see 31.00 Also debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 Allow changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If yes, see instructions. 33.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? 34.00 If line 36 is yes, was the fiscal year end of the home office? 35.00 If line 36 is yes, was the fiscal year end of the home office? 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, wa		COMPLETED BY COST DELMBURSED AND TEEDA HOSDIT	TALC ONLY (EVC	EDT CILLIDDENC LI	OCDLTALC)		1.00	
22.00   lave assets been relifed for Medicare purposes? If yes, see instructions   22.00			ALS UNLT (LAC	LFT CHILDRENS H	USFITALS)			
13.00   Nave changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.   23.00			es? If ves se	e instructions				22 00
reporting period? If yes, see instructions.  24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.  25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit converted to the provider's capitalization policy changed during the cost reporting period? If yes, submit converted to the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) period? If yes, see instructions.  28.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  29.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  32.01 If I in a 21 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions are instructions.  33.00 If I in a 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians?  34.00 Were home office costs claimed on the cost report?  35.00 If I in a 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians?  36.00 If I in a 36 is yes, has a home office cost statement been prepared by the home office?  37.00 I in the set home office costs claimed on the cost report?  38.00 I in a 36 is yes, was the fiscal year end o	23. 00				als made duri	ng the cost		23. 00
Were new   leases and/or amendments to existing   leases entered into during this cost reporting period?   24.00						g		
If yes, see Instructions   25.00   Have there been new capital jzed leases entered into during the cost reporting period? If yes, see   25.00   Have there been new capital jzed leases entered into during the cost reporting period? If yes, see   26.00   10   10   10   10   10   10   10	24.00	Were new leases and/or amendments to existing	g Leases enter	ed into during	this cost rep	porting period?		24. 00
1. Instructions. 1. On Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see 1. On Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit copy. 1. Interest Expense 1. On Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 1. On I has the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 1. On I has existing dobt been replaced prior to its scheduled maturity with new debt? If yes, see 1. Instructions. 1. On Has existing dobt been replaced prior to its scheduled maturity with new debt? If yes, see 1. Instructions. 1. On Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 1. On Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 1. On Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 1. On Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 1. On Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 1. On Has a changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 1. On I file 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If yes, see instructions. 1. On I file 32 is yes, were the requirements of sec. 2135.2 applied pertaining to competitive bidding? If yes, see instructions. 1. On Detate of the provider period? If yes, see instructions. 1. On Detate of the provider period? If yes, see instructions. 1. On Detate of the provider period? If yes, see instructions. 1. On Detate of the home office? 1. On Detate of the provider period? If yes, see instructions. 1. On Detate of the home office? 1. On Detate of the provider render services to othe				•				
Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.   27.00	25.00	Have there been new capitalized leases entere	ed into during	the cost repor	ting period?	If yes, see		25. 00
Instructions.								
27.00   Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	26. 00		uired during t	he cost reporti	ng period? If	f yes, see		26. 00
Copy.   Interest Expense	07.00				. 10.16			07.00
Interest Expense	27.00		igea auring tr	ie cost reportin	g perioa? If	yes, submit		27.00
Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.   29.00								
period? If yes, see instructions.  10.00 Bid 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 10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 11.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 12.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 13.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 14.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 15.00 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. 16.00 Were home office costs  16.00 Were home office costs claimed on the cost report? 17.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, see instructions. 18.00 If line 36 is yes, was the fiscal year end of the home office. 18.00 If line 36 is yes, was the fiscal year end of the home office? If yes, see instructions. 18.00 If line 36 is yes, was the fiscal year end of the home office. 19.00 If line 36 is yes, was the fiscal year end of the home office. 19.00 If line 36 is yes, was the fiscal year end of the home office. 19.00 If line 36 is yes, was the fiscal year end of the home office. 19.00 If line 36 is yes, was the fiscal year end of the home office. 19.00 If line 36 is yes, and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 19.00 Enter the telephone number	28 00		rs of credit e	entered into dur	ing the cost	renorting		28 00
29. 00   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   30. 00   Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.   31. 00   Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see   31. 00   Instructions.   31. 00   Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.   32. 00   If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see instructions.   33. 00   If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians?   11 yes, see instructions.   12 yes, see instructions.   13 yes, see instructions.   14 yes, see instructions.   15 yes, see instructions.   16 yes, see instructions.   17 yes, see instructions.   17 yes, see instructions.   18 yes, see instructions.   18 yes, see instructions.   19 yes, see instructions.   19 yes, see instructions.   10 yes, see instru	20.00		3 Or Crear C	intered into dar	ring the cost	roportring		20.00
treated as a funded depreciation account? If yes, see instructions  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  43.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  43.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  43.00 If I in 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  44.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.  45.00 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.  46.00 Were home office costs claimed on the cost report?  47.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.  48.00 If line 36 is yes, was the fiscal year end of the home office.  49.00 If line 36 is yes, was the fiscal year end of the home office.  40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  41.00 Cost Report Preparer Contact Information  41.00 Cost Report Preparer Contact Information  41.00 Enter the telephone number and email address of the cost 260-373-8406  41.00 Enter the telephone number and email address of the cost 260-373-8406  41.00 Enter the telephone number and email address of the cost 260-373-8406  42.00 Enter the telephone number and email address of the cost 260-373-8406	29. 00		account and/or	bond funds (De	bt Service Re	eserve Fund)		29. 00
instructions.  31. 00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  Purchased Services  32. 00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  32. 00 If I line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see Instructions.  Provider-Based Physicians  34. 00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.  35. 00 If I 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.  Y/N Date  1. 00 2. 00  Home Office Costs  Were home office costs claimed on the cost report?  17 yes, see instructions.  8. 00 If I line 36 is yes, was the fiscal year end of the home office?  18 yes, see instructions.  18 yes, see instructions.  19 yes, see instructions.  10 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  17 yes, see instructions.  18 yes, see instructions.  19 yes, see instructions.  10 If I line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  10 I line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  10 I line 36 is yes, did the provider render services to the home office?  11 yes, see instructions.  12 yes, see instructions.  13 yes yes, line the fielephone number and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  14 yes, see instructions.  15 yes, see instructions.  16 yes, see instructions.  17 yes, see instructions.  18 yes, see instructions.  19 yes, see instructions.  10 yes								
Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.   Purchased Services	30.00	Has existing debt been replaced prior to its	schedul ed mat	urity with new	debt? If yes,	see		30.00
instructions.  Purchased Services  32. 00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  33. 00 If Iline 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If no, see instructions.  Provider-Based Physicians  34. 00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.  15. 00 If Iline 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.  16. 00 Were home office costs  17. NN Date 1.00 2.00  18. 00 If Iline 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.  18. 00 If Iline 36 is yes, was the fiscal year end of the home office. If Iline 36 is yes, enter in column 2 the fiscal year end of the home office.  19. 00 If Iline 36 is yes, did the provider render services to other chain components? If yes, see instructions.  10. 00 If Iline 36 is yes, did the provider render services to other chain components? If yes, see instructions.  10. 00 If Iline 36 is yes, did the provider render services to other chain components? If yes, see instructions.  11. 00 Cost Report Preparer Contact Information  12. 00 Enter the first name, Iast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  12. 00 Enter the meployer/company name of the cost report PARKVIEW HEALTH SYSTEM, INC preparer.  13. 00 Enter the telephone number and email address of the cost 260-373-8406  ERIC. NICKESON®PARKVIEW.COM 43. 00								
Purchased Services Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  32.00  1f line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  33.00  Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.  16.00  17 yes, see instructions.  18 yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.  18 y/N Date 1.00 2.00  19 yes, see instructions.  20 yere home office costs claimed on the cost report? If yes, see instructions.  21 yes, see instructions.  22 yell in a 36 is yes, was the fiscal year end of the home office? If yes, see instructions.  23 yes yes yes, and the provider render services to other chain components? If yes, see instructions.  24 yes yes, and the provider render services to the home office? If yes, see instructions.  25 yes, did the provider render services to the home office? If yes, see instructions.  26 yes, did the provider render services to the home office? If yes, see instructions.  27 yes, yes, yes, yes, yes, yes, yes, yes,	31. 00		ity without i	ssuance of new	debt? If yes,	see		31. 00
Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.   33.00   If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.   Provider-Based Physicians     34.00   Are services furnished at the provider facility under an arrangement with provider-based physicians?								
arrangements with suppliers of services? If yes, see instructions.  If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  Provider-Based Physicians  33.00  Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.  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.    Home Office Costs   Y/N   Date	22.00			6	-1 -4-1			
1f line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.   33.00   1f line 34 is yes, dependent of the provider facility under an arrangement with provider-based physicians?   34.00   1f 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.    Home Office Costs	32.00				a thi bugh coi	iti actuai		32.00
no, see instructions.  Provider-Based Physicians  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  If yes, see instructions.  15.00 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.    Home Office Costs	33. 00				a to competit	tive bidding? If		33. 00
Provider-Based Physicians   Are services furnished at the provider facility under an arrangement with provider-based physicians?   34.00   If Jine 34 is yes, were there new agreements or amended existing agreements with the provider-based   35.00   If Jine 34 is yes, were there new agreements or amended existing agreements with the provider-based   35.00   Physicians during the cost reporting period? If yes, see instructions.   Y/N   Date   1.00   2.00				p p	9			
If yes, see instructions.    1								
St. 00   If i ine 34 is yes, were there new agreements or amended existing agreements with the provider-based   35.00   physicians during the cost reporting period? If yes, see instructions.   Y/N   Date   1.00   2.00	34.00	Are services furnished at the provider facili	ty under an a	rrangement with	provi der-bas	sed physi ci ans?		34. 00
physicians during the cost reporting period? If yes, see instructions.    Home Office Costs								
Home Office Costs  Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been prepared by the home office?  If line 36 is yes, has a home office cost statement been prepared by the home office?  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.  If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report PARKVIEW HEALTH SYSTEM, INC PREPARKVIEW.COM 43.00  Enter the telephone number and email address of the cost 260-373-8406  ERIC. NICKESON@PARKVIEW.COM 43.00	35. 00				ts with the p	provi der-based		35. 00
Home Office Costs  Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  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.  If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report PARKVIEW HEALTH SYSTEM, INC PREPARKVIEW. COM 43.00  Enter the telephone number and email address of the cost 260-373-8406  ERIC. NICKESON@PARKVIEW.COM 43.00		physicians during the cost reporting period?	IT yes, see I	nstructions.		V/N	Data	
Home Office Costs  Were home office costs claimed on the cost report?  36.00  1f line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  38.00  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.  If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see instructions.  In 1.00  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report preparer.  In 00  Enter the telephone number and email address of the cost 260-373-8406  ERIC. NI CKESON@PARKVI EW. COM 43.00  43.00								
Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been prepared by the home office?  If line 36 is yes, has a home office cost statement been prepared by the home office?  If line 36 is yes, was the fiscal year end of the home office.  If line 36 is yes, enter in column 2 the fiscal year end of the home office.  If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see  Instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  In cost Report Preparer Company name of the cost report preparer.  PARKVIEW HEALTH SYSTEM, INC  PARKVIEW HEALTH SYSTEM, INC  ERIC. NICKESON® PARKVIEW. COM  43.00		Home Office Costs				1.00	2.00	
If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  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.  If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see  Instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report preparer.  PARKVIEW HEALTH SYSTEM, INC  ERIC. NICKESON@PARKVIEW.COM 43.00	36. 00		eport?					36. 00
If yes, see instructions.  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.  If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see  If line 36 is yes, did the provider render services to the home office? If yes, see  If line 36 is yes, did the provider render services to the home office? If yes, see  If line 36 is yes, did the provider render services to the home office? If yes, see  If line 36 is yes, did the provider render services to the home office? If yes, see  If line 36 is yes, did the provider render services to the home office? If yes, see  If line 36 is yes, did the provider render services to the home office? If yes, see  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to the home office.  If line 36 is yes, did the provider render services to other chain components? If yes, see  If line 36 is yes, did the provider render services to other chain components? If yes, see  If line 36 is yes, did the provider render services to other chain components? If yes, see  If line 36 is yes, did the provider render services to other chain components? If yes, see  If line 36 is yes, did the provider render services to	37.00	If line 36 is yes, has a home office cost sta	atement been p	repared by the	home office?			37. 00
the provider? If yes, enter in column 2 the fiscal year end of the home office.  If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  If line 36 is yes, did the provider render services to the home office? If yes, see  10.00 If line 36 is yes, did the provider render services to the home office? If yes, see  1.00 2.00  Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report PARKVIEW HEALTH SYSTEM, INC  Enter the telephone number and email address of the cost 260-373-8406  ERIC. NI CKESON® PARKVIEW. COM 43.00								
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  10.00 If line 36 is yes, did the provider render services to the home office? If yes, see  1.00 2.00  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report preparer.  13.00 Enter the telephone number and email address of the cost 260-373-8406  ERIC. NI CKESON® PARKVI EW. COM 43.00	38. 00							38. 00
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instructions.    Cost Report Preparer Contact Information	40.00			h66:0	16			40.00
Cost Report Preparer Contact Information  Inter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Inter the employer/company name of the cost report preparer.  In contact Information  In contact Information  ERIC  PARKVIEW HEALTH SYSTEM, INC  In contact Information  FRIC  FRIC  41.00  42.00  FRIC. NI CKESON®PARKVIEW. COM  FRIC. NI	40.00		ervices to the	e nome office?	ii yes, see			40.00
Cost Report Preparer Contact Information  In 100 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  In 200 Enter the employer/company name of the cost report preparer.  In 201 PARKVIEW HEALTH SYSTEM, INC preparer.  In 300 Enter the telephone number and email address of the cost 260-373-8406  ERIC. NI CKESON®PARKVIEW. COM 43.00		THISTI UCTIONS.						
Cost Report Preparer Contact Information  In cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report preparer.  PARKVIEW HEALTH SYSTEM, INC  Enter the telephone number and email address of the cost 260-373-8406  ERIC. NI CKESON®PARKVIEW. COM 43.00				1.	00	2.	00	
Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  12.00 Enter the employer/company name of the cost report preparer.  13.00 Enter the telephone number and email address of the cost  ERIC NICKESON  A1.00  41.00  42.00  42.00  43.00		Cost Report Preparer Contact Information						
respectively. Enter the employer/company name of the cost report preparer.  13.00 Enter the telephone number and email address of the cost 260-373-8406  PARKVI EW HEALTH SYSTEM, INC  ERI C. NI CKESON@PARKVI EW. COM 43.00	41.00	Enter the first name, last name and the title	e/position	ERI C		NI CKESON		41. 00
12.00 Enter the employer/company name of the cost report preparer.  PARKVIEW HEALTH SYSTEM, INC 42.00 PARKVIEW HEALTH SYSTEM, INC PARKVIEW HEA		, ,	1, 2, and 3,					
preparer.    3.00   Enter the telephone number and email address of the cost   260-373-8406   ERIC. NICKESON@PARKVIEW. COM   43.00		, ,		L				1
13.00 Enter the telephone number and email address of the cost 260-373-8406 ERIC. NICKESON@PARKVIEW. COM 43.00	42.00		report	PARKVI EW HEALT	H SYSTEM, INC			42. 00
	42.00	• •	of the sest	240 272 0404		EDIC NICKECONO		12 00
proport proparer in cordinas rand z, respectivery.	43.00	•		200-3/3-8406		ERI C. NI CRESUN®I	-AKKVIEW. COM	43.00
		1. Spo. 1. proper of 111 containing 1 and 2, 1 espective	<i>y</i> .	T		ı		11

report preparer in columns 1 and 2, respectively.

In Lieu of Form CMS-2552-10 COMMUNITY HOSPT. OF NOBLE CTY, INC. HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150146 Peri od: Worksheet S-2 From 01/01/2015 To 12/31/2015 Part II Date/Time Prepared: 5/16/2016 4:15 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 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) 17.00 Was the cost report prepared using the PS&R 04/08/2016 17.00 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) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 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 this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. 20.00 If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position DIRECTOR REIMBURSEMENT 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00

Health Financial Systems COMMUNITY HORSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 150146 

					''	0 12/31/2013	5/16/2016 4: 1	
							I/P Days / 0/P	<b>у</b>
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1, 00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		31	11, 315	0, 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and				,			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			31	11, 315	0.00	0	7.00
	beds) (see instructions)				·			
8.00	INTENSIVE CARE UNIT							8.00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			31	11, 315	0.00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27.00	Total (sum of lines 14-26)			31				27.00
28.00	Observation Bed Days						0	28.00
29.00	Ambul ance Tri ps							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
					-		•	

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC

Provider CCN: 150146

| Period: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/16/2016 4:15 pm

		_				5/16/2016 4:1	5 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	2, 216	233	5, 694			1.00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 354	1, 160				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0	_			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00 8. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 216	233	5, 694			7. 00
9. 00	INTENSIVE CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		73	555			13. 00
14. 00	Total (see instructions)	2, 216	306	6, 249		213. 00	14. 00
15. 00	CAH visits	2,210	0	0, 247	0.00	213.00	15. 00
16. 00	SUBPROVIDER - IPF	١	Ÿ	O			16. 00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	213. 00	27. 00
28. 00	Observation Bed Days		186	1, 272			28. 00
29. 00	Ambul ance Tri ps	1, 600					29. 00
30. 00	Employee discount days (see instruction)			102			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	40	68			32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32. 01
33 00	LTCH non-covered days	0					33.00

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 150146

Peri od: From 01/01/2015 To 12/31/2015 Date/Time Prepared:

				'		5/16/2016 4: 1	5 pm
	·	Full Time		Di sch	arges		
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	'	Workers				Pati ents	
		11.00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and			0 629	481	1, 808	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			393	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00		0 629	481	1, 808	
15. 00	CAH visits			1		.,	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32.00
32.01	outpatient days (see instructions)						32.01
33 ∪∪	LTCH non-covered days						33. 00
33.00	LIGHTHON-COVERED Days	I I		I			33.00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Provider CCN: 150146

					To	12/31/2015	Date/Time Pre 5/16/2016 4:1	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Salaries (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col . 4	COI . 3)	
	DADE LA WAGE DATA	1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	14, 031, 184	3, 765, 359	17, 796, 543	596, 021. 00	29. 86	1.00
2. 00	instructions)		0		0	0.00	0.00	2. 00
2.00	Non-physician anesthetist Part A		U		U	0.00	0.00	2.00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
4. 00	B  Physician-Part A -		54, 000	0	54, 000	428. 00	126. 17	4. 00
1. 00	Admi ni strati ve		01,000		01,000			
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0		0	0. 00 0. 00	l .	
6. 00	Non-physician-Part B		0	1	0	0.00		
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00		
7. 01	approved program) Contracted interns and		0	_	0	0. 00	0.00	7. 01
7.01	residents (in an approved		O	Ĭ		0.00	0.00	7.01
8. 00	programs) Home office personnel		4, 735, 565		4 725 545	124 027 00	27 01	8. 00
9. 00	SNF	44. 00	4, 735, 565		4, 735, 565 0	124, 926. 00 0. 00		
10.00	Excluded area salaries (see		1, 809, 923	204, 227	2, 014, 150	87, 735. 00	22. 96	10. 00
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		0	0	0	0.00	0.00	11. 00
12 00	Care		0		0	0.00	0.00	12. 00
12. 00	Contract labor: Top level management and other		U		U	0.00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		0	0	0	0. 00	0.00	13. 00
13.00	A - Administrative		Ö					
14. 00	Home office salaries & wage-related costs		4, 735, 565	0	4, 735, 565	124, 926. 00	37. 91	14. 00
15. 00	Home office: Physician Part A		0	0	0	0.00	0.00	15. 00
47.00	- Administrative					0.00		47.00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		4, 636, 996	0	4, 636, 996			17. 00
18. 00	Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		777, 197		777, 197			19. 00
20. 00	Non-physician anesthetist Part		777, 197		777, 197			20.00
	A							
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	О	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	_	0			22. 01
23. 00	Physician Part B		0	1	O			23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	1	0			24.00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	2, 167, 630 657, 155			0. 00 144, 450. 00		1
28. 00	Administrative & General under	3. 00	037, 133	0	0, 303, 233	0.00		1
00.00	contract (see inst.)					0.00		00.00
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	329, 957	36, 381	366, 338	0. 00 15, 495. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		31. 00
32.00	Housekeepi ng	9. 00	227, 722	25, 274	252, 996	21, 411. 00		
33. 00	Housekeeping under contract (see instructions)		U		U	0.00	0. 00	33. 00
34. 00	Di etary	10. 00	320, 342	-105, 762	214, 580	14, 809. 00		
35. 00	Di etary under contract (see instructions)		0	0	0	0. 00	0.00	35. 00
36. 00	Cafeteri a	11. 00	0	135, 772	135, 772	11, 217. 00		
37.00	Maintenance of Personnel	12. 00	447.443	0	0	0.00		
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	417, 462 0	46, 029 0	463, 491 0	12, 376. 00 0. 00		38. 00 39. 00
	Pharmacy	15. 00	536, 166	59, 153	595, 319	11, 967. 00		40. 00

Health Financial Systems	COMM	UNITY HOSPT.	0F 1	NOBLE CTY, IN	IC.	In Li€	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION				Provi der		Peri od:	Worksheet S-3	
						From 01/01/2015		
						To 12/31/2015		
							5/16/2016 4: 1	5 pm
	Worksheet A	Amount	Re	ecl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on	n of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
			Wo	orksheet A-6)	3)	col. 4		
	1.00	2. 00		3. 00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00		0	0		0.00	0.00	41. 00
Records Library								
42.00 Social Service	17. 00		0	0		0.00	0.00	42.00
43.00 Other General Service	18. 00		0	0		0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150146 Peri od: Worksheet S-3 From 01/01/2015 To 12/31/2015 Part III Date/Time Prepared: 5/16/2016 4:15 pm Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . Salaries in col . 5) (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 9, 295, 619 3, 765, 359 13, 060, 978 471, 095. 00 27. 72 1.00 instructions) 2.00 1, 809, 923 204, 227 2, 014, 150 87, 735.00 22. 96 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 7, 485, 696 3, 561, 132 11, 046, 828 383, 360. 00 28.82 3.00 minus line 2) 4.00 Subtotal other wages & related 4, 735, 565 4, 735, 565 124, 926. 00 37.91 4.00 costs (see inst.) Subtotal wage-related costs 5.00 4, 636, 996 Ω 4, 636, 996 0.00 41. 98 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 16, 858, 257 3, 561, 132 20, 419, 389 508, 286. 00 40 17 7.00 Total overhead cost (see 4, 656, 434 2, 737, 295 7, 393, 729 231, 725. 00 31.91 7.00 instructions)

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part IV | To 12/31/2015 | Date/Time Prepared: Provider CCN: 150146

			5 pm
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	344, 892	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	327, 551	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	55, 475	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3, 154, 244	8. 00
9.00	Prescription Drug Plan	0	1
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	27, 427	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	68, 588	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	
15.00	'Workers' Compensation Insurance	30, 381	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	1, 324, 391	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	49, 486	21.00
	instructions))		
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	31, 757	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5, 414, 192	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	COMMUNITY HOSPT. OF NOB	SLE CTY, INC.	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150146	Peri od: From 01/01/2015	Worksheet S-3
				Date/Time Prepared

			0 12/31/2015		
	Cost Center Description		Contract Labor	5/16/2016 4:1 Benefit Cost	o piii
	oust dented beset per on		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0	1.00
2.00	Hospi tal		0	0	2.00
3.00	Subprovi der - I PF				3. 00
4.00	Subprovi der - I RF				4. 00
5.00	Subprovi der - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9. 00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA				11. 00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15. 00
16.00	Hospi tal -Based-CMHC				16.00
17. 00	Renal Dialysis				17. 00
18. 00	Other		0	0	18. 00

	Financial Systems COMMUNITY HOSPT. OF NOBLE AL UNCOMPENSATED AND INDIGENT CARE DATA P		N 15014/		u of Form CMS-2			
HUSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovi der CC	N: 150146	Peri od: From 01/01/2015	Worksheet S-10	U		
				To 12/31/2015	Date/Time Prep 5/16/2016 4:1	pared: 5 pm		
					1. 00			
	Uncompensated and indigent care cost computation				1.00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line	202 column	1 8)	0. 215865	1.00		
	Medicaid (see instructions for each line)			,				
2.00	Net revenue from Medicaid				1, 144, 459	2. 00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		Υ	3. 00				
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental pa		om Medicaio	l?	N	4. 00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Me	edi cai d			1, 176, 694	5. 00		
6.00	Medicaid charges				17, 118, 386	6.00		
7. 00 8. 00	Medicaid cost (line 1 times line 6)	oo 2 and E. i.f.	3, 695, 260 1, 374, 107	7. 00 8. 00				
6.00	Difference between net revenue and costs for Medicaid program (lir < zero then enter zero)	ile / illi ilus	Sull Of TH	ies z anu s, m	1, 3/4, 10/	0.00		
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for eac	h line)					
9. 00	Net revenue from stand-alone SCHIP	.5 . 6. 646			1, 532	9.00		
10.00	Stand-alone SCHIP charges				9, 134			
11.00	Stand-alone SCHIP cost (line 1 times line 10)				1, 972			
12.00	Difference between net revenue and costs for stand-alone SCHIP (li	ine 11 min	us line 9;	if < zero then	440	12. 00		
	enter zero)							
	Other state or local government indigent care program (see instructions for each line)							
13. 00	Net revenue from state or local indigent care program (Not include		1, 503, 064					
14. 00	Charges for patients covered under state or local indigent care pr	rogram (No	t included	in lines 6 or	13, 025, 810	14.00		
15. 00	10) 							
16. 00	Difference between net revenue and costs for state or local indige	ne 15 minus line	1, 308, 752					
10.00	13; if < zero then enter zero)	ent care p	rogram (iii	10 10 11111103 11110	1,000,702	10.00		
	Uncompensated care (see instructions for each line)							
17. 00	Private grants, donations, or endowment income restricted to fundi				8, 276	17. 00		
18. 00	Government grants, appropriations or transfers for support of hosp				0	18. 00		
19. 00	Total unreimbursed cost for Medicaid, SCHIP and state and local i 8, 12 and 16)	indigent c	are program	ns (sum of lines	2, 683, 299	19. 00		
			Uni nsured	Insured	Total (col. 1			
		_	pati ents	pati ents	+ col . 2)			
			1.00	2.00	3. 00			
20. 00	Total initial obligation of patients approved for charity care (at charges excluding non-reimbursable cost centers) for the entire fa		1, 174, 06	1, 115, 302	2, 289, 371	20. 00		
21. 00	Cost of initial obligation of patients approved for charity care		253, 44	10 240, 755	494, 195	21. 00		
21.00	times line 20)		255, 4-	240, 733	474, 173	21.00		
22. 00	Partial payment by patients approved for charity care		69	7, 652	8, 348	22. 00		
23. 00	Cost of charity care (line 21 minus line 22)		252, 74		485, 847			
					1.00			
24. 00	Does the amount in line 20 column 2 include charges for patient da	avs bevond	a Length o	of stav limit	1. 00 N	24. 00		
20	imposed on patients covered by Medicaid or other indigent care pro					0		
25. 00	If line 24 is "yes," charges for patient days beyond an indigent	care prog	ram's Lengt	h of stay limit	0	25. 00		
26. 00	Total bad debt expense for the entire hospital complex (see instru	9, 050, 873						
27. 00		,			112, 941			
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line				8, 937, 932			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expens	se (line 1	times line	28)	1, 929, 387			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 415, 234			
21 00	Total unreimbursed and uncompensated care cost (line 19 plus line				5, 098, 533			

