

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. ELECTRONICALLY FILED COST REPORT DATE: 05-28-2013 TIME: 09:04
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 USE ONLY 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 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 WHERE 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 01/01/2012 AND ENDING 12/31/2012, 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 V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		-102,799	-924,263	21,546	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		-102,799	-924,263	21,546	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.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 401 SAWYER ROAD
 2 CITY: KENDALLVILLE

STATE: IN

P.O.BOX: 728
 ZIP CODE: 46755-0728 COUNTY: NOBLE

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	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: 01/01/2012			TO: 12/31/2012				20
21	TYPE OF CONTROL				2				21

INPATIENT PPS INFORMATION

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.							1	2
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		OUT-OF	OUT-OF		OTHER		
		MEDICAID	MEDICAID	STATE	MEDICAID	MEDICAID			
		PAID	UNPAID	PAID	UNPAID	HMO	MEDICAID		
		DAYS	DAYS	DAYS	DAYS	DAYS	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.	406	207		2	7	575	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 THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)							1 Y	2 Y 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX	
		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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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 AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

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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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	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.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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.1 / (COL.3 + COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			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				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?			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.			N 86
TITLE V AND XIX INPATIENT SERVICES				
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				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 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.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	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: PREMIUMS: 46,805 PAID LOSSES: 51,815 SELF INSURANCE: 103,161			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 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

ALL PROVIDERS

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.	1 Y	2 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	TITLE
		PART A	PART B	V	XIX
		1	2	3	4
155	HOSPITAL	N	N		N 155
156	SUBPROVIDER - IPF	N	N		156
157	SUBPROVIDER - IRF	N	N		157
158	SUBPROVIDER - (OTHER)	N	N		158
159	SNF	N	N		159
160	HHA	N	N		160
161	CMHC		N		161

PROVIDER CCN: 15-0146 COMMUNITY HOSPT. OF NOBLE CTY,
PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165
ENTER 'Y' FOR YES OR 'N' FOR NO.

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.

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 A MEANINGFUL USER (LINE 167 IS 'Y'),
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 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. 1.00 169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1	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)	1	2	1	
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	
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.	Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
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		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	2	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	
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	
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N	15	
PS&R REPORT DATA		PART A		PART B	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	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	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

22	HAVE ASSETS BEEN RELIEFED 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	
	1	2	
36			WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? 36
37			IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 37
38	N		IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. 38
39			IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. 39
40			IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 40

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: ERIC	LAST NAME: NICKESON	TITLE: DIRECTOR REIMBURSEME	41
42	EMPLOYER: PARKVIEW HEALTH SYSTEM, INC			42
43	PHONE NUMBER: 260-373-8406	E-MAIL ADDRESS: ERIC.NICKESON@PARKVIEW.COM		43

