



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
PARTS I, II & III

**PART I - COST REPORT STATUS**

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT		DATE: 05/28/2014	TIME: 11:36
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT			
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT			
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.			
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____	
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____	
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.	
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN		
	4 -REOPENED			
	5 -AMENDED			

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY COMMUNITY HOSPT. OF NOBLE CTY, INC. (15-0146) {(PROVIDER NAME(S) AND NUMBER(S))} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) \_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		34,892	64,528	-3,617		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		34,892	64,528	-3,617		200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:										
1	STREET: 401 SAWYER ROAD	P.O. BOX: 728							1	
2	CITY: KENDALLVILLE	STATE: IN	ZIP CODE: 46755-0728	COUNTY: NOBLE					2	
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:										
							PAYMENT SYSTEM (P, T, O, OR N)			
0	1	2	3	4	5	6	7	8		
COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV- IDER TYPE	DATE CERTIFIED	V	XVIII	XIX		
3	HOSPITAL	COMMUNITY HOSPT. OF NOBLE CTY, INC.	15-0146	21140	1	05/30/2000	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 01 / 01 / 2013	TO: 12 / 31 / 2013							20
21	TYPE OF CONTROL (see instructions)	2								21
INPATIENT PPS INFORMATION							1	2		
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.						Y	N		22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)						N	N		22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.						3	N		23
		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF- STATE MEDICAID PAID DAYS	OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS			
		1	2	3	4	5	6			
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	424	163		4	664		24		
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25		
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2				26		
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			2				27		
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35		
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:	ENDING:			36		
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37		
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:	ENDING:			38		
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)						Y	Y		39



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
	1	2	3	4	
OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63



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## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2)		
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				64	
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4)	
	1	2	3	4	5	
65						65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2)		
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				66	
ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4)	
	1	2	3	4	5	
67						67
INPATIENT PSYCHIATRIC FACILITY PPS		1	2	3		
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			70	
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				71	
INPATIENT REHABILITATION FACILITY PPS		1	2	3		
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			75	
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76	
LONG TERM CARE HOSPITAL PPS						
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		80	
TEFRA PROVIDERS						
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		85	
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.				86	



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WORKSHEET S-2  
PART I

		V	XIX	
TITLE V AND XIX SERVICES		1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS		1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	PHYSICAL OCCUPATIONAL SPEECH RESPIRATORY	109
MISCELLANEOUS COST REPORTING INFORMATION				
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:	47,079	PAID LOSSES SELF INSURANCE	35,640 118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	Y		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	Y	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121
TRANSPLANT CENTER INFORMATION				
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

ALL PROVIDERS						
		1	2			
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	15H032			140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.						
141	NAME: PARKVIEW HEALTH SYSTEM, INC.	CONTRACTOR'S NAME: WISCONSIN PHYSICIAN SERVICES CONTRACTOR'S NUMBER: 08101				141
142	STREET: 10501 CORPORATE DRIVE	P.O. BOX: 5600				142
143	CITY: FORT WAYNE	STATE: IN	ZIP CODE: 46845			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y				144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N				145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N				146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				149
DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)						
		TITLE XVIII		TITLE V	TITLE XIX	
		PART A	PART B	2	3	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N			156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10
MULTICAMPUS						
165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				165
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					166
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5
HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT						
167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y			167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)					168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)		0.75			169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)			10/01/2012	09/30/2013	170



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## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

## COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N	
		1		2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	04/30/2013	Y	04/30/2013
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		Y	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS.	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	



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## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: ERIC	LAST NAME: NICKESON	TITLE: DIRECTOR REIMBURSEMENT
42	EMPLOYER: PARKVIEW HEALTH SYSTEM, INC		
43	PHONE NUMBER: 260-373-8406	E-MAIL ADDRESS: ERIC.NICKESON@PARKVIEW.COM	







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## HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
PARTS II-III

## PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
<b>SALARIES</b>							
1	200	12,565,039		12,565,039	601,792.00	20.88	1
2							2
3							3
4		103,356		103,356	561.00	184.24	4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8		4,635,118		4,635,118	132,235.00	35.05	8
9	44						9
10		1,585,433	210,833	1,796,266	79,674.00	22.55	10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11							11
12							12
13							13
14		4,952,575		4,952,575	135,309.00	36.60	14
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17		5,019,669		5,019,669			17
18							18
19		794,105		794,105			19
20							20
21							21
22		103,356		103,356			22
22.01							22.01
23							23
24							24
25							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26		1,647,458	-1,647,458				26
27		816,383	733,913	1,550,296	153,727.00	10.08	27
28							28
29							29
30		297,160	24,521	321,681	13,952.00	23.06	30
31							31
32		268,027	22,117	290,144	22,893.00	12.67	32
33							33
34		328,748	-101,689	227,059	10,531.00	21.56	34
35							35
36			126,327	126,327	16,006.00	7.89	36
37							37
38		383,980	31,686	415,666	14,094.00	29.49	38
39							39
40		455,934	37,623	493,557	10,732.00	45.99	40
41							41
42							42
43							43

## PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		7,929,921		7,929,921	469,557.00	16.89	1
2	EXCLUDED AREA SALARIES (see instructions)		1,585,433	210,833	1,796,266	79,674.00	22.55	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		6,344,488	-210,833	6,133,655	389,883.00	15.73	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		4,952,575		4,952,575	135,309.00	36.60	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		5,123,025		5,123,025		83.52%	5
6	TOTAL (sum of lines 3 through 5)		16,420,088	-210,833	16,209,255	525,192.00	30.86	6
7	TOTAL OVERHEAD COST (see instructions)		4,197,690	-772,960	3,424,730	241,935.00	14.16	7



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## HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

## PART IV - WAGE RELATED COST

PART IV

## PART A - CORE LIST

		AMOUNT REPORTED	
	<b>RETIREMENT COST</b>		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	341,193	2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,095,646	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	25,628,684	4
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	43,301	7
	<b>HEALTH AND INSURANCE COST</b>		
8	HEALTH INSURANCE (Purchased or Self Funded)	2,852,788	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	25,678	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	55,210	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	101,342	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-EMPLOYERS PORTION ONLY	1,246,469	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	<b>OTHER</b>		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)	27,804	21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	24,343	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	31,442,458	24

## PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	Supporting Exhibit for Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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## WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

<b>STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD</b>				
1	WAGE INDEX FISCAL YEAR ENDING DATE	09/30/2014		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	01/01/2010	12/31/2010	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH	7/01/2010		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	1/01/2009		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	1/01/2012		5
<b>STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)</b>				
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

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

<b>STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD</b>				
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE	1/01/2009		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	1/01/2012		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	<b>DEPOSIT DATE(S)</b>	<b>CONTRIB-UTION(S)</b>	11
11.01		02/28/2009	5,000,000	11.01
11.02		04/30/2009	2,500,000	11.02
11.03		05/31/2009	10,000,000	11.03
11.04		10/31/2009	5,000,000	11.04
11.05		01/31/2010	5,000,000	11.05
11.06		02/28/2010	5,300,000	11.06
11.07		07/31/2010	5,000,000	11.07
11.08		10/31/2010	5,000,000	11.08
11.09		03/31/2011	8,600,000	11.09
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD	51,400,000		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)	1,427,778		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2	12		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)	17,133,336		16
<b>STEP 4: TOTAL PENSION COST FOR WAGE INDEX</b>				
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)	8,495,348		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	8,495,348		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	25,628,684		19



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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**PART V - CONTRACT LABOR AND BENEFIT COST**

**HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:**

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



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## HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

## UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.246124	1
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## MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID		1,663,074	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		675,691	5
6	MEDICAID CHARGES		17,757,217	6
7	MEDICAID COST (line 1 times line 6)		4,370,477	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.		2,031,712	8

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

9	NET REVENUE FROM STAND-ALONE SCHIP		14,015	9
10	STAND-ALONE SCHIP CHARGES		47,231	10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11,625	11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.			12

## OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)			13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)			14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)			15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.			16

## UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		545	17	
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS			18	
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		2,031,712	19	
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	1,538,939	1,694,849	3,233,788	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	378,770	417,143	795,913	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	4,334	87,519	91,853	22
23	COST OF CHARITY CARE (line 21 minus line 22)	374,436	329,624	704,060	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?		N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)			25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		7,217,000	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		103,818	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)		7,113,182	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)		1,750,725	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)		2,454,785	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)		4,486,497	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	CAP REL COSTS-BLDG & FIXT		2,235,042	2,235,042	-507,367	1,727,675	-1,379,317	348,358	1
2	00200	CAP REL COSTS-MVBLE EQUIP				774,245	774,245	40,784	815,029	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	1,647,458	4,304,126	5,951,584	-1,647,458	4,304,126	-7,210,730	-2,906,604	4
5	00500	ADMINISTRATIVE & GENERAL	816,383	13,068,924	13,885,307	686,625	14,571,932	-2,720,041	11,851,891	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	297,160	862,840	1,160,000	22,569	1,182,569	-1,613	1,180,956	7
8	00800	LAUNDRY & LINEN SERVICE				159,819	159,819		159,819	8
9	00900	HOUSEKEEPING	268,027	256,343	524,370	-138,115	386,255	-55	386,200	9
10	01000	DIETARY	328,748	193,798	522,546	-193,189	329,357	-1,033	328,324	10
11	01100	CAFETERIA				215,601	215,601	-140,009	75,592	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	383,980	6,461	390,441	28,398	418,839		418,839	13
14	01400	CENTRAL SERVICES & SUPPLY		68	68		68		68	14
15	01500	PHARMACY	455,934	75,889	531,823	37,151	568,974	-664,480	-95,506	15
16	01600	MEDICAL RECORDS & LIBRARY								16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	03000	ADULTS & PEDIATRICS	2,185,608	354,695	2,540,303	-329,687	2,210,616	-21,551	2,189,065	30
43	04300	NURSERY				59,585	59,585		59,585	43
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	OPERATING ROOM	939,769	416,284	1,356,053	5,306	1,361,359		1,361,359	50
52	05200	DELIVERY ROOM & LABOR ROOM				437,037	437,037		437,037	52
53	05300	ANESTHESIOLOGY		977,830	977,830		977,830	-949,640	28,190	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,254,792	746,040	2,000,832	-14,058	1,986,774	-14,909	1,971,865	54
54.01	05401	CAT SCAN								54.01
60	06000	LABORATORY		1,499,497	1,499,497	-2,270	1,497,227		1,497,227	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	449,645	73,276	522,921	31,268	554,189	-5,768	548,421	65
66	06600	PHYSICAL THERAPY	875,393	218,913	1,094,306	-379,803	714,503	-106,308	608,195	66
67	06700	OCCUPATIONAL THERAPY				256,458	256,458		256,458	67
68	06800	SPEECH PATHOLOGY				132,327	132,327		132,327	68
69	06900	ELECTROCARDIOLOGY		37,264	37,264		37,264		37,264	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		894,915	894,915	-376,134	518,781		518,781	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				373,529	373,529		373,529	72
73	07300	DRUGS CHARGED TO PATIENTS		1,803,537	1,803,537	-9,546	1,793,991		1,793,991	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	09000	CLINIC	19,153	955	20,108	4,070	24,178		24,178	90
91	09100	EMERGENCY	1,057,556	197,266	1,254,822	-1,622	1,253,200	-5,261	1,247,939	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
95	09500	AMBULANCE SERVICES	1,445,031	334,534	1,779,565	116,368	1,895,933	-5,907	1,890,026	95
		<b>SPECIAL PURPOSE COST CENTERS</b>								
118		SUBTOTALS (sum of lines 1-117)	12,424,637	28,558,497	40,983,134	-258,893	40,724,241	-13,185,838	27,538,403	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,081	720	23,801	1,563	25,364		25,364	190
192	19200	PHYSICIANS' PRIVATE OFFICES	39,761	8,967	48,728	1,336	50,064		50,064	192
194	07950	OTHER NONREIMBURSABLE						-40,564	-40,564	194
194.01	07951	PAIN CLINIC								194.01
194.02	07952	OCC HEALTH		-193,238	-193,238	193,238	80,004		80,004	194.02
194.03	07953	FOUNDATION					80,004		80,004	194.03
194.04	07954	PHYSICIAN OFFICES	9,355	69,662	79,017	772	79,789		79,789	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	68,205	311,122	379,327	-18,020	361,307		361,307	194.05
194.06	07956	VACANT SPACE								194.06
200		TOTAL (sum of lines 118-199)	12,565,039	28,755,730	41,320,769		41,320,769	-13,226,402	28,094,367	200



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INTEREST EXPENSE	A					1
500	TOTAL RECLASSIFICATIONS						500
	CODE LETTER - A						
1	REHAB THERAPY	B	OCCUPATIONAL THERAPY	67	205,154	51,304	1
2			SPEECH PATHOLOGY	68	105,855	26,472	2
500	TOTAL RECLASSIFICATIONS				311,009	77,776	500
	CODE LETTER - B						
1	INSURANCE	C	CAP REL COSTS-BLDG & FIXT	1		23,716	1
2			CAP REL COSTS-MVBLE EQUIP	2		8,870	2
500	TOTAL RECLASSIFICATIONS					32,586	500
	CODE LETTER - C						
1	EQUIPMENT LEASE	D	CAP REL COSTS-BLDG & FIXT	1		107,948	1
2			CAP REL COSTS-MVBLE EQUIP	2		126,344	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
500	TOTAL RECLASSIFICATIONS					234,292	500
	CODE LETTER - D						
1	DRUGS CHARGED TO PATIENTS	E	DRUGS CHARGED TO PATIENTS	73		2,600	1
500	TOTAL RECLASSIFICATIONS					2,600	500
	CODE LETTER - E						
1	CLINIC DIETICIAN	F	CLINIC	90	2,490		1
500	TOTAL RECLASSIFICATIONS				2,490		500
	CODE LETTER - F						
1	PTO	G	ADMINISTRATIVE & GENERAL	5	813,917		1
2			OPERATION OF PLANT	7	24,521		2
3			HOUSEKEEPING	9	22,117		3
4			DIETARY	10	27,128		4
5			NURSING ADMINISTRATION	13	31,686		5
6			PHARMACY	15	37,623		6
7			ADULTS & PEDIATRICS	30	180,354		7
8			OPERATING ROOM	50	77,549		8
9			RADIOLOGY-DIAGNOSTIC	54	103,544		9
10			RESPIRATORY THERAPY	65	37,104		10
11			PHYSICAL THERAPY	66	72,237		11
12			CLINIC	90	1,580		12
13			EMERGENCY	91	87,269		13
14			AMBULANCE SERVICES	95	119,243		14
15			GIFT, FLOWER, COFFEE SHOP & C	190	1,905		15
16			PHYSICIANS' PRIVATE OFFICES	192	3,281		16
17			COMMUNITY & VOLUNTEER SERVICE	194.05	5,628		17
18			PHYSICIAN OFFICES	194.04	772		18
500	TOTAL RECLASSIFICATIONS				1,647,458		500
	CODE LETTER - G						
1	CAFETERIA	H	CAFETERIA	11	126,327	89,274	1
500	TOTAL RECLASSIFICATIONS				126,327	89,274	500
	CODE LETTER - H						
1	DEPRECIATION	I	CAP REL COSTS-MVBLE EQUIP	2		639,031	1
500	TOTAL RECLASSIFICATIONS					639,031	500
	CODE LETTER - I						
1	HOME OFFICE SALARY	J	CENTRAL SERVICES & SUPPLY	14	262,099		1
2			ADMINISTRATIVE & GENERAL	5	2,002,544		2
3			MEDICAL RECORDS & LIBRARY	16	384,969		3
500	TOTAL RECLASSIFICATIONS				2,649,612		500
	CODE LETTER - J						



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
1	LAUNDRY	K	LAUNDRY & LINEN SERVICE	8		159,819	1
500	TOTAL RECLASSIFICATIONS					159,819	500
	CODE LETTER - K						
1	OCCH HEALTH	L	OCC HEALTH	194.02		193,238	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	TOTAL RECLASSIFICATIONS					193,238	500
	CODE LETTER - L						
1	IMPLANTS	M	IMPL. DEV. CHARGED TO PATIENT	72		373,529	1
500	TOTAL RECLASSIFICATIONS					373,529	500
	CODE LETTER - M						
1	OB	N	NURSERY	43	52,245	7,340	1
2			DELIVERY ROOM & LABOR ROOM	52	383,197	53,840	2
500	TOTAL RECLASSIFICATIONS				435,442	61,180	500
	CODE LETTER - N						
1	REBATES	O					1
500	TOTAL RECLASSIFICATIONS						500
	CODE LETTER - O						
1	OTHER	P	FOUNDATION	194.03	80,004		1
500	TOTAL RECLASSIFICATIONS				80,004		500
	CODE LETTER - P						
	GRAND TOTAL (INCREASES)				5,252,342	1,863,325	

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



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INTEREST EXPENSE	A						
500	TOTAL RECLASSIFICATIONS						1	
	CODE LETTER - A						500	
1	REHAB THERAPY	B	PHYSICAL THERAPY	66	311,009	77,776		
2							1	
500	TOTAL RECLASSIFICATIONS				311,009	77,776	2	
	CODE LETTER - B						500	
1	INSURANCE	C	ADMINISTRATIVE & GENERAL	5		32,586	12	
2							12	
500	TOTAL RECLASSIFICATIONS					32,586	2	
	CODE LETTER - C						500	
1	EQUIPMENT LEASE	D	ADMINISTRATIVE & GENERAL	5		14,702	9	
2			OPERATION OF PLANT	7		1,952	9	
3			HOUSEKEEPING	9		413		
4			DIETARY	10		2,226		
5			NURSING ADMINISTRATION	13		688		
6			PHARMACY	15		472		
7			ADULTS & PEDIATRICS	30		13,326		
8			OPERATING ROOM	50		72,243		
9			RADIOLOGY-DIAGNOSTIC	54		64,088		
10			RESPIRATORY THERAPY	65		4,819		
11			PHYSICAL THERAPY	66		26,953		
12			EMERGENCY	91		4,104		
13			AMBULANCE SERVICES	95		2,371		
14			GIFT, FLOWER, COFFEE SHOP & C	190		342		
15			PHYSICIANS' PRIVATE OFFICES	192		1,945		
16			COMMUNITY & VOLUNTEER SERVICE	194.05		23,648		
500	TOTAL RECLASSIFICATIONS					234,292		
	CODE LETTER - D						500	
1	DRUGS CHARGED TO PATIENTS	E	NURSING ADMINISTRATION	13		2,600		
500	TOTAL RECLASSIFICATIONS					2,600		
	CODE LETTER - E						500	
1	CLINIC DIETICIAN	F	DIETARY	10	2,490			
500	TOTAL RECLASSIFICATIONS				2,490			
	CODE LETTER - F						500	
1	PTO	G	EMPLOYEE BENEFITS DEPARTMENT	4	1,647,458			
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
500	TOTAL RECLASSIFICATIONS				1,647,458			
	CODE LETTER - G						500	
1	CAFETERIA	H	DIETARY	10	126,327	89,274		
500	TOTAL RECLASSIFICATIONS				126,327	89,274		
	CODE LETTER - H						500	
1	DEPRECIATION	I	CAP REL COSTS-BLDG & FIXT	1		639,031	9	
500	TOTAL RECLASSIFICATIONS					639,031		
	CODE LETTER - I						500	
1	HOME OFFICE SALARY	J	CENTRAL SERVICES & SUPPLY	14	262,099			
2			ADMINISTRATIVE & GENERAL	5	2,002,544			
3			MEDICAL RECORDS & LIBRARY	16	384,969			
500	TOTAL RECLASSIFICATIONS				2,649,612			
	CODE LETTER - J						500	