	•	MUNITY HOSPI. OF				u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	DE EXPENSES	Provi der	F	Period: From 01/01/2015 Fo 12/31/2015	Worksheet A Date/Time Pre 5/16/2016 4:1	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	J
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		2, 115, 909 0	2, 115, 909 (		1, 686, 740 602, 256	2. 00
3. 00 4. 00	OO300 OTHER CAP REL COSTS   OO400 EMPLOYEE BENEFITS DEPARTMENT	2, 167, 630	4, 161, 491	6, 329, 12°	1 -2, 167, 630	4, 161, 491	3. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	657, 155	12, 750, 738	13, 407, 893		14, 219, 286	
7. 00	00700 OPERATION OF PLANT	329, 957	965, 229	1, 295, 186		1, 330, 318	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	· ·	151, 516	151, 516	
9.00	00900 HOUSEKEEPI NG	227, 722	339, 342	567, 064		440, 758	
10.00	01000 DI ETARY 01100 CAFETERI A	320, 342	216, 971	537, 313		320, 532	
11. 00 12. 00	01200 MAI NTENANCE OF PERSONNEL		4, 253 0	4, 253	245, 320	249, 579 0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	417, 462	9, 300	426, 762	45, 921	472, 683	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	(	0	0	14. 00
15. 00	01500 PHARMACY	536, 166	761, 447	1, 297, 613	48, 451	1, 346, 064	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	(	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	(		0	
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL		0	(		0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV		0	(		. 0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	o o	o	(	o o	. 0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	2, 530, 055	552, 873	3, 082, 928		2, 717, 056	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	(	108, 673	108, 673	43. 00
50. 00	05000 OPERATI NG ROOM	1, 014, 113	387, 515	1, 401, 628	93, 533	1, 495, 161	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		516, 705	516, 705	
53.00	05300 ANESTHESI OLOGY	0	773, 807	773, 807	7 0	773, 807	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 269, 753	751, 520	2, 021, 273	40, 586	2, 061, 859	
54. 01	05401 CAT SCAN	0	0 157 070	0 157 07	0	0	
60. 00 62. 30	O6000   LABORATORY   O6250   BLOOD   CLOTTING FOR HEMOPHILIACS	0	2, 157, 072	2, 157, 072	-812	2, 156, 260	60.00
65. 00	06500 RESPIRATORY THERAPY	484, 562	95, 768	580, 330	50, 477	630, 807	
66. 00	06600 PHYSI CAL THERAPY	1, 016, 111	178, 868			828, 561	
67. 00	06700 OCCUPATI ONAL THERAPY	0	7, 734	7, 734	323, 577	331, 311	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	(	143, 549	143, 549	
69.00	06900 ELECTROCARDI OLOGY	0	9, 957	9, 957		9, 957	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		803, 517	803, 517	-332, 004 331, 013	471, 513 331, 013	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		1, 735, 964	1, 735, 964		1, 727, 534	
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0	(	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	o	(	o	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS	20.250	913	30, 17	1 0 520	38, 710	90.00
90.00	09000 CLI NI C 09100 EMERGENCY	29, 258 1, 220, 975	237, 818				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,220,773	237,010	1, 450, 775	05, 014	1, 544, 407	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 652, 186	298, 704	1, 950, 890	179, 299	2, 130, 189	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		13, 873, 447	29, 316, 710	43, 190, 157	7 -191, 862	42, 998, 295	1118. 00
100 00	NONREIMBURSABLE COST CENTERS     1900  GIFT, FLOWER, COFFEE SHOP & CANTEEN	17, 469	435	17, 904	1, 628	10 532	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	32, 118	3, 878				192. 00
	07950 OTHER NONREI MBURSABLE	0	0	(			194. 00
	07951 PAIN CLINIC	0	o		o		194. 01
	07952 OCC HEALTH	0	-96, 017	-96, 01			194. 02
	3 O 7 9 5 3 FOUNDATION	0	0	(	80, 004		194. 03
	07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES	108, 150	403, 874	512, 02 <sup>4</sup>	0 4 12, 136	524, 160	194.04
	07956 VACANT SPACE	0	0	312, 02	0		194. 06
200.00		14, 031, 184	29, 628, 880	43, 660, 064	4 o		

Health Financial Systems COMM RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	MUNITY HOSPT. OF OF EXPENSES	NOBLE CTY, INC.  Provider CCN	: 150146   Peri od:   Wo	of Form CMS-2552-10 orksheet A
			From 01/01/2015 To 12/31/2015 Da	ate/Time Prepared: /16/2016 4:15 pm
Cost Center Description	(See A-8) F	Net Expenses For Allocation		10, 2010 11 10 pm
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	-1, 327, 769	358, 971		1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	71, 862	674, 118		2. 00
3.00 00300 OTHER CAP REL COSTS	0	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 757, 458	2, 404, 033		4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-1, 470, 108	12, 749, 178		5. 00
7. 00 00700 OPERATION OF PLANT	-7, 882	1, 322, 436		7. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	0 -49	151, 516 440, 709		8. 00 9. 00
10. 00   01000 DI ETARY	-7, 913	312, 619		10.00
11. 00 01100 CAFETERI A	-176, 456	73, 123		11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		12. 00
13.00 01300 NURSING ADMINISTRATION	-250, 000	222, 683		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		14. 00
15. 00   01500   PHARMACY	-682, 848	663, 216		15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	0		16. 00
17. 00   01700   SOCIAL SERVICE 19. 00   01900   NONPHYSICIAN ANESTHETISTS	0	0		17. 00 19. 00
20. 00   02000   NURSI NG SCHOOL	0	0		20.00
21. 00   02100   &R SERVI CES-SALARY & FRI NGES APPRV		0		21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	O		22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS	40, 262	2, 757, 318		30.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	108, 673		43. 00
50. 00 05000 OPERATING ROOM	0	1, 495, 161		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	516, 705		52. 00
53. 00 05300 ANESTHESI OLOGY	-763, 979	9, 828		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-12, 632	2, 049, 227		54. 00
54. 01   05401   CAT   SCAN	0	0		54. 01
60. 00   06000   LABORATORY 62. 30   06250   BLOOD   CLOTTING FOR HEMOPHILIACS	0	2, 156, 260		60. 00 62. 30
65. 00   06500   RESPIRATORY THERAPY	-4, 001	626, 806		65. 00
66. 00   06600   PHYSI CAL THERAPY	-165, 376	663, 185		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	331, 311		67. 00
68.00 06800 SPEECH PATHOLOGY	0	143, 549		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	9, 957		69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	471, 513		71. 00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	0	331, 013 1, 727, 534		72. 00 73. 00
76. 97   07697   CARDI AC REHABILITATION		1, 727, 554		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	O	0		76. 98
76. 99 07699 LI THOTRI PSY	0	0		76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00   09000   CLI NI C	-540	38, 170		90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART	0	1, 544, 407		91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS				92.00
95. 00 09500 AMBULANCE SERVICES	-63, 218	2, 066, 971		95. 00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1-117)	-6, 578, 105	36, 420, 190		118. 00
NONREI MBURSABLE COST CENTERS	0.070	47, 050		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	-3, 279 0	16, 253 38, 073		190. 00 192. 00
194. 00 07950 OTHER NONREIMBURSABLE		30, 073		192.00
194. 01 07951 PAIN CLINIC		0		194. 01
194. 02 07952 OCC HEALTH	0	ō		194. 02
194. 03 07953 FOUNDATI ON	0	80, 004		194. 03
194.04 07954 PHYSICIAN OFFICES	0	0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	-166, 375	357, 785		194. 05
194.06 07956 VACANT SPACE 200.00  TOTAL (SUM OF LINES 118-199)	0 -6, 747, 759	0 36, 912, 305		194. 06 200. 00
200.00    TOTAL (30W OF LINES 110-177)	0, 141, 109	30, 712, 300		1200.00

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPT. OF NOBLE CTY, INC.

Provider CCN: 150146

Peri od: From 01/01/2015 To 12/31/2015 Date/Time Prepared:

					5/16/2016 4:1	
		Increases				
	Cost Center 2.00	Li ne #	Sal ary	Other 5 00		
	B - REHAB THERAPY	3. 00	4.00	5. 00		
1.00	OCCUPATI ONAL THERAPY	67. 00	255, 599	71, 285		1. 00
2.00	SPEECH PATHOLOGY	<u>68.</u> 00	11 <u>2, 2</u> 45	<u>31, 3</u> 04		2. 00
	0		367, 844	102, 589		
1 00	C - I NSURANCE	1 00	ما	2/ 0/2		1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	26, 062 9, 779		1. 00 2. 00
2.00	0			35, 841		2.00
	D - EQUIPMENT LEASE			22/ 2		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	63, 409		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	73, 837		2. 00
3.00		0.00	0	0		3. 00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	o	Ö		7. 00
8.00		0.00	O	O		8. 00
9.00		0.00	0	0		9. 00
10.00		0. 00	0	0		10.00
11.00		0.00	0	0		11. 00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	o	0		16. 00
	0 — — — — —			137, 246		
	E - DRUGS CHARGED TO PATIENTS					
1. 00		0.00	0	0		1. 00
	F - CLINIC DIETICIAN		U	U		-
1. 00	CLINIC	90.00	5, 313	0		1.00
	0		5, 313	0		_
	G - PTO					4
1.00	ADMINISTRATIVE & GENERAL	5.00	942, 719	0		1.00
2. 00 3. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	36, 381 25, 274	0		2. 00 3. 00
4. 00	DI ETARY	10.00	35, 323	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	46, 029	0		5. 00
6.00	PHARMACY	15. 00	59, 153	О		6. 00
7.00	ADULTS & PEDIATRICS	30. 00	263, 364	0		7. 00
8. 00	OPERATING ROOM	50.00	111, 818	0		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	140, 027	0		9. 00
10. 00 11. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	53, 427 112, 038	0		10. 00 11. 00
12.00	CLINIC	90.00	3, 226	0		12.00
13. 00	EMERGENCY	91.00	134, 624	Ö		13. 00
14.00	AMBULANCE SERVICES	95.00	182, 173	0		14. 00
15.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	2, 003	0		15. 00
4 / 00	CANTEEN	100.00	0.544			4, 00
16. 00 17. 00	PHYSICIANS' PRIVATE OFFICES COMMUNITY & VOLUNTEER	192. 00 194. 05	3, 541 16, 510	0		16. 00 17. 00
17.00	SERVICES	194.03	10, 510	U		17.00
	0		2, 167, 630	<sub>0</sub>		
	H - CAFETERIA					
1. 00	CAFETERI A	<u>11.</u> 00	135, 772	109, 554		1. 00
	U         DEPRECIATION		135, 772	109, 554		-
1. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	ol	518, 640		1.00
	0			518, 640		
	J - HOME OFFICE SALARY					
1.00	ADMI NI STRATI VE & GENERAL	<u>5.</u> 00	<u>3, 765, 3</u> 59	0		1. 00
	0		3, 765, 359	0		_
1. 00	K - LAUNDRY LAUNDRY & LINEN SERVICE	8.00	0	151, 516		1.00
1.00	0			151, 516		1.00
	L - OCCH HEALTH	,	- '	, ,		1
1.00	OCC HEALTH	194. 02	0	96, 017		1. 00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
5. 00 6. 00		0. 00 0. 00	U	0		5. 00 6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	ő	o		8. 00
9. 00		0.00	o	0		9. 00
		· · · · · · · · · · · · · · · · · · ·				

Heal th	Financial Systems	COMM	MUNITY HOSPT. O	F NOBLE CTY, I	NC.	In Lieu of Form CMS-2552-		
RECLAS	SI FI CATI ONS			Provi der	CCN: 150146	Peri od:	Worksheet A-	6
						From 01/01/2015 To 12/31/2015	Date/Time Pr 5/16/2016 4:	epared: 15 pm
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4.00	5. 00				
	0		0	96, 017	•			
	M - IMPLANTS							
1.00	IMPL. DEV. CHARGED TO	72.00	0	331, 013	3			1. 00
	PATI ENTS							
	0		o	331, 013	3			
	N - OB							
1.00	NURSERY	43.00	98, 711	9, 962	2			1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	469, 338	47, 367	,			2. 00
	0 — — — — —		568, 049	57, 329				
	P - OTHER							
1.00	FOUNDATI ON	194. 03	0	80, 004				1. 00
			<sub>0</sub>	80, 004	Ī			
500.00	Grand Total: Increases		7, 009, 967	1, 619, 749	<u></u>			500.00
					1			1

RECLASSI FI CATI ONS

Provi der CCN: 150146

Peri od: Worksheet A-6 From 01/01/2015

Date/Time Prepared:

12/31/2015

5/16/2016 4:15 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 B - REHAB THERAPY 1.00 PHYSI CAL THERAPY 66.00 367, 844 102, 589 0 1.00 0 2.00 0.00 2.00 367, 844 102, 589 - INSURANCE 1.00 5. 00 ADMINISTRATIVE & GENERAL 35, 841 12 1.00 2.00 0.00 2.00 0 12 ō 35, 841 D - EQUIPMENT LEASE ADMINISTRATIVE & GENERAL 1.00 5.00 15, 481 10 1.00 2 00 OPERATION OF PLANT 7 00 0 10 2 00 1, 249 3.00 HOUSEKEEPI NG 9.00 0 64 0 3.00 4.00 DI ETARY 10.00 o 1, 465 0 4.00 5.00 NURSING ADMINISTRATION 13.00 0 108 0 5.00 PHARMACY 0 10 702 6.00 15 00 0 6 00 0 7.00 ADULTS & PEDIATRICS 30.00 0 3,858 7.00 8.00 OPERATING ROOM 50.00 o 17, 993 0 8.00 RADI OLOGY-DI AGNOSTI C 9.00 54.00 0 66, 482 0 9.00 0 0 RESPIRATORY THERAPY 65.00 2.950 10.00 10.00 11.00 PHYSICAL THERAPY 66.00 0 3, 419 0 11.00 EMERGENCY 91.00 o 0 12.00 4, 388 12.00 AMBULANCE SERVICES 95.00 0 0 2.874 13.00 13.00 14.00 GIFT, FLOWER, COFFEE SHOP & 190.00 0 375 0 14.00 15.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 1, 464 0 15.00 COMMUNITY & VOLUNTEER 16.00 194.05 4, 374 16.00 SERVI CES 0 137, 246 - DRUGS CHARGED TO PATIENTS 0. 00 1.00 1.00 0 0 - CLINIC DIETICIAN 1.00 10.00 5, 313 0 DI ETARY 1.00 5. 313 0 G - PTO 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 2, 167, 630 0 0 1.00 0 0 2.00 0.00 2.00 0 3.00 0.00 0 0 3.00 0 4.00 0.00 0 0 4.00 5.00 0.00 0 0 0 5.00 6.00 0.00 0 0 0 6.00 0 0 7.00 0.00 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00 10.00 0.00 0 10.00 0 0 11.00 11.00 0.00 0 0 12.00 0.00 0 12.00 13.00 0.00 0 0 13.00 0 14.00 0.00 0 0 14.00 0 15.00 0.00 0 0 15.00 16.00 0.00 0 0 16.00 17.00 0.00 0 17.00 2, 167, 630 H - CAFETERIA 1.00 DI ETARY 10.00 135, 772 109, 554 0 1.00 135, 772 109, 554 - DEPRECIATION 1. 00 1.00 CAP REL COSTS-BLDG & FIXT 518, 640 9 1.00 518, 640 J - HOME OFFICE SALARY 1.00 ADMI NI STRATI VE & GENERAL 5.00 3, 765, 359 0 1.00 3, 765, 359 K - LAUNDRY HOUSEKEEPI NG 1 00 9.00 0 151, 516 0 1 00 151, 516 - OCCH HEALTH 1.00 OPERATING ROOM 50.00 292 0 1.00 RADI OLOGY-DI AGNOSTI C 0 32, 959 2 00 0 54.00 2 00 3.00 LABORATORY 60.00 0 812 0 3.00 5.00 PHYSICAL THERAPY 66.00 0 4,604 0 5.00 6.00 OCCUPATIONAL THERAPY 67.00 0 3.307 0 6.00 MEDICAL SUPPLIES CHARGED TO 7.00 71.00 0 991 0 7.00 PATI ENT 8.00 DRUGS CHARGED TO PATIENTS 73.00 0 8, 430 0 8.00

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10 RECLASSI FI CATI ONS Provi der CCN: 150146 Peri od: Worksheet A-6 From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/16/2016 4:15 pm Decreases Wkst. A-7 Ref. 10.00 Cost Center Li ne # Sal ary 0ther 8.00 6. 00 7.00 9.00 9. 00 EMERGENCY 91.00 44, 622 9. 00 0 96, 017 M - IMPLANTS
MEDICAL SUPPLIES CHARGED TO 1.00 71.00 0 331, 013 0 1.00 PATI ENT ō 0 N - OB 331, 013 1.00 ADULTS & PEDIATRICS 30.00 568, 049 0 57, 329 1.00 2.00 0.00 2.00 0 568, 049 57, 329

3, 244, 608

80, 004

80, 004

5, 385, 108

O

1.00

500.00

5. 00

P - OTHER

500.00 Grand Total: Decreases

1.00

ADMINISTRATIVE & GENERAL

9.00

Reconciling Items

10.00 Total (line 8 minus line 9)

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150146 Peri od: Worksheet A-7 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/16/2016 4:15 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements Bal ances 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 637, 235 48, 275 0 48, 275 2.00 Land Improvements 0 2.00 0 3.00 3, 109, 044 450, 578 3.00 Buildings and Fixtures 450, 578 0 57, 402 0 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 276, 802 24, 733 0 24, 733 5.00 1, 412, 143 217, 225 0 6.00 Movable Equipment 11, 601, 436 1, 412, 143 126, 454 6.00 0 7.00 HIT designated Assets 2, 622, 528 217, 225 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 18, 304, 447 2, 152, 954 2, 152, 954 126, 454 8.00 9.00 Reconciling Items 2, 622, 528 304, 074 0 304, 074 9.00 15, 681, 919 Total (line 8 minus line 9) 1, 848, 880 1, 848, 880 10.00 0 126, 454 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 1.00 2.00 Land Improvements 685, 510 122, 417 2.00 . Buildings and Fixtures 3.00 3, 559, 622 371, 538 3.00 4.00 Building Improvements 57, 402 1,000 4.00 5.00 Fi xed Equipment 301, 535 25, 227 5.00 12, 887, 125 6.00 Movable Equipment 7, 986, 339 6.00 7. 00 7.00 HIT designated Assets 2, 839, 753 Ω Subtotal (sum of lines 1-7) 8.00 20, 330, 947 8, 506, 521 8.00

2, 926, 602

17, 404, 345

8, 506, 521

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-255										
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7				
					From 01/01/2015					
					To 12/31/2015					
			CI	JMMARY OF CAPI	TAI	5/16/2016 4:1	5 piii			
			30	JIVIIVIARY OF CAPT	TAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see				
					instructions)	instructions)				
		9. 00	10.00	11. 00	12.00	13. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2						
1.00	CAP REL COSTS-BLDG & FIXT	2, 115, 909	0		0 0	0	1. 00			
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00			
3.00	Total (sum of lines 1-2)	2, 115, 909	0		0 0	0	3. 00			
		SUMMARY O	F CAPITAL							
	Cost Center Description	0ther	Total (1) (sum							
		Capi tal -Rel ate	of cols. 9							
		d Costs (see	through 14)							
		instructions)								
		14. 00	15. 00							
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 115, 909				1. 00			
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00			
3.00	Total (sum of lines 1-2)	0	2, 115, 909				3. 00			

Heal th	Financial Systems COMM	UNITY HOSPT. OF			In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 01/01/2015 Fo 12/31/2015	Worksheet A-7 Part III Date/Time Pre 5/16/2016 4:1	pared:
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2.00	3, 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	4, 604, 069	0	4, 604, 069	0. 272710	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12, 887, 125	608, 554	12, 278, 57	0. 727290	0	2.00
3.00	Total (sum of lines 1-2)	17, 491, 194	608, 554	16, 882, 640	1. 000000	0	3.00
		ALLOCAT	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	)	269, 500	· ·	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	)	590, 502	· ·	
3.00	Total (sum of lines 1-2)	0	0	)	860, 002	137, 246	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)			
					d Costs (see	through 14)	
					instructions)		
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS OF	INTEDS					

0 0 0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

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

26, 062 9, 779 35, 841

0 0 0

358, 971 1. 00 674, 118 2. 00 1, 033, 089 3. 00

0 0 0

1.00

2.00

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10

ADJUSTMENTS TO EXPENSES Provider CCN: 150146 Period: From 01/01/2015 To 12/31/2015 Date/Time Prepared:

					To 12/31/2015		
				Expense Classification on		5/16/2016 4: 1	5 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	_	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4.00	5.00	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00		
	(chapter 2)		-				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	О	6.00
7. 00	Telephone services (pay stations excluded) (chapter	А	-5, 849	ADMINISTRATIVE & GENERAL	5.00	0	7. 00
8. 00	21)   Tel evi si on and radio servi ce   (chapter 21)	А	-1, 783	OPERATION OF PLANT	7.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -763, 979		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.		-703, 777		0.00		
	(chapter 23)		-		0.00		
12. 00	Related organization transactions (chapter 10)	A-8-1	1, 814, 921			0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	A	-49. 938	CAFETERI A	0. 00 11. 00		
15. 00	Rental of quarters to employee and others		0		0.00		
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00		
21. 00	Income from imposition of interest, finance or penalty		0		0.00		21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	О	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL	A	-68, 369	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL	A		CAP REL COSTS-MVBLE EQUIP	2.00		
	COSTS-MVBLE EQUIP	'`					
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33.00
	(3)	<u>                                     </u>	<u> </u>	<u> </u>		<u> </u>	<u> </u>

ADJUSTMENTS TO EXPENSES Provider CCN: 150146 Peri od: Worksheet A-8 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/16/2016 4:15 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 33. 02 TELEPHONE -978 EMPLOYEE BENEFITS DEPARTMENT 33. 02 4.00 Α PHYSICIAN RECRUITMENT -24, 869 ADMINI STRATI VE & GENERAL 33.04 Α 5.00 0 33.04 33. 05 PHARMACY SALES В -680, 634 PHARMACY 15.00 33.05 -1, 756, 480 EMPLOYEE BENEFITS DEPARTMENT 33.06 SELF INSURANCE 4.00 33.06 Α LOBBY DUES -3, 468 ADMINISTRATIVE & GENERAL 33 09 5 00 ol 33 09 Α -125, 682 PHYSI CAL THERAPY 33.12 I NTERUNI T Α 66.00 33.12 33. 13 I NTERUNI T Α -3, 273, 828 ADMI NI STRATI VE & GENERAL 5.00 33.13 I NTERUNI T -1, 259, 400 CAP REL COSTS-BLDG & FIXT 9 33. 14 33 14 Α 1 00 -124, 126 COMMUNITY & VOLUNTEER 33.15 I NTERUNI T Α 194.05 33.15 SERVI CES I NTERUNI T Α -12, 632 RADI OLOGY-DI AGNOSTI C 54.00 33.16 33.16 33. 17 OTHER OPERATING REVENUE В -68, 292 ADMI NI STRATI VE & GENERAL 5.00 0 33. 17 OTHER OPERATING REVENUE -6, 099 OPERATION OF PLANT 0 33.18 В 7.00 33.18 33.19 OTHER OPERATING REVENUE В -49 HOUSEKEEPI NG 9.00 33.19 OTHER OPERATING REVENUE -7, 913 DI ETARY 10.00 33.20 33.20 В OTHER OPERATING REVENUE 33. 21 В -126, 518 CAFETERI A 11.00 33. 21 -250, 000 NURSING ADMINISTRATION 33. 22 OTHER OPERATING REVENUE В 13.00 0 33, 22 33. 23 OTHER OPERATING REVENUE В -2, 214 PHARMACY 15.00 ol 33. 23 33. 26 OTHER OPERATING REVENUE В -4, 001 RESPIRATORY THERAPY 65.00 33. 26 -39, 694 PHYSI CAL THERAPY OTHER OPERATING REVENUE 33. 27 33.27 В 66.00 OTHER OPERATING REVENUE -540 CLINIC 90.00 0 33.28 В 33.28 33. 29 OTHER OPERATING REVENUE В -63, 218 AMBULANCE SERVICES 95.00 33. 29 33.30 OTHER OPERATING REVENUE -3, 279 GIFT, FLOWER, COFFEE SHOP & 190.00 33.30 В CANTEEN OTHER OPERATING REVENUE -42, 249 COMMUNITY & VOLUNTEER 33. 31 33. 31 В 194.05 O SERVI CES 33. 32 **TELEMETRY** 40, 262 ADULTS & PEDIATRICS 30.00 33.32 Α 33 33 ADMIN PHYS SALARIES Α 91, 277 ADMI NI STRATI VE & GENERAL 5.00 33.33 50.00 TOTAL (sum of lines 1 thru 49) -6, 747, 759 50.00 (Transfer to Worksheet A, column 6, line 200.)