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200					1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING	103,356		103,356	617.00	167.51	4.01
5	PHYSICIAN-PART B						5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL	3,417,174		3,417,174	97,128.00	35.18	8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	1,449,120	-46,174	1,402,946	72,951.00	19.23	10
	OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)						11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE						13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS	3,417,174		3,417,174	97,128.00	35.18	14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)	4,298,741		4,298,741			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS	570,690		570,690			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE	103,356		103,356			22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS	1,566,747	-1,566,747				26
27	ADMINISTRATIVE & GENERAL	834,645	2,829,608	3,664,253	82,933.00	44.18	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT	266,655	26,869	293,524	12,819.00	22.90	30
31	LAUNDRY & LINEN SERVICE						31
32	HOUSEKEEPING	262,006	26,402	288,408	23,989.00	12.02	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY	322,817	-98,807	224,010	15,880.00	14.11	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA		127,115	127,115	10,542.00	12.06	36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION	399,532	40,259	439,791	14,301.00	30.75	38
39	CENTRAL SERVICES AND SUPPLY		262,099	262,099	16,996.00	15.42	39
40	PHARMACY	440,436	44,381	484,817	11,003.00	44.06	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		384,969	384,969	21,198.00	18.16	41
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	8,525,890	2,649,612	11,175,502	468,348.00	23.86	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	1,449,120	-46,174	1,402,946	72,951.00	19.23	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	7,076,770	2,695,786	9,772,556	395,397.00	24.72	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	3,417,174		3,417,174	97,128.00	35.18	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	4,402,097		4,402,097		45.05	5
6	TOTAL (SUM OF LINES 3 THRU 5)	14,896,041	2,695,786	17,591,827	492,525.00	35.72	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	4,092,838	2,076,148	6,168,986	209,661.00	29.42	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
RETIREMENT COST			
1	401K EMPLOYER CONTRIBUTIONS	290,031	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	975,966	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)			
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	39,486	7
HEALTH AND INSURANCE COST			
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,045,679	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	19,941	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	44,439	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	41,242	15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES			
17	FICA-EMPLOYERS PORTION ONLY	1,114,132	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER			
21	EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	23,264	21
22	DAY CARE COSTS AND ALLOWANCES	5,369	22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	3,599,549	24
PART B - OTHER THAN CORE RELATED COST			
25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 15-0146 COMMUNITY HOSPT. OF NOBLE CTY,
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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	BENEFIT
0		LABOR	COST
		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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART 1, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.216493	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,943,236	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					5
6	MEDICAID CHARGES				18,125,233	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,923,987	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.				1,980,751	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP				31,564	9
10	STAND-ALONE SCHIP CHARGES				116,939	10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)				25,316	11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,980,751	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		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	1,610,634	785,788	2,396,422		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	348,691	170,118	518,809		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	4,244	12,770	17,014		22
23	COST OF CHARITY CARE	344,447	157,348	501,795		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)			7,709,000		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			31,261		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			7,677,739		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,662,177		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			2,163,972		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			4,144,723		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS		
		1	2	3	4		
GENERAL SERVICE COST CENTERS							
1	00100		2,464,135	2,464,135	-727,891	1	
2	00200				1,000,083	2	
3	00300					3	
4	00400	1,566,747	4,004,145	5,570,892	-1,566,747	4	
5	00500	834,645	11,813,041	12,647,686	-1,855,940	5	
6	00600					6	
7	00700	266,655	587,508	854,163	25,637	7	
8	00800				157,429	8	
9	00900	262,006	230,065	492,071	-131,214	9	
10	01000	322,817	171,441	494,258	-182,811	10	
11	01100				209,054	11	
12	01200					12	
13	01300	399,532	7,728	407,260	39,555	13	
14	01400		157	157	-13	14	
15	01500	440,436	67,787	508,223	1,485,556	15	
16	01600					16	
17	01700					17	
19	01900					19	
20	02000					20	
21	02100					21	
22	02200					22	
23	02300					23	
INPATIENT ROUTINE SERV COST CENTERS							
30	03000	2,051,821	320,329	2,372,150	-247,158	30	
43	04300				101,048	43	
ANCILLARY SERVICE COST CENTERS							
50	05000	934,772	538,830	1,473,602	24,680	50	
52	05200				339,585	52	
53	05300		970,470	970,470		53	
54	05400	1,228,199	590,865	1,819,064	-21,466	54	
54.01	05401					54.01	
60	06000		134,036	134,036	-2,177	60	
62.30	06250					62.30	
63	06300		114,418	114,418		63	
65	06500	495,076	88,061	583,137	44,271	65	
66	06600	670,478	179,511	849,989	-287,352	66	
67	06700				189,050	67	
68	06800				58,161	68	
69	06900		1,529,755	1,529,755	-1,441,662	69	
71	07100		725,905	725,905	-81,421	71	
72	07200				78,923	72	
73	07300		1,575,124	1,575,124	-11,643	73	
76.97	07697					76.97	
76.98	07698					76.98	
76.99	07699					76.99	
OUTPATIENT SERVICE COST CENTERS							
90	09000	19,649	1,310	20,959	6,202	90	
91	09100	1,001,111	180,189	1,181,300	15,860	91	
92	09200					92	
OTHER REIMBURSABLE COST CENTERS							
95	09500	1,288,578	295,729	1,584,307	-62,757	95	
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (SUM OF LINES 1-117)		11,782,522	26,590,539	38,373,061	-2,845,158	118
NONREIMBURSABLE COST CENTERS							
190	19000	23,326	887	24,213	2,012	190	
192	19200	64,458	4,193	68,651	4,891	192	
194	07950					194	
194.01	07951					194.01	
194.02	07952		-185,289	-185,289	185,289	194.02	
194.03	07953				80,004	194.03	
194.04	07954	28,011		28,011	2,570,912	194.04	
194.05	07955	44,747	166,394	211,141	2,050	194.05	
194.06	07956					194.06	
200	TOTAL (SUM OF LINES 118-199)		11,943,064	26,576,724	38,519,788	200	