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## RECLASSIFICATIONS

## WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	LAUNDRY	K	HOUSEKEEPING	9		159,819	1	
500	TOTAL RECLASSIFICATIONS					159,819	500	
	CODE LETTER - K							
1	OCCH HEALTH	L	RADIOLOGY-DIAGNOSTIC	54		53,514	1	
2			LABORATORY	60		2,270	2	
3			RESPIRATORY THERAPY	65		1,017	3	
4			PHYSICAL THERAPY	66		36,302	4	
5			MEDICAL SUPPLIES CHARGED TO P	71		2,605	5	
6			DRUGS CHARGED TO PATIENTS	73		12,146	6	
7			EMERGENCY	91		84,787	7	
8			ADULTS & PEDIATRICS	30		93	8	
9			AMBULANCE SERVICES	95		504	9	
500	TOTAL RECLASSIFICATIONS					193,238	500	
	CODE LETTER - L							
1	IMPLANTS	M	MEDICAL SUPPLIES CHARGED TO P	71		373,529	1	
500	TOTAL RECLASSIFICATIONS					373,529	500	
	CODE LETTER - M							
1	OB	N	ADULTS & PEDIATRICS	30	435,442	61,180	1	
2							2	
500	TOTAL RECLASSIFICATIONS				435,442	61,180	500	
	CODE LETTER - N							
1	REBATES	O					1	
500	TOTAL RECLASSIFICATIONS						500	
	CODE LETTER - O							
1	OTHER	P	ADMINISTRATIVE & GENERAL	5	80,004		1	
500	TOTAL RECLASSIFICATIONS				80,004		500	
	CODE LETTER - P							
	GRAND TOTAL (DECREASES)				5,252,342	1,863,325		

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



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## RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
PARTS I, II & III

## PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPRE- CIATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND								1
2	LAND IMPROVEMENTS	314,997					314,997	6,536	2
3	BUILDINGS AND FIXTURES	2,144,076	745,055		745,055		2,889,131	22,566	3
4	BUILDING IMPROVEMENTS	57,402					57,402		4
5	FIXED EQUIPMENT	253,913	8,931		8,931		262,844	25,071	5
6	MOVABLE EQUIPMENT	12,372,068	24,937		24,937	1,550	12,395,455	7,450,743	6
7	HIT DESIGNATED ASSETS	1,371,729	920,121		920,121		2,291,850		7
8	SUBTOTAL (sum of lines 1-7)	16,514,185	1,699,044		1,699,044	1,550	18,211,679	7,504,916	8
9	RECONCILING ITEMS	1,336,102	781,426		781,426		2,117,528		9
10	TOTAL (line 7 minus line 9)	15,178,083	917,618		917,618	1,550	16,094,151	7,504,916	10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of cols. 9 through 14)	
		DEPRE- CIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	2,235,042							2,235,042	1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (sum of lines 1-2)	2,235,042							2,235,042	3

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

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

## PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	3,261,529		3,261,529	0.182454					1
2	CAP REL COSTS-MVBLE EQU	14,950,150	335,782	14,614,368	0.817546					2
3	TOTAL (sum of lines 1-2)	18,211,679	335,782	17,875,897	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPRE- CIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	324,642			23,716				348,358	1
2	CAP REL COSTS-MVBLE EQUIP	806,159			8,870				815,029	2
3	TOTAL (sum of lines 1-2)	1,130,801			32,586				1,163,387	3

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



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## ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	WKST A-7 REF.
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)	B	16,855	PHARMACY	15	3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	A	-23,531	ADMINISTRATIVE & GENERAL	5	7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-1,613	OPERATION OF PLANT	7	8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-953,736			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-201,750			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	A	-36,942	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES	A	-45,013	CAP REL COSTS-BLDG & FIXT	1	9 26
27	DEPRECIATION--MOVABLE EQUIPMENT	A	45,013	CAP REL COSTS-MVBLE EQUIP	2	9 27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33						33
33.01	TELEPHONE	A	-3,946	CAP REL COSTS-MVBLE EQUIP	2	9 33.01
33.02	TELEPHONE	A	-3,811	EMPLOYEE BENEFITS DEPARTMENT	4	33.02
33.03	TELEVISION OFFSET - DEPR	A	-283	CAP REL COSTS-MVBLE EQUIP	2	9 33.03
33.04	PHYSICIAN RECRUITMENT	A	-25,000	ADMINISTRATIVE & GENERAL	5	33.04
33.05	PHARMACY SALES	B	-679,759	PHARMACY	15	33.05
33.06	SELF INSURANCE	A	-7,206,919	EMPLOYEE BENEFITS DEPARTMENT	4	33.06
33.07	COMMUNITY HEALTH	A	-104,283	ADMINISTRATIVE & GENERAL	5	33.07
33.08	COMMUNITY HEALTH	A	-2,575	CAFETERIA	11	33.08
33.09	LOBBY DUES	A	-3,808	ADMINISTRATIVE & GENERAL	5	33.09
33.12	INTERUNIT	A	-1,334,304	CAP REL COSTS-BLDG & FIXT	1	9 33.12
33.13	INTERUNIT	A	-2,298,051	ADMINISTRATIVE & GENERAL	5	33.13
33.14	INTERUNIT	A	-40,564	OTHER NONREIMBURSABLE	194	33.14
33.15	INTERUNIT	A	-12,141	RADIOLOGY-DIAGNOSTIC	54	33.15
33.16	INTERUNIT	A	-94,262	PHYSICAL THERAPY	66	33.16
33.17	OTHER OPERATING REVENUE	B	-63,618	ADMINISTRATIVE & GENERAL	5	33.17
33.18	OTHER OPERATING REVENUE	B	-55	HOUSEKEEPING	9	33.18
33.19	OTHER OPERATING REVENUE	B	-1,033	DIETARY	10	33.19
33.20	OTHER OPERATING REVENUE	B	-100,492	CAFETERIA	11	33.20
33.21	OTHER OPERATING REVENUE	B	-1,576	PHARMACY	15	33.21
33.22	OTHER OPERATING REVENUE	B	-21,551	ADULTS & PEDIATRICS	30	33.22
33.23	OTHER OPERATING REVENUE	B	-2,768	RADIOLOGY-DIAGNOSTIC	54	33.23
33.24	OTHER OPERATING REVENUE	B	-5,768	RESPIRATORY THERAPY	65	33.24
33.25	OTHER OPERATING REVENUE	B	-12,046	PHYSICAL THERAPY	66	33.25
33.26	OTHER OPERATING REVENUE	B	-1,165	EMERGENCY	91	33.26
33.27	OTHER OPERATING REVENUE	B	-5,907	AMBULANCE SERVICES	95	33.27
34						34
35						35
36						36
37						37
38						38



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED					
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-13,226,402				50

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

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



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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
1	2	3	4	5	6	7	
1						9	1
2						9	2
3							3
3.01	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	8,845,250	9,047,000	-201,750		3.01
4							4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12		8,845,250	9,047,000	-201,750		5

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

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE		
			NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
B			PARKVIEW HEALTH SYSTEM, INC.		

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	53	ANESTHESIOLOGY DR A	977,759	904,403	73,356	200,300	292	28,119	1,406	1
2	91	EMERGENCY DR B	30,000		30,000	200,300	269	25,904	1,295	2
200		TOTAL	1,007,759	904,403	103,356		561	54,023	2,701	200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	53	ANESTHESIOLOGY DR A					28,119	45,237	949,640	1
2	91	EMERGENCY DR B					25,904	4,096	4,096	2
200		TOTAL					54,023	49,333	953,736	200





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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:  OCCUPATIONAL       PHYSICAL       RESPIRATORY       SPEECH PATHOLOGY

**PART V - OVERTIME COMPUTATION**

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

**PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65





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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

**PART V - OVERTIME COMPUTATION**

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

**PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65





COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

**PART V - OVERTIME COMPUTATION**

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

**PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65





COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT	348,358	348,358					1
2	CAP REL COSTS-MVBLE EQUIP	815,029		815,029				2
4	EMPLOYEE BENEFITS DEPARTMENT	-2,906,604			-2,906,604			4
5	ADMINISTRATIVE & GENERAL	11,851,891	89,368	13,992		11,955,251	11,955,251	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,180,956	34,198	26,343		1,241,497	777,648	7
8	LAUNDRY & LINEN SERVICE	159,819	2,942			162,761	101,950	8
9	HOUSEKEEPING	386,200	4,255	5,301		395,756	247,893	9
10	DIETARY	328,324	8,761	8,446		345,531	216,433	10
11	CAFETERIA	75,592	5,667			81,259	50,899	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	418,839	1,192	926		420,957	263,679	13
14	CENTRAL SERVICES & SUPPLY	68	10,945	516		11,529	7,222	14
15	PHARMACY	-95,506	3,227	99,520		7,241	4,536	15
16	MEDICAL RECORDS & LIBRARY		4,930			4,930	3,088	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	2,189,065	50,620	75,486		2,315,171	1,450,175	30
43	NURSERY	59,585	740	2,468		62,793	39,332	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	1,361,359	38,561	184,448		1,584,368	992,415	50
52	DELIVERY ROOM & LABOR ROOM	437,037	4,752	12,555		454,344	284,592	52
53	ANESTHESIOLOGY	28,190				28,190	17,658	53
54	RADIOLOGY-DIAGNOSTIC	1,971,865	23,093	251,143		2,246,101	1,406,910	54
54.01	CAT SCAN							54.01
60	LABORATORY	1,497,227	6,811			1,504,038	942,098	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	548,421	5,857	45,542		599,820	375,715	65
66	PHYSICAL THERAPY	608,195	2,336	10,725		621,256	389,142	66
67	OCCUPATIONAL THERAPY	256,458				256,458	160,640	67
68	SPEECH PATHOLOGY	132,327				132,327	82,887	68
69	ELECTROCARDIOLOGY	37,264	487			37,751	23,646	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	518,781				518,781	324,954	71
72	IMPL. DEV. CHARGED TO PATIENTS	373,529				373,529	233,971	72
73	DRUGS CHARGED TO PATIENTS	1,793,991				1,793,991	1,123,718	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC	24,178				24,178	15,145	90
91	EMERGENCY	1,247,939	21,557	18,685		1,288,181	806,890	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES	1,890,026		54,083		1,944,109	1,217,749	95
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	27,538,403	320,299	810,179		30,412,098	11,560,985	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,364	2,722	2,385		30,471	19,086	190
192	PHYSICIANS' PRIVATE OFFICES	50,064	19,361	2,465		71,890	45,030	192
194	OTHER NONREIMBURSABLE	-40,564				-40,564		194
194.01	PAIN CLINIC							194.01
194.02	OCC HEALTH							194.02
194.03	FOUNDATION	80,004				80,004	50,113	194.03
194.04	PHYSICIAN OFFICES	79,789	5,052			84,841	53,143	194.04
194.05	COMMUNITY & VOLUNTEER SERVICES	361,307	924			362,231	226,894	194.05
194.06	VACANT SPACE							194.06
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER				-2,906,604	-2,906,604		201
202	TOTAL (sum of lines 118-201)	28,094,367	348,358	815,029	-2,906,604	28,094,367	11,955,251	202