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined

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

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

DEFICE COSTS

From 01/01/2015

UFFICE	00313			To 12/31/2015	Date/Time Pre 5/16/2016 4:1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	9, 609, 921	7, 795, 000	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
3. 01	0.00			0	0	3. 01
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			9, 609, 921	7, 795, 000	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

nas i	iot been	posted to works	ileet A,	COI UIII IS I	ariu/ or	Z, the	amoun	t allowable 3	nour a be	Thui cated Till (	corumir 4	or this part.	
									Rel ated	Organi zati on (	(s) and/	or Home Office	
		0   (4)							_	N.		Б	
		Symbol (1)			Name	:		Percentage of		Name		Percentage of	
								Ownershi p				Ownershi p	
		1. 00			2.00			3. 00		4. 00		5. 00	
	B. INTERRELATIONSHIP TO 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Comonit under the tro Attition		
6.00	В	0.00 PARKVIEW HEALTH SYSTEM, INC. 100.0	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate 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 organi zati on.
- 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

Heal th	Financial Syste	ems			COMMUNITY HOSE	PT. OF NOE	SLE CTY, I	NC.		In Lie	eu of Form CMS	-2552-10
STATEME	NT OF COSTS OF	SERVI CES	FROM	RELATED	ORGANIZATIONS AND	HOME	Provi der	CCN: 1		Peri od:	Worksheet A-	8-1
OFFICE	COSTS									From 01/01/2015		
										To 12/31/2015	Date/Time Pr 5/16/2016 4:	
	Net	Wkst. A-7	Ref.				·				107 107 2010 1.	
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND AD	JUSTN	MENTS REC	QUIRED AS A RESULT	Γ OF TRANS	SACTIONS W	ITH RE	ELATED 0	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	1, 814, 921		0									1.00
2.00	0		0									2. 00
3.00	0		0									3. 00
3. 01	0		0									3. 01
4.00	0		0									4. 00
5 00	1 91/ 021											5 00

\* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

1103 1101	been posted to worksheet A,	cordinate and or 2, the amount arrowable should be that cated in cordinate this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	3.		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
9. 00 10. 00 100. 00		10.00
100.00		100.00

- (1) Use the following symbols to indicate 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

| In Lieu of Form CMS-2552-10 | Provider CCN: 150146 | Period: | Worksheet A-8-2 | From 01/01/2015 | Data/Time Propagation

							Γο 12/31/2015	Date/Time Pre 5/16/2016 4:	
	Wkst. A Line #	Cost Center/Physician	Total	Profess	si onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Compo	nent	Component		ider Component	
						'		Hours	
	1. 00	2. 00	3.00	4. (	00	5. 00	6. 00	7. 00	
1.00	53. 00	ANESTHESI OLOGY	773, 762	7	749, 762			85	1. 00
2.00	91. 00	EMERGENCY	30, 000		0	30, 000	239, 400	343	2. 00
3.00	0.00		0	)	0	0	0	0	3. 00
4.00	0.00		0	)	0	0	0	0	4. 00
5.00	0. 00		0		0	0	0	0	5. 00
6.00	0. 00		0		0	0	0	0	6. 00
7.00	0.00		0		0	0	0	0	7. 00
8.00	0.00		0	ol	0	0	0	0	8. 00
9.00	0.00		0		0	0	0	0	9. 00
10.00	0.00		0	ol	0	0	0	0	10.00
200.00			803, 762		749, 762	54,000		428	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Perce	ent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadj ust	ted RCE	Memberships &	Component	of Mal practice	
				Lim	i t	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00	2. 00	8. 00	9. (		12. 00	13.00	14.00	
1.00		ANESTHESI OLOGY	9, 783		489			0	1
2.00		EMERGENCY	39, 478	8	1, 974		1	0	
3.00	0. 00		0		0	0	0	0	
4.00	0. 00	4	0	)	0	0	0	0	
5.00	0. 00		0		0	0	0	0	
6.00	0. 00		0	)	0	0	0	0	0.00
7. 00	0. 00		0	)	0	0	0	0	
8. 00	0. 00		0	)	0	0	0	0	0.00
9. 00	0. 00		0	)	0	0	0	0	
10. 00	0. 00		0	)	0	0	0	0	1
200.00			49, 261		2, 463		0	0	200. 00
	Wkst. A Line #	,	Provi der	Adj uste		RCE	Adjustment		
		I denti fi er	Component	Lim	i t	Di sal I owance			
			Share of col.						
	1. 00	2.00	14 15. 00	16.	00	17. 00	18. 00		
1. 00		ANESTHESI OLOGY	15.00		9, 783				1. 00
2. 00		EMERGENCY		1	39, 478			•	2.00
3. 00	0.00				37, 470	0			3. 00
4. 00	0.00				0	0	0		4. 00
5. 00	0.00				0	0	0		5.00
6. 00	0.00			(	0				6. 00
6. 00 7. 00	0.00				0				7.00
	0.00				0				8. 00
8. 00 9. 00					0				9.00
	0.00	4			0				1
10.00	0. 00			(	40.271	14 017	763, 979		10.00
200.00	l	I	0	η	49, 261	14, 217	103,979	l	200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150146 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/16/2016 4:15 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP EMPLOYEE Subtotal for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 358, 971 358. 971 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 674, 118 674, 118 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 404, 033 2, 404, 033 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 12, 749, 178 92, 091 8 076 724, 761 13, 574, 106 5 00 7.00 00700 OPERATION OF PLANT 1, 322, 436 35, 240 17,613 49, 486 1, 424, 775 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 151, 516 3, 032 154, 548 8.00 00900 HOUSEKEEPI NG 440, 709 4, 385 2, 581 34, 176 481, 851 9.00 9.00 01000 DI ETARY 28 986 357, 071 10 00 312, 619 9.027 10 00 6, 439 11.00 01100 CAFETERI A 73, 123 5,840 18, 341 97, 304 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 1, 228 339, 613 13.00 222, 683 53,092 62, 610 13.00 01400 CENTRAL SERVICES & SUPPLY 11, 278 14.00 11, 278 14 00 15.00 01500 PHARMACY 663, 216 3, 326 87, 996 80, 418 834, 956 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 5,080 5,080 16.00 01700 SOCIAL SERVICE 17.00 0 0 17.00 C 0 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19 00 02000 NURSING SCHOOL 0 0 0 20.00 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 0 22.00 C 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 757, 318 62, 300 300, 612 3, 172, 392 30.00 52, 162 04300 NURSERY 123, 900 43.00 108,673 762 1, 131 13, 334 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 1, 495, 161 39, 736 178, 799 152, 095 1, 865, 791 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 516, 705 4, 897 6,510 63, 400 591, 512 52.00 05300 ANESTHESI OLOGY 53.00 9.828 9.828 53.00 05400 RADI OLOGY-DI AGNOSTI C 190, 439 54.00 2,049,227 23, 797 164, 124 2, 427, 587 54.00 54.01 05401 CAT SCAN 0 54.01 06000 LABORATORY 60.00 2, 156, 260 7,019 0 0 2, 163, 279 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 65.00 626, 806 6,036 30, 148 72,674 735, 664 65.00 06600 PHYSI CAL THERAPY 102, 705 779, 843 66.00 663.185 2.407 66.00 11, 546 06700 OCCUPATIONAL THERAPY 34, 527 365, 838 67.00 331, 311 0 67.00 68.00 06800 SPEECH PATHOLOGY 143, 549 0 15, 163 158, 712 68.00 69.00 06900 ELECTROCARDI OLOGY 9, 957 502 0 10, 459 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 471, 513 71 00 C 0 0 471, 513 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 331,013 C 0 0 331, 013 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 727, 534 0 0 0 1, 727, 534 73.00 07697 CARDIAC REHABILITATION 76. 97 0 0 0 76.97 0 0 07698 HYPERBARI C OXYGEN THERAPY 0 0 76 98 76 98 0 Ω 0 76. 99 07699 LI THOTRI PSY 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 38, 170 5, 106 43, 276 90.00 09100 EMERGENCY 1, 758, 999 91.00 1.544.407 22, 213 9, 259 183, 120 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES
SPECIAL PURPOSE COST CENTERS 247, 793 2, 066, 971 30, 660 95.00 0 2, 345, 424 95.00 SUBTOTALS (SUM OF LINES 1-117) 36, 420, 190 330, 058 670, 274 2, 379, 746 36, 363, 146 118. 00 118.00 NONREI MBURSABLE COST CENTERS 23, 743 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2.630 16, 253 2.805 2 055 192.00 19200 PHYSICIANS' PRIVATE OFFICES 38,073 19, 950 1, 468 4,817 64, 308 192. 00 194. 00 07950 OTHER NONREIMBURSABLE 0 194.00 0 0 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 0 194. 02 07952 OCC HEALTH 01194.02 0 C 0 194. 03 07953 FOUNDATI ON 80,004 0 0 80, 004 194. 03 194. 04 07954 PHYSICIAN OFFICES 5, 206 194. 04 5, 206 C 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 375, 898 194. 05 357, 785 16, 840 952 321 0 194.06 194.06 07956 VACANT SPACE C200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 36, 912, 305 358, 971 674, 118 2.404.033 36, 912, 305 202. 00 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150146

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: | 5/16/2016 4:15 pm

						5/16/2016 4:1	5 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	13, 574, 106					5. 00
7.00	00700 OPERATION OF PLANT	828, 686	2, 253, 461				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	89, 889	29, 492	273, 929			8. 00
9.00	00900 HOUSEKEEPI NG	280, 257	42, 660	11, 247	816, 015		9. 00
10.00	01000 DI ETARY	207, 682	87, 822	390	32, 854	685, 819	10. 00
11. 00	01100 CAFETERI A	56, 595	56, 810	389	21, 252	0	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	197, 528	11, 946	0	4, 469	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 560	109, 718	8, 292	41, 045	0	14.00
15.00	01500 PHARMACY	485, 632	32, 352	2 0	12, 103	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 955	49, 422	2	18, 489	0	16. 00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	Ö	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	l o	0	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	Ó	ol o	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	Ó	ol o	0	0	23. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 845, 147	507, 448	95, 567	189, 833	685, 819	30.00
43.00	04300 NURSERY	72, 063		1		0	43.00
	ANCILLARY SERVICE COST CENTERS	,	, , ,		,	-	
50.00	05000 OPERATING ROOM	1, 085, 193	386, 560	72, 026	144, 610	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	344, 039				0	52.00
53.00	05300 ANESTHESI OLOGY	5, 716		0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 411, 948		27, 301	86, 603	Ō	54.00
54. 01	05401 CAT SCAN	0	0	0	0	Ō	54. 01
60.00	06000 LABORATORY	1, 258, 219	68, 279	678	25, 543	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	427, 881	58, 717	1, 672	21, 966	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	453, 577	23, 415		8, 759	_	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	212, 781	20, 110		0,707	Ö	67. 00
68. 00	06800 SPEECH PATHOLOGY	92, 311	Ö		0	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	6, 083	4, 886		1, 828	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	274, 244	1, 000		1, 020	ő	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	192, 526			0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 004, 779			0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	1,004,777	0		0	Ö	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			0	0	76. 98
76. 99		0	0		0	Ö	76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS			,	<u> </u>	0	70.77
90. 00		25, 170	0	0	0	0	90.00
91. 00	09100 EMERGENCY	1, 023, 080	216, 099	1		ő	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,020,000	210,077	02,077	00,011	Ĭ	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95 00	09500 AMBULANCE SERVI CES	1, 364, 160	C	0	0	0	95. 00
75.00	SPECIAL PURPOSE COST CENTERS	1, 304, 100		,	9	0	75.00
118. 00		13, 254, 701	1, 972, 180	270, 813	710, 790	685, 819	118 00
110.00	NONREI MBURSABLE COST CENTERS	10, 201, 701	1,772,100	270,010	710,770	000,017	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 810	27, 288	0	10, 208	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	37, 403		1			192.00
	07950 OTHER NONREI MBURSABLE	0,7,100	.,,,,,,	0,	0	-	194. 00
	1 07951 PAIN CLINIC	0	Ö	0	0		194. 01
	2 07952 OCC HEALTH	0	Ô	0	_		194. 02
	3 07953 FOUNDATION	46, 532	i n	ا ا	n		194. 03
	4 07954 PHYSI CI AN OFFI CES	3, 028	50, 644	ا ،	18, 945		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	218, 632			3, 466		194. 05
	07755 COMMONT TO A VOLUMTEER SERVICES	1 210,002	,, 200		0, 700		194. 06
200.00							200.00
201.00		0	0		0	n	201.00
202.00		13, 574, 106	2, 253, 461	273, 929	816, 015		
232.00	1.07.2 (33 1.1.33 110 201)		2,200, 101	2,0,727	0.10, 0.10	000,017	,_02. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150146 Peri od: Worksheet B From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/16/2016 4:15 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** SERVICES & PERSONNEL ADMI NI STRATI ON **SUPPLY** 11. 00 12.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 232, 350 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 560, 955 13.00 7.399 13.00 176, 893 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 0 2, 796 1, 374, 994 15.00 7 155 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 0 0 0 0 17.00 01700 SOCIAL SERVICE 0 0 0 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 C 0 0 0 20.00 02000 NURSING SCHOOL 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 0 21 00 C Ω 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 C 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 43, 300 0 233, 309 24, 749 559 30.00 43.00 04300 NURSERY 2,058 0 11,091 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 16, 960 50 00 21 125 n 113 824 26, 197 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 9, 788 0 52, 740 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 0 0 6, 919 54.00 05400 RADI OLOGY-DI AGNOSTI C 28, 380 0 0 54.00 5 05401 CAT SCAN 0 54.01 0 0 0 54.01 0 60.00 06000 LABORATORY 0 0 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 0 0 62.30 65 00 06500 RESPIRATORY THERAPY 11 660 Ω 0 7 469 0 65 00 06600 PHYSI CAL THERAPY 0 66.00 12, 288 0 1, 796 62 66.00 06700 OCCUPATIONAL THERAPY 5,644 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 2,478 0 0 68.00 06900 ELECTROCARDI OLOGY O 69 00 0 Ω 69 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 76, 772 71.00 0 C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 3.009 1, 354, 229 73.00 07697 CARDIAC REHABILITATION 0 76. 97 76.97 0 Ω 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 785 0 64 0 91.00 09100 EMERGENCY 27,837 149, 991 14, 321 195 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 2, 893 95.00 45, 379 12, 120 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 225, 276 0 560, 955 176, 212 1, 374, 903 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 660  $\cap$ 0 190, 00 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1.278 0 0 72 0 192.00 194. 00 07950 OTHER NONREIMBURSABLE 0 194. 00 0 0 0 0 0 194. 01 194. 01 07951 PAIN CLINIC 0 0 0 0 194. 02 07952 OCC HEALTH 0 0 0 0 194. 02 0 194. 03 07953 FOUNDATI ON 91 194. 03 0 0 1.244

3,892

232, 350

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560, 955

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176, 893

0 194, 04

0 194. 05

0 194.06

0 201, 00

1, 374, 994 202. 00

200.00

194. 04 07954 PHYSICIAN OFFICES

194.06 07956 VACANT SPACE

200.00

201.00

202.00

194. 05 07955 COMMUNITY & VOLUNTEER SERVICES

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150146 | Period: From 01/01/2015 | Part I Date/Time Prepared:

				Т	o 12/31/2015	Date/Time Pre 5/16/2016 4:1	
						INTERNS &	, p
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICIAN	NURSING SCHOOL	RESI DENTS SERVI CES-SALAR	
	Sost contor bescription	RECORDS &	SERVICE	ANESTHETI STS	10001110 3011002	Y & FRINGES	
		16. 00	17. 00	19. 00	20.00	APPRV 21. 00	
	GENERAL SERVICE COST CENTERS	10.00	17.00	19.00	20.00	21.00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	00500 ADMI NI STRATI VE & GENERAL						5. 00
	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	OO8OO  LAUNDRY & LINEN SERVICE   OO9OO  HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10. 00
	01100   CAFETERI A   01200   MAINTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
	01400 CENTRAL SERVICES & SUPPLY						14. 00
	01500   PHARMACY   01600   MEDICAL RECORDS & LIBRARY	75, 946					15. 00 16. 00
	01700 SOCI AL SERVI CE	0	О				17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	С			19. 00
	02000   NURSI NG SCHOOL   02100   I&R SERVI CES-SALARY & FRI NGES APPRV	0	0		0	0	20. 00 21. 00
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	Ö	ő			Ü	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0				23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS  03000 ADULTS & PEDI ATRI CS	4, 757	0		0	0	30. 00
	04300 NURSERY	254					43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS  05000 OPERATI NG ROOM	8, 767	Ι ο		0	0	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	1, 259				0	52. 00
53.00	05300 ANESTHESI OLOGY	1, 320	0	1		0	53. 00
54. 00 54. 01	05400   RADI OLOGY-DI AGNOSTI C   05401   CAT SCAN	21, 249	0			0	54. 00 54. 01
	06000 LABORATORY	7, 729	Ö	Ö		0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0 7/0	0			0	62. 30
65. 00 66. 00	06500   RESPI RATORY   THERAPY   06600   PHYSI CAL   THERAPY	2, 763 1, 397	0		_	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	441	o	C		0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY	213 234	0			0	68. 00 69. 00
	06900  ELECTROCARDIOLOGY   07100  MEDICAL SUPPLIES CHARGED TO PATIENT	2, 311			_	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 012	0	C	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	7, 154	0		0	0	73. 00 76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	1		0	76. 97 76. 98
76. 99	07699 LI THOTRI PSY	0	0	c	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	83	0	С	0	0	90. 00
91.00	09100 EMERGENCY	11, 384					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
	09500 AMBULANCE SERVICES	3, 619	0	С	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1-117)   NONREI MBURSABLE COST CENTERS	75, 946	0	C	0	0	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	С	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192. 00
	07950 OTHER NONREIMBURSABLE   07951 PAIN CLINIC	0	0				194. 00 194. 01
194. 02	07952 OCC HEALTH	0	0	ď	_	0	194. 02
	07953 FOUNDATION	0	0	C	_		194. 03
	07954 PHYSICIAN OFFICES   07955 COMMUNITY & VOLUNTEER SERVICES	0	0				194. 04 194. 05
194. 06	07956 VACANT SPACE	0	o	C	0	0	194. 06
200. 00 201. 00			0	C I	_		200. 00 201. 00
201.00		75, 946	-				201.00
				•	'		

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150146 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/16/2016 4:15 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED Subtotal Intern & Total PRGM COSTS **PRGM** Residents Cost **APPRV** & Post Stepdown Adjustments 22.00 23.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 20.00 02000 NURSING SCHOOL 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 802, 880 6, 802, 880 30.00 04300 NURSERY 0 0 219, 835 219, 835 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 3, 741, 053 3, 741, 053 50.00 0 o 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 065, 069 1, 065, 069 52.00 05300 ANESTHESI OLOGY 0000000000000 0 53.00 0 16, 864 16, 864 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 4, 241, 493 4, 241, 493 54.00 54.01 05401 CAT SCAN 0 0 54.01 06000 LABORATORY 0 60.00 3, 523, 727 3, 523, 727 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 65.00 1, 267, 792 0 0 0 1, 267, 792 65.00 06600 PHYSI CAL THERAPY 1, 281, 137 1, 281, 137 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 584, 704 584, 704 67.00 68.00 06800 SPEECH PATHOLOGY 253, 714 253, 714 68.00 69.00 06900 ELECTROCARDI OLOGY 23, 490 0 0 0 23, 490 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 824 840 71 00 Ω 824 840 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 524, 551 524, 551 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 096, 705 4, 096, 705 73.00 07697 CARDIAC REHABILITATION 0 0 76. 97 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76 98 76 98 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 69, 378 0 69, 378 90.00 09100 EMERGENCY 0 91.00 C 3, 335, 446 0 3, 335, 446 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 0 3, 773, 595 3, 773, 595 95.00 0 0 95.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 35, 646, 273 0 35, 646, 273 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 75, 710 190. 00 0 75, 710 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 372, 867 0 372, 867 192. 00 194. 00 07950 OTHER NONREIMBURSABLE 0 0 0 194. 00 0 C 0 194. 01 07951 PAIN CLINIC 000000000 0 194. 01 0 0 194. 02 07952 OCC HEALTH 01194.02 0 0 194. 03 07953 FOUNDATI ON 0 127, 871 0 0 0 127, 871 194. 03 194. 04 07954 PHYSICIAN OFFICES 77, 823 194. 04 77, 823 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 611, 761 194. 05 0 611, 761 0 194.06 194.06 07956 VACANT SPACE 0 C 200.00 Cross Foot Adjustments 0 200.00 0 0 201.00 Negative Cost Centers 0 C 0 201.00 36, 912, 305 202.00 TOTAL (sum lines 118-201) 36, 912, 305 202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 150146

		To 12/31/2015					
			CAPI TAL REI	LATED COSTS		5/16/2016 4: 1	5 pm
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
	CENEDAL CEDALCE COCT CENTEDS	0	1.00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	o	0	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 715, 139	l	8, 076	2, 815, 306	0	5. 00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	0	35, 240 3, 032		52, 853 3, 032	0	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	4, 385		6, 966	0	9. 00
10.00	01000 DI ETARY	0	9, 027	6, 439	15, 466	0	10. 00
11.00	01100 CAFETERI A	0	5, 840	0	5, 840	0	11. 00
12. 00 13. 00	O1200   MAI NTENANCE OF PERSONNEL   O1300   NURSI NG   ADMI NI STRATI ON	0	0 1, 228	0 53, 092	0 54, 320	0	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11, 278		11, 278	0	14. 00
15. 00	01500 PHARMACY	0	3, 326		91, 322	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	5, 080	0	5, 080	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00 19. 00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0	0	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	Ö	ő	o	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	o	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS   03000   ADULTS & PEDI ATRI CS	0	52, 162	62, 300	114, 462	0	30.00
43. 00	04300 NURSERY	Ö		· ·	1, 893	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	39, 736		218, 535	0	50.00
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	0	4, 897	6, 510	11, 407	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	23, 797	164, 124	187, 921	0	54.00
54. 01	05401 CAT SCAN	0	0	0	0	0	54. 01
60.00	06000 LABORATORY	0	7, 019	0	7, 019	0	60.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	0 6, 036	0 30, 148	24 104	0	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 407		36, 184 13, 953	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	O	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	502	0	502	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0	o	0	73. 00
76. 97	07697 CARDI AC REHABILI TATI ON	0	0	0	О	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	O7699 LITHOTRIPSY   OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90. 00	09000 CLINIC	T 0	0	0	ol	0	90.00
91. 00	09100 EMERGENCY	0	22, 213	9, 259	31, 472	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS  O9500 AMBULANCE SERVICES	0	0	30, 660	30, 660	0	95. 00
93.00	SPECIAL PURPOSE COST CENTERS	0	0	30, 000	30, 660[		95.00
118.00		2, 715, 139	330, 058	670, 274	3, 715, 471	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0			4, 860		190. 00 192. 00
	07950 OTHER NONREIMBURSABLE	0 0		1, 468 0	21, 418 0		194. 00
	07951 PAIN CLINIC	0		0	ő		194. 01
194. 02	07952 OCC HEALTH	0	0	0	o	0	194. 02
	07953 FOUNDATION	0	0	0	0		194. 03
	07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES	0	5, 206 952		5, 206 1, 273		194. 04 194. 05
	07955 COMMUNITY & VOLUNTEER SERVICES	0	752	321	1, 2/3		194. 05
200.00				]	ő	Ü	200. 00
201.00	Negative Cost Centers		0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	2, 715, 139	358, 971	674, 118	3, 748, 228	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150146

						5/16/2016 4:1	5 pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	8.00	9. 00	10.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	2, 815, 306					5. 00
7. 00	00700 OPERATION OF PLANT	171, 872	224, 725				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	18, 643	2, 941				8.00
9. 00	00900 HOUSEKEEPI NG	58, 126	4, 254				9. 00
10. 00	01000 DI ETARY	43,074	8, 758			70, 166	10.00
11. 00	01100 CAFETERI A	11, 738	5, 665	35	1, 832	0	11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	o	0	12.00
13. 00	01300 NURSING ADMINISTRATION	40, 968	1, 191	0	385	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 360	10, 942	745	3, 539	0	14. 00
15. 00	01500 PHARMACY	100, 722	3, 226	0	1, 044	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	613	4, 929	0	1, 594	0	
	01700 SOCIAL SERVICE	0	0	0	0	0	
	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
	02000 NURSI NG SCHOOL	0	0	0	0	0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	) 0	0	0	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	382, 684	50, 608	8, 588	16, 369	70, 166	30.00
	03000 NURSERY	14, 946	740	1		70, 166	
	ANCI LLARY SERVI CE COST CENTERS	14, 940	740	/  25	239	0	43.00
50. 00	05000 OPERATING ROOM	225, 072	38, 549	6, 472	12, 468	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	71, 355	4, 750	· ·		0	
53. 00	05300 ANESTHESI OLOGY	1, 186	4, 730	0	1, 330	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	292, 842	23, 086	1	7, 467	0	
54. 01	05401 CAT SCAN	0	20,000	0		0	
60. 00	06000 LABORATORY	260, 959	6, 809	61	2, 202	0	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	O	0		0	62. 30
65. 00	06500 RESPI RATORY THERAPY	88, 744	5, 855	150	1, 894	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	94, 073	2, 335	0	755	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	44, 131	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	19, 146	0	0	0	0	
69. 00	06900 ELECTROCARDI OLOGY	1, 262	487	0	158	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	56, 879	0	0	0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	39, 930	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	208, 394	0	0	0	0	
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
	07699 LI THOTRI PSY	0	C	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	F 220	0	J 0	O	0	90.00
90. 00 91. 00	09100 EMERGENCY	5, 220	21, 550	1		0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	212, 190	21, 330	4, 736	0, 970	U	91.00
	OTHER REIMBURSABLE COST CENTERS						72.00
	09500 AMBULANCE SERVICES	282, 931	О	0	O	0	95. 00
	SPECIAL PURPOSE COST CENTERS	202, 731		,, ,	<u> </u>		75.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	2, 749, 060	196, 675	24, 336	61, 285	70 166	118. 00
	NONREI MBURSABLE COST CENTERS	2////000	.,0,0,0	2.,,000	0.7200	70,100	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 864	2, 721	0	880	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	7, 758					192.00
194. 00	07950 OTHER NONREIMBURSABLE	0	0	0	o	0	194. 00
194. 01	07951 PAIN CLINIC	0	0	0	o	0	194. 01
194. 02	07952 OCC HEALTH	0	0	0	0	0	194. 02
	07953 FOUNDATI ON	9, 651	0	0	0		194. 03
	07954 PHYSICIAN OFFICES	628	5, 050		1, 633		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	45, 345	924	0	299		194. 05
	07956 VACANT_SPACE	0	0	0	0	0	194. 06
200.00	Cross Foot Adjustments			1			200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	2, 815, 306	224, 725	24, 616	70, 357	70, 166	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 150146