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	1,736,244	-237,462	1,498,782	1
2	00200	1,000,083	1,130,868	2,130,951	2
3	00300				3
4	00400	4,004,145	-892,357	3,111,788	4
5	00500	10,791,746	-7,064,689	3,727,057	5
6	00600				6
7	00700	879,800	-1,514	878,286	7
8	00800	157,429		157,429	8
9	00900	360,857	-55	360,802	9
10	01000	311,447	-1,033	310,414	10
11	01100	209,054	-150,859	58,195	11
12	01200				12
13	01300	446,815		446,815	13
14	01400	144	391,346	391,490	14
15	01500	1,993,779	-508,515	1,485,264	15
16	01600		548,457	548,457	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,124,992	-21,551	2,103,441	30
43	04300	101,048		101,048	43
ANCILLARY SERVICE COST CENTERS					
50	05000	1,498,282		1,498,282	50
52	05200	339,585		339,585	52
53	05300	970,470	-936,958	33,512	53
54	05400	1,797,598	-14,671	1,782,927	54
54.01	05401				54.01
60	06000	131,859		131,859	60
62.30	06250				62.30
63	06300	114,418		114,418	63
65	06500	627,408	-5,768	621,640	65
66	06600	562,637	-12,046	550,591	66
67	06700	189,050		189,050	67
68	06800	58,161		58,161	68
69	06900	88,093		88,093	69
71	07100	644,484		644,484	71
72	07200	78,923		78,923	72
73	07300	1,563,481		1,563,481	73
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	27,161		27,161	90
91	09100	1,197,160	-5,188	1,191,972	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
95	09500	1,521,550	-5,907	1,515,643	95
SPECIAL PURPOSE COST CENTERS					
118		35,527,903	-7,787,902	27,740,001	118
NONREIMBURSABLE COST CENTERS					
190	19000	26,225		26,225	190
192	19200	73,542		73,542	192
194	07950				194
194.01	07951				194.01
194.02	07952				194.02
194.03	07953	80,004		80,004	194.03
194.04	07954	2,598,923		2,598,923	194.04
194.05	07955	213,191		213,191	194.05
194.06	07956				194.06
200		38,519,788	-7,787,902	30,731,886	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER	
		COST CENTER	LINE #			
	1	2	3	4	5	
1 INTEREST EXPENSE	A					1
500 TOTAL RECLASSIFICATIONS						500
CODE LETTER - A						
1 REHAB THERAPY	B	OCCUPATIONAL THERAPY	67	148,287	40,763	1
2		SPEECH PATHOLOGY	68	45,620	12,541	2
500 TOTAL RECLASSIFICATIONS				193,907	53,304	500
CODE LETTER - B						
1 INSURANCE	C	CAP REL COSTS-BLDG & FIXT	1		17,407	1
2		CAP REL COSTS-MVBLE EQUIP	2		6,635	2
500 TOTAL RECLASSIFICATIONS					24,042	500
CODE LETTER - C						
1 EQUIPMENT LEASE	D	CAP REL COSTS-BLDG & FIXT	1		131,547	1
2		CAP REL COSTS-MVBLE EQUIP	2		116,603	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
17						17
500 TOTAL RECLASSIFICATIONS					248,150	500
CODE LETTER - D						
1 DRUGS CHARGED TO PATIENTS	E	DRUGS CHARGED TO PATIENTS	73		3	1
500 TOTAL RECLASSIFICATIONS					3	500
CODE LETTER - E						
1 CLINIC DIETICIAN	F	CLINIC	90	4,222		1
500 TOTAL RECLASSIFICATIONS				4,222		500
CODE LETTER - F						
1 PTO	G	ADMINISTRATIVE & GENERAL	5	827,064		1
2		OPERATION OF PLANT	7	26,869		2
3		HOUSEKEEPING	9	26,402		3
4		DIETARY	10	32,530		4
5		NURSING ADMINISTRATION	13	40,259		5
6		PHARMACY	15	44,381		6
7		ADULTS & PEDIATRICS	30	206,753		7
8		OPERATING ROOM	50	94,194		8
9		RADIOLOGY-DIAGNOSTIC	54	94,164		9
10		RESPIRATORY THERAPY	65	49,886		10
11		PHYSICAL THERAPY	66	67,561		11
12		CLINIC	90	1,980		12
13		EMERGENCY	91	100,878		13
14		GIFT, FLOWER, COFFEE SHOP & C	190	2,350		14
15		PHYSICIANS' PRIVATE OFFICES	192	6,496		15
16		COMMUNITY & VOLUNTEER SERVICE	194.05	2,102		16
17		PHYSICIAN OFFICES	194.04	2,822		17
500 TOTAL RECLASSIFICATIONS				1,626,691		500
CODE LETTER - G						
1 CAFETERIA	H	CAFETERIA	11	127,115	81,939	1
500 TOTAL RECLASSIFICATIONS				127,115	81,939	500
CODE LETTER - H						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 DEPRECIATION	I	CAP REL COSTS-MVBLE EQUIP	2			876,845 1
500 TOTAL RECLASSIFICATIONS						876,845 500
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						
1 LAUNDRY	K	LAUNDRY & LINEN SERVICE	8			157,429 1
500 TOTAL RECLASSIFICATIONS						157,429 500
CODE LETTER - K						
1 OCCH HEALTH	L	OCC HEALTH	194.02			185,289 1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
500 TOTAL RECLASSIFICATIONS						185,289 500
CODE LETTER - L						
1 IMPLANTS	M	IMPL. DEV. CHARGED TO PATIENT	72			78,923 1
500 TOTAL RECLASSIFICATIONS						78,923 500
CODE LETTER - M						
1 OB	N	NURSERY	43		90,589	10,459 1
2		DELIVERY ROOM & LABOR ROOM	52		304,437	35,148 2
500 TOTAL RECLASSIFICATIONS					395,026	45,607 500
CODE LETTER - N						
1 REBATES	O					1
500 TOTAL RECLASSIFICATIONS						500
CODE LETTER - O						
1 OTHER	P	FOUNDATION	194.03			80,004 1
2		PHARMACY	15			1,441,662 2
3		PHYSICIAN OFFICES	194.04			2,568,090 3
500 TOTAL RECLASSIFICATIONS						4,089,756 500
CODE LETTER - P						
GRAND TOTAL (INCREASES)					4,996,573	5,841,287