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4)	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT EQUIPMENT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING (cols.0-4) 9	DIETARY TRATIVE & GENERAL 10	
<b>GENERAL SERVICE COST CENTERS</b>								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,019,145		2,019,145				7
8	LAUNDRY & LINEN SERVICE	264,711		26,426	291,137			8
9	HOUSEKEEPING	643,649		38,224	21,887	703,760		9
10	DIETARY	561,964		78,690	403	28,334	669,391	10
11	CAFETERIA	132,158		50,903	403	18,329		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	684,636		10,704		3,854		13
14	CENTRAL SERVICES & SUPPLY	18,751		98,309	7,774	35,398		14
15	PHARMACY	11,777		28,988		10,438		15
16	MEDICAL RECORDS & LIBRARY	8,018		44,283		15,945		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	ADULTS & PEDIATRICS	3,765,346		454,685	99,360	163,721	669,391	30
43	NURSERY	102,125		6,646	303	2,393		43
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	2,576,783		346,365	74,129	124,716		50
52	DELIVERY ROOM & LABOR ROOM	738,936		42,682	303	15,368		52
53	ANESTHESIOLOGY	45,848						53
54	RADIOLOGY-DIAGNOSTIC	3,653,011		207,429	28,770	74,690		54
54.01	CAT SCAN							54.01
60	LABORATORY	2,446,136		61,180	693	22,029		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	975,535		52,611	1,837	18,944		65
66	PHYSICAL THERAPY	1,010,398		20,980		7,554		66
67	OCCUPATIONAL THERAPY	417,098						67
68	SPEECH PATHOLOGY	215,214						68
69	ELECTROCARDIOLOGY	61,397		4,378		1,576		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	843,735						71
72	IMPL. DEV. CHARGED TO PATIENTS	607,500						72
73	DRUGS CHARGED TO PATIENTS	2,917,709						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	CLINIC	39,323						90
91	EMERGENCY	2,095,071		193,629	52,430	69,721		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95	AMBULANCE SERVICES	3,161,858						95
<b>SPECIAL PURPOSE COST CENTERS</b>								
118	SUBTOTALS (sum of lines 1-117)	30,017,832		1,767,112	288,292	613,010	669,391	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,557		24,451		8,804		190
192	PHYSICIANS' PRIVATE OFFICES	116,920		173,903	2,845	62,618		192
194	OTHER NONREIMBURSABLE	-40,564						194
194.01	PAIN CLINIC							194.01
194.02	OCC HEALTH							194.02
194.03	FOUNDATION	130,117						194.03
194.04	PHYSICIAN OFFICES	137,984		45,378		16,339		194.04
194.05	COMMUNITY & VOLUNTEER SERVICES	589,125		8,301		2,989		194.05
194.06	VACANT SPACE							194.06
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER	-2,906,604						201
202	TOTAL (sum of lines 118-201)	28,094,367		2,019,145	291,137	703,760	669,391	202



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	CAFETERIA SUBTOTAL (cols.0-4)	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY & LINEN SERVICE	MEDICAL RECORDS + LIBRARY	SUBTOTAL	
		11	13	14	15	16	24	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA	201,793						11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	7,387	706,581					13
14	CENTRAL SERVICES & SUPPLY			160,232				14
15	PHARMACY	5,625		2,639	59,467			15
16	MEDICAL RECORDS & LIBRARY					68,246		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	42,443	311,572	14,066	85	5,282	5,525,951	30
43	NURSERY	1,067	7,829			94	120,457	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	20,251	148,653	22,343	889	7,374	3,321,503	50
52	DELIVERY ROOM & LABOR ROOM	8,002	57,433			1,031	863,755	52
53	ANESTHESIOLOGY					1,015	46,863	53
54	RADIOLOGY-DIAGNOSTIC	25,907		6,700	22	21,863	4,018,392	54
54.01	CAT SCAN							54.01
60	LABORATORY					6,683	2,536,721	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	9,903		4,949		2,240	1,066,019	65
66	PHYSICAL THERAPY	8,997		3,529	3	1,283	1,052,744	66
67	OCCUPATIONAL THERAPY	3,495				436	421,029	67
68	SPEECH PATHOLOGY	1,803				173	217,190	68
69	ELECTROCARDIOLOGY					718	68,069	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			77,387		2,866	923,988	71
72	IMPL. DEV. CHARGED TO PATIENTS					1,102	608,602	72
73	DRUGS CHARGED TO PATIENTS			2,981	58,059	3,568	2,982,317	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC	486		50		24	39,883	90
91	EMERGENCY	24,670	181,094	10,020	15	9,182	2,635,832	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES	37,234		14,851	308	3,312	3,217,563	95
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	197,270	706,581	159,515	59,381	68,246	29,666,878	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654		15			83,481	190
192	PHYSICIANS' PRIVATE OFFICES	1,302		593			358,181	192
194	OTHER NONREIMBURSABLE						-40,564	194
194.01	PAIN CLINIC							194.01
194.02	OCC HEALTH							194.02
194.03	FOUNDATION	1,090					131,207	194.03
194.04	PHYSICIAN OFFICES						199,701	194.04
194.05	COMMUNITY & VOLUNTEER SERVICES	1,477		109	86		602,087	194.05
194.06	VACANT SPACE							194.06
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER						-2,906,604	201
202	TOTAL (sum of lines 118-201)	201,793	706,581	160,232	59,467	68,246	28,094,367	202



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		25	26				
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS		5,525,951				30
43	NURSERY		120,457				43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM		3,321,503				50
52	DELIVERY ROOM & LABOR ROOM		863,755				52
53	ANESTHESIOLOGY		46,863				53
54	RADIOLOGY-DIAGNOSTIC		4,018,392				54
54.01	CAT SCAN						54.01
60	LABORATORY		2,536,721				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		1,066,019				65
66	PHYSICAL THERAPY		1,052,744				66
67	OCCUPATIONAL THERAPY		421,029				67
68	SPEECH PATHOLOGY		217,190				68
69	ELECTROCARDIOLOGY		68,069				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		923,988				71
72	IMPL. DEV. CHARGED TO PATIENTS		608,602				72
73	DRUGS CHARGED TO PATIENTS		2,982,317				73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	CLINIC		39,883				90
91	EMERGENCY		2,635,832				91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	AMBULANCE SERVICES		3,217,563				95
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)		29,666,878				118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		83,481				190
192	PHYSICIANS' PRIVATE OFFICES		358,181				192
194	OTHER NONREIMBURSABLE		-40,564				194
194.01	PAIN CLINIC						194.01
194.02	OCC HEALTH						194.02
194.03	FOUNDATION		131,207				194.03
194.04	PHYSICIAN OFFICES		199,701				194.04
194.05	COMMUNITY & VOLUNTEER SERVICES		602,087				194.05
194.06	VACANT SPACE						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER		-2,906,604				201
202	TOTAL (sum of lines 118-201)		28,094,367				202