					10	12/31/2015	5/16/2016 4:1	
		Cost Center Description	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	o piii
			11. 00	12.00	13. 00	14. 00	15. 00	
		L SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1 1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1 1	ADMINISTRATIVE & GENERAL						5. 00
7.00	1 1	OPERATION OF PLANT						7. 00
8.00		LAUNDRY & LINEN SERVICE						8.00
9.00		HOUSEKEEPI NG						9.00
10.00	1 1	DI ETARY CAFETERI A	OF 110					10.00
11. 00 12. 00	1 1	MAINTENANCE OF PERSONNEL	25, 110	,				11. 00 12. 00
13. 00	1 1	NURSING ADMINISTRATION	800		97, 664			13. 00
14. 00	1 1	CENTRAL SERVICES & SUPPLY	000			27, 864		14.00
15. 00	1 1	PHARMACY	773		٦	440	197, 527	15. 00
16. 00	1 1	MEDICAL RECORDS & LIBRARY	0	Ö	1	0	0	16. 00
17. 00		SOCIAL SERVICE	0	l c	o	0	0	17. 00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	C	o	0	0	19. 00
20.00		NURSI NG SCHOOL	0	C	0	0	0	20. 00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	C	0	0	0	21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	C	1	0	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	C	0	0	0	23. 00
		ENT ROUTINE SERVICE COST CENTERS		· -		1		
30.00		ADULTS & PEDI ATRI CS	4, 679		· ·	3, 898	80	•
43. 00		NURSERY	222	C	1, 931	0	0	43. 00
50. 00		ARY SERVICE COST CENTERS OPERATING ROOM	2 202		19, 817	4, 127	2 424	50. 00
52. 00		DELIVERY ROOM & LABOR ROOM	2, 283 1, 058	l e	1	4, 127	2, 436 0	52.00
53. 00		ANESTHESI OLOGY	1,038			0	0	53.00
54. 00	1 1	RADI OLOGY-DI AGNOSTI C	3, 067		1	1, 090	1	54.00
54. 01	1 1	CAT SCAN	0,007		٦	0	0	54. 01
60.00	1 1	LABORATORY	0	ĺ		0	0	60.00
62. 30	1 1	BLOOD CLOTTING FOR HEMOPHILIACS	0	ĺ	1	o	0	62. 30
65. 00	1 1	RESPI RATORY THERAPY	1, 260	C	0	1, 177	0	65. 00
66.00	06600	PHYSI CAL THERAPY	1, 328	C	0	283	9	66. 00
67.00	06700	OCCUPATIONAL THERAPY	610	C	0	0	0	67. 00
68. 00	06800	SPEECH PATHOLOGY	268	C	0	0	0	68. 00
69. 00		ELECTROCARDI OLOGY	0	[ C	1	0	0	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	٦	12, 093	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	C	0	0	0	
73.00		DRUGS CHARGED TO PATIENTS	0			474	194, 544	73.00
76. 97 76. 98		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0			0	0	76. 97 76. 98
76. 96 76. 99		LI THOTRI PSY	0			0	0	•
70. 77		TENT SERVICE COST CENTERS	0		,	<u> </u>		70.77
90.00	09000		85	С	0	10	0	90. 00
		EMERGENCY	3, 008	ŀ		2, 256	28	ł
		OBSERVATION BEDS (NON-DISTINCT PART			,	, , ,		92.00
	OTHER	REIMBURSABLE COST CENTERS						
95.00		AMBULANCE SERVICES	4, 905	C	0	1, 909	416	95. 00
		L PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24, 346	C	97, 664	27, 757	197, 514	118. 00
		MBURSABLE COST CENTERS		_		_1		
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	71			0		190. 00
		PHYSI CI ANS' PRI VATE OFFI CES	138	l		11		192. 00
		OTHER NONREI MBURSABLE	0			0		194. 00
		PAIN CLINIC OCC HEALTH	0	l c	1	0	0	194. 01 194. 02
		FOUNDATION	134			0		194. 02
		PHYSI CI AN OFFI CES	0			ol Ol		194. 04
		COMMUNITY & VOLUNTEER SERVICES	421		ا م	96		194. 05
		VACANT SPACE	0	c	ol ol	ol		194. 06
200.00		Cross Foot Adjustments						200. 00
201.00		Negative Cost Centers	0	[ c	0	O		201. 00
202.00		TOTAL (sum lines 118-201)	25, 110	C	97, 664	27, 864	197, 527	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10 Worksheet B

Part II

Date/Time Prepared: 12/31/2015 5/16/2016 4:15 pm INTERNS & **RESI DENTS** NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR Cost Center Description MEDI CAL SOCIAL SERVICE Y & FRINGES RECORDS & ANESTHETI STS LI BRARY **APPRV** 17.00 19.00 16.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 12, 216 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19 00 Ω 0 02000 NURSING SCHOOL 20.00 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23 00 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 765 0 30.00 43.00 04300 NURSERY 41 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 410 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 203 52.00 05300 ANESTHESI OLOGY 53.00 212 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 3.417 54.00 54.01 05401 CAT SCAN 0 54.01 06000 LABORATORY 60.00 1, 243 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 0 65 00 445 65 00 06600 PHYSI CAL THERAPY 66.00 225 66.00 06700 OCCUPATIONAL THERAPY 67.00 71 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 34 06900 ELECTROCARDI OLOGY 0 69.00 38 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 372 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 163 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 1, 151 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 07699 LI THOTRI PSY 76.99 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 1,831 C 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 582 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 12, 216 0 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 Ω 192 00 194.00 07950 OTHER NONREI MBURSABLE 0 0 194.00 0 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 0 0 0 194.02 194. 03 07953 FOUNDATI ON 0 194 03 194. 04 07954 PHYSICIAN OFFICES 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194. 05 194.06 07956 VACANT SPACE 0 0 194. 06 Cross Foot Adjustments 0 200. 00 200.00 201.00 Negative Cost Centers 0 0 0 0 201. 00 TOTAL (sum lines 118-201) 0 202.00 202.00

Provider CCN: 150146

Peri od:

From 01/01/2015

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150146 Peri od: Worksheet B From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/16/2016 4:15 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED Subtotal Intern & Total PRGM COSTS **PRGM** Residents Cost **APPRV** & Post Stepdown Adjustments 22.00 23. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 20.00 02000 NURSING SCHOOL 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 692, 919 692, 919 30.00 43.00 04300 NURSERY 20, 037 0 20, 037 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 531, 169 531, 169 50.00 o 52.00 05200 DELIVERY ROOM & LABOR ROOM 99.516 99.516 52.00 05300 ANESTHESI OLOGY 0 53.00 1, 398 1, 398 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 521, 344 0 0 0 521, 344 54.00 05401 CAT SCAN 54.01 C Ω 54.01 06000 LABORATORY 60.00 278, 293 278, 293 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 65.00 135, 709 0 0 0 0 0 0 0 135, 709 65.00 06600 PHYSI CAL THERAPY 112, 961 112, 961 66.00 66.00 06700 OCCUPATI ONAL THERAPY 44, 812 67.00 44, 812 67.00 68.00 06800 SPEECH PATHOLOGY 19, 448 19, 448 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 447 2, 447 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 69.344 71 00 69 344 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 40,093 40,093 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 404, 563 404, 563 73.00 07697 CARDIAC REHABILITATION 0 76. 97 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76 98 76 98 0 0 76.99 07699 LI THOTRI PSY 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 5, 328 0 5, 328 90.00 09100 EMERGENCY 91.00 310, 155 0 310, 155 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 321, 403 321, 403 0 95.00 95.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 3, 610, 939 0 3, 610, 939 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 11, 396 190. 00 11, 396 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 55, 220 0 55, 220 192. 00 194. 00 07950 OTHER NONREIMBURSABLE 0 0 194. 00 C 0 194. 01 07951 PAIN CLINIC 0 194. 01 0 194. 02 07952 OCC HEALTH 01194.02 0 194. 03 07953 FOUNDATI ON 9, 798 0 0 0 9, 798 194. 03

12, 517 194. 04

48, 358 194. 05

0 194.06

0 200.00

0 201.00 3, 748, 228 202. 00

12, 517

48, 358

3, 748, 228

C

0

O

194. 04 07954 PHYSICIAN OFFICES

194.06|07956|VACANT SPACE

200.00

201.00

202.00

194. 05 07955 COMMUNITY & VOLUNTEER SERVICES

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

<i>J</i>	OMMUNITY HOSPT. OF				u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Pre 5/16/2016 4:1	pared:
	CAPITAL REL	ATED COSTS			107 107 2010 1. 1	J Dill
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	1.00	2.00	4. 00	5A	5. 00	
GENERAL SERVICE COST CENTERS	447.005		1			4 00
1.00   00100   CAP REL COSTS-BLDG & FIXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP	117, 225	607, 199				1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	1			4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	30, 073	7, 274			23, 338, 199	
7. 00   00700   OPERATION OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE	11, 508 990	15, 865 0	1	0	1, 424, 775 154, 548	
9. 00   00900   HOUSEKEEPI NG	1, 432	2, 325		0	481, 851	1
10. 00   01000   DI ETARY	2, 948	5, 800		0	357, 071	
11. 00   01100   CAFETERI A 12. 00   01200   MAI NTENANCE OF PERSONNEL	1, 907	0		0	97, 304 0	1
13.00 01300 NURSING ADMINISTRATION	401	47, 822	463, 491	0	339, 613	1
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	3, 683	0 79, 261	~	0	11, 278	
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	1, 086 1, 659	79, 201	095, 319	0	834, 956 5, 080	
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00   01900   NONPHYSI CI AN ANESTHETI STS 20. 00   02000   NURSI NG SCHOOL	0	0	0	0	0	
21. 00   02100   I &R SERVI CES-SALARY & FRINGES APPRV	0	0	Ö	0	0	1
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23.00   02300   PARAMED ED PRGM-(SPECIFY)   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23. 00
30. 00 03000 ADULTS & PEDI ATRI CS	17, 034	56, 116	2, 225, 370	0	3, 172, 392	30. 00
43. 00 O4300 NURSERY	249	1, 019	98, 711	0	123, 900	43. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00 05000 OPERATI NG ROOM	12, 976	161, 048	1, 125, 931	0	1, 865, 791	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 599	5, 864	469, 338	0	591, 512	52. 00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	0 7, 771	0 147, 832	1	0	9, 828 2, 427, 587	1
54. 01   05401   CAT SCAN	0	0	0	0	2, 427, 307	1
60. 00   06000   LABORATORY	2, 292	0	1	0	2, 163, 279	
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS 65. 00   06500   RESPIRATORY THERAPY	1, 971	0 27, 155	1	0	0 735, 664	62. 30 65. 00
66. 00   06600   PHYSI CAL THERAPY	786	10, 400	760, 305	0	779, 843	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			365, 838 158, 712	
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	164	0	, , , ,	0	10, 459	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	471, 513	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	331, 013 1, 727, 534	
76. 97   07697   CARDI AC   REHABI LI TATI ON	0	Ö		0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	1	0	0	
76. 99 07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90. 00 09000 CLI NI C	0			0	43, 276	
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART	7, 254	8, 340	1, 355, 599	0	1, 758, 999	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	27, 616	1, 834, 359	0	2, 345, 424	95. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	107, 783	603, 737	17, 616, 752	-13, 574, 106	22, 789, 040	118. 00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	01/	1 051	10 470		22.742	100.00
192. 00 19000 GFF, FLOWER, COFFEE SHOP & CANTEEN	916 6, 515				23, 743 64, 308	190.00
194.00 07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194. 00
194. 01 07951  PALN CLINIC 194. 02 07952  OCC HEALTH	0	0	0	0		194. 01 194. 02
194. 03 07953 FOUNDATION	0	0		0	80, 004	
194.04 07954 PHYSICIAN OFFICES	1, 700		1	0	5, 206	194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194. 06 07956 VACANT SPACE	311	289 0	124, 660	0	375, 898 0	194. 05 194. 06
200.00 Cross Foot Adjustments					O	200. 00
201.00 Negative Cost Centers	250 071	/74 440	2 404 222		10 574 407	201. 00
202.00   Cost to be allocated (per Wkst. B, Part I)	358, 971	674, 118	2, 404, 033		13, 574, 106	202.00
203.00 Unit cost multiplier (Wkst. B, Part	3. 062239	1. 110209	0. 135084		0. 581626	1
204.00   Cost to be allocated (per Wkst. B, Part II)					2, 815, 306	204.00

Health Financial Systems COMM	IUNITY HOSPT. OF	NOBLE CTY, IN	IC.	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015	Worksheet B-1		
				Γο 12/31/2015			
	CAPITAL REL	ATED COSTS					
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM COST)		
	1. 00	2. 00	4. 00	5A	5. 00		
205.00 Unit cost multiplier (Wkst. B, Part			0. 000000	D	0. 120631	205. 00	

Health Financial Systems

COMMUNITY HOSPT. OF NOBLE CTY, INC.

Provider CCN: 150146 | Period: From 01/01/2015 | Date/Time Prepared: 5/16/2016 4: 15 pm

Cost Center Description

OPERATION OF LAUNDRY & HOUSEKEEPING (SOUARE FEET) (MEALS SERVED) (HOURS WORKED)

COMMUNITY HOSPT. OF NOBLE CTY, INC.

In Lieu of Form CMS-2552-10

Worksheet B-1

Date/Time Prepared: 5/16/2016 4: 15 pm

CAFETERIA (HOURS WORKED)

7. 00 8. 00 9. 00 10. 00 11. 00

					5/16/2016 4: 1:	o pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(HOURS WORKED)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7.00	8. 00	9.00	10.00	11. 00	
GENERAL SERVICE COST CENTERS						
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
l						
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00   00500   ADMINISTRATIVE & GENERAL						5.00
7.00   OO700   OPERATION OF PLANT	75, 644					7.00
8.00   00800 LAUNDRY & LINEN SERVICE	990	275, 120				8. 00
9. 00 00900 HOUSEKEEPI NG	1, 432	l				9.00
10. 00 01000 DI ETARY	2, 948	l				10.00
11. 00 01100 CAFETERI A	1, 907	391	1, 907	30, 377	200 424	11. 00
		l		0	388, 636	
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 O1300 NURSING ADMINISTRATION	401	0	401	0	12, 376	13. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY	3, 683	8, 328	3, 683	0	0	14. 00
15. 00   01500   PHARMACY	1, 086	0	1, 086	0	11, 967	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 659	0	1, 659	0	0	16.00
17. 00   01700   SOCIAL SERVICE	0	l o	0	0	Ö	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	١		0	0	19. 00
	0	0	0	0	_	
20. 00   02000   NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00   02100   1 &R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22.00   02200   I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS		•	•			
30. 00 03000 ADULTS & PEDI ATRI CS	17, 034	95, 982	17, 034	30, 377	72, 425	30.00
43. 00   04300   NURSERY	249					43. 00
ANCI LLARY SERVI CE COST CENTERS	247	211		U	3, 443	43.00
	40.07/	70.000	40.07/		05.004	F0 00
50. 00   05000   OPERATI NG ROOM	12, 976	1			35, 334	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 599	277	1, 599	0	16, 372	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	7, 771	27, 420	7, 771	0	47, 469	54.00
54. 01   05401   CAT   SCAN	0	0	0	0	0	54. 01
60. 00   06000 LABORATORY	2, 292	681	2, 292	0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	001	2,2,2	0	0	62. 30
	-	1 /70		0		
65. 00 06500 RESPI RATORY THERAPY	1, 971	1, 679		0	19, 503	65. 00
66. 00   06600   PHYSI CAL THERAPY	786	0	786	0	20, 553	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0	0	0	0	9, 440	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	4, 145	68.00
69. 00 06900 ELECTROCARDI OLOGY	164	0	164	ol	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l o	l o	0	o	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	l o	١	0	Ö	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	73. 00
	0	0	0	0	_	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	1, 313	90.00
91. 00 09100 EMERGENCY	7, 254	52, 928	7, 254	0	46, 561	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	,		,			92.00
OTHER REIMBURSABLE COST CENTERS						,2,00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	75, 903	95. 00
				U	13, 703	93.00
SPECIAL PURPOSE COST CENTERS	// 000	074 000	(0.700	00.077	07/ 00/	440.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	66, 202	271, 990	63, 780	30, 377	376, 804	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	916	0	916	0	1, 104	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	6, 515	3, 130	6, 515	0	2, 138	192. 00
194. 00 07950 OTHER NONREI MBURSABLE	0	ľ	1	0	0	194. 00
194. 01 07951 PAIN CLINIC	0	i n	0	0		194. 01
194. 02 07952 OCC HEALTH	0	٥		0		194. 02
		0	0	0		
194. 03 07953 FOUNDATION	1 700	0		0		194. 03
194. 04 07954 PHYSI CI AN OFFI CES	1, 700	0	1, 700			194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	311	0	311	0		194. 05
194. 06 07956 VACANT SPACE	0	0	0	0	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	2, 253, 461	273, 929	816, 015	685, 819		
Part I)	۷, ۲۵۵, 40۱	213,729	010,013	000, 019	232, 330	202.00
1 1 7	20 700247	0 005471	11 144204	22 574017	0 507040	202 00
203.00 Unit cost multiplier (Wkst. B, Part I)	29. 790347	ł	11. 144396		0. 597860	
204.00 Cost to be allocated (per Wkst. B,	224, 725	24, 616	70, 357	70, 166	25, 110	∠∪4. ∪∪
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	2. 970824	0. 089474	0. 960872	2. 309840	0. 064611	205. 00
11)						

				To	com 01/01/2015 o 12/31/2015	Date/Time Pre 5/16/2016 4:1	
	Cost Center Description	MAINTENANCE OF PERSONNEL (MEALS SERVED)	ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY	5 piii
			(DI RECT NRSI NG	(COSTED		(GROSS	
		12. 00	HRS) 13. 00	REQUI S. ) 14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	T		Ī			
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE			1, 851, 424 29, 265 0	2, 415, 109 0 0	165, 131, 959 0	1
9. 00	01900 NONPHYSICIAN ANESTHETISTS			Ō	o	0	
0.00	02000 NURSI NG SCHOOL	(	o o	0	0	0	
1. 00 2. 00	02100   &R SERVICES-SALARY & FRINGES APPRV 02200   &R SERVICES-OTHER PRGM COSTS APPRV			0	0	0	1
3. 00	02300 PARAMED ED PRGM-(SPECIFY)		1	0	Ö	0	
0 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		72 425	250,020	002	10 241 024	30.0
0. 00 3. 00	03000 ADULTS & PEDIATRICS 04300 NURSERY			259, 028 0	982 0	10, 341, 034 552, 050	
	ANCILLARY SERVICE COST CENTERS						l
0. 00 2. 00	05000 OPERATING ROOM   05200 DELIVERY ROOM & LABOR ROOM		,	274, 190 0	29, 790 0	19, 059, 069 2, 737, 983	
3. 00	05300 ANESTHESI OLOGY		1	0	0	2, 869, 042	53. (
4. 00 4. 01	05400  RADI OLOGY-DI AGNOSTI C   05401  CAT SCAN			72, 421 0	9	46, 223, 809 0	1
0. 00	06000 LABORATORY			Ö	o	16, 801, 229	1
2. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS			70. 17/	0	0 000	
5. 00 6. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY			78, 176 18, 801	109	6, 006, 973 3, 037, 548	
7. 00	06700 OCCUPATI ONAL THERAPY			0	0	958, 253	67. (
8. 00 9. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY			0	0	463, 662 509, 649	
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			803, 517	0	5, 024, 792	1
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS			0	0	2, 200, 910	1
3. 00 6. 97	07300 DRUGS CHARGED TO PATIENTS   07697 CARDIAC REHABILITATION			31, 490 0	2, 378, 637 0	15, 552, 514 0	1
6. 98	07698 HYPERBARI C OXYGEN THERAPY		o	0	0	0	76.
6. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS		0	0	0	0	76.
0. 00	09000 CLINIC		ol l	674	0	179, 940	90.
1. 00	09100 EMERGENCY		46, 561	149, 891	342	24, 747, 124	
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.
5. 00	09500 AMBULANCE SERVI CES	(	0	126, 848	5, 081	7, 866, 378	95.
18. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)		174, 135	1, 844, 301	2, 414, 950	165, 131, 959	110
	NONREI MBURSABLE COST CENTERS		ار 174, 135	1, 644, 301	2, 414, 930	105, 151, 757	1116.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(	1	10	0		190.
	19200   PHYSICIANS' PRIVATE OFFICES   07950   OTHER NONREIMBURSABLE		1	749 0	0		192. 194.
	07951 PAIN CLINIC		1	0	0		194.
	07952 OCC HEALTH	C		0	0		194.
	07953 FOUNDATION 07954 PHYSICIAN OFFICES			0	159		194. 194.
	07955 COMMUNITY & VOLUNTEER SERVICES			6, 364	0		194.
	07956 VACANT_SPACE	C		0	0	0	194.
00. 00 01. 00							200. 201.
01.00	9		560, 955	176, 893	1, 374, 994	75, 946	
	Part I)	0.0005					
03. 00 04. 00		0.000000	3. 221380 97, 664	0. 095544 27, 864	0. 569330 197, 527	0. 000460 12, 216	
	Part II)						
05.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 560852	0. 015050	0. 081788	0.000074	1205. (

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150146

Peri od: Worksheet B-1 From 01/01/2015 To 12/31/2015 Date/Time Prepared:

							5/16/2016 4: 1	
						INTERNS &	RESIDENTS	
		Cost Center Description	SOCIAL SERVICE		NURSING SCHOOL	SERVI CES-SALAR		
			(TIME SPENT)	ANESTHETI STS (ASSI GNED	(ASSI GNED	Y & FRINGES APPRV	PRGM COSTS APPRV	
				TIME)	TIME)	(ASSI GNED	(ASSI GNED	
			17. 00	19. 00	20. 00	TI ME) 21. 00	TI ME) 22. 00	
1 00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT			I			1 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPING						9. 00
10.00	1	DIETARY						10.00
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	1	NURSING ADMINISTRATION						13. 00
14.00	1	CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY						15. 00 16. 00
17. 00		SOCIAL SERVICE	0					17. 00
19.00	1	NONPHYSI CI AN ANESTHETI STS	0	0				19. 00
20. 00 21. 00	1	NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV	0		C	0		20. 00 21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	•
23. 00		PARAMED ED PRGM-(SPECIFY)	0					23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	0	C	ol	0	30. 00
43. 00		NURSERY	0		l .		0	
		LARY SERVICE COST CENTERS						
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	0	l .		0	
53. 00	1	ANESTHESI OLOGY	0				0	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	0	o c	o	0	•
54. 01	1	CAT SCAN	0	0	1	-	0	54. 01
60. 00 62. 30	1	LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1		0	60. 00 62. 30
65. 00	1	RESPI RATORY THERAPY	0	0	o c	o	0	65. 00
66. 00	1	PHYSI CAL THERAPY	0	0	C	0	0	66.00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0				0	67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	0	0	o c	o	0	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0			0	72. 00 73. 00
76. 97	1	CARDI AC REHABI LI TATI ON	0	0	d	o	0	76. 97
	1	HYPERBARI C OXYGEN THERAPY	0	0	C	0	0	76. 98
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	0	0	<u> </u>	0	0	76. 99
90.00	09000	CLI NI C	0	0	C	0	0	1
		EMERGENCY	0	0	C	0	0	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS						92.00
95. 00	09500	AMBULANCE SERVICES	0	0	C	0	0	95. 00
110 00		AL PURPOSE COST CENTERS	1 0	0	J	ا	0	110 00
118. 00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	0	0	<u> </u>	0	0	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 00
		OTHER NONREIMBURSABLE PAIN CLINIC	0	0				194. 00 194. 01
		OCC HEALTH	0	Ö	, c	Ö		194. 02
		FOUNDATION	0	0	C	0		194. 03
		PHYSICIAN OFFICES COMMUNITY & VOLUNTEER SERVICES	0	0		0		194. 04 194. 05
		VACANT SPACE	0	0				194. 05
200.00	1	Cross Foot Adjustments						200. 00
201. 00 202. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	_	_			0	201. 00 202. 00
202.00		Part I)					Ü	202.00
203.00	1	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.000000	0. 000000	0. 000000	
204. 00		Cost to be allocated (per Wkst. B, Part II)	0	0	'l C	9	0	204. 00
	1	i <del> /</del>	1	•	1	ı I		

Health Financial Systems COM	MUNITY HOSPT. OI	NOBLE CTY, IN	IC.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2015	D-+- /T: D	
				Го 12/31/2015 	Date/Time Pre 5/16/2016 4:1	
				INTERNS &	RESI DENTS	
Cost Center Description	SOCIAL SERVICE		NURSING SCHOOL	SERVI CES-SALAR		
		ANESTHETI STS		Y & FRINGES	PRGM COSTS	
	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
		TIME)	TIME)	(ASSI GNED	(ASSI GNED	
				TIME)	TIME)	
	17. 00	19. 00	20.00	21.00	22. 00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0.000000	0. 000000	205. 00

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150146 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/16/2016 4:15 pm Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17. 00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING SCHOOL 20.00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 53.00 00000000000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 54 00 54.01 05401 CAT SCAN 54.01 06000 LABORATORY 60.00 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 65.00 06500 RESPIRATORY THERAPY 65 00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 07697 CARDIAC REHABILITATION 76.97 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 76. 99 07699 LI THOTRI PSY 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190.00 00000 192.00 194.00 07950 OTHER NONREIMBURSABLE 194. 00 194. 01 07951 PAIN CLINIC 194. 01 194. 02 07952 OCC HEALTH 194. 02 194. 03 07953 FOUNDATION 194. 03 194. 04 07954 PHYSICIAN OFFICES 194.04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194.05 194.06 07956 VACANT SPACE 0 194.06 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203. 00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 205.00 H)