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 INTEREST EXPENSE	A					1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A						500
1 REHAB THERAPY	B	PHYSICAL THERAPY	66	193,907	53,304	1
2						2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B				193,907	53,304	500
1 INSURANCE	C	ADMINISTRATIVE & GENERAL	5		24,042	12 1
2						12 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					24,042	500
1 EQUIPMENT LEASE	D	ADMINISTRATIVE & GENERAL	5		10,868	9 1
2		OPERATION OF PLANT	7		1,232	9 2
3		HOUSEKEEPING	9		187	3
4		DIETARY	10		2,065	4
5		NURSING ADMINISTRATION	13		701	5
6		CENTRAL SERVICES & SUPPLY	14		13	6
7		PHARMACY	15		487	7
8		ADULTS & PEDIATRICS	30		13,189	8
9		OPERATING ROOM	50		69,514	9
10		RADIOLOGY-DIAGNOSTIC	54		64,317	10
11		RESPIRATORY THERAPY	65		4,640	11
12		PHYSICAL THERAPY	66		72,893	12
13		EMERGENCY	91		3,719	13
14		AMBULANCE SERVICES	95		2,330	14
15		GIFT, FLOWER, COFFEE SHOP & C	190		338	15
16		PHYSICIANS' PRIVATE OFFICES	192		1,605	16
17		COMMUNITY & VOLUNTEER SERVICE	194.05		52	17
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					248,150	500
1 DRUGS CHARGED TO PATIENTS	E	NURSING ADMINISTRATION	13		3	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					3	500
1 CLINIC DIETICIAN	F	DIETARY	10	4,222		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - F				4,222		500
1 PTO	G	EMPLOYEE BENEFITS	4	1,566,747		1
2		AMBULANCE SERVICES	95	59,944		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
17						17
500 TOTAL RECLASSIFICATIONS CODE LETTER - G				1,626,691		500
1 CAFETERIA	H	DIETARY	10	127,115	81,939	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - H				127,115	81,939	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 DEPRECIATION	I	CAP REL COSTS-BLDG & FIXT	1		876,845	9 1
500 TOTAL RECLASSIFICATIONS					876,845	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						
1 LAUNDRY	K	HOUSEKEEPING	9		157,429	1
500 TOTAL RECLASSIFICATIONS					157,429	500
CODE LETTER - K						
1 OCCH HEALTH	L	RADIOLOGY-DIAGNOSTIC	54		51,313	1
2		LABORATORY	60		2,177	2
3		RESPIRATORY THERAPY	65		975	3
4		PHYSICAL THERAPY	66		34,809	4
5		MEDICAL SUPPLIES CHRGED TO PA	71		2,498	5
6		DRUGS CHARGED TO PATIENTS	73		11,646	6
7		EMERGENCY	91		81,299	7
8		ADULTS & PEDIATRICS	30		89	8
9		AMBULANCE SERVICES	95		483	9
500 TOTAL RECLASSIFICATIONS					185,289	500
CODE LETTER - L						
1 IMPLANTS	M	MEDICAL SUPPLIES CHRGED TO PA	71		78,923	1
500 TOTAL RECLASSIFICATIONS					78,923	500
CODE LETTER - M						
1 OB	N	ADULTS & PEDIATRICS	30	395,026	45,607	1
2						2
500 TOTAL RECLASSIFICATIONS				395,026	45,607	500
CODE LETTER - N						
1 REBATES	O					1
500 TOTAL RECLASSIFICATIONS						500
CODE LETTER - O						
1 OTHER	P	ADMINISTRATIVE & GENERAL	5		80,004	1
2		ELECTROCARDIOLOGY	69		1,441,662	2
3		ADMINISTRATIVE & GENERAL	5		2,568,090	3
500 TOTAL RECLASSIFICATIONS					4,089,756	500
CODE LETTER - P						