COMPU-MAX

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL	2,148,211	89,368	13,992	2,251,571	2,251,571		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		34,198	26,343	60,541	146,457	206,998	7
8	LAUNDRY & LINEN SERVICE		2,942		2,942	19,201	2,709	8
9	HOUSEKEEPING		4,255	5,301	9,556	46,687	3,919	9
10	DIETARY		8,761	8,446	17,207	40,762	8,067	10
11	CAFETERIA		5,667		5,667	9,586	5,218	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		1,192	926	2,118	49,659	1,097	13
14	CENTRAL SERVICES & SUPPLY		10,945	516	11,461	1,360	10,078	14
15	PHARMACY		3,227	99,520	102,747	854	2,972	15
16	MEDICAL RECORDS & LIBRARY		4,930		4,930	582	4,540	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS		50,620	75,486	126,106	273,113	46,613	30
43	NURSERY		740	2,468	3,208	7,408	681	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM		38,561	184,448	223,009	186,905	35,509	50
52	DELIVERY ROOM & LABOR ROOM		4,752	12,555	17,307	53,598	4,376	52
53	ANESTHESIOLOGY					3,326		53
54	RADIOLOGY-DIAGNOSTIC		23,093	251,143	274,236	264,968	21,265	54
54.01	CAT SCAN							54.01
60	LABORATORY		6,811		6,811	177,428	6,272	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		5,857	45,542	51,399	70,760	5,394	65
66	PHYSICAL THERAPY		2,336	10,725	13,061	73,288	2,151	66
67	OCCUPATIONAL THERAPY					30,254		67
68	SPEECH PATHOLOGY					15,610		68
69	ELECTROCARDIOLOGY		487		487	4,453	449	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					61,200		71
72	IMPL. DEV. CHARGED TO PATIENTS					44,064		72
73	DRUGS CHARGED TO PATIENTS					211,634		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC					2,852		90
91	EMERGENCY		21,557	18,685	40,242	151,964	19,850	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES			54,083	54,083	229,343		95
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	2,148,211	320,299	810,179	3,278,689	2,177,316	181,160	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,722	2,385	5,107	3,595	2,507	190
192	PHYSICIANS' PRIVATE OFFICES		19,361	2,465	21,826	8,481	17,828	192
194	OTHER NONREIMBURSABLE							194
194.01	PAIN CLINIC							194.01
194.02	OCC HEALTH							194.02
194.03	FOUNDATION					9,438		194.03
194.04	PHYSICIAN OFFICES		5,052		5,052	10,009	4,652	194.04
194.05	COMMUNITY & VOLUNTEER SERVICES		924		924	42,732	851	194.05
194.06	VACANT SPACE							194.06
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,148,211	348,358	815,029	3,311,598	2,251,571	206,998	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING FIXTURES	DIETARY MOVABLE EQUIPMENT	CAFETERIA SUBTOTAL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	24,852						8
9	HOUSEKEEPING	1,868	62,030					9
10	DIETARY	34	2,497	68,567				10
11	CAFETERIA	34	1,616		22,121			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		340		810	54,024		13
14	CENTRAL SERVICES & SUPPLY	664	3,120				26,683	14
15	PHARMACY		920		617		440	15
16	MEDICAL RECORDS & LIBRARY		1,405					16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	8,481	14,430	68,567	4,651	23,822	2,342	30
43	NURSERY	26	211		117	599		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	6,328	10,993		2,220	11,366	3,721	50
52	DELIVERY ROOM & LABOR ROOM	26	1,355		877	4,391		52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	2,456	6,583		2,840		1,116	54
54.01	CAT SCAN							54.01
60	LABORATORY	59	1,942					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	157	1,670		1,086		824	65
66	PHYSICAL THERAPY		666		986		588	66
67	OCCUPATIONAL THERAPY				383			67
68	SPEECH PATHOLOGY				198			68
69	ELECTROCARDIOLOGY		139					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						12,887	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS						496	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC				53		8	90
91	EMERGENCY	4,476	6,145		2,704	13,846	1,668	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES				4,082		2,473	95
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	24,609	54,032	68,567	21,624	54,024	26,563	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		776		72		3	190
192	PHYSICIANS' PRIVATE OFFICES	243	5,519		143		99	192
194	OTHER NONREIMBURSABLE							194
194.01	PAIN CLINIC							194.01
194.02	OCC HEALTH							194.02
194.03	FOUNDATION				120			194.03
194.04	PHYSICIAN OFFICES		1,440					194.04
194.05	COMMUNITY & VOLUNTEER SERVICES		263		162		18	194.05
194.06	VACANT SPACE							194.06
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	24,852	62,030	68,567	22,121	54,024	26,683	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	PHARMACY & LINEN SERVICE	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	41,653					15
16	MEDICAL RECORDS & LIBRARY		11,457				16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	60	887	569,072		569,072	30
43	NURSERY		16	12,266		12,266	43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	623	1,238	481,912		481,912	50
52	DELIVERY ROOM & LABOR ROOM		173	82,103		82,103	52
53	ANESTHESIOLOGY		170	3,496		3,496	53
54	RADIOLOGY-DIAGNOSTIC	15	3,672	577,151		577,151	54
54.01	CAT SCAN						54.01
60	LABORATORY		1,122	193,634		193,634	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		376	131,666		131,666	65
66	PHYSICAL THERAPY	2	215	90,957		90,957	66
67	OCCUPATIONAL THERAPY		73	30,710		30,710	67
68	SPEECH PATHOLOGY		29	15,837		15,837	68
69	ELECTROCARDIOLOGY		120	5,648		5,648	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		481	74,568		74,568	71
72	IMPL. DEV. CHARGED TO PATIENTS		185	44,249		44,249	72
73	DRUGS CHARGED TO PATIENTS	40,666	599	253,395		253,395	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	CLINIC		4	2,917		2,917	90
91	EMERGENCY	11	1,541	242,447		242,447	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	AMBULANCE SERVICES	216	556	290,753		290,753	95
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)	41,593	11,457	3,102,781		3,102,781	118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			12,060		12,060	190
192	PHYSICIANS' PRIVATE OFFICES			54,139		54,139	192
194	OTHER NONREIMBURSABLE						194
194.01	PAIN CLINIC						194.01
194.02	OCC HEALTH						194.02
194.03	FOUNDATION			9,558		9,558	194.03
194.04	PHYSICIAN OFFICES			21,153		21,153	194.04
194.05	COMMUNITY & VOLUNTEER SERVICES	60		45,010		45,010	194.05
194.06	VACANT SPACE						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER	66,897		66,897		66,897	201
202	TOTAL (sum of lines 118-201)	108,550	11,457	3,311,598		3,311,598	202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	RECON-CILIATION	
		1	2	4	5A	5		
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT	117,225						1
2	CAP REL COSTS-MVBLE EQUIP		698,740					2
4	EMPLOYEE BENEFITS DEPARTMENT			12,565,039				4
5	ADMINISTRATIVE & GENERAL	30,073	11,996	1,550,296	-11,955,251	19,086,284		5
6	MAINTENANCE & REPAIRS						31,041,535	6
7	OPERATION OF PLANT	11,508	22,584	321,681		1,241,497		7
8	LAUNDRY & LINEN SERVICE	990				162,761		8
9	HOUSEKEEPING	1,432	4,545	290,144		395,756		9
10	DIETARY	2,948	7,241	227,059		345,531		10
11	CAFETERIA	1,907		126,327		81,259		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	401	794	415,666		420,957		13
14	CENTRAL SERVICES & SUPPLY	3,683	442			11,529		14
15	PHARMACY	1,086	85,320	493,557		7,241		15
16	MEDICAL RECORDS & LIBRARY	1,659				4,930		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	17,034	64,716	1,930,520		2,315,171		30
43	NURSERY	249	2,116	52,245		62,793		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	12,976	158,131	1,017,318		1,584,368		50
52	DELIVERY ROOM & LABOR ROOM	1,599	10,764	383,197		454,344		52
53	ANESTHESIOLOGY					28,190		53
54	RADIOLOGY-DIAGNOSTIC	7,771	215,309	1,358,336		2,246,101		54
54.01	CAT SCAN							54.01
60	LABORATORY	2,292				1,504,038		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,971	39,044	486,749		599,820		65
66	PHYSICAL THERAPY	786	9,195	636,621		621,256		66
67	OCCUPATIONAL THERAPY			205,154		256,458		67
68	SPEECH PATHOLOGY			105,855		132,327		68
69	ELECTROCARDIOLOGY	164				37,751		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					518,781		71
72	IMPL. DEV. CHARGED TO PATIENTS					373,529		72
73	DRUGS CHARGED TO PATIENTS					1,793,991		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC			23,223		24,178		90
91	EMERGENCY	7,254	16,019	1,144,825		1,288,181		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES		46,366	1,564,274		1,944,109		95
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	107,783	694,582	12,333,047	-11,955,251	18,456,847		118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	916	2,045	24,986		30,471		190
192	PHYSICIANS' PRIVATE OFFICES	6,515	2,113	43,042		71,890		192
194	OTHER NONREIMBURSABLE				40,564			194
194.01	PAIN CLINIC							194.01
194.02	OCC HEALTH							194.02
194.03	FOUNDATION			80,004		80,004		194.03
194.04	PHYSICIAN OFFICES	1,700		10,127		84,841		194.04
194.05	COMMUNITY & VOLUNTEER SERVICES	311		73,833		362,231		194.05
194.06	VACANT SPACE							194.06
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	348,358	815,029			11,955,251		202
203	UNIT COST MULT-WS B PT I	2,971,704	1,166,427			0,626,379		203
204	COST TO BE ALLOC PER B PT II					2,251,571		204
205	UNIT COST MULT-WS B PT II					0,117,968		205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS ACCUM COST	OPERATION OF PLANT EQUIPMENT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING CILATION SQUARE FEET	DIETARY TRATIVE & GENERAL MEALS SERVED	CAFETERIA RECON-CILATION HOURS WORKED	
		6	7	8	9	10	11	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS	31,041,535						6
7	OPERATION OF PLANT	2,019,145	75,644					7
8	LAUNDRY & LINEN SERVICE	264,711	990	300,915				8
9	HOUSEKEEPING	643,649	1,432	22,622	73,222			9
10	DIETARY	561,964	2,948	417	2,948	31,759		10
11	CAFETERIA	132,158	1,907	417	1,907		385,021	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	684,636	401		401		14,094	13
14	CENTRAL SERVICES & SUPPLY	18,751	3,683	8,035	3,683			14
15	PHARMACY	11,777	1,086		1,086		10,732	15
16	MEDICAL RECORDS & LIBRARY	8,018	1,659		1,659			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	3,765,346	17,034	102,696	17,034	31,759	80,984	30
43	NURSERY	102,125	249	313	249		2,035	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	2,576,783	12,976	76,619	12,976		38,638	50
52	DELIVERY ROOM & LABOR ROOM	738,936	1,599	313	1,599		15,267	52
53	ANESTHESIOLOGY	45,848						53
54	RADIOLOGY-DIAGNOSTIC	3,653,011	7,771	29,736	7,771		49,430	54
54.01	CAT SCAN							54.01
60	LABORATORY	2,446,136	2,292	716	2,292			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	975,535	1,971	1,899	1,971		18,894	65
66	PHYSICAL THERAPY	1,010,398	786		786		17,166	66
67	OCCUPATIONAL THERAPY	417,098					6,669	67
68	SPEECH PATHOLOGY	215,214					3,441	68
69	ELECTROCARDIOLOGY	61,397	164		164			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	843,735						71
72	IMPL. DEV. CHARGED TO PATIENTS	607,500						72
73	DRUGS CHARGED TO PATIENTS	2,917,709						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC	39,323					927	90
91	EMERGENCY	2,095,071	7,254	54,191	7,254		47,070	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES	3,161,858					71,042	95
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	30,017,832	66,202	297,974	63,780	31,759	376,389	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,557	916		916		1,248	190
192	PHYSICIANS' PRIVATE OFFICES	116,920	6,515	2,941	6,515		2,485	192
194	OTHER NONREIMBURSABLE	-40,564						194
194.01	PAIN CLINIC							194.01
194.02	OCC HEALTH							194.02
194.03	FOUNDATION	130,117					2,080	194.03
194.04	PHYSICIAN OFFICES	137,984	1,700		1,700			194.04
194.05	COMMUNITY & VOLUNTEER SERVICES	589,125	311		311		2,819	194.05
194.06	VACANT SPACE							194.06
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I		2,019,145	291,137	703,760	669,391	201,793	202
203	UNIT COST MULT-WS B PT I		26,692732	0,967506	9,611319	21,077206	0,524109	203
204	COST TO BE ALLOC PER B PT II		206,998	24,852	62,030	68,567	22,121	204
205	UNIT COST MULT-WS B PT II		2,736476	0,082588	0,847150	2,158979	0,057454	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY & LINEN SERVICE COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE		
	13	14	15	16		

GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS DEPARTMENT					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION	183,655				13
14	CENTRAL SERVICES & SUPPLY		1,852,938			14
15	PHARMACY		30,523	1,801,770		15
16	MEDICAL RECORDS & LIBRARY				120,536,459	16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	80,984	162,663	2,575	9,331,938	30
43	NURSERY	2,035			165,472	43
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	38,638	258,373	26,935	13,027,879	50
52	DELIVERY ROOM & LABOR ROOM	14,928			1,821,442	52
53	ANESTHESIOLOGY				1,792,734	53
54	RADIOLOGY-DIAGNOSTIC		77,484	656	38,592,168	54
54.01	CAT SCAN					54.01
60	LABORATORY		5		11,806,996	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY		57,230		3,956,782	65
66	PHYSICAL THERAPY		40,808	105	2,266,093	66
67	OCCUPATIONAL THERAPY				770,601	67
68	SPEECH PATHOLOGY				305,325	68
69	ELECTROCARDIOLOGY				1,267,903	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		894,915		5,063,299	71
72	IMPL. DEV. CHARGED TO PATIENTS				1,947,221	72
73	DRUGS CHARGED TO PATIENTS		34,469	1,759,100	6,303,142	73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC		573		42,653	90
91	EMERGENCY	47,070	115,867	465	16,223,145	91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES		171,740	9,332	5,851,666	95
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	183,655	1,844,650	1,799,168	120,536,459	118
NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		175			190
192	PHYSICIANS' PRIVATE OFFICES		6,858			192
194	OTHER NONREIMBURSABLE					194
194.01	PAIN CLINIC					194.01
194.02	OCC HEALTH					194.02
194.03	FOUNDATION					194.03
194.04	PHYSICIAN OFFICES					194.04
194.05	COMMUNITY & VOLUNTEER SERVICES		1,255	2,602		194.05
194.06	VACANT SPACE					194.06
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	COST TO BE ALLOC PER B PT I	706,581	160,232	59,467	68,246	202
203	UNIT COST MULT-WS B PT I	3,847,328	0.086475	0.033005	0.000566	203
204	COST TO BE ALLOC PER B PT II	54,024	26,683	41,653	11,457	204
205	UNIT COST MULT-WS B PT II	0.294160	0.014400	0.023118	0.000095	205



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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



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## COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	5,525,951		5,525,951		5,525,951	30
43	NURSERY	120,457		120,457		120,457	43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	3,321,503		3,321,503		3,321,503	50
52	DELIVERY ROOM & LABOR ROOM	863,755		863,755		863,755	52
53	ANESTHESIOLOGY	46,863		46,863	45,237	92,100	53
54	RADIOLOGY-DIAGNOSTIC	4,018,392		4,018,392		4,018,392	54
54.01	CAT SCAN						54.01
60	LABORATORY	2,536,721		2,536,721		2,536,721	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,066,019		1,066,019		1,066,019	65
66	PHYSICAL THERAPY	1,052,744		1,052,744		1,052,744	66
67	OCCUPATIONAL THERAPY	421,029		421,029		421,029	67
68	SPEECH PATHOLOGY	217,190		217,190		217,190	68
69	ELECTROCARDIOLOGY	68,069		68,069		68,069	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	923,988		923,988		923,988	71
72	IMPL. DEV. CHARGED TO PATIENTS	608,602		608,602		608,602	72
73	DRUGS CHARGED TO PATIENTS	2,982,317		2,982,317		2,982,317	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	CLINIC	39,883		39,883		39,883	90
91	EMERGENCY	2,635,832		2,635,832	4,096	2,639,928	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	892,563		892,563		892,563	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	AMBULANCE SERVICES	3,217,563		3,217,563		3,217,563	95
200	SUBTOTAL (SEE INSTRUCTIONS)	30,559,441		30,559,441	49,333	30,608,774	200
201	LESS OBSERVATION BEDS	892,563		892,563		892,563	201
202	TOTAL (SEE INSTRUCTIONS)	29,666,878		29,666,878		29,716,211	202



## COMPU-MAX

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## COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	8,194,004		8,194,004				30
43	NURSERY	165,472		165,472				43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	3,596,184	9,431,695	13,027,879	0.254953	0.254953	0.254953	50
52	DELIVERY ROOM & LABOR ROOM	1,657,497	163,945	1,821,442	0.474215	0.474215	0.474215	52
53	ANESTHESIOLOGY	491,677	1,301,057	1,792,734	0.026141	0.026141	0.051374	53
54	RADIOLOGY-DIAGNOSTIC	3,372,720	35,219,448	38,592,168	0.104125	0.104125	0.104125	54
54.01	CAT SCAN							54.01
60	LABORATORY	2,488,595	9,318,401	11,806,996	0.214849	0.214849	0.214849	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,621,120	2,335,662	3,956,782	0.269416	0.269416	0.269416	65
66	PHYSICAL THERAPY	227,559	2,038,534	2,266,093	0.464563	0.464563	0.464563	66
67	OCCUPATIONAL THERAPY	9,668	760,933	770,601	0.546364	0.546364	0.546364	67
68	SPEECH PATHOLOGY	34,082	271,243	305,325	0.711340	0.711340	0.711340	68
69	ELECTROCARDIOLOGY	486,932	780,971	1,267,903	0.053686	0.053686	0.053686	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,467,639	3,595,660	5,063,299	0.182487	0.182487	0.182487	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,444,633	502,588	1,947,221	0.312549	0.312549	0.312549	72
73	DRUGS CHARGED TO PATIENTS	2,735,429	3,567,713	6,303,142	0.473148	0.473148	0.473148	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC	3,612	39,041	42,653	0.935057	0.935057	0.935057	90
91	EMERGENCY	2,091,095	14,132,050	16,223,145	0.162474	0.162474	0.162726	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		1,137,934	1,137,934	0.784372	0.784372	0.784372	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES		5,851,666	5,851,666	0.549854	0.549854	0.549854	95
200	SUBTOTAL (SEE INSTRUCTIONS)	30,087,918	90,448,541	120,536,459				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	30,087,918	90,448,541	120,536,459				202



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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
PART I

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	569,072		569,072	6,544	86.96	2,230	193,921	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	12,266		12,266	548	22.38			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	581,338		581,338	7,092		2,230	193,921	200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0146

WORKSHEET D  
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	481,912	13,027,879	0.036991	1,261,294	46,657	50
52	DELIVERY ROOM & LABOR ROOM	82,103	1,821,442	0.045076			52
53	ANESTHESIOLOGY	3,496	1,792,734	0.001950	171,568	335	53
54	RADIOLOGY-DIAGNOSTIC	577,151	38,592,168	0.014955	1,632,244	24,410	54
54.01	CAT SCAN						54.01
60	LABORATORY	193,634	11,806,996	0.016400	1,113,234	18,257	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	131,666	3,956,782	0.033276	788,304	26,232	65
66	PHYSICAL THERAPY	90,957	2,266,093	0.040138	121,633	4,882	66
67	OCCUPATIONAL THERAPY	30,710	770,601	0.039852	5,099	203	67
68	SPEECH PATHOLOGY	15,837	305,325	0.051869	20,517	1,064	68
69	ELECTROCARDIOLOGY	5,648	1,267,903	0.004455	312,562	1,392	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,568	5,063,299	0.014727	303,670	4,472	71
72	IMPL. DEV. CHARGED TO PATIENTS	44,249	1,947,221	0.022724	687,690	15,627	72
73	DRUGS CHARGED TO PATIENTS	253,395	6,303,142	0.040201	1,747,592	70,255	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	CLINIC	2,917	42,653	0.068389	1,523	104	90
91	EMERGENCY	242,447	16,223,145	0.014945	1,010,572	15,103	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	91,918	1,137,934	0.080776			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	2,322,608	106,325,317		9,177,502	228,993	200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)					30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers



COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
6		7		8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)	6,544		2,230		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	548				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	7,092		2,230		200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0146

WORKSHEET D  
PART IV

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	CAT SCAN							54.01
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0146

WORKSHEET D  
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	13,027,879			1,261,294		2,207,692	50
52	DELIVERY ROOM & LABOR ROOM	1,821,442						52
53	ANESTHESIOLOGY	1,792,734			171,568		258,005	53
54	RADIOLOGY-DIAGNOSTIC	38,592,168			1,632,244		8,586,867	54
54.01	CAT SCAN							54.01
60	LABORATORY	11,806,996			1,113,234		147,966	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,956,782			788,304		438,265	65
66	PHYSICAL THERAPY	2,266,093			121,633			66
67	OCCUPATIONAL THERAPY	770,601			5,099			67
68	SPEECH PATHOLOGY	305,325			20,517			68
69	ELECTROCARDIOLOGY	1,267,903			312,562		416,376	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,063,299			303,670		248,186	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,947,221			687,690		124,015	72
73	DRUGS CHARGED TO PATIENTS	6,303,142			1,747,592		2,054,940	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC	42,653			1,523		6,106	90
91	EMERGENCY	16,223,145			1,010,572		3,192,026	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,137,934					461,117	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	106,325,317			9,177,502		18,141,561	200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0146