Health Financial Systems	COM	MUNITY HOSPT. O	F NOBLE CTY, I	NC.	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COST	S TO CHARGES			F	Period: From 01/01/2015 Fo 12/31/2015	Worksheet C Part I Date/Time Pre 5/16/2016 4:1	epared: 5 pm
			Ti tl	e XVIII	Hospi tal	PPS	
·					Costs		
Cost Center Desc	cription	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERV		_					_
30.00 03000 ADULTS & PEDIATR	RLCS	6, 802, 880		6, 802, 880		6, 802, 880	•
43. 00 04300 NURSERY		219, 835		219, 835	5 0	219, 835	43. 00
ANCILLARY SERVICE COST	T CENTERS	1	,				
50. 00   05000   OPERATI NG ROOM		3, 741, 053		3, 741, 053		3, 741, 053	
52. 00   05200   DELI VERY ROOM &	LABOR ROOM	1, 065, 069		1, 065, 069		1, 065, 069	
53. 00   05300   ANESTHESI OLOGY		16, 864	l .	16, 864		31, 081	
54. 00   05400   RADI OLOGY-DI AGNO	OSTI C	4, 241, 493		4, 241, 493		4, 241, 493	
54.01 05401 CAT SCAN		0			ا ا	0	
60. 00   06000   LABORATORY		3, 523, 727		3, 523, 727		3, 523, 727	
62. 30   06250   BLOOD CLOTTING F		0			ار	0	62. 30
65. 00 06500 RESPIRATORY THER		1, 267, 792				1, 267, 792	
66. 00 06600 PHYSI CAL THERAPY		1, 281, 137	l .	1, 281, 137		1, 281, 137	
67. 00 06700 OCCUPATI ONAL THE		584, 704	l .	584, 704		584, 704	
68.00 06800 SPEECH PATHOLOGY		253, 714		253, 714		253, 714	
69. 00   06900   ELECTROCARDI OLOG		23, 490		23, 490		23, 490	
71.00 07100 MEDICAL SUPPLIES		824, 840		824, 840		824, 840	
72. 00   07200   I MPL. DEV. CHARG		524, 551	l .	524, 551		524, 551	
73.00 07300 DRUGS CHARGED TO		4, 096, 705		4, 096, 705		4, 096, 705	
76. 97 07697 CARDI AC REHABI LI		0			1 1	0	1
76. 98   07698   HYPERBARI C OXYGE	N THERAPY	0				0	76. 98
76. 99 07699 LI THOTRI PSY		0			0	0	76. 99
OUTPATIENT SERVICE COS	ST CENTERS		1		_		
90. 00 09000 CLI NI C		69, 378		69, 378		69, 378	
91. 00   09100   EMERGENCY		3, 335, 446	l .	3, 335, 446		3, 335, 446	•
92. 00 09200 OBSERVATI ON BEDS		1, 242, 210		1, 242, 210	)	1, 242, 210	92. 00
OTHER REIMBURSABLE COS		0 770 505		0 770 50	-1 -1	0 770 505	05.00
95. 00 09500 AMBULANCE SERVIC		3, 773, 595		3, 773, 595		-,,	
200.00 Subtotal (see in		36, 888, 483		1,,			
201.00 Less Observation		1, 242, 210	l .	1, 242, 210		1, 242, 210	
202.00   Total (see instr	TUCTI ONS)	35, 646, 273	1	35, 646, 273	3 14, 217	35, 660, 490	1202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150146 Peri od: Worksheet C From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/16/2016 4:15 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 8, 756, 619 8, 756, 619 30.00 30.00 43.00 04300 NURSERY 552,050 552,050 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 354, 859 12, 704, 210 19, 059, 069 0.196287 0.000000 50.00 2. 737. 983 05200 DELIVERY ROOM & LABOR ROOM 2, 737, 983 0.388998 0.000000 52.00 52 00 53.00 05300 ANESTHESI OLOGY 926, 913 1, 942, 129 2, 869, 042 0.005878 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 553, 175 41, 670, 634 46, 223, 809 0.091760 0.000000 54.00 05401 CAT SCAN 0.000000 0.000000 54.01 54.01 13, 300, 276 06000 LABORATORY 3, 500, 953 16, 801, 229 0. 209730 0.000000 60.00 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 65.00 06500 RESPIRATORY THERAPY 1, 744, 842 4, 262, 131 6, 006, 973 0. 211053 0.000000 65.00 2, 745, 026 66.00 06600 PHYSI CAL THERAPY 3, 037, 548 0.421767 0.000000 66.00 292, 522 67.00 06700 OCCUPATIONAL THERAPY 24, 978 933, 275 958, 253 0.610177 0.000000 67.00 06800 SPEECH PATHOLOGY 28, 335 435, 327 463, 662 0.547196 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 437, 469 72, 180 509, 649 0.046091 0.000000 69.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 1, 877, 908 5.024.792 71 00 3, 146, 884 0.164154 0.000000 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,860,011 340, 899 2, 200, 910 0. 238334 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 6, 089, 711 15, 552, 514 0. 263411 0.000000 73.00 9, 462, 803 73.00 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 76.97 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0.000000 0.000000 76.98 76.99 07699 LI THOTRI PSY 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2 358 177 582 179 940 0.385562 0.000000 90 00 09100 EMERGENCY 91.00 2, 901, 990 21, 845, 134 24, 747, 124 0.134781 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 584, 415 1, 584, 415 0.784018 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 7, 866, 378 7, 866, 378 0.479712 200.00 Subtotal (see instructions) 42, 642, 676 122, 489, 283 165, 131, 959 200.00 201.00 Less Observation Beds 201. 00 202 00 Total (see instructions) 42, 642, 676 122, 489, 283 165 131 959 202 00

Heal th Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150146
From 01/01/2015
To 12/31/2015
Part I
Date/Time Prepared:

5/16/2016 4:15 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0. 196287 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 388998 52.00 05300 ANESTHESI OLOGY 53.00 0.010833 53.00 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C 0.091760 54.00 54.01 05401 CAT SCAN 0.000000 54.01 60.00 06000 LABORATORY 0. 209730 60.00 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 65. 00 06500 RESPIRATORY THERAPY 0. 211053 65.00 66. 00 06600 PHYSI CAL THERAPY 0. 421767 66.00 67. 00 06700 OCCUPATIONAL THERAPY 0. 610177 67.00 68.00 | 06800 | SPEECH PATHOLOGY 0.547196 68.00 69.00 06900 ELECTROCARDI OLOGY 0.046091 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 164154 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0. 238334 72.00 72.00 73.00 0. 263411 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 76. 98 76. 98 07699 LI THOTRI PSY 76. 99 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 385562 90.00 09100 EMERGENCY 0. 134781 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 0. 784018 92.00 95.00 09500 AMBULANCE SERVICES 0. 479712 95.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 202. 00

Health Financial Systems		COMMUNITY HOSPT. OI	F NOBLE CTY, II	NC.	In Lieu of Form CMS-25		2552-10
СОМРИТ	FATION OF RATIO OF COSTS TO CHARGES			<u> </u>	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/16/2016 4:1	
			Ti t	le XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 802, 880		6, 802, 880		6, 802, 880	
43. 00	04300 NURSERY	219, 835		219, 83!	5 0	219, 835	43. 00
	ANCILLARY SERVICE COST CENTERS		1	1			
50. 00		3, 741, 053	l .	3, 741, 053		3, 741, 053	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 065, 069		1, 065, 069		1, 065, 069	
53.00		16, 864		16, 86		31, 081	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 241, 493		4, 241, 493	3 0	4, 241, 493	
54. 01	05401 CAT SCAN	0		(	0	0	54. 01
60.00	06000 LABORATORY	3, 523, 727		3, 523, 72	7 0	3, 523, 727	60.00
62. 30		0	_		0	0	
65.00	06500 RESPIRATORY THERAPY	1, 267, 792	l .			1, 267, 792	
66.00	06600 PHYSI CAL THERAPY	1, 281, 137		1, 281, 13		1, 281, 137	
67. 00	1	584, 704		584, 704		584, 704	
68. 00		253, 714		253, 714		253, 714	
69. 00		23, 490	l .	23, 490		23, 490	1
71. 00				824, 840		824, 840	
	07200 IMPL. DEV. CHARGED TO PATIENTS	524, 551		524, 55		524, 551	
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	4, 096, 705		4, 096, 70	0	4, 096, 705	1
	1	0				0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0				0	
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS				J  U	0	76. 99
90. 00		69, 378		69, 378	8 0	69, 378	90.00
91. 00		3, 335, 446	l .	3, 335, 446		3, 335, 446	
	09200 OBSERVATION BEDS (NON-DISTINCT PA			1, 242, 210		1, 242, 210	
72.00	OTHER REIMBURSABLE COST CENTERS	1, 242, 210	1	1, 242, 210	<u>ا</u>	1, 242, 210	1 /2.00
95 00	09500 AMBULANCE SERVICES	3, 773, 595		3, 773, 59!	5 0	3, 773, 595	95 00
200.00		36, 888, 483	l .				
201.00		1, 242, 210		1, 242, 210		1, 242, 210	
202.00		35, 646, 273		1			
	1 (	1 22, 2.0, 2.0	'		-1=	,, ,,0	, .=

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150146 Peri od: Worksheet C From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/16/2016 4:15 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 8, 756, 619 8, 756, 619 30.00 30.00 43.00 04300 NURSERY 552,050 552,050 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 354, 859 12, 704, 210 19, 059, 069 0.196287 0.000000 50.00 2. 737. 983 05200 DELIVERY ROOM & LABOR ROOM 2, 737, 983 0.388998 0.000000 52.00 52 00 53.00 05300 ANESTHESI OLOGY 926, 913 1, 942, 129 2, 869, 042 0.005878 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 553, 175 41, 670, 634 46, 223, 809 0.091760 0.000000 54.00 05401 CAT SCAN 0.000000 0.000000 54.01 54.01 13, 300, 276 06000 LABORATORY 3, 500, 953 16, 801, 229 0. 209730 0.000000 60.00 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 65.00 06500 RESPIRATORY THERAPY 1, 744, 842 4, 262, 131 6, 006, 973 0. 211053 0.000000 65.00 2, 745, 026 66.00 06600 PHYSI CAL THERAPY 3, 037, 548 0.000000 66.00 292, 522 0.421767 67.00 06700 OCCUPATIONAL THERAPY 24, 978 933, 275 958, 253 0.610177 0.000000 67.00 06800 SPEECH PATHOLOGY 28, 335 435, 327 463, 662 0.547196 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 437, 469 72, 180 509, 649 0.046091 0.000000 69.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 1, 877, 908 5.024.792 71 00 3, 146, 884 0.164154 0.000000 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,860,011 340, 899 2, 200, 910 0. 238334 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 6, 089, 711 15, 552, 514 0. 263411 0.000000 73.00 9, 462, 803 73.00 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 76.97 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0.000000 0.000000 76.98 76.99 07699 LI THOTRI PSY 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2 358 177 582 179 940 0.385562 0.000000 90 00 09100 EMERGENCY 91.00 2, 901, 990 21, 845, 134 24, 747, 124 0.134781 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 584, 415 1, 584, 415 0.784018 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 7, 866, 378 7, 866, 378 0.479712 200.00 Subtotal (see instructions) 42, 642, 676 122, 489, 283 165, 131, 959 200.00 201.00 Less Observation Beds 201. 00 202 00 Total (see instructions) 42, 642, 676 122, 489, 283 165 131 959 202 00

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150146 | Period: From 01/01/2015 | Part I To 12/31/2015 | Part I Date/Time Prepared:

				To 12/31/2015	Date/Time Prepared: 5/16/2016 4:15 pm
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient	1, 1	, , , , , , , , , , , , , , , , , , ,	
	·	Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30. 00
43.00	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0. 196287			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 388998			52.00
53.00	05300 ANESTHESI OLOGY	0. 010833			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 091760			54.00
54. 01	05401 CAT SCAN	0. 000000			54. 01
60.00	06000 LABORATORY	0. 209730			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65.00	06500 RESPI RATORY THERAPY	0. 211053			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 421767			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 610177			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 547196			68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 046091			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 164154			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 238334			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 263411			73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99	07699 LI THOTRI PSY	0. 000000			76. 99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0. 385562			90.00
91. 00	09100 EMERGENCY	0. 134781			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 784018			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0. 479712			95. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00

Health Financial Systems COMMUNITY HOSPT.
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 150146

Title NIX						12/01/2010	5/16/2016 4:1	
Columbridge							PPS	
AMCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00		Cost Center Description	Total Cost	Capital Cost	Operating Cos	Capi tal	Operating Cost	
ANCILLARY SERVICE COST CENTERS								
NOTE			I, col. 26)	II col. 26)		-	Amount	
ANCILLARY SERVICE COST CENTERS   S0.00   COSCOO   OFFARTING ROOM   S0.00   COSCOO   OFFARTING ROOM   S0.00   S0.00   COSCOO   DELI VERY ROOM & LABOR ROOM   S0.00   S0.00   COSCOO   DELI VERY ROOM & LABOR ROOM   S0.00   S0.00   COSCOO   DELI VERY ROOM & LABOR ROOM   S0.00   S0.00   COSCOO   DELI VERY ROOM & LABOR ROOM   S0.00   S0.00   COSCOO								
50.00			1.00	2. 00	3. 00	4. 00	5. 00	
52. 00   05200   DELIVERY ROOM & LABOR ROOM   1, 065, 069   99, 516   965, 553   0   0   52. 00   53. 00   05300   ARSTHESI OLOGY   16, 864   1, 398   15, 466   0   0   53. 00   54. 01   05401   CAT SCAN   0   0   0   0   0   54. 01   05401   CAT SCAN   0   0   0   0   0   60. 00   06000   LABORATORY   3, 523, 727   278, 293   3, 245, 434   0   0   60. 00   65. 00   06500   RODO   CLOTTING FOR HEMOPHILIACS   0   0   0   0   0   65. 00   06500   RESPIRATORY THERAPY   1, 267, 792   135, 709   1, 132, 083   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   1, 281, 137   112, 961   1, 168, 176   0   0   66. 00   67. 00   06700   OCCUPATIONAL THERAPY   584, 704   44, 812   539, 892   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   253, 714   19, 448   234, 266   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   233, 490   2, 447   21, 043   0   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   824, 840   69, 344   755, 496   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   524, 551   40, 093   484, 458   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   524, 551   40, 093   484, 458   0   0   72. 00   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   76. 99   07699   LITHOTRI PSY   0   0   0   0   0   0   76. 99   07699   LITHOTRI PSY   0   0   0   0   0   0   76. 99   07699   LITHOTRI PSY   0   0   0   0   0   76. 99   07699   LITHOTRI PSY   0   0   0   0   0   77. 00   09000   ERREGENCY   3, 335, 446   310, 155   3, 025, 291   0   0   91. 00   791. 00   09100   ERREGENCY   3, 335, 446   310, 155   3, 025, 291   0   0   70   09100   DEBREGENCY   3, 335, 446   310, 155   3, 025, 291   0   0   70   09100   DEBREGENCY   3, 335, 446   310, 155   3, 025, 291   0   0   70   09100   DEBREGENCY   3, 335, 446   310, 155   3, 025, 291   0   0   70   09100   DEBREGENCY   3, 335, 446   310, 155   3, 025, 291   0   0   70   09100   DEBREGENCY   0   0   0   70   09100   DEBREGENCY   0   0   70   09100   DEBREGENCY   0   0   0   70   09100   DEBREG								
53.00         05300 ANESTHESI OLOGY         16,864         1,398         15,466         0         0         53.00           54.01         05400 RADI OLOGY-DI AGNOSTI C         4,241,493         521,344         3,720,149         0         0         54.01           60.00         06000 LABORATORY         3,523,727         278,293         3,245,434         0			1 ' '					
54. 00         0 5400   05401   05401   0AT SCAN         0         0         0         0         0         54. 01           60. 00   05401   0AT SCAN         0         0         0         0         0         54. 01           60. 00   06000   LABORATORY         3, 523, 727         278, 293         3, 245, 434         0         0         60. 00           62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS         0         0         0         0         0         0         62. 30           65. 00   06500   RESPI RATORY THERAPY         1, 267, 792   135, 709   1, 132, 083         0         0         65. 00           66. 00   06600   PHYSI CAL THERAPY         1, 281, 137   112, 961   1, 168, 176         0         0         66. 00           67. 00   06700   OCCUPATI ONAL THERAPY         1, 281, 137   112, 961   1, 168, 176         0         0         66. 00           68. 00   06800   SPEECH PATHOLOGY         253, 714   44, 812   539, 892   0         0         67. 00           69. 00   06900   ELECTROCARDI OLOGY         23, 490   2, 447   21, 043   0         0         68. 00           71. 00   0700   MEDI CAL SUPPLIES CHARGED TO PATI ENTS         824, 854   69, 344   755, 496   0         0         0         0         71. 00           72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS         40, 093   484			1 ' '				0	
54. 01   05401   CAT SCAN   0   0   0   0   0   0   0   0   0			1		•		0	
60. 00   06000   LABORATORY   3,523,727   278,293   3,245,434   0   0   60. 00   62. 30   6250   BLOOD CLOTTING FOR HEMOPHILIACS   0   0   0   0   0   0   62. 30   65. 00   06500   RESPIRATORY THERAPY   1,267,792   135,709   1,132,083   0   065. 00   66.			4, 241, 493	521, 344	3, 720, 14	9 0	0	
62. 30		05401  CAT SCAN	0	0	)	0	0	54. 01
65. 00 06500 RESPIRATORY THERAPY 1, 267, 792 135, 709 1, 132, 083 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 281, 137 112, 961 1, 168, 176 0 0 66. 00 67. 00 0CCUPATI ONAL THERAPY 584, 704 44, 812 539, 892 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 253, 714 19, 448 234, 266 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 23, 490 2, 447 21, 043 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 824, 840 69, 344 755, 496 0 0 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 524, 551 40, 093 484, 458 0 0 72. 00 7300 DRUGS CHARGED TO PATI ENTS 4, 096, 705 404, 563 3, 692, 142 0 0 73. 00 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3, 523, 727	278, 293	3, 245, 43	1 0	0	60.00
66. 00			0	0	)	0	0	
67. 00	65.00	06500 RESPI RATORY THERAPY	1, 267, 792	135, 709	1, 132, 08	3 0	0	65. 00
68. 00	66.00	06600 PHYSI CAL THERAPY	1, 281, 137	112, 961	1, 168, 17	5 0	0	66. 00
69. 00	67.00	06700 OCCUPATI ONAL THERAPY	584, 704	44, 812	539, 89	2 0	0	67.00
71. 00	68.00	06800 SPEECH PATHOLOGY	253, 714	19, 448	234, 26	5 0	0	68. 00
72. 00	69.00	06900 ELECTROCARDI OLOGY	23, 490	2, 447	21, 04	3 0	0	69. 00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	824, 840	69, 344	755, 49	0	0	71. 00
76. 97	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	524, 551	40, 093	484, 45	3 0	0	72. 00
76. 98   07698   HYPERBARI C 0XYGEN THERAPY   0   0   0   0   0   0   0   76. 98 76. 99   07699   LI THOTRI PSY   0   0   0   0   0   0   0   0   76. 99  OUTPATI ENT SERVI CE COST CENTERS  90. 00   09000   CLI NI C   69, 378   5, 328   64, 050   0   0   0   90. 00  91. 00   09100   EMERGENCY   3, 335, 446   310, 155   3, 025, 291   0   0   91. 00  92. 00   09200   08SERVATI ON BEDS (NON-DI STI NCT PART   1, 242, 210   126, 528   1, 115, 682   0   0   92. 00  OTHER REI MBURSABLE COST CENTERS  95. 00   09500   AMBULANCE SERVI CES   3, 773, 595   321, 403   3, 452, 192   0   0   95. 00  200. 00   Subtotal (sum of lines 50 thru 199)   29, 865, 768   3, 024, 511   26, 841, 257   0   0   200. 00  201. 00   Less Observation Beds   1, 242, 210   126, 528   1, 115, 682   0   0   201. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	4, 096, 705	404, 563	3, 692, 14	2 0	0	73. 00
76. 99 07699 LITHOTRI PSY 0 0 0 0 0 0 76. 99  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 69, 378 5, 328 64, 050 0 0 90. 00  91. 00 09100 EMERGENCY 3, 335, 446 310, 155 3, 025, 291 0 0 91. 00  92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 1, 242, 210 126, 528 1, 115, 682 0 0 92. 00  OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 3, 773, 595 321, 403 3, 452, 192 0 0 95. 00  200. 00 Subtotal (sum of lines 50 thru 199) 29, 865, 768 3, 024, 511 26, 841, 257 0 0 200. 00  201. 00 Less Observation Beds 1, 242, 210 126, 528 1, 115, 682 0 0 201. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	)	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
90. 00	76. 99	07699 LI THOTRI PSY	0	0		0	0	76. 99
91. 00								
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   1,242,210   126,528   1,115,682   0   0   92. 00   0THER REIMBURSABLE COST CENTERS   3,773,595   321,403   3,452,192   0   0   95. 00   0.00	90.00	09000 CLI NI C	69, 378	5, 328	64, 050	0	0	90.00
OTHER REIMBURSABLE COST CENTERS           95. 00         09500 AMBULANCE SERVICES         3,773,595         321,403         3,452,192         0         0         95.00           200. 00         Subtotal (sum of lines 50 thru 199)         29,865,768         3,024,511         26,841,257         0         0         200.00           201. 00         Less Observation Beds         1,242,210         126,528         1,115,682         0         0         201.00	91.00	09100 EMERGENCY	3, 335, 446	310, 155	3, 025, 29	0	0	91.00
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 242, 210	126, 528	1, 115, 68	2 0	0	92. 00
200.00 Subtotal (sum of lines 50 thru 199) 29,865,768 3,024,511 26,841,257 0 0 200.00 201.00 Less Observation Beds 1,242,210 126,528 1,115,682 0 0 201.00		OTHER REIMBURSABLE COST CENTERS						
201.00 Less Observation Beds 1, 242, 210 126, 528 1, 115, 682 0 0 201.00	95.00	09500 AMBULANCE SERVICES	3, 773, 595	321, 403	3, 452, 19:	2 0	0	95. 00
	200.00	Subtotal (sum of lines 50 thru 199)	29, 865, 768	3, 024, 511	26, 841, 25	7 0	0	200. 00
202.00   Total (line 200 minus line 201)   28,623,558   2,897,983   25,725,575   0   0   202.00	201.00	Less Observation Beds	1, 242, 210	126, 528	1, 115, 68	2 0	0	201. 00
	202.00	Total (line 200 minus line 201)	28, 623, 558	2, 897, 983	25, 725, 57	5 0	0	202. 00

Health Financial Systems COMMUNITY HOSPT.
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF In Lieu of Form CMS-2552-10 Peri od: Worksheet C
From 01/01/2015 Part II
To 12/31/2015 Date/Time Prepared: 5/16/2016 4:15 pm Provider CCN: 150146 REDUCTIONS FOR MEDICALD ONLY

						5/16/2016 4: 15 pm
				le XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to Charg	е	
		Operating Cost	Part I, column	Ratio (col.	6	
		Reducti on	8)	/ col. 7)		
		6.00	7.00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	3, 741, 053	19, 059, 069	0. 19628	7	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 065, 069	2, 737, 983	0. 38899	8	52. 00
53.00	05300 ANESTHESI OLOGY	16, 864	2, 869, 042	0. 00587	8	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 241, 493	46, 223, 809	0. 09176	0	54.00
54.01	05401 CAT SCAN	0	0	0.00000	0	54. 01
60.00	06000 LABORATORY	3, 523, 727	16, 801, 229	0. 20973	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0	62. 30
65.00	06500 RESPI RATORY THERAPY	1, 267, 792	6, 006, 973	0. 21105	3	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 281, 137	3, 037, 548	0. 42176	7	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	584, 704	958, 253	0. 61017	7	67. 00
68.00	06800 SPEECH PATHOLOGY	253, 714	463, 662	0. 54719	6	68. 00
69.00	06900 ELECTROCARDI OLOGY	23, 490	509, 649	0. 04609	1	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	824, 840	5, 024, 792	0. 16415	4	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	524, 551	2, 200, 910	0. 23833	4	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 096, 705	15, 552, 514	0. 26341	1	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.00000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	•	•		
90.00	09000 CLI NI C	69, 378	179, 940	0. 38556	2	90.00
91.00	09100 EMERGENCY	3, 335, 446	24, 747, 124	0. 13478	1	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 242, 210	1, 584, 415	0. 78401	8	92. 00
	OTHER REIMBURSABLE COST CENTERS		,			
95.00	09500 AMBULANCE SERVI CES	3, 773, 595	7, 866, 378	0. 47971	2	95. 00
200.00	1 1	29, 865, 768				200. 00
201.00	1 1 ,	1, 242, 210				201. 00
202.00	1 1	28, 623, 558				202. 00
		•	•	•		'

Health Financial Systems COMM	MUNITY HOSPT. O	F NOBLE CTY, II	NC.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015		nared:
				10 12/31/2013	5/16/2016 4:1	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	692, 919	C	692, 91	9 6, 966	99. 47	30.00
43. 00 NURSERY	20, 037		20, 03	7 555	36. 10	43.00
200.00 Total (lines 30-199)	712, 956		712, 95	6 7, 521		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 216	220, 426	b			30.00
43. 00 NURSERY	0	C				43.00
200.00 Total (lines 30-199)	2, 216	220, 426	<b>5</b>			200. 00

Health Financial Systems COMM	MUNITY HOSPT. O	F NOBLE CTY, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2015		nanad.
				To 12/31/2015	Date/Time Pre 5/16/2016 4:1	
		Ti tl	e XVIII	Hospi tal	PPS	o piii
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_					
50. 00   05000   OPERATI NG ROOM	531, 169		•		47, 803	
52.00  05200 DELIVERY ROOM & LABOR ROOM	99, 516		•		0	52. 00
53. 00   05300   ANESTHESI OLOGY	1, 398				120	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	521, 344	46, 223, 809			22, 689	54.00
54. 01  05401 CAT SCAN	0		0.00000		0	54. 01
60. 00   06000   LABORATORY	278, 293	16, 801, 229	0. 01656	4 1, 426, 903	23, 635	60.00
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	_	0.0000		0	62. 30
65. 00 06500 RESPIRATORY THERAPY	135, 709	6, 006, 973	0. 02259	2 713, 477	16, 119	65. 00
66. 00   06600 PHYSI CAL THERAPY	112, 961	3, 037, 548	0. 03718	8 152, 052	5, 655	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	44, 812	958, 253	0. 04676	4 8, 573	401	67. 00
68. 00 06800 SPEECH PATHOLOGY	19, 448	463, 662	0. 04194	4 19, 181	805	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 447	509, 649	0. 00480	1 246, 052	1, 181	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	69, 344	5, 024, 792	0. 01380	0 354, 895	4, 898	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	40, 093	2, 200, 910	0. 01821	7 812, 522	14, 802	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	404, 563	15, 552, 514	0. 02601	3 2, 249, 049	58, 505	73. 00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0	0	0.00000	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000	0	0	76. 98
76. 99   07699 LI THOTRI PSY	0	0	0. 00000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	5, 328	179, 940	0. 02961	0 296	9	90.00
91. 00 09100 EMERGENCY	310, 155	24, 747, 124	0. 01253	3 1, 371, 729	17, 192	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	126, 528	1, 584, 415	0. 07985	8 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	2, 703, 108	147, 956, 912		11, 327, 490	213, 814	200. 00

Health Financial Systems COMM	MUNITY HOSPT. O	F NOBLE CTY, II	NC.	In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der		Period: From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/16/2016 4:1	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0		0	0	30. 00
43. 00   04300   NURSERY	0	0	)	o	0	43.00
200.00 Total (lines 30-199)	0	0	)	o	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpatient		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 966	0.00	2, 21	6 0	,	30.00
43. 00   04300 NURSERY	555	0.00		0	,	43.00
200.00 Total (lines 30-199)	7, 521		2, 21	6 0	,	200.00
		'	•	'	•	•

Health Financial Systems	COMMUNITY HOSPT. OF NOB	SLE CTY, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150146	From 01/01/2015	Worksheet D Part IV Date/Time Prepared: 5/16/2016 4:15 pm

11111000				Т	o 12/31/2015	Date/Time Pre 5/16/2016 4:1	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
						4)	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS		_	_	_	_	
50. 00	05000 OPERATI NG ROOM	0	C		0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0	0	0	52. 00
	05300 ANESTHESI OLOGY	0	C	0	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	C		0	0	54.00
	05401 CAT SCAN	0	C	0	0	0	54. 01
60. 00	06000 LABORATORY	0	C	0	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	C	0	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	C	0	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	C	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	C	0	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	C	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	C	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	C	) <u> </u>	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	C	) C	0	0	, , , , , ,
	09100 EMERGENCY	0	C	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C	) <u> </u>	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	1			1		
	09500 AMBULANCE SERVICES					1	95. 00
200. 00	Total (lines 50-199)	[ 0	C	)  C	0	, 0	200. 00