GRAND TOTAL (DECREASES)				2,346,961	8,490,899	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS	314,997					314,997	6,536	2
3 BUILDINGS AND FIXTURES	2,052,066	92,010		92,010		2,144,076	17,405	3
4 BUILDING IMPROVEMENTS	1,000	56,402		56,402		57,402		4
5 FIXED EQUIPMENT	253,912					253,912	25,071	5
6 MOVABLE EQUIPMENT	11,658,775	1,142,702		1,142,702	429,408	12,372,069	7,139,282	6
7 HIT DESIGNATED ASSETS		1,371,729		1,371,729		1,371,729		7
8 SUBTOTAL (SUM OF LINES 1-7)	14,280,750	2,662,843		2,662,843	429,408	16,514,185	7,188,294	8
9 RECONCILING ITEMS	-175,314	1,869,797		1,869,797	287,127	1,407,356		9
10 TOTAL (LINE 7 MINUS LINE 9)	14,456,064	793,046		793,046	142,281	15,106,829	7,188,294	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)	
							(SUM OF COLS. 9-14) 15	
1 CAP REL COSTS-BLDG & FIXT	2,464,135						2,464,135	1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)	2,464,135						2,464,135	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 7	TOTAL	
								(SUM OF COLS. 5-7) 8	
1 CAP REL COSTS-BLDG & FIXT	2,770,387		2,770,387	0.182955					1
2 CAP REL COSTS-MVBLE EQUIP	12,372,069		12,372,069	0.817045					2
3 TOTAL (SUM OF LINES 1-2)	15,142,456		15,142,456	1.000000					3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)	
							(SUM OF COLS. 9-14) 15	
1 CAP REL COSTS-BLDG & FIXT	1,481,375				17,407		1,498,782	1
2 CAP REL COSTS-MVBLE EQUIP	2,124,316				6,635		2,130,951	2
3 TOTAL	3,605,691				24,042		3,629,733	3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	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	-349	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	-24,999	ADMINISTRATIVE & GENERAL	5	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-1,514	OPERATION OF PLANT	7	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-941,054			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-487,849			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	A	-43,799	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 OVERPAYMENT					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	-41,672	CAP REL COSTS-BLDG & FIXT	1	9 26
27 DEPRECIATION--MOVABLE EQUIPMENT	A	227,113	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	-3,806	EMPLOYEE BENEFITS	4	33.02
33.03 TELEVISION OFFSET - DEPR	A	-283	CAP REL COSTS-MVBLE EQUIP	2	9 33.03
33.04 PHYSICIAN RECRUITMENT	A	-78,878	ADMINISTRATIVE & GENERAL	5	33.04
33.05 PHARMACY SALES	B	-506,590	PHARMACY	15	33.05
33.06 SELF INSURANCE	A	-1,656,113	EMPLOYEE BENEFITS	4	33.06
33.07 COMMUNITY HEALTH	A	-103,099	ADMINISTRATIVE & GENERAL	5	33.07
33.08 COMMUNITY HEALTH	A	-6,568	CAFETERIA	11	33.08
33.09 LOBBY DUES	A	-3,745	ADMINISTRATIVE & GENERAL	5	33.09
33.11 TRANSCRIPTION	A	73	EMERGENCY	91	33.11
33.12 INTERUNIT	A	-1,364,856	CAP REL COSTS-BLDG & FIXT	1	9 33.12
33.13 INTERUNIT	A	-2,518,086	ADMINISTRATIVE & GENERAL	5	33.13
33.15 INTERUNIT	A	-11,903	RADIOLOGY-DIAGNOSTIC	54	33.15
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