WORKSHEET D  
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	0.254953	2,207,692			562,858		50
52	DELIVERY ROOM & LABOR ROOM	0.474215						52
53	ANESTHESIOLOGY	0.026141	258,005			6,745		53
54	RADIOLOGY-DIAGNOSTIC	0.104125	8,586,867			894,108		54
54.01	CAT SCAN							54.01
60	LABORATORY	0.214849	147,966			31,790		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.269416	438,265			118,076		65
66	PHYSICAL THERAPY	0.464563						66
67	OCCUPATIONAL THERAPY	0.546364						67
68	SPEECH PATHOLOGY	0.711340						68
69	ELECTROCARDIOLOGY	0.053686	416,376			22,354		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.182487	248,186			45,291		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.312549	124,015			38,761		72
73	DRUGS CHARGED TO PATIENTS	0.473148	2,054,940			972,291		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC	0.935057	6,106			5,709		90
91	EMERGENCY	0.162474	3,192,026			518,621		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.784372	461,117			361,687		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES	0.549854						95
200	SUBTOTAL (see instructions)		18,141,561			3,578,291		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)		18,141,561			3,578,291		202

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
PART I

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	569,072		569,072	6,544	86.96	417	36,262	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	12,266		12,266	548	22.38	289	6,468	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	581,338		581,338	7,092		706	42,730	200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0146

WORKSHEET D  
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	481,912	13,027,879	0.036991	532,170	19,686	50
52	DELIVERY ROOM & LABOR ROOM	82,103	1,821,442	0.045076			52
53	ANESTHESIOLOGY	3,496	1,792,734	0.001950	47,853	93	53
54	RADIOLOGY-DIAGNOSTIC	577,151	38,592,168	0.014955	255,212	3,817	54
54.01	CAT SCAN						54.01
60	LABORATORY	193,634	11,806,996	0.016400	234,094	3,839	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	131,666	3,956,782	0.033276	94,419	3,142	65
66	PHYSICAL THERAPY	90,957	2,266,093	0.040138	15,015	603	66
67	OCCUPATIONAL THERAPY	30,710	770,601	0.039852	312	12	67
68	SPEECH PATHOLOGY	15,837	305,325	0.051869			68
69	ELECTROCARDIOLOGY	5,648	1,267,903	0.004455	26,647	119	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,568	5,063,299	0.014727	98,533	1,451	71
72	IMPL. DEV. CHARGED TO PATIENTS	44,249	1,947,221	0.022724	110,575	2,513	72
73	DRUGS CHARGED TO PATIENTS	253,395	6,303,142	0.040201	512,364	20,598	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	CLINIC	2,917	42,653	0.068389			90
91	EMERGENCY	242,447	16,223,145	0.014945	156,080	2,333	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	91,918	1,137,934	0.080776			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	2,322,608	106,325,317		2,083,274	58,206	200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)					30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers



COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
6		7		8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)	6,544		417		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	548		289		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	7,092		706		200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0146

WORKSHEET D  
PART IV

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	CAT SCAN							54.01
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0146

WORKSHEET D  
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	13,027,879			532,170			50
52	DELIVERY ROOM & LABOR ROOM	1,821,442						52
53	ANESTHESIOLOGY	1,792,734			47,853			53
54	RADIOLOGY-DIAGNOSTIC	38,592,168			255,212			54
54.01	CAT SCAN							54.01
60	LABORATORY	11,806,996			234,094			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,956,782			94,419			65
66	PHYSICAL THERAPY	2,266,093			15,015			66
67	OCCUPATIONAL THERAPY	770,601			312			67
68	SPEECH PATHOLOGY	305,325						68
69	ELECTROCARDIOLOGY	1,267,903			26,647			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,063,299			98,533			71
72	IMPL. DEV. CHARGED TO PATIENTS	1,947,221			110,575			72
73	DRUGS CHARGED TO PATIENTS	6,303,142			512,364			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC	42,653						90
91	EMERGENCY	16,223,145			156,080			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,137,934						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	106,325,317			2,083,274			200

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0146

WORKSHEET D  
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	0.254953		696,254			177,512	50
52	DELIVERY ROOM & LABOR ROOM	0.474215						52
53	ANESTHESIOLOGY	0.026141		89,118			2,330	53
54	RADIOLOGY-DIAGNOSTIC	0.104125		3,192,619			332,431	54
54.01	CAT SCAN							54.01
60	LABORATORY	0.214849		925,902			198,929	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.269416		145,104			39,093	65
66	PHYSICAL THERAPY	0.464563		138,527			64,355	66
67	OCCUPATIONAL THERAPY	0.546364		72,558			39,643	67
68	SPEECH PATHOLOGY	0.711340		52,687			37,478	68
69	ELECTROCARDIOLOGY	0.053686		111,063			5,963	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.182487		128,555			23,460	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.312549		12,178			3,806	72
73	DRUGS CHARGED TO PATIENTS	0.473148		519,993			246,034	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	CLINIC	0.935057		2,838			2,654	90
91	EMERGENCY	0.162474		2,389,317			388,202	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.784372		204,952			160,759	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
95	AMBULANCE SERVICES	0.549854						95
200	SUBTOTAL (see instructions)			8,681,665			1,722,649	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)			8,681,665			1,722,649	202

(A) Worksheet A line numbers



COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0146

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	6,544	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	6,544	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	5,487	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,230	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

**SWING-BED ADJUSTMENT**

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	5,525,951	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,525,951	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	5,525,951	37



COMPU-MAX

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0146

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					844.43	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,883,079	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					1,883,079	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
							1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					2,305,661	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					4,188,740	49
	<b>PASS-THROUGH COST ADJUSTMENTS</b>						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					193,921	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					228,993	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					422,914	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					3,765,826	53
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0146

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					1,057	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					844.43	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					892,563	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	569,072	5,525,951	0.102982	892,563	91,918	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0146

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	6,544	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	6,544	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	5,487	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	417	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	548	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	289	16

**SWING-BED ADJUSTMENT**

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	5,525,951	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,525,951	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	5,525,951	37



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COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0146

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					844.43	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					352,127	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					352,127	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)	120,457	548	219.81	289	63,525	42
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					569,382	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					985,034	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					42,730	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					58,206	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					100,936	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					884,098	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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



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COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0146

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					1,057	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0146

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS		3,188,166		30
43	NURSERY				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.254953	1,261,294	321,571	50
52	DELIVERY ROOM & LABOR ROOM	0.474215			52
53	ANESTHESIOLOGY	0.051374	171,568	8,814	53
54	RADIOLOGY-DIAGNOSTIC	0.104125	1,632,244	169,957	54
54.01	CAT SCAN				54.01
60	LABORATORY	0.214849	1,113,234	239,177	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.269416	788,304	212,382	65
66	PHYSICAL THERAPY	0.464563	121,633	56,506	66
67	OCCUPATIONAL THERAPY	0.546364	5,099	2,786	67
68	SPEECH PATHOLOGY	0.711340	20,517	14,595	68
69	ELECTROCARDIOLOGY	0.053686	312,562	16,780	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.182487	303,670	55,416	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.312549	687,690	214,937	72
73	DRUGS CHARGED TO PATIENTS	0.473148	1,747,592	826,870	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	CLINIC	0.935057	1,523	1,424	90
91	EMERGENCY	0.162726	1,010,572	164,446	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.784372			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		9,177,502	2,305,661	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		9,177,502		202

(A) Worksheet A line numbers



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0146

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS		1,121,407		30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.254953	532,170	135,678	50
52	DELIVERY ROOM & LABOR ROOM	0.474215			52
53	ANESTHESIOLOGY	0.051374	47,853	2,458	53
54	RADIOLOGY-DIAGNOSTIC	0.104125	255,212	26,574	54
54.01	CAT SCAN				54.01
60	LABORATORY	0.214849	234,094	50,295	60
62.30	BLOOD CLOTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.269416	94,419	25,438	65
66	PHYSICAL THERAPY	0.464563	15,015	6,975	66
67	OCCUPATIONAL THERAPY	0.546364	312	170	67
68	SPEECH PATHOLOGY	0.711340			68
69	ELECTROCARDIOLOGY	0.053686	26,647	1,431	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.182487	98,533	17,981	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.312549	110,575	34,560	72
73	DRUGS CHARGED TO PATIENTS	0.473148	512,364	242,424	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	CLINIC	0.935057			90
91	EMERGENCY	0.162726	156,080	25,398	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.784372			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		2,083,274	569,382	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		2,083,274		202

(A) Worksheet A line numbers



COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

CHECK [XX] HOSPITAL  
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	2,380,211			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	722,528			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	36,655			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	1,719,982			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	28.10			4
	<b>INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS</b>				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	<b>INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON</b>				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	<b>DISPROPORTIONATE SHARE ADJUSTMENT</b>				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0469			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2028			31
32	SUM OF LINES 30 AND 31	0.2497			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0979			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	250,707			34
		PRIOR TO OCTOBER 1	ON OR AFTER OCTOBER 1		
	<b>UNCOMPENSATED CARE ADJUSTMENT</b>				
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
35.01	FACTOR 3 (see instructions)		0.000042081		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		380,681		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		95,953		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	95,953			36
	<b>ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES</b>				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40



COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

CHECK [XX] HOSPITAL  
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)				46
47	SUBTOTAL (see instructions)	3,486,054			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	3,486,054			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	252,381			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	3,738,435			59
60	PRIMARY PAYER PAYMENTS	5,271			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	3,733,164			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	519,628			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	602			63
64	ALLOWABLE BAD DEBTS (see instructions)	60,705			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	39,458			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	29,800			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	3,252,392			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.96	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2013)	290,302			70.96
70.97	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2014)	98,201			70.97
71	AMOUNT DUE PROVIDER (see instructions)	3,640,895			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	54,978			71.01
72	INTERIM PAYMENTS	3,551,025			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	34,892			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	532,361			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	Supporting Exhibit for Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97)