Health Financial Systems	COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lie					2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2015		
			[	To 12/31/2015	Date/Time Pre	pared:
					5/16/2016 4:1	5 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7.00	8. 00	9. 00	10.00	

		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		I npati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	19, 059, 069	0.000000	0.000000	1, 715, 209	50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	2, 737, 983	0.000000	0. 000000	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	2, 869, 042	0.000000	0.000000	245, 914	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	46, 223, 809	0.000000	0.000000	2, 011, 638	54.00
54. 01  05401   CAT   SCAN	0	0	0. 000000	0.000000	0	54. 01
60. 00   06000   LABORATORY	0	16, 801, 229	0.000000	0.000000	1, 426, 903	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 000000	0.000000	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	6, 006, 973	0. 000000	0.000000	713, 477	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	3, 037, 548	0. 000000	0.000000	152, 052	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	958, 253	0. 000000	0. 000000	8, 573	67.00
68. 00 06800 SPEECH PATHOLOGY	0	463, 662	0. 000000	0. 000000	19, 181	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	509, 649	0. 000000	0. 000000	246, 052	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 024, 792		0. 000000	354, 895	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 200, 910		0. 000000	812, 522	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	15, 552, 514	0. 000000	0.000000	2, 249, 049	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 000000	0. 000000	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 000000		0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 000000		0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	179, 940	0.000000	0.000000	296	90.00
91. 00 09100 EMERGENCY	0	24, 747, 124	0. 000000	0. 000000	1, 371, 729	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 584, 415	0. 000000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	147, 956, 912			11, 327, 490	200. 00
			•			

THROUGH COSTS

					12, 01, 2010	5/16/2016 4:1	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col.	9		
		x col. 10)		x col. 12)			
	T	11. 00	12. 00	13. 00			
	ANCILLARY SERVICE COST CENTERS			ı	_		4
50. 00	05000 OPERATING ROOM	0	2, 909, 309		0		50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53.00	05300 ANESTHESI OLOGY	0	392, 451		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 163, 137		0		54.00
54. 01	05401 CAT SCAN	0	0		0		54. 01
60.00	06000 LABORATORY	0	536, 525		0		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62. 30
65. 00	06500 RESPI RATORY THERAPY	0	680, 049	l .	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	61, 865		0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	5, 780		0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1, 014		0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	42, 063		0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	229, 036		0		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	61, 319	l .	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 755, 262		0		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0		76. 98
76. 99	07699 LI THOTRI PSY	0	0		0		76. 99
	OUTPATIENT SERVICE COST CENTERS		0.110	1			
	09000 CLI NI C	0	8, 140		0		90.00
91.00	09100 EMERGENCY	0	4, 650, 825	l .	0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	861, 839		U		92.00
05.00	OTHER REIMBURSABLE COST CENTERS	1					05.00
	09500 AMBULANCE SERVICES		22 250 744				95. 00
200.00	Total (lines 50-199)	0	22, 358, 614	l	0		200. 00

Heal th	Financial Systems COMM	MUNITY HOSPT. OF	NOBLE CTY, II	NC.	In Lie	u of Form CMS-	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
					From 01/01/2015 To 12/31/2015	Part V Date/Time Pre	narod:
					10 12/31/2013	5/16/2016 4:1	pareu. 5 nm
			Ti tl	e XVIII	Hospi tal	PPS	<u>o p</u>
			<u> </u>	Charges	<u> </u>	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1		1			
	05000 OPERATING ROOM	0. 196287	2, 909, 309	1	0	571, 060	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 388998	0	1	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 005878	392, 451		0	2, 307	
		0. 091760	9, 163, 137		0	840, 809	
54. 01	05401   CAT   SCAN	0. 000000	0	1	0	0	0 0 .
60.00	06000 LABORATORY	0. 209730	536, 525		0	112, 525	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	1	0	0	02.00
65.00	06500 RESPI RATORY THERAPY	0. 211053	680, 049	1	0	143, 526	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 421767	61, 865		0	26, 093	
67.00	06700 OCCUPATI ONAL THERAPY	0. 610177	5, 780		0 0	3, 527	67.00
68.00	06800 SPEECH PATHOLOGY	0. 547196	1, 014		0 0	555	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 046091	42, 063		0 0	1, 939	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 164154	229, 036	,	0 0	37, 597	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 238334	61, 319	1	0 0	14, 614	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 263411	2, 755, 262		0	725, 766	73. 00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0	)	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	)	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0	)	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 385562	8, 140		0 0	3, 138	90.00
91.00	09100 EMERGENCY	0. 134781	4, 650, 825		0 0	626, 843	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 784018	861, 839		0	675, 697	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 479712			0		95. 00
200.00			22, 358, 614		0 0	3, 785, 996	
201.00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		22, 358, 614		0 0	3, 785, 996	202. 00

| Peri od: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared: Provider CCN: 150146

				10 12/31/2015	5/16/2016 4:1	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM			1			50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM						52. 00
53. 00   05300   ANESTHESI OLOGY	0					53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0					54. 00
54. 01   05401   CAT   SCAN	0					54. 01
60. 00   06000   LABORATORY	0					60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		á			62. 30
65. 00 06500 RESPIRATORY THERAPY	0		á			65.00
66. 00 06600 PHYSI CAL THERAPY	0	Ì				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ì				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	ď				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		ol			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l	ol			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	l c				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C				73. 00
76. 97 07697 CARDIAC REHABILITATION	0	C				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C	)			76. 98
76. 99 07699 LI THOTRI PSY	0	C	)			76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C				90.00
91. 00   09100   EMERGENCY	0	C				91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	0		)			92. 00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES	0	_				95. 00
200.00 Subtotal (see instructions)	0	(	ון			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges 202.00 Net Charges (line 200 +/- line 201)	_	,				202. 00
202.00	1	0	<b>1</b> 1			J2U2. UU

Health Financial Systems COMM	IUNI TY HOSPT. OI	F NOBLE CTY, II	NC.	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/16/2016 4:1	
		Ti t	le XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	692, 919	0	692, 919	6, 966	99. 47	30.00
43. 00 NURSERY	20, 037		20, 037	555	36. 10	43.00
200.00 Total (lines 30-199)	712, 956		712, 956	7, 521		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30.00 ADULTS & PEDIATRICS	233	23, 177	'			30.00
43. 00 NURSERY	73	2, 635	5			43. 00
200.00 Total (lines 30-199)	306	25, 812	2			200. 00

Health Financial Systems COMM	MUNITY HOSPT. OI	F NOBLE CTY, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/16/2016 4:1	
		Ti t	le XIX	Hospi tal	PPS	э рііі
Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	531, 169	19, 059, 069	0. 02787	0 1, 537, 329	42, 845	50.00
52.00  05200 DELIVERY ROOM & LABOR ROOM	99, 516	2, 737, 983	0. 03634	6 0	0	52.00
53. 00   05300   ANESTHESI OLOGY	1, 398	2, 869, 042	0. 00048	7 163, 296	80	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	521, 344	46, 223, 809	0. 01127	9 546, 024	6, 159	54.00
54. 01  05401 CAT SCAN	0	0	0.00000	0 0	0	54. 01
60. 00   06000   LABORATORY	278, 293	16, 801, 229	0. 01656	4 519, 289	8, 602	60.00
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	135, 709	6, 006, 973	0. 02259	255, 340	5, 769	65. 00
66. 00   06600 PHYSI CAL THERAPY	112, 961	3, 037, 548	0. 03718	8 18, 499	688	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	44, 812	958, 253	0. 04676	4 2, 859	134	67. 00
68. 00 06800 SPEECH PATHOLOGY	19, 448	463, 662	0. 04194	4 584	24	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 447	509, 649	0.00480	1 27, 096	130	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	69, 344	5, 024, 792	0. 01380	0 213, 392	2, 945	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	40, 093	2, 200, 910	0. 01821	7 102, 250	1, 863	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	404, 563	15, 552, 514	0. 02601	3 1, 060, 313	27, 582	73. 00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0	0	0.00000	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	5, 328	179, 940	0. 02961	0 666	20	90.00
91. 00 09100 EMERGENCY	310, 155	24, 747, 124	0. 01253	384, 792	4, 823	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	126, 528	1, 584, 415	0. 07985	8 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	2, 703, 108	147, 956, 912		4, 831, 729	101, 664	200. 00

Health Financial Systems COMM	Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form					
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der		Period: From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cos	,	Total Costs (sum of cols. 1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00  03000  ADULTS & PEDI ATRI CS	0	0	)	0	- 0	30. 00
43. 00   04300   NURSERY	0	0	)	O	0	43.00
200.00 Total (lines 30-199)	0	0	)	0	0	200.00
Cost Center Description	Days	Per Diem (col. 5 ÷ col. 6)	Program Days	Pass-Through Cost (col. 7 x col. 8)		
	6.00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	6, 966	0.00	23:	3 0	,	30.00
43. 00   04300   NURSERY	555	0.00	7:	3 0	,	43.00
200.00   Total (lines 30-199)	7, 521		300	6 0		200. 00

Health Financial Systems	COMMUNITY HOSPT. OF NOB	SLE CTY, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150146		Worksheet D Part IV Date/Time Prepared: 5/16/2016 4:15 pm

	666.6				Т	o 12/31/2015	Date/Time Pre 5/16/2016 4:1	
				Ti tl	e XIX	Hospi tal	PPS	-
	Cost Center Description	Non Physician	Nursing S	School	Allied Health	All Other	Total Cost	
	·	Anestheti st				Medi cal	(sum of col 1	
		Cost				Education Cost	through col.	
							4)	
		1.00	2.00	)	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0	)	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	)	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	)	0	0	0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	)	0	0	0	0	54. 00
54. 01	05401   CAT   SCAN	0	)	0	0	0	0	54. 01
60.00	06000 LABORATORY	0	)	0	0	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	)	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	)	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	)	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	)	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	)	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	)	0	0	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	)	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	)	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	)	0	0	0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	)	0	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	)	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0		0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS							
90. 00	09000 CLI NI C	0	)	0	0	0	0	90. 00
	09100 EMERGENCY	0	)	0	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS							
	09500 AMBULANCE SERVICES							95. 00
200.00	Total (lines 50-199)	0	)	0	0	0	0	200. 00

Health Financial Systems	COMMUNITY HOODT OF	E NOD	LE CTV III	IC.	la lio	u of Form CMC (	DEED 10
Health Financial Systems  APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	COMMUNITY HOSPT. OI SERVICE OTHER PASS				Peri od:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS					From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre 5/16/2016 4:1	
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Total	Tota	I Charges	Ratio of Cos	t Outpatient	I npati ent	
	Outpati ent			to Charges	Ratio of Cost	Program	
	Cost (sum of				. to Charges	Charges	

					07 107 20 10 1. 10	<u> </u>
			le XIX	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		I npati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.	to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS	1		•			
50.00   05000   OPERATING ROOM	0	19, 059, 069			1, 537, 329	
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	2, 737, 983			0	52.00
53. 00   05300   ANESTHESI OLOGY	0	2, 869, 042			163, 296	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	46, 223, 809	0.000000	0.000000	546, 024	54. 00
54. 01  05401   CAT   SCAN	0	0	0.000000	0.000000	0	54. 01
60. 00   06000   LABORATORY	0	16, 801, 229	0.000000	0.000000	519, 289	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	6, 006, 973	0.000000	0.000000	255, 340	65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 037, 548	0. 000000	0.000000	18, 499	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	958, 253	0. 000000	0.000000	2, 859	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	463, 662	0. 000000	0. 000000	584	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	509, 649	0. 000000	0. 000000	27, 096	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 024, 792	0. 000000	0. 000000	213, 392	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 200, 910	0. 000000	0. 000000	102, 250	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	15, 552, 514			1, 060, 313	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 000000		0	76, 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 000000		0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 000000		0	76. 99
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLI NI C	0	179, 940	0.000000	0.000000	666	90.00
91, 00 09100 EMERGENCY	0	24, 747, 124			384, 792	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 584, 415			0	
OTHER REIMBURSABLE COST CENTERS	-	., .,			-	
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	147, 956, 912			4, 831, 729	
	1	1, ,00, ,	1	ı I	., 55., 72.	

Date/Time Prepared: 5/16/2016 4:15 pm Title XIX Hospi tal PPS Cost Center Description I npati ent Outpati ent Outpati ent Program Program Program Pass-Through Pass-Through Charges Costs (col. Costs (col. x col . 10) 11.00 x col. 12) 13.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 01 0 05401 CAT SCAN 54.01 54.01 60.00 06000 LABORATORY 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 65.00 06500 RESPIRATORY THERAPY 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 66.00 67. 00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 69. 00 06900 ELECTROCARDI OLOGY 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 76. 97 07697 CARDIAC REHABILITATION 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 07699 LI THOTRI PSY 0 76. 99 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 00 09000 CLI NI C 0 0 90.00 91. 00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

o

0

0

200.00

200.00

Total (lines 50-199)

Cost Center Description			WUNITY HUSPI. U				eu or Form CMS	2552-10
Title XIX	APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der			Worksheet D	
Title XIX								
Title XIX						To 12/31/2015		
Cost Center Description				T: +	Lo VIV	Haani tal		5 pm
Cost Center Description				1111		ноѕрі таі		
Ratio From Worksheet C, Part I. col. 9   Services   Subject To   Ded. & Colns.   See inst. )   Ded. & Colns.   See inst.   See inst.   Ded. & Colns.   Ded. & Colns.   See inst.   Ded. & Colns.   See		0+ 0+ D	C+ +- Ch	DDC Delimbrose		0+		
Morksheet C, Part I, col. 9		Cost Center Description						
Part I, col. 9							(see inst.)	
Note   Ded. & Coins.   Coins								
Note			Part I, coi. 9		,			
ANCI LLARY SERVICE COST CENTERS								
ANCILLARY SERVICE COST CENTERS			1.00	0.00				
50. 00   05000   0PERATING ROOM   0. 196287   0   2, 160, 352   0   0   0   50. 05		LLADY OFFINIAE COOT OFFITEDO	1.00	2.00	3.00	4.00	5.00	
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0.388998   0   0   0   0   0   52. 00   53. 00   05300   AMESTHESI OLOGY   0.005878   0.286, 741   0   0.53.00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.091760   0.7, 158, 716   0   0.54. 00   54. 01   05401   CAT SCAN   0.000000   0   0   0   0   60. 00   06000   LABORATORY   0.209730   0.209730   0.2060, 448   0   0.60.00   62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0.000000   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0.211653   0.386, 423   0   0.65. 00   66. 00   06600   PHYSI CAL THERAPY   0.421767   0.515, 860   0   0.65. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0.610177   0.273, 432   0   0.67. 00   68. 00   06800   SPEECH PATHOLOGY   0.5417196   0.231, 593   0.0680   69. 00   06900   ELECTROCARDI OLOGY   0.046091   0.14, 445   0.0680   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0.164154   0.256, 266   0.071. 00   72. 00   07200   MPL. DEV. CHARGED TO PATI ENT   0.164154   0.256, 266   0.071. 00   76. 98   07699   CARDI AC REHABI LI TATI ON   0.000000   0.00000   0.00000   0.00000   76. 98   07699   CARDI AC REHABI LI TATI ON   0.000000   0.00000   0.00000   0.00000   0.00000   76. 99   07699   CLINIC   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   76. 90   07699   CLINIC   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000				1		_1	_	
53. 00   05300   ANESTHESI OLOGY   0.005878   0   286, 741   0   0   53. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.091760   0   7,158, 716   0   0   54. 00   60. 00   06400   CAT SCAN   0.000000   0   0   0   0   60. 00   06000   LABORATORY   0.209730   0   2,060,448   0   0   60. 00   62. 30   06250   BLOOD CLOTTI NG FOR HEMOPHI LI ACS   0.000000   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0.211053   0   386,423   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0.421767   0   515,860   0   0   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0.610177   0   273,432   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0.547196   0   231,593   0   0   69. 00   06900   ELECTROCARDI OLOGY   0.046091   0   14,445   0   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0.164154   0   256,266   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.238334   0   24,701   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.238334   0   24,701   0   0   72. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   0.000000   0   0   0   0   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0.000000   0   0   0   0   76. 99   07699   LI HOTRI PSY   0.000000   0   0   0   0   76. 90   07699   LI TORTI PSY   0.000000   0   0   0   0   76. 90   07699   LI TORTI PSY   0.000000   0   0   0   0   71. 00   07100   EMERGENCY   0.134781   0   6,488,596   0   0   90. 0   71. 00   07100   EMERGENCY   0.134781   0   6,488,596   0   0   90. 0   71. 00   07100   EMERGENCY   0.134781   0   6,488,596   0   0   90. 0   71. 00   07100   Subtotal (see instructions)   0   22,639,693   0   0   20.00000   71. 00   07100   Subtotal (see instructions)   0   0.00000   0   0   71. 00   07100   Subtotal (see instructions)   0   0.00000   0   0   71. 00   07100   Subtotal (see instructions)   0   0.00000   0   71. 00   07100   Subtotal (see instructions)   0   0.000000   0   71. 00   07100   07100   07100   07100   71. 00   07100   07100   07100   07100   71. 00   07100   07100					2, 160, 35	2 0	ľ	
54. 00						0	0	
54. 01   05401   CAT SCAN   0.000000   0   0   0   0   0   54. 00   60. 00   06000   LABORATORY   0.209730   0   2,060,448   0   0   60.00   62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0.000000   0   0   0   0   65. 00   06500   RESPIRATORY THERAPY   0.211053   0   386,423   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0.421767   0   515,860   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0.610177   0   273,432   0   0   67. 00   69. 00   06800   SPEECH PATHOLOGY   0.547196   0   231,593   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0.046091   0   14,445   0   0   69. 00   71. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATIENT   0.164154   0   256,266   0   0   71. 00   72. 00   07200   MPU. DEV. CHARGED TO PATIENTS   0.238334   0   24,701   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.238334   0   24,701   0   0   72. 00   76. 99   07697   CARDI AC REHABI LITATI ON   0.000000   0   0   0   0   76. 9   76. 99   07699   LITHOTRI PSY   0.000000   0   0   0   0   0   76. 99   07699   LITHOTRI PSY   0.000000   0   0   0   0   90. 00   09000   CLINIC C   0.385562   0   4,736   0   0   91. 00   91. 00   09100   MERGENCY   0.134781   0   6,488,596   0   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0.784018   0   561,427   0   0   92. 00   95. 00   09500   ABBULANCE SERVICES   0.479712   0   1,227,270   95. 00   09500   ABBULANCE SERVICES   0.479712   0   1,227,270   90. 00   00   00   00   00   00   00   0							0	53. 00
60. 00 06000 LABORATORY 0. 209730 0 2, 060, 448 0 0 0 60. 062. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0			l .	l .	7, 158, 71	6 0	0	54.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 0 0 0 0 62. 3 65. 00 6500 RESPIRATORY THERAPY 0.211053 0 386, 423 0 0 65. 00 66. 00	54. 01   0540	01 CAT SCAN	0. 000000	0		0	0	54. 01
65. 00 06500 RESPIRATORY THERAPY 0. 211053 0 386, 423 0 0 665.00 666.00 06600 PHYSI CAL THERAPY 0. 421767 0 515, 860 0 0 66.00 667.00 0CCUPATI ONAL THERAPY 0. 610177 0 273, 432 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0. 610177 0 273, 432 0 0 67.00 0CCUPATI ONAL THERAPY 0. 610177 0 273, 432 0 0 67.00 0CCUPATI ONAL THERAPY 0. 640177 0 273, 432 0 0 67.00 0CCUPATI ONAL THERAPY 0. 640091 0 14, 445 0 0 68.00 0CCUPATI ONAL SUPPLIES CHARGED TO PATI ENT 0. 164154 0 256, 266 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 164154 0 256, 266 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 238334 0 24, 701 0 0 72.00 07300 DRUGS CHARGED TO PATI ENTS 0. 263411 0 988, 687 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 263411 0 988, 687 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60.00 0600	00 LABORATORY	0. 209730	0	2, 060, 44	8 0	0	60.00
66. 00	62. 30 0625	BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62. 30
67. 00 06700 OCCUPATIONAL THERAPY	65.00 0650	00 RESPI RATORY THERAPY	0. 211053	0	386, 42	3 0	0	65.00
68. 00	66.00 0660	OO PHYSI CAL THERAPY	0. 421767	0	515, 86	0 0	0	66. 00
68. 00	67.00 0670	OO OCCUPATIONAL THERAPY	0. 610177	0	273, 43	2 0	0	67.00
71. 00	68. 00 0680	OO SPEECH PATHOLOGY	0. 547196	0	231, 59	3 0	0	68. 00
71. 00	69. 00 0690	OO ELECTROCARDI OLOGY	0. 046091	1 0	14. 44	5 0	0	69.00
72. 00				l .			0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 263411 0 988, 687 0 0 73. 0 76. 97 07697 CARDI AC REHABILITATION 0. 000000 0 0 0 0 0 76. 9 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0. 000000 0 0 0 0 0 0 76. 9 07699 LITHOTRI PSY 0. 000000 0 0 0 0 0 0 0 76. 9 0UTPATIENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0. 385562 0 4, 736 0 0 99. 0 91. 00 09100 EMERGENCY 0. 134781 0 6, 488, 596 0 0 91. 0 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0. 784018 0 561, 427 0 0 92. 0 0THER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 0. 479712 0 1, 227, 270 95. 0 200. 00 Subtotal (see instructions) 0 22, 639, 693 0 0 200. 0		l e e e e e e e e e e e e e e e e e e e		l .			0	72. 00
76. 97							0	73. 00
76. 98   07698   HYPERBARI C 0XYGEN THERAPY   0. 000000   0   0   0   0   0   76. 9   76. 99   07699   LI THOTRI PSY   0. 000000   0   0   0   0   0   76. 9   76. 99   07699   LI THOTRI PSY   0. 000000   0   0   0   0   0   76. 90   00   09100   CLI NI C   0. 385562   0   4, 736   0   0   0   77. 00   09100					100,00	0 0	o o	76. 97
76. 99 07699 LITHOTRI PSY 0. 000000 0 0 0 0 0 76. 9  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0. 385562 0 4, 736 0 0 90. 0  91. 00 09100 EMERGENCY 0. 134781 0 6, 488, 596 0 0 91. 0  92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 784018 0 561, 427 0 0 0  OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 0. 479712 0 1, 227, 270  200. 00 Subtotal (see i nstructions) 0 22, 639, 693 0 0 200. 0						0 0	o o	76. 98
OUTPATIENT SERVICE COST CENTERS   O				l .		0 0	l o	76. 99
90. 00			0. 000000			<u> </u>	<u> </u>	1 70. 77
91. 00   09100   EMERGENCY   0. 134781   0   6, 488, 596   0   0   91. 0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0. 784018   0   561, 427   0   0   95. 00   09500   AMBULANCE SERVICES   0. 479712   0   1, 227, 270   95. 0   200. 00   Subtotal (see instructions)   0   22, 639, 693   0   0   200. 00			0.385562		A 73	6 0	n	90.00
92. 00							· -	91.00
OTHER REI MBURSABLE COST CENTERS         0.479712         0 1,227,270         95. 0           200. 00         Subtotal (see instructions)         0 22,639,693         0 0 200. 0								
95. 00 09500 AMBULANCE SERVICES 0. 479712 0 1, 227, 270 95. 0 200. 00 Subtotal (see instructions) 0 22, 639, 693 0 0 200. 0			0.704010	0	301, 42	7	0	72.00
200.00   Subtotal (see instructions)   0   22,639,693   0   0   200.00			0 470712		1 227 27			95 00
			0.4/9/12				_	
ZUI, UUI     LESS FDF CITIII C LAD, SELVICES-FI UUI AIII					22, 039, 09	0		
	201.00					U U		201.00
Only Charges 202.00 Net Charges (line 200 +/- line 201) 0 22,639,693 0 0 202.0	202 00				22 620 60	2	_	202. 00
202. 00	202.00	inet charges (Title 200 +/- Title 201)	1	1	22,039,09	٥ ا	ı	1202.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 150146 Peri od: Worksheet D From 01/01/2015 To 12/31/2015 Part V Date/Time Prepared: 5/16/2016 4:15 pm Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 424, 049 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 1. 685 0 53.00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0 656, 884 54.00 54.01 05401 CAT SCAN 54.01 60.00 06000 LABORATORY 0 60.00 432 138 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 65. 00 06500 RESPIRATORY THERAPY 81, 556 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 217, 573 66.00 06700 OCCUPATIONAL THERAPY 0 166, 842 67 00 67 00 68.00 06800 SPEECH PATHOLOGY 126, 727 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 666 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 42,067 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 5, 887 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 260, 431 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 76. 98 07699 LI THOTRI PSY 76. 99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 1,826 874, 539 09100 EMERGENCY 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 440, 169 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 588, 736 95.00 Subtotal (see instructions) 200.00 0 200.00 4, 321, 775 Less PBP Clinic Lab. Services-Program 201.00 201. 00

4, 321, 775

202.00

Only Charges

Net Charges (line 200 +/- line 201)

202.00

Health Financial Systems	COMMUNITY HOSPT. OF NOB	LE CTY, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150146	Peri od: From 01/01/2015	Worksheet D-1
				Date/Time Prepared: 5/16/2016 4:15 pm
		Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	5/16/2016 4:1 PPS	5 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	oveludina newborn)		6, 966	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed days,			6, 966	2.00
3.00	Private room days (excluding swing-bed and observation bed days	). If you have only pr	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		5, 694	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0,074	5. 00
	reporting period	3 7			
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	1 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	2, 216	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, ent			0	40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program	0	14. 00		
15. 00	Total nursery days (title V or XIX only)	(		0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	0. 00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0. 00	19. 00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0. 00			
	reporting period	arter becomber 31 of the	10 0031		
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost report	na period (line	6, 802, 880 0	21. 00 22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		6, 802, 880	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		-	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	11 0113)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,	ļ	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	6, 802, 880	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i		I	976. 58	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1)  Program general inpatient routine service cost (line 9 x line 3)	•		2, 164, 101	39. 00
40. 00	Medically necessary private room cost applicable to the Program	-		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		2, 164, 101	41. 00

JIVIPUI	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150146	Peri od: From 01/01/2015	Worksheet D-1	1	
					To 12/31/2015	Date/Time Pre 5/16/2016 4:1		
	0.10.1.0	T		e XVIII	Hospi tal	PPS		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per SDiem (col. 1		Program Cost (col. 3 x col.		
		Impatrent oost	Impatront bay.	col . 2)	·	4)		
- 00	NUDCEDY (+: +1 - V 0 VIV1.)	1.00	2.00	3.00	4.00	5. 00	12	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.	00 0		42.	
00	INTENSIVE CARE UNIT						43.	
00	CORONARY CARE UNIT						44.	
00	BURN INTENSIVE CARE UNIT						45	
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46 47	
00	Cost Center Description						47	
	<u> </u>					1.00		
00	Program inpatient ancillary service cost (Wk			>		2, 094, 299		
00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructi	ons)		4, 258, 400	49	
00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	220, 426	50	
00	III)		•					
00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	213, 814	51	
00	Total Program excludable cost (sum of lines	50 and 51)				434, 240	52	
00	Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	ysician anest	hetist, and	3, 824, 160		
	medical education costs (line 49 minus line !	52)						
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54	
00	Target amount per discharge					0.00		
00	0 Target amount (line 54 x line 55)							
00	DO Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) DO Bonus payment (see instructions)							
00	, , , , , , , , , , , , , , , , , , , ,							
	market basket	. 0.		•		0.00		
00								
00	which operating costs (line 53) are less than					C	61	
	amount (line 56), otherwise enter zero (see		.5 (5 0. /	00), 0 0	. the target			
00	Relief payment (see instructions)					0		
00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	63	
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	С	64	
	instructions)(title XVIII only)	Ü		·				
00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65	
00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVI	II only). For	O	66	
	CAH (see instructions)	•	·		3,			
00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eporting period	0	67	
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	ortina period	o	68	
	(line 13 x line 20)				3 1			
00	Total title V or XIX swing-bed NF inpatient					0	69	
00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				)		70	
00	Adjusted general inpatient routine service of	-			,		71	
00	Program routine service cost (line 9 x line						72	
00	Medically necessary private room cost applications are recorded to the cost application and the cost applications are recorded to the cost application and the cost application and the cost application are recorded to the cost application and the cost application and the cost application are recorded to the cost application and the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application are recorded to the cost application and the cost application are recorded to the cost application are recorded to the cost application and the cost application are recorded to the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application and the cost application are recorded to the cost application are recorded to the cost		•				73	
00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II. column		75	
	26, line 45)		(					
00	Per diem capital related costs (line 75 ÷ lin	,					76	
00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77	
00	Aggregate charges to beneficiaries for excess	,	rovi der recor	ds)			79	
00	Total Program routine service costs for compa	arison to the c		*.	nus line 79)		80	
00	Inpatient routine service cost per diem limit						81	
00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		* .				82	
00	Program inpatient ancillary services (see in:		/				84	
00	Utilization review - physician compensation	(see instructio					85	
00	Total Program inpatient operating costs (sum		rough 85)				86	
	PART IV - COMPUTATION OF OBSERVATION BED PASS					4 070		
00	Total observation bed days (see instructions)	)				1, 272	2 87	

1, 272 87. 00 976. 58 88. 00 1, 242, 210 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems COM	MUNITY HOSPT. 0	F NOBLE CTY, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 Fo 12/31/2015	Date/Time Prep 5/16/2016 4:1	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capi tal -related cost	692, 919	6, 802, 880	0. 10185	7 1, 242, 210	126, 528	90.00
91.00 Nursing School cost		6, 802, 880	0. 000000	1, 242, 210	0	91.00
92.00 Allied health cost		6, 802, 880	0. 000000	1, 242, 210	0	92.00
93.00 All other Medical Education		6, 802, 880	0. 000000	1, 242, 210	0	93. 00

Health Financial Systems	COMMUNITY HOSPT. OF NOE	BLE CTY, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150146	Peri od: From 01/01/2015	Worksheet D-1	
			To 12/31/2015	Date/Time Pre 5/16/2016 4:1	
		Title XIX	Hospi tal	PPS	
Cost Center Description					

		Title XIX	Hospi tal	5/16/2016 4: 1 PPS	5 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days	d and newborn days)	ivate room days,	6, 966 6, 966 0	1. 00 2. 00 3. 00
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	5, 694 0	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	<i>y</i> ,		0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	swi ng-bed and	233	9. 00	
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on	y (including private r	oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX lafter December 31 of the cost reporting period (if calendar yea			0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)			0 555	
16. 00	Nursery days (title V or XIX only)			73	
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	0.00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	20. 00		
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost report	ing ported (Line	6, 802, 880 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	•		0	23. 00
	x line 18)	·			
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	·		0	
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 6, 802, 880	
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and object various bed on	ui ges)	0	
30. 00				0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	- 1: 22)/ :+	±:>	0.00	1
34.00	Average per diem private room charge differential (line 32 minu		u ons)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35. 00 36. 00
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	0 6, 802, 880	•
57.00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	a p. 1 vato 100m cost ui		5, 502, 500	37.00
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMFNTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see i			976. 58	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	•		227, 543	•
40. 00	Medically necessary private room cost applicable to the Program	•		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		227, 543	41.00

CUMPLIT	Financial Systems COMM ATION OF INPATIENT OPERATING COST	UNI TY HOSPT. 0			CCN: 150146	Peri od:	11 210	eu of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST		Prov	n der	CCN: 150146	From 01/01.	/2015	worksneet D-1	
						To 12/31.			
				Ti t	le XIX	Hospi ta	1	5/16/2016 4: 1 PPS	o piii
	Cost Center Description	Total	Total		Average Pe	r Program		Program Cost	
		Inpatient Cost	I npati ent	Days	Diem (col. 1 col. 2)	÷		(col. 3 x col. 4)	
		1.00	2.00		3.00	4. 00		5. 00	
42. 00	NURSERY (title V & XIX only)	219, 835		555	396.	10	73	28, 915	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT							I	43.00
44. 00	CORONARY CARE UNIT				•				44. 00
45.00	BURN INTENSIVE CARE UNIT								45. 00
	SURGICAL INTENSIVE CARE UNIT								46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description								47. 00
								1. 00	
	Program inpatient ancillary service cost (Wks				`			918, 362	
49.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)	see instr	uctio	ns)			1, 174, 820	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	servi ces	(from	Wkst. D, su	ım of Parts I	and	25, 812	50.00
51. 00	III) Pass through costs applicable to Program inpa	atient ancilla	rv service	s (fr	om Wkst D	sum of Parts	: []	101, 664	51.00
	and IV)		, 301 VI CC	J (11	J III.Jt. D,	Sam Or Furts			
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud	,	elated no	n_nhv	vsician anest	hetist and		127, 476 1, 047, 344	
33. 00	medical education costs (line 49 minus line 5		oratea, no	ii piiy		netrat, and		1,047,344	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION								
	Program discharges Target amount per discharge							0.00	
									56. 00
									57. 00
58. 00 59. 00								0.00	
39.00	market basket								39.00
	Lesser of lines 53/54 or 55 from prior year of the contract of							0.00	
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than							0	61. 00
	amount (line 56), otherwise enter zero (see i		13 (111103	0 1 X	00), 01 1% 0	in the target	-		
62.00	Relief payment (see instructions)							0	
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstrt	ictions)						03.00
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 o	f the	cost report	ing period (	(See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	to after Decemb	or 21 of	tho o	oct roportir	a pariod (Sa		0	65. 00
65.00	instructions)(title XVIII only)	is after beceiling	Del 31 01	the c	ost reportin	ig perrou (se	ee		05.00
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus l	ine 6	5)(title XVI	II only). Fo	or	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	n December	31 o	of the cost r	eportina per	i od	0	67. 00
	(line 12 x line 19)	· ·							
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after [	December 3	1 of	the cost rep	orting perio	od	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient							0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU					'>		I	70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co					)			70.00
72. 00	Program routine service cost (line 9 x line 7								72. 00
73.00	Medically necessary private room cost application								73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient					Part II. col	umn		74. 00 75. 00
	26, line 45)								
76. 00	Per diem capital related costs (line 75 ÷ lin	. *							76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus								77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		orovi der ir	ecord	is)				79. 00
	Total Program routine service costs for compa		cost limit	ati on	(line 78 mi	nus line 79)	1		80.00
81. 00 82. 00	Inpatient routine service cost per diem limit		1)						81. 00 82. 00
83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		· * .						83.00
84. 00	Program inpatient ancillary services (see ins		,						84. 00
85. 00	Utilization review - physician compensation	•							85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		irougn 85)						86. 00

1, 272 87. 00 976. 58 88. 00 1, 242, 210 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems COM	MUNITY HOSPT. O	F NOBLE CTY, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/16/2016 4:1	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	692, 919	6, 802, 880	0. 10185	7 1, 242, 210	126, 528	90.00
91.00 Nursing School cost	C	6, 802, 880	0. 000000	1, 242, 210	0	91.00
92.00 Allied health cost	C	6, 802, 880	0. 000000	1, 242, 210	0	92.00
93.00 All other Medical Education	c	6, 802, 880	0. 00000	1, 242, 210	0	93. 00

Health Financial Systems	COMMUNITY HOSPT. OF				eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 150146	Peri od: From 01/01/2015	Worksheet D-3	
				To 12/31/2015		
		Ti +I	e XVIII	Hospi tal	5/16/2016 4: 1 PPS	5 рт
Cost Center Description		11 (1	Ratio of Cos		Inpati ent	
oost denter bescription			To Charges	Program	Program Costs	
			l onar goo	Charges	(col. 1 x col.	
				51121 955	2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				3, 658, 023		30.00
43. 00 04300 NURSERY						43.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM			0. 19628		336, 673	
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 38899		0	52. 0
53. 00   05300   ANESTHESI OLOGY			0. 01083		2, 664	
54. 00   05400   RADI OLOGY-DI AGNOSTI C			0. 09176		184, 588	
54. 01   05401   CAT   SCAN			0.00000		0	
50. 00  06000 LABORATORY			0. 20973		299, 264	
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS			0.00000		0	62.3
55. 00 06500 RESPIRATORY THERAPY			0. 21105		150, 581	65. C
66. 00 06600 PHYSI CAL THERAPY			0. 42176			
57. 00 06700 OCCUPATI ONAL THERAPY			0. 61017			
8. 00 06800 SPEECH PATHOLOGY			0. 54719		10, 496	
9. 00 06900 ELECTROCARDI OLOGY			0. 04609	·	11, 341	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NT		0. 16415			
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 23833	·	193, 652	
3.00 07300 DRUGS CHARGED TO PATIENTS			0. 26341		l	
6. 97 07697 CARDI AC REHABI LI TATI ON			0.00000		0	
6. 98 07698 HYPERBARI C OXYGEN THERAPY			0.00000		0	76. 9
6. 99 07699 LI THOTRI PSY			0.00000	00 0	0	76. 9
OUTPATIENT SERVICE COST CENTERS						1
0. 00   09000   CLI NI C			0. 38556			
1. 00   09100   EMERGENCY			0. 13478			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAI	RT		0. 7840	18 0	0	92. (
OTHER REIMBURSABLE COST CENTERS						
5.00 09500 AMBULANCE SERVICES						95. 0
200.00 Total (sum of lines 50-94 and 96-9	<del>7</del> 8)		1	11, 327, 490	2, 094, 299	1200 (

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

95. 00 2, 094, 299 200. 00 201. 00 202. 00

11, 327, 490

200. 00 201. 00 202. 00

Hool +b Fi	inancial Systems	COMMUNITY HOSPT. OF NO	DIE CTV II	NC.	In Lie	eu of Form CMS-:	2552 10
	THANCILLARY SERVICE COST APPORTIONMENT			CCN: 150146	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D-3	pared:
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description			Ratio of Cos	t Inpatient	Inpatient	
				To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
				1.00	2. 00	3. 00	
11	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS				2, 340, 828		30. 00
	4300 NURSERY				314, 727		43. 00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM			0. 19628		301, 758	
	5200 DELIVERY ROOM & LABOR ROOM			0. 38899		0	
	5300 ANESTHESI OLOGY			0. 01083			
	5400 RADI OLOGY-DI AGNOSTI C			0. 09176			
	5401 CAT SCAN			0.00000		0	
	6000 LABORATORY			0. 20973		l .	
	6250 BLOOD CLOTTING FOR HEMOPHILIACS			0.00000		0	
	6500 RESPI RATORY THERAPY			0. 2110			
	6600 PHYSI CAL THERAPY			0. 42176	· ·		
	6700 OCCUPATI ONAL THERAPY			0. 61017			
	6800 SPEECH PATHOLOGY			0. 54719			
	6900 ELECTROCARDI OLOGY			0. 04609			
	7100 MEDICAL SUPPLIES CHARGED TO PATIEN	T		0. 1641	· ·		
	7200 IMPL. DEV. CHARGED TO PATIENTS			0. 23833			
	7300 DRUGS CHARGED TO PATIENTS			0. 2634			
	7697 CARDIAC REHABILITATION			0.00000		0	
	7698 HYPERBARIC OXYGEN THERAPY			0.00000		0	
	7699 LI THOTRI PSY			0.00000	00 0	0	76. 99
	JTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C			0. 38556			
	9100 EMERGENCY			0. 13478	· ·		
	9200 OBSERVATION BEDS (NON-DISTINCT PAR	Т		0. 7840	18 C	0	92. 00
	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES						95. 00
200.00	Total (sum of lines 50-94 and 96-9	,			4, 831, 729		
201 00	Less PBP Clinic Laboratory Service	s-Program only charges	(Line 61)	1		il .	201 00

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

918, 362 200. 00 201. 00 202. 00

4, 831, 729

201.00 202.00

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS  1.00 DRG Amounts Other than Outlier Payments  1.01 DRG amounts other than outlier payments for discharges occurring to October 1 (see instructions)  1.02 DRG amounts other than outlier payments for discharges occurring after October 1 (see instructions)  1.03 DRG for federal specific operating payment for Model 4 BPCI for	prior	2 XVIII	To 12/31/2015  Hospi tal	Date/Time Prep 5/16/2016 4:15 PPS	
1.00 DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring after October 1 (see instructions)	prior		·	PPS	
<ul> <li>DRG Amounts Other than Outlier Payments</li> <li>DRG amounts other than outlier payments for discharges occurring to October 1 (see instructions)</li> <li>DRG amounts other than outlier payments for discharges occurring after October 1 (see instructions)</li> </ul>		0	1 00		
<ul> <li>DRG Amounts Other than Outlier Payments</li> <li>DRG amounts other than outlier payments for discharges occurring to October 1 (see instructions)</li> <li>DRG amounts other than outlier payments for discharges occurring after October 1 (see instructions)</li> </ul>			1.00	2. 00	
to October 1 (see instructions)  1.02 DRG amounts other than outlier payments for discharges occurring after October 1 (see instructions)			0		1. 00
1.02 DRG amounts other than outlier payments for discharges occurring after October 1 (see instructions)	on or		2, 608, 454		1. 01
·	011 01		833, 456		1. 02
1.03   DRG for rederal specific operating payment for Model 4 BPC/ for					1 00
discharges occurring prior to October 1 (see instructions)			0		1. 03
1.04 DRG for federal specific operating payment for Model 4 BPCI for			o		1. 04
discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions)			36, 356		2. 00
2.01 Outlier reconciliation amount			0		2. 01
2.02 Outlier payment for discharges for Model 4 BPCI (see instructions 3.00 Managed Care Simulated Payments	5)		0		2. 02 3. 00
<ul><li>3.00 Managed Care Simulated Payments</li><li>4.00 Bed days available divided by number of days in the cost reportin</li></ul>	ıq		27. 52		4. 00
period (see instructions)					
Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most re	cent		0.00		5. 00
cost reporting period ending on or before 12/31/1996. (see instruc	ti ons)				
6.00 FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance	wi +b 42		0.00		6. 00
CFR 413.79(e)	WI LII 42				
7.00 MMA Section 422 reduction amount to the IME cap as specified unde	r 42		0.00		7. 00
CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA Section 5503 reduction amount to the IME cap as specified und	er 42		0.00		7. 01
CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1,			0.00		,, , ,
then see instructions. 8.00 Adjustment (increase or decrease) to the FTE count for allopathic	and		0.00		8. 00
osteopathic programs for affiliated programs in accordance with 4			0.00		0.00
413. 75(b), 413. 79(c)(2)(i v), 64 FR 26340 (May 12, 1998), and 67 F	R 50069				
(August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots	under		0.00		8. 01
section 5503 of the ACA. If the cost report straddles July 1, 201					
instructions. 8.02   The amount of increase if the hospital was awarded FTE cap slots	from a		0.00		8. 02
closed teaching hospital under section 5506 of ACA. (see instruct			0.00		0. 02
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (and 8,02) (see instructions)	8, 8,01		0.00		9. 00
10.00 FTE count for allopathic and osteopathic programs in the current	year		0.00		10. 00
from your records			0.00		11 00
11.00 FTE count for residents in dental and podiatric programs.  12.00 Current year allowable FTE (see instructions)			0. 00 0. 00		11. 00 12. 00
13.00 Total allowable FTE count for the prior year.			0.00		13.00
14.00 Total allowable FTE count for the penultimate year if that year e or after September 30, 1997, otherwise enter zero.	nded on		0.00		14. 00
15.00 Sum of lines 12 through 14 divided by 3.			0.00		15. 00
16.00 Adjustment for residents in initial years of the program			0.00		16.00
17.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjusted rolling average FTE count	·		0. 00 0. 00		17. 00 18. 00
19.00 Current year resident to bed ratio (line 18 divided by line 4).			0. 000000		19. 00
20.00 Prior year resident to bed ratio (see instructions)			0.000000		20.00
21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions)			0.000000		21. 00 22. 00
22.01 IME payment adjustment - Managed Care (see instructions)			0		22. 01
Indirect Medical Education Adjustment for the Add-on for Section 23.00 Number of additional allopathic and osteopathic IME FTE resident		e MMA	0.00		23. 00
slots under 42 Sec. 412.105 (f)(1)(iv)(C).	Cap		0.00		23.00
24.00 IME FTE Resident Count Over Cap (see instructions)			0.00		24. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lowe line 23 or line 24 (see instructions)	101		0.00		25. 00
26.00 Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
27.00   IME payments adjustment factor. (see instructions) 28.00   IME add-on adjustment amount (see instructions)			0.000000		27. 00 28. 00
28.01 IME add-on adjustment amount - Managed Care (see instructions)			ő		28. 01
29.00 Total IME payment ( sum of lines 22 and 28)			0		29. 00
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0		29. 01
30.00 Percentage of SSI recipient patient days to Medicare Part A patie	nt days		2. 16		30. 00
(see instructions) 31.00 Percentage of Medicaid patient days (see instructions)			23. 46		31. 00
32.00 Sum of lines 30 and 31			25. 62		32.00
33.00 Allowable disproportionate share percentage (see instructions)			10. 35		33.00
34.00  Disproportionate share adjustment (see instructions)	I		89, 060	l	34. 00

35. 00 35. 01 35. 02 35. 03 Hospital enter ze en	sated Care Adjustment compensated care amount (see instructions)   (see instructions)   uncompensated care payment (If line 34 is zero, ro on this line) (see instructions)   share of the hospital uncompensated care payment see instructions)   compensated care (sum of columns 1 and 2 on line  all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions)   RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions)   RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment)   dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions)   average length of stay to one week (line 43 by line 41 divided by 7 days)   weekly cost for dialysis treatments (see ions)   ditional payment (line 45 times line 44 times line	Title XVIII	Peri od: From 01/01/2015 From	Date/Time Pre 5/16/2016 4:11 PPS On/After October 1 2.00 6,406,145,534 0.000034471 220,826 55,508	35. 00 35. 01 35. 02
35. 00 Total un 35. 01 Factor 3 35. 02 Hospi tal enter ze 35. 03 Pro rata amount (36. 00 Total un 35. 03) Additiona 40. 00 Total Meexcl udin 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGs 42. 00 Di vi de I qual i fy 7 Total Me 682, 683 Ratio of di vi ded 45. 00 Average i instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	compensated care amount (see instructions)   (see instructions)   uncompensated care payment (If line 34 is zero, ro on this line) (see instructions)   share of the hospital uncompensated care payment see instructions)   compensated care (sum of columns 1 and 2 on line  all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions)  RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions)  RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment)   dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days)   weekly cost for dialysis treatments (see ions)	0	Pri or to October 1 1.00  7, 647, 644, 885 0.00035440 271, 033 202, 718 258, 226 0.000 0.00 0.00 0.00 0.00 0.00	PPS On/After October 1 2.00 6,406,145,534 0.000034471 220,826 55,508	35. 00 35. 01 35. 02 35. 03 36. 00 40. 00 41. 01 42. 00
35. 00 Total un 35. 01 Factor 3 35. 02 Hospi tal enter ze 35. 03 Pro rata amount (36. 00 Total un 35. 03) Additiona 40. 00 Total Me excludin 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGs 42. 00 Di vi de I qual i fy Total Me 682, 683 Ratio of di vi ded 45. 00 Average i instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	compensated care amount (see instructions)   (see instructions)   uncompensated care payment (If line 34 is zero, ro on this line) (see instructions)   share of the hospital uncompensated care payment see instructions)   compensated care (sum of columns 1 and 2 on line  all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions)  RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions)  RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment)   dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days)   weekly cost for dialysis treatments (see ions)	0	Pri or to October 1 1.00  7, 647, 644, 885 0.00035440 271, 033 202, 718 258, 226 0.000 0.00 0.00 0.00 0.00 0.00	0n/After 0ctober 1 2.00 6,406,145,534 0.00034471 220,826 55,508	35. 01 35. 02 35. 03 36. 00 40. 00 41. 01 42. 00
35. 00 Total un 35. 01 Factor 3 35. 02 Hospi tal enter ze 35. 03 Pro rata amount (36. 00 Total un 35. 03) Additiona 40. 00 Total Me excludin 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGs 42. 00 Di vi de I qual i fy Total Me 682, 683 Ratio of di vi ded 45. 00 Average i instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	compensated care amount (see instructions)   (see instructions)   uncompensated care payment (If line 34 is zero, ro on this line) (see instructions)   share of the hospital uncompensated care payment see instructions)   compensated care (sum of columns 1 and 2 on line  all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions)  RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions)  RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment)   dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days)   weekly cost for dialysis treatments (see ions)		7, 647, 644, 885 0. 000035440 271, 033 202, 718 258, 226 0 0 0 0	0ctober 1 2.00 6,406,145,534 0.000034471 220,826 55,508	35. 01 35. 02 35. 03 36. 00 40. 00 41. 01 42. 00
35. 00 Total un 35. 01 Factor 3 35. 02 Hospi tal enter ze 35. 03 Pro rata amount (36. 00 Total un 35. 03) Additiona 40. 00 Total Me excludin 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGs 42. 00 Di vi de I qual i fy Total Me 682, 683 Ratio of di vi ded 45. 00 Average i instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	compensated care amount (see instructions)   (see instructions)   uncompensated care payment (If line 34 is zero, ro on this line) (see instructions)   share of the hospital uncompensated care payment see instructions)   compensated care (sum of columns 1 and 2 on line  all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions)  RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions)  RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment)   dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days)   weekly cost for dialysis treatments (see ions)		7, 647, 644, 885 0. 000035440 271, 033 202, 718 258, 226 0 0 0 0	6, 406, 145, 534 0. 000034471 220, 826 55, 508	35. 01 35. 02 35. 03 36. 00 40. 00 41. 01 42. 00
35. 00 Total un 35. 01 Factor 3 35. 02 Hospi tal enter ze 35. 03 Pro rata amount (36. 00 Total un 35. 03) Additiona 40. 00 Total Me excludin 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGs 42. 00 Di vi de I qual i fy Total Me 682, 683 Ratio of di vi ded 45. 00 Average i instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	compensated care amount (see instructions)   (see instructions)   uncompensated care payment (If line 34 is zero, ro on this line) (see instructions)   share of the hospital uncompensated care payment see instructions)   compensated care (sum of columns 1 and 2 on line  all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions)  RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions)  RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment)   dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days)   weekly cost for dialysis treatments (see ions)	discharges (lines 40 through	0. 000035440 271, 033 202, 718 258, 226 0 0 0 0	0. 000034471 220, 826 55, 508	35. 01 35. 02 35. 03 36. 00 40. 00 41. 01 42. 00
35. 01 Factor 3 35. 02 Hospital enter ze 35. 03 Pro rata amount (: 36. 00 Total un. 35. 03) Additiona 40. 00 Total Meexcludin 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGS 42. 00 Divide I qualify: 43. 00 Total Meexcludin 685 (see 41. 01 Total Seep 682, 683 42. 00 Divide I qualify: 43. 00 Average instruct 46. 00 Average instruct 46. 00 Total ad41. 01) 47. 00 Subtotal	(see instructions) uncompensated care payment (If line 34 is zero, ro on this line) (see instructions) share of the hospital uncompensated care payment see instructions) compensated care (sum of columns 1 and 2 on line all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions) RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions) RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see instructions)	discharges (lines 40 through	0. 000035440 271, 033 202, 718 258, 226 0 0 0 0	0. 000034471 220, 826 55, 508	35. 01 35. 02 35. 03 36. 00 40. 00 41. 01 42. 00
35. 02 Hospital enter ze 35. 03 Pro rata amount (c) 36. 00 Total un 35. 03) Additiona 40. 00 Total Me excludin 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGs 42. 00 Di vi de I qual i fy 43. 00 Rati o of di vi ded 145. 00 Average i instruct 46. 00 Average i instruct 46. 00 Subtotal	uncompensated care payment (If line 34 is zero, ro on this line) (see instructions) share of the hospital uncompensated care payment see instructions) compensated care (sum of columns 1 and 2 on line all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions) RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions) RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see instructions)	discharges (lines 40 through	271, 033 202, 718 258, 226 0 0 0 0.00	220, 826 55, 508	35. 02 35. 03 36. 00 40. 00 41. 00 42. 00
enter ze Pro rata amount (; 36. 00 Total un 35. 03) Addi ti ona 40. 00 Total Me excl udi n 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGs 42. 00 Di vi de I qual i fy 43. 00 Rati o of di vi ded i 45. 00 Average i instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	ro on this line) (see instructions) share of the hospital uncompensated care payment see instructions) compensated care (sum of columns 1 and 2 on line  all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions) RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions) RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see	discharges (lines 40 through	202, 718 258, 226 0 0 0 0.00	55, 508	35. 03 36. 00 40. 00 41. 00 41. 01 42. 00
35. 03	share of the hospital uncompensated care payment see instructions) compensated care (sum of columns 1 and 2 on line all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions) RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions) RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)	discharges (Lines 40 through	258, 226 0 0 0 0.00		36. 00 40. 00 41. 00 41. 01 42. 00
amount (0 Total un 35.03) Additiona Total Meexcludin 685 (see 41.00 Total ES 682, 683 41.01 Total ES MS-DRGs 42.00 Divide I qualify Total Me682, 683 Ratio of divided 45.00 Average instruct 46.00 Total ad 41.01) 47.00 Subtotal	see instructions) compensated care (sum of columns 1 and 2 on line  all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions) RD Medicare discharges excluding MS-DRGs 652, , 684 an 685. (see instructions) RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, , 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)	discharges (lines 40 through	258, 226 0 0 0 0.00		36. 00 40. 00 41. 00 41. 01 42. 00
36. 00 Total un 35. 03) Additiona 40. 00 Total Me excludin 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGS 42. 00 Divide I qualify 43. 00 Total Me 682, 683 Ratio of divided 45. 00 Average instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	compensated care (sum of columns 1 and 2 on line all payment for high percentage of ESRD beneficiary dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions)  RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions)  RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see inst)	discharges (lines 40 through	0 0 0 0 0 0		40. 00 41. 00 41. 01 42. 00
40. 00 Total Me excl udin 685 (see 41. 00 Total ES 682, 683 41. 01 Total ES MS-DRGs 42. 00 Di vi de 1 qual i fy 43. 00 Ratio of di vi ded 45. 00 Average i instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions)  RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions)  RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions)  ine 41 by line 40 (if less than 10%, you do not for adjustment)  dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions)  average length of stay to one week (line 43 by line 41 divided by 7 days)  weekly cost for dialysis treatments (see ions)	discharges (lines 40 through	0 0 0.00		41. 00 41. 01 42. 00
40. 00 Total Me excl udin 685 (see 41. 00 Total ES 682, 683 Total ES MS-DRGs Di vi de I qual i fy 43. 00 Total Me 682, 683 Ratio of di vi ded 45. 00 Average i instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	dicare discharges on Worksheet S-3, Part I g discharges for MS-DRGs 652, 682, 683, 684 and instructions)  RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions)  RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)	arsenarges (Tries to through	0 0 0.00		41. 00 41. 01 42. 00
excluding 685 (see 41.00 685 (see Total ES 682, 683 Total ES MS-DRGs 42.00 Divide I qualify Total Me 682, 683 Ratio of divided 45.00 Average instruct 46.00 Total ad 41.01) 47.00 Subtotal	g discharges for MS-DRGs 652, 682, 683, 684 and instructions) RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions) RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0 0 0.00		41. 00 41. 01 42. 00
41. 00 Total ES 682, 683 41. 01 Sms-DRGs 42. 00 Di vi de I qual i fy 7 Total Me 682, 683 44. 00 Ratio of di vi ded I 45. 00 Average instruct 7 Total ad 41. 01) 47. 00 Subtotal	RD Medicare discharges excluding MS-DRGs 652, 684 an 685. (see instructions) RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0.00		41. 01 42. 00
41. 01 682, 683 42. 00 Di vi de I qual i fy 43. 00 Rati o of di vi ded I 45. 00 Average i nstruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	, 684 an 685. (see instructions) RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0.00		41. 01 42. 00
41. 01 Total ES MS-DRGs 42. 00 Di vi de I qual i fy Total Me 682, 683 44. 00 Rati o of di vi ded I 45. 00 Average i instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	RD Medicare covered and paid discharges excluding 652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0		42. 00
MS-DRGs 42.00 Divide I qualify 43.00 Total Me 682, 683 44.00 Ratio of divided I 45.00 Average instruct 46.00 Total ad 41.01) 47.00 Subtotal	652, 682, 683, 684 an 685. (see instructions) ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0		42. 00
42.00 Di vi de I qual i fy 43.00 Total Me 682, 683 Ratio of di vi ded 45.00 Average instruct 46.00 Total ad 41.01) 47.00 Subtotal	ine 41 by line 40 (if less than 10%, you do not for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0		
43.00   Total Med 682, 683   44.00   Ratio of divided   45.00   Average instruct   Total ad 41.01   47.00   Subtotal	for adjustment) dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0		
43.00 Total Me 682, 683 44.00 Ratio of divided 45.00 Average instruct 46.00 Total ad 41.01) 47.00 Subtotal	dicare ESRD inpatient days excluding MS-DRGs 652, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0. 000000		43. 00
44. 00 Rati o of di vi ded 45. 00 Average i nstruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	, 684 an 685. (see instructions) average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0. 000000		43.00
44. 00 Ratio of divided (45. 00 Average instruct 46. 00 Total ad 41. 01) 47. 00 Subtotal	average length of stay to one week (line 43 by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0. 000000		
di vi ded 45.00 Average i nstruct 46.00 Total add 41.01) 47.00 Subtotal	by line 41 divided by 7 days) weekly cost for dialysis treatments (see ions)		0.000000		44.00
45. 00 Average instruct 46. 00 Total add 41. 01) 47. 00 Subtotal	weekly cost for dialysis treatments (see ions)			ļ.	44.00
i nstruct 46.00 Total add 41.01) 47.00 Subtotal	ions)		0.00		45. 00
46. 00 Total add 41. 01) 47. 00 Subtotal		1		ļ.	
41. 01) 47. 00 Subtotal	, , ,		0		46.00
				ļ	
40 00 11: 1	(see instructions)		3, 825, 552		47.00
48.00 Hospi tal	specific payments (to be completed by SCH and		0	ļ.	48. 00
	ll rural hospitals only.(see instructions)			ļ	
	yment for inpatient operating costs (see		3, 825, 552	ļ.	49. 00
instruct	•				
	for inpatient program capital (from Wkst. L, Pt. I		281, 000		50.00
	II, as applicable)			ļ.	51.00
	n payment for inpatient program capital (Wkst. L, see instructions)		U	ļ.	31.00
· ·	raduate medical education payment (from Wkst. E-4,		0		52.00
	see instructions).				02.00
	and Allied Health Managed Care payment		0	ļ.	53.00
54.00 Special	add-on payments for new technologies		0	ļ.	54.00
55.00 Net orga	n acquisition cost (Wkst. D-4 Pt. III, col. 1,		0	!	55.00
line 69)				ļ	
56.00 Cost of	physicians' services in a teaching hospital (see		0	ļ.	56. 00
intructi					
	service other pass through costs (from Wkst. D,		0	ļ.	57. 00
	column 9, lines 30 through 35).			ļ	
	y service other pass through costs from Wkst. D,		0	ļ.	58. 00
	col. 11 line 200)		4 104 EE2		59.00
,	um of amounts on lines 49 through 58) payer payments		4, 106, 552 7, 461		60.00
,	ount payable for program beneficiaries (line 59		4, 099, 091		61.00
minus li	1 3 1 9		1, 377, 071		51.00
	les billed to program beneficiaries		579, 600		62. 00
	nce billed to program beneficiaries		0		63.00
64.00 Allowable	e bad debts (see instructions)		44, 580	!	64.00
65.00 Adjusted	reimbursable bad debts (see instructions)		28, 977	!	65.00
66.00 Allowable	e bad debts for dual eligible beneficiaries (see		25, 347	ļ	66.00
instruct	,			ļ	
1	(line 61 plus line 65 minus lines 62 and 63)		3, 548, 468	ļ.	67. 00
	received from manufacturers for replaced devices		0	ļ.	68. 00
	icable to MS-DRGs (see instructions)				
	payments reconciliation (sum of lines 93, 95 and		0	ļ.	69. 00
	SCH see instructions)				70.00
	JUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) MONSTRATION PROJECT		0	•	70.50
1			0		70. 30
instruct	ACO demonstration payment adjustment amount (see				10.89
	s payment HVBP adjustment amount (see		0		70. 90
instruct					. 5. 70
	s payment HRR adjustment amount (see instructions)		0		70. 91
	Model 1 discount amount (see instructions)		0		70. 92
	ment adjustment amount (see instructions)		18, 608		70. 93
,	stment amount (see instructions)		-13, 894		70. 94
70.95   Recovery	of accel erated depreciation		0		70. 95