EXHIBIT 4

		AMOUNTS FROM E PART A	PRIOR TO 10/1/2010 OR AFTER 3/31/2015 PRE/POST ENTITLEMENT	10/01/2012 through 09/30/2013	3.01	10/01/2013 through 03/31/2014	4.01	(COLUMNS 2 THROUGH 4) TOTAL	5
		1	2	3	3.01	4	4.01	5	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS								1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES PRIOR TO 10/1/2013	2,380,211		2,380,211				2,380,211	1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES ON/AFTER 10/1/2013	722,528				722,528		722,528	1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4								1.03
2	OUTLIER PAYMENTS FOR DISCHARGES	36,655		8,681		27,974		36,655	2
2.01	OUTLIER PAYMENT FOR DISCHARGES FOR MODEL 4 BPCI								2.01
3	OPERATING OUTLIER RECONCILIATION								3
4	MANAGED CARE SIMULATED PAYMENTS	1,719,982		1,304,587		415,395		1,719,982	4
	<b>INDIRECT MEDICAL EDUCATION ADJUSTMENT</b>								
5	AMOUNT FROM WORKSHEET E PART A, LINE 21								5
6	IME PAYMENT ADJUSTMENT								6
	<b>INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422</b>								
7	AMOUNT FROM WORKSHEET E PART A, LINE 27								7
8	IME ADD-ON ADJUSTMENT								8
9	TOTAL IME PAYMENT								9
	<b>DISPROPORTIONATE SHARE ADJUSTMENT</b>								
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE	0.0979	0.0979	0.0979	0.0979	0.0979	0.0979		10
11	DISPROPORTIONATE SHARE ADJUSTMENT	250,707		233,023		17,684		250,707	11
11.01	UNCOMPENSATED CARE PAYMENTS	95,953				95,953		95,953	11.01
	<b>ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES</b>								
12	TOTAL ESRD ADDITIONAL PAYMENT								12
13	SUBTOTAL	3,486,054		2,621,915		864,139		3,486,054	13
14	HOSPITAL SPECIFIC PAYMENTS								14
15	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS - E PART A LINE 49	3,486,054		2,621,915		864,139		3,486,054	15
16	PAYMENT FOR INPATIENT PROGRAM CAPITAL	252,381		190,712		61,669		252,381	16
17	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES								17
18	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT								18
19	SUBTOTAL			2,812,627		925,808		3,738,435	19
	<b>CAPITAL PAYMENTS</b>								
20	CAPITAL DRG OTHER THAN OUTLIER	245,427		188,050		57,377		245,427	20
20.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER								20.01
21	CAPITAL DRG OUTLIER PAYMENTS	6,954		2,662		4,292		6,954	21
21.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS								21.01
22	INDIRECT MEDICAL EDUCATION PERCENTAGE								22
23	INDIRECT MEDICAL EDUCATION ADJUSTMENT								23
24	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE								24
25	DISPROPORTIONATE SHARE ADJUSTMENT								25
26	TOTAL PROSPECTIVE CAPITAL PAYMENTS	252,381		190,712		61,669		252,381	26
	<b>LOW VOLUME ADJUSTMENT</b>								
27	LOW VOLUME ADJUSTMENT FACTOR			0.103214		0.106071			27
28	LOW VOLUME ADJUSTMENT			290,302				290,302	28
29	LOW VOLUME ADJUSTMENT					98,201		98,201	29



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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**COMPONENT CCN: 15-0146**

**WORKSHEET E  
PART B**

**CHECK APPLICABLE BOX:**  HOSPITAL     IPF     IRF     SUB (OTHER)     SNF

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	3,578,291			2
3	PPS PAYMENTS	2,729,654			3
4	OUTLIER PAYMENT (see instructions)	23,940			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.864			5
6	LINE 2 TIMES LINE 5	3,091,643			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0.8907			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	2,753,594			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	678,671			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	2,074,923			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	2,074,923			30
31	PRIMARY PAYER PAYMENTS	263			31
32	SUBTOTAL (line 30 minus line 31)	2,074,660			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	99,016			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	64,360			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	62,313			36
37	SUBTOTAL (see instructions)	2,139,020			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	2,139,020			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	32,299			40.01
41	INTERIM PAYMENTS	2,042,193			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	64,528			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

**TO BE COMPLETED BY CONTRACTOR**

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



COMPU-MAX

COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0146

WORKSHEET E-1  
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,551,025		2,042,193	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT					
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
						3.01
						3.02
						3.03
						3.04
						3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
						3.52
						3.53
						3.54
						3.55
						3.56
						3.57
						3.58
						3.59
						3.99
4	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,551,025		2,042,193	4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
						5.01
						5.02
						5.03
						5.04
						5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
						5.52
						5.53
						5.54
						5.55
						5.56
						5.57
						5.58
						5.59
						5.99
6	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		89,870		96,827	6.01
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		3,640,895		2,139,020	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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



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## CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK                     HOSPITAL     CAH  
 APPLICABLE BOX:

## TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

## HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,677	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,230	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,305	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	5,487	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	120,536,459	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	3,233,788	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,045,430	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	20,909	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,024,521	10

## INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,028,138	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-3,617	32



COMPU-MAX

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0146

WORKSHEET E-3  
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES		1,722,649	2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)		1,722,649	4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)		1,722,649	7
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	2,083,274	8,681,665	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	2,083,274	8,681,665	12
	<b>CUSTOMARY CHARGES</b>			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	2,083,274	8,681,665	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	2,083,274	6,959,016	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)		1,722,649	21
	<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21		1,722,649	29
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)		1,722,649	31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)		1,722,649	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)		1,722,649	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)		1,722,649	40
41	INTERIM PAYMENTS		1,722,649	41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



## COMPU-MAX

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## BALANCE SHEET

## WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	CASH ON HAND AND IN BANKS	1,400				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	16,052,008				4
5	OTHER RECEIVABLES	2,243,521				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-9,042,018				6
7	INVENTORY	215,653				7
8	PREPAID EXPENSES	25,702				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	9,496,266				11
<b>FIXED ASSETS</b>						
12	LAND					12
13	LAND IMPROVEMENTS	314,996				13
14	ACCUMULATED DEPRECIATION	-204,775				14
15	BUILDINGS	2,889,131				15
16	ACCUMULATED DEPRECIATION	-755,649				16
17	LEASEHOLD IMPROVEMENTS	57,402				17
18	ACCUMULATED AMORTIZATION	-8,792				18
19	FIXED EQUIPMENT	52,820				19
20	ACCUMULATED DEPRECIATION	-28,672				20
21	AUTOMOBILES AND TRUCKS	81,333				21
22	ACCUMULATED DEPRECIATION	-81,333				22
23	MAJOR MOVABLE EQUIPMENT	11,812,719				23
24	ACCUMULATED DEPRECIATION	-10,219,294				24
25	MINOR EQUIPMENT DEPRECIABLE	711,426				25
26	ACCUMULATED DEPRECIATION	-336,563				26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE	181,812				29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	4,466,561				30
<b>OTHER ASSETS</b>						
31	INVESTMENTS	6,366				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	847,636				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	854,002				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	14,816,829				36
<b>LIABILITIES AND FUND BALANCES</b>						
	(Omit Cents)	1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	ACCOUNTS PAYABLE	437,008				37
38	SALARIES, WAGES & FEES PAYABLE	684,692				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	69,789				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	-382,368				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	809,121				45
<b>LONG TERM LIABILITIES</b>						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	171,217				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	171,217				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	980,338				51
<b>CAPITAL ACCOUNTS</b>						
52	GENERAL FUND BALANCE	13,836,491				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	13,836,491				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	14,816,829				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		13,843,757			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		8,396,233			2
3	TOTAL (sum of line 1 and line 2)		22,239,990			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		22,239,990			11
12	DEDUCTIONS (debit adjustments)	8,403,498				12
13	ASSET TRANSFERS					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		8,403,498			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		13,836,492			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	ASSET TRANSFERS					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



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## STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
PARTS I & II

## PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	HOSPITAL	7,797,495		7,797,495	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	7,797,495		7,797,495	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	7,797,495		7,797,495	17
18	ANCILLARY SERVICES	25,641,390		25,641,390	18
19	OUTPATIENT SERVICES		96,720,527	96,720,527	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE		6,423,542	6,423,542	23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	33,438,885	103,144,069	136,582,954	28

## PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		41,320,769	29
30	PROVISION FOR BAD DEBT	7,216,836		30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		7,216,836	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		48,537,605	43



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## STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	136,582,954	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	82,243,839	2
3	NET PATIENT REVENUES (line 1 minus line 2)	54,339,115	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	48,537,605	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	5,801,510	5

## OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	-16,855	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	108,436	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)		24
24.01	OTHER (GAIN/(LOSS) ON SALE OF ASSETS)	-573	24.01
24.02	OTHER (EMS SUBSIDY)	178,909	24.02
24.03	OTHER (OTHER REVENUE)	2,324,806	24.03
25	TOTAL OTHER INCOME (sum of lines 6-24)	2,594,723	25
26	TOTAL (line 5 plus line 25)	8,396,233	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	8,396,233	29



COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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**CALCULATION OF CAPITAL PAYMENT**

**COMPONENT CCN: 15-0146**

**WORKSHEET L**

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

**PART I - FULLY PROSPECTIVE METHOD**

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	245,427	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	6,954	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	15.24	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	252,381	12

**PART II - PAYMENT UNDER REASONABLE COST**

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

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



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COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:36 Version: 2014.03
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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0146

WORKSHEET L

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

**PART I - FULLY PROSPECTIVE METHOD**

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

**PART II - PAYMENT UNDER REASONABLE COST**

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

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS						30
43	NURSERY						43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	CAT SCAN						54.01
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
95	AMBULANCE SERVICES						95
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)						118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
194	OTHER NONREIMBURSABLE						194
194.01	PAIN CLINIC						194.01
194.02	OCC HEALTH						194.02
194.03	FOUNDATION						194.03
194.04	PHYSICIAN OFFICES						194.04
194.05	COMMUNITY & VOLUNTEER SERVICES						194.05
194.06	VACANT SPACE						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)						202