Health Financial Systems	COMMUNITY HOSPT. OF NOBL	E CTY, INC.	In Li e	eu of Form CMS-2552-10
CALCULATION OF DEIMPHOSEMENT SETTLEMENT		Providor CCN: 150146	Pori od:	Workshoot E

Health Financial Systems COMMUNITY HOSPT. 0	F NOB	LE CTY, INC.	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2015	Part A	
		-	To 12/31/2015	Date/Time Pre	pared:
				5/16/2016 4:1	5 pm
	_	Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy)		201	5 344, 818		70. 96
(Enter in column 0 the corresponding federal year for the					
period prior to 10/1)					
70.97 Low volume adjustment for federal fiscal year (yyyy)		201	6 117, 984		70. 97
(Enter in column 0 the corresponding federal year for the		201	117, 704		'0. //
period ending on or after 10/1)					
j.					70. 98
			0		
70.99 HAC adjustment amount (see instructions)			0		70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus			4, 015, 984		71. 00
lines 69 & 70)					
71.01   Sequestration adjustment (see instructions)			80, 320		71. 01
72.00  Interim payments			3, 882, 960		72.00
73.00 Tentative settlement (for contractor use only)			0		73.00
74.00 Balance due provider (Program) (line 71 minus lines 71.01,			52, 704		74.00
72, and 73)					
75.00 Protested amounts (nonallowable cost report items) in			160, 170		75. 00
accordance with CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			<u>'</u>		
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see			0		90.00
instructions)					
91.00 Capital outlier from Wkst. L, Pt. I, line 2			o		91.00
92.00 Operating outlier reconciliation adjustment amount (see			0		92.00
instructions)					
93.00 Capital outlier reconciliation adjustment amount (see			o		93.00
instructions)					
94.00 The rate used to calculate the time value of money (see			0.00		94.00
instructions)					
95.00 Time value of money for operating expenses (see			0		95.00
instructions)					
96.00 Time value of money for capital related expenses (see			0		96.00
instructions)					
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount			•		
100.00 HSP bonus amount (see instructions)			0	0	100.00
HVBP Adjustment for HSP Bonus Payment			•		
101.00 HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instruct	i ons)		0		102.00
HRR Adjustment for HSP Bonus Payment			<u> </u>		1
103.00 HRR adjustment factor (see instructions)			0.0000	0, 0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instruction	ons)		0		104. 00
12 12 12 13 13 13 13 13 13 13 13 13 13 13 13 13			١	Ü	1.555

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 150146

						0 12/31/2013	5/16/2016 4:1	5 pm
		W/S E Dort A	Amounts (from		e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	C	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	2, 608, 454	0	2, 608, 454	0	2, 608, 454	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	833, 456	0	C	833, 456	833, 456	1. 02
1. 03	occurring on or after October  1  DRG for Federal specific	1. 03	0	0	C	0	0	1. 03
1.03	operating payment for Model 4 BPCI occurring prior to October 1	1. 03	o o	0	C		0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	C	0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	36, 356	0	24, 402	11, 954	36, 356	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	C	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	C	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju	3. 00	0	0	C	0	0	4. 00
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	C	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	C	0	0	6. 01
	managed care (see instructions)							
7 00	Indirect Medical Education Adju	ustment for the	0.000000	0.000000	ne MMA 0.000000	0. 000000		   7.00
7. 00	IME payment adjustment factor (see instructions)		0.000000	0.000000	0.000000	0.00000		
8. 00	IME adjustment (see instructions)	28. 00	0	0	С	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	C	O	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	О	0	9. 01
	Di sproporti onate Share Adjustmo	ent						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1035	0. 1035	0. 1035	0. 1035		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	89, 060	0	67, 494	21, 566	89, 060	11. 00
11. 01	Uncompensated care payments	36.00	258, 226	0	202, 718	55, 508	258, 226	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	RD beneficiary of	di scharges 0	C		0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	3, 825, 552	0	2, 903, 068		3, 825, 552	
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	0	0	2, 903, 006	922, 464	3, 823, 332	14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	3, 825, 552	0	2, 903, 068	922, 484	3, 825, 552	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	281, 000	0	211, 426	69, 574	281, 000	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	C	0	0	17. 00
17. 01	Net organ aquisition cost	55.00	0	0	C	0	0	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	O	0	C		0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	C	0	0	18. 00

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 150146 Peri od: Worksheet E From 01/01/2015 Part A Exhibit 4
Date/Time Prepared: 12/31/2015 5/16/2016 4:15 pm Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 Part A) On/After 10/01 line Ε, Entitlement through 4) 0 1 00 2 00 3 00 4.00 5 00 19.00 SUBTOTAL 992, 058 3, 114, 494 4, 106, 552 19. 00 W/S L, line (Amounts from L) 2.00 3.00 4.00 5.00 0 1.00 20.00 Capital DRG other than outlier 273, 903 205, 993 67, 910 273, 903 20.00 1 00 20.01 Model 4 BPCI Capital DRG other 1.01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 7,097 5, 433 7,097 21.00 1,664 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) Indirect medical education 23.00 23.00 6.00 0 adjustment (see instructions) Allowable disproportionate 0.0000 0.0000 24.00 10 00 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 0 25.00 adjustment (see instructions) Total prospective capital 26.00 12.00 281,000 211, 426 69, 574 281,000 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2.00 1.00 3.00 4.00 5.00 27.00 Low volume adjustment factor 0. 110714 0.118929 27. 00 Low volume adjustment 70.96 344, 818 344, 818 28.00 28.00 (transfer amount to Wkst. E, Pt. A, line) Low volume adjustment 70.97 117, 984 117, 984 29.00 (transfer amount to Wkst. E, Pt. A. line) 100.00 Transfer low volume 100.00

adjustments to Wkst. E, Pt. A.

Health Financial Systems	COMMUNITY HOSPT. OF NOB	LE CTY, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150146	Peri od: From 01/01/2015	Worksheet E
				Date/Time Prepared:

			To 12/31/2015		
		Title XVIII	Hospi tal	5/16/2016 4: 1 PPS	5 pm
			•		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			0	1. 00
2. 00	Medical and other services (see Fish detrons)  Medical and other services reimbursed under OPPS (see instructi	ons)		3, 785, 996	
3. 00	PPS payments			3, 248, 545	3. 00
4.00	Outlier payment (see instructions)			10, 641	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 864	5. 00
6.00	Line 2 times line 5			3, 271, 101	
7.00	Sum of line 3 plus line 4 divided by line 6			99. 64	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, coi. 13, 11 ne 200		0	9. 00 10. 00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0	11.00
	Reasonable charges				
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for pa			0	
16. 00	Amounts that would have been realized from patients liable for	payment for services of	on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0.000000	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	Ö	19. 00
	instructions)		, (		
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		0	21. 00
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	ctions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ctrons)		3, 259, 186	
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0, 207, 100	21.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			760, 598	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)	)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	2 and 23] (see	2, 498, 588	27. 00
20.00	instructions)	- 50)			20.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, lin ESRD direct medical education costs (from Wkst. E-4, line 36)	e 50)		0 0	28. 00 29. 00
30. 00	Subtotal (sum of lines 27 through 29)			2, 498, 588	
31. 00	Primary payer payments			733	
32. 00	Subtotal (line 30 minus line 31)			2, 497, 855	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			129, 175	
35. 00	Adjusted reimbursable bad debts (see instructions)			83, 964	
36.00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	CTI ONS)		111, 689	
37. 00 38. 00	MSP-LCC reconciliation amount from PS&R			2, 581, 819 0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			ő	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	ŕ	0	39. 99
40.00	Subtotal (see instructions)			2, 581, 819	40. 00
40. 01	Sequestration adjustment (see instructions)			51, 636	1
41. 00	Interim payments			2, 468, 095	1
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance	o with CMS Bub 15.2	chantor 1	62, 088 0	•
44. 00	§115. 2	e with GWB PUD. 10-2,	спартег Т,		44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money				92. 00
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94. 00

0

2, 530, 183

NPR Date (Mo/Day/Yr)

2 00

6.02

7.00

8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 150146 Peri od: Worksheet E-1 From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/16/2016 4:15 pm Title XVIII Hospi tal PPS Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 3, 882, 960 2, 468, 095 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 2, 468, 095 3, 882, 960 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 52, 704 62,088 6.01

C

Contractor

Number

1 00

3, 935, 664

0

6 02

7.00

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

Heal th	n Financial Systems COMMUNITY HOSPT. OF NO	BLE CTY, INC.	In Lie	u of Form CMS-2	2552-10
CALCU	LATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150146	Peri od:	Worksheet E-1	
			From 01/01/2015		
			To 12/31/2015	Date/Time Prep 5/16/2016 4:1	
		Title XVIII	Hospi tal	PPS	5 PIII
		I II II E XVIII	HOSPI tai	FF3	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00		2 Dt Lool 15 Lino	1.4	1, 808	1. 00
	Total hospital discharges as defined in AARA §4102 from Wkst. S		14		
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	2		2, 216	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2		1, 354	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		5, 694	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	0.0		165, 131, 959	
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 lir			2, 289, 371	
7. 00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)			338, 850	8. 00
9. 00	Sequestration adjustment amount (see instructions)			6, 777	9. 00
10. 00		ee instructions)		332, 073	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			341, 280	30.00
31.00	Other Adjustment (specify)			0	31.00
22 00	Dalance due provider (line 0 (or line 10) minus line 20 and lin	a 21) (and instruction	۵۱	0 207	22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

341, 280 30. 00 0 31. 00 -9, 207 32. 00

Health Financial Systems COMMUNITY HOSPT. OF NO BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 150146

Peri od: Worksheet G From 01/01/2015 To 12/31/2015 Date/Time Prepared:

			'	0 12/31/2013	5/16/2016 4:1	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund	0.00		
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	2, 294		0	0	1.00
2. 00	Temporary investments	0	1		0	2. 00
3.00	Notes receivable	0	C	0	0	3. 00
4.00	Accounts recei vable	17, 656, 484	. c	0	0	4. 00
5.00	Other recei vable	3, 247, 097	C	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-11, 441, 198	l .	0	0	6. 00
7.00	Inventory	254, 320	l .	0	0	7. 00
8.00	Prepaid expenses	39, 651	1	_	0	8.00
9. 00 10. 00	Other current assets Due from other funds	0		_	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	9, 758, 648			0	11. 00
11.00	FIXED ASSETS	7,700,010	1	<u> </u>		11.00
12.00	Land	0	C	0	0	12.00
13.00	Land improvements	685, 510	o c	0	0	13. 00
14. 00	Accumulated depreciation	-317, 139	1	0	0	14. 00
15. 00	Bui I di ngs	3, 469, 806	1	0	0	15. 00
16.00	Accumulated depreciation	-1, 119, 948	1		0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	57, 402 -14, 483	1		0	17. 00 18. 00
19. 00	Fi xed equipment	52, 820	1		0	19. 00
20. 00	Accumulated depreciation	-34, 978	1		0	20. 00
21.00	Automobiles and trucks	81, 334	l .	0	0	21. 00
22. 00	Accumul ated depreciation	-81, 334	- C	0	0	22. 00
23. 00	Major movable equipment	11, 728, 790	l .		0	23. 00
24. 00	Accumulated depreciation	-10, 034, 539	l .		0	24. 00
25. 00	Mi nor equi pment depreci abl e	983, 204	l .		0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	-504, 678	C	_	0	26. 00 27. 00
28. 00	Accumulated depreciation				0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e				0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	4, 951, 767	-	-	0	30. 00
	OTHER ASSETS					
31. 00	Investments	5, 000	l .		0	31. 00
32. 00	Deposits on Leases	0			0	32.00
33. 00 34. 00	Due from owners/officers Other assets	732, 834			0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	737, 834	1		0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	15, 448, 249	1		0	36. 00
00.00	CURRENT LIABILITIES	10/110/21/			<u> </u>	00.00
37.00	Accounts payable	628, 020	C	0	0	37. 00
38. 00	Salaries, wages, and fees payable	749, 316	C	0	0	38. 00
39. 00	Payroll taxes payable	0	C	0	0	39. 00
40.00	Notes and Loans payable (short term)	128, 471		0	0	40.00
41. 00 42. 00	Deferred income Accelerated payments	0		0	0	41. 00 42. 00
43. 00	Due to other funds		C	0	0	
44. 00	Other current liabilities	-62, 019			0	
45.00	Total current liabilities (sum of lines 37 thru 44)	1, 443, 788		0	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	-		0	
47. 00	Notes payable	0	1		0	
48. 00 49. 00	Unsecured Loans Other Long term Liebilities	171 244	1		0	48. 00 49. 00
50.00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49	171, 344 171, 344			0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	1, 615, 132	l .		0	51.00
	CAPITAL ACCOUNTS	, , , , ,				
52.00	General fund balance	13, 833, 117				52. 00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
20.00	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	13, 833, 117	l .		0	
60.00	Total liabilities and fund balances (sum of lines 51 and	15, 448, 249	C	0	0	60. 00
	[59]	I	I			l

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150146 Peri od: Worksheet G-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/16/2016 4:15 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 13, 833, 117 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 12, 377, 345 2.00 3.00 Total (sum of line 1 and line 2) 26, 210, 462 0 3.00 4.00 Additions (credit adjustments) (specify) 0 4.00 00000 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 26, 210, 462 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 ASSET TRANSFERS 12, 377, 346 13.00 14.00 0 14.00 0 0 15.00 0 15.00 16.00 0 0 16.00 17.00 0 17.00 12, 377, 346 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 13, 833, 116 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 ASSET TRANSFERS 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0

0

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150146 Period: From 01/01/2015 To 12/31/2015 Date/Time Prepared:

			To 12/31/2015	Date/Time Prep 5/16/2016 4:1	
	Cost Center Description	I npati ent	Outpati ent	Total	J PIII
	555 C 5511 C 55551 1 P C 511	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES			2. 22	
	General Inpatient Routine Services				
1.00	Hospi tal	8, 781, 5	50	8, 781, 550	1. 00
2.00	SUBPROVI DER - I PF			., . ,	2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5. 00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7. 00	SKILLED NURSING FACILITY			_	7. 00
8. 00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	8, 781, 5	50	8, 781, 550	10.00
	Intensive Care Type Inpatient Hospital Services	7 37 7 3 1 7	50	0,701,000	
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes	0	0	16. 00
10.00	11-15)	1103		Ö	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 781, 5	50	8, 781, 550	17. 00
18. 00	Ancillary services	34, 469, 7		34, 469, 771	18. 00
19. 00	Outpatient services	0.1, 107, 7	0 120, 477, 009	120, 477, 009	19. 00
20. 00	RURAL HEALTH CLINIC		0 0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22. 00	HOME HEALTH AGENCY		Ĭ	J	22. 00
23. 00	AMBULANCE SERVICES		0 7, 900, 720	7, 900, 720	23. 00
24. 00	CMHC		7,700,720	7, 700, 720	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 43, 251, 3	21 128, 377, 729	171, 629, 050	28. 00
20.00	G-3, line 1)	, mest. 10, 201, 0	120, 077, 727	171, 027, 000	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		43, 660, 064		29. 00
30.00	PROVISION FOR BAD DEBT	9, 050, 8	73		30. 00
31.00			0		31. 00
32.00			0		32. 00
33.00			0		33. 00
34.00			0		34.00
35.00			0		35. 00
36.00	Total additions (sum of lines 30-35)		9, 050, 873		36. 00
37.00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39.00			0		39. 00
40.00			0		40.00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	transfer	52, 710, 937		43.00
	to Wkst. G-3, line 4)				
		*	•	•	

Heal th	Financial Systems COMMUNITY HOSPT. OF NO	BLE CTY, INC.	In Lie	eu of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provi der CCN: 150146		Worksheet G-3	
			From 01/01/2015	D-+- /Ti D	
			To 12/31/2015	Date/Time Prep 5/16/2016 4:1	
				37 107 20 10 4. 1	J pili
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		171, 629, 050	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			108, 387, 188	2. 00
3.00	Net patient revenues (line 1 minus line 2)			63, 241, 862	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		52, 710, 937	4.00
5.00	Net income from service to patients (line 3 minus line 4)			10, 530, 925	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			-596	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			126, 518	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16. 00	Revenue from sale of medical and surgical supplies to other that	n patients		0	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
18. 00	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER (SPECIFY)			0	24.00

1, 224

0

168, 694

1, 550, 580

1, 846, 420

12, 377, 345

24. 01

24.02

24.03

25.00

26. 00 27. 00

0 28.00 12,377,345 29.00

24. 01

24. 02 EMS SUBSIDY

24. 03 OTHER REVENUE

GAIN/LOSS ON SALE OF CAPITAL ASSETS

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY)

ALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 150146	Peri od: From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/16/2016 4:1	
		Title XVIII	Hospi tal	PPS	<u>о рііі</u>
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				1
. 00	Capital DRG other than outlier			273, 903	1.
. 01	Model 4 BPCI Capital DRG other than outlier			0	1.
. 00	Capital DRG outlier payments			7, 097	2.
. 01	Model 4 BPCI Capital DRG outlier payments			0	2.
. 00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	16. 07	3.
. 00	Number of interns & residents (see instructions)			0.00	4.
. 00	Indirect medical education percentage (see instructions)			0.00	5.
. 00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)			0	6.
00	Percentage of SSI recipient patient days to Medicare Part A   30) (see instructions)		, part A line	0.00	7.
00	Percentage of Medicaid patient days to total days (see instru	uctions)		0.00	
00	Sum of lines 7 and 8	- \		0.00	
0.00	Allowable disproportionate share percentage (see instructions	S)		0. 00 0	ı
1.00	Disproportionate share adjustment (see instructions)			_	
2. 00	Total prospective capital payments (see instructions)			281, 000	12.
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	
00	Program inpatient ancillary capital cost (see instructions)			0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	
00	Capital cost payment factor (see instructions)			0	4.
00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1. 00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	cos (soo instructions)		0	
00	Net program inpatient capital costs for extraordinary circumstant [Net program inpatient capital costs (line 1 minus line 2)	ces (see mistructions)		0	3
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
00	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0.00	
00	Adjustment to capital minimum payment level for extraordinary	,	Line 6)	0.00	
	Capital minimum payment level (line 5 plus line 7)	, (		0	
	Current year capital payments (from Part I, line 12, as appli	i cabl e)		0	9
00	icultetti vedi cabital pavillettis (11011 Part I. 1111e 12. as appi	•	less line 9)	0	10
00	Current year comparison of capital minimum payment level to	capital payments (fine o			11
00 00 . 00			or year	0	' '
00 00 0. 00 . 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	capital payment (from pri	,	0	
00 00 . 00 . 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over (Worksheet L, Part III, line 14)	capital payment (from pri ayments (line 10 plus lin	ie 11)		
00 00 00 . 00 . 00 . 00 . 00	Current year comparison of capital minimum payment level to a Carryover of accumulated capital minimum payment level over a Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over a comparison.	capital payment (from pri ayments (line 10 plus lin r the amount on this line	ne 11)	0	12
00 00 . 00 . 00 . 00 . 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over (Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pacturent year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment (from pri ayments (line 10 plus lin r the amount on this line capital payment for the f	ne 11)	0 0	12 13 14
00 00 00 0. 00 1. 00 2. 00 3. 00 4. 00	Current year comparison of capital minimum payment level to a Carryover of accumulated capital minimum payment level over a Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over a comparison.	capital payment (from pri ayments (line 10 plus lin r the amount on this line capital payment for the f	ne 11)	0	12 13 14 15