PROVIDER CCN: 15-0146 COMMUNITY HOSPT. OF NOBLE CTY,
PERIOD FROM 01/01/2012 TO 12/31/2012

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VERSION: 2012.11
05/28/2013 09:04

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER 3	LINE NO. 4	
					38
					39
					40
					41
					42
					43
					44
					45
					46
					47
					48
					49
50	TOTAL (SUM OF LINES 1 THRU 49)	-7,787,902			50
	TRANSFER TO WKST A, COL. 6, LINE 200)				

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 THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	1	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1,169,066		9 1
2	2	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	907,984		9 2
3	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	767,562		3
3.01	5	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	3,413,736	7,686,000	-4,272,264 4.01
3.02	14	CENTRAL SERVICES & SUPPLY	HOME OFFICE ALLOCATION	391,346		4.02
3.03	16	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	548,457		4.03
4						4
5		TOTALS (SUM OF LINES 1-4)		7,198,151	7,686,000	-487,849 5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----		TYPE OF BUSINESS
		PERCENT OF OWNERSHIP	PERCENT OF OWNERSHIP	
1	2	3	4	5
6	B		PARKVIEW HEALTH SYSTEM, INC.	6
7				7
8				8
9				9
10				10

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	53 ANESTHESIOLOGY DR A	970,470	897,114	73,356	200,300	348	33,512	1,676	1
2	91 EMERGENCY DR B	30,000		30,000	200,300	269	25,904	1,295	2
200	TOTAL	1,000,470	897,114	103,356		617	59,416	2,971	200

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
1	53 ANESTHESIOLOGY					33,512	39,844	936,958	1
2	91 EMERGENCY					25,904	4,096	4,096	2
200	TOTAL					59,416	43,940	941,054	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,498,782	1,498,782				1
2 CAP REL COSTS-MVBLE EQUIP	2,130,951		2,130,951			2
4 EMPLOYEE BENEFITS	3,111,788			3,111,788		4
5 ADMINISTRATIVE & GENERAL	3,727,057	345,477	30,317	781,379	4,884,230	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	878,286	132,204	49,912	62,592	1,122,994	7
8 LAUNDRY & LINEN SERVICE	157,429	11,373			168,802	8
9 HOUSEKEEPING	360,802	16,451	7,744	61,501	446,498	9
10 DIETARY	310,414	33,867	13,763	47,769	405,813	10
11 CAFETERIA	58,195	21,908		27,106	107,209	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	446,815	4,607	1,465	93,782	546,669	13
14 CENTRAL SERVICES & SUPPLY	391,490	42,310	1,956	55,891	491,647	14
15 PHARMACY	1,485,264	12,476	144,593	103,384	1,745,717	15
16 MEDICAL RECORDS & LIBRARY	548,457	19,059		82,092	649,608	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,103,441	195,687	102,027	397,389	2,798,544	30
43 NURSERY	101,048	2,861	7,676	19,317	130,902	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,498,282	149,068	409,981	219,420	2,276,751	50
52 DELIVERY ROOM & LABOR ROOM	339,585	18,369	29,310	64,919	452,183	52
53 ANESTHESIOLOGY	33,512		10,729		44,241	53
54 RADIOLOGY-DIAGNOSTIC	1,782,927	133,962	1,103,003	281,985	3,301,877	54
54.01 CAT SCAN						54.01
60 LABORATORY	131,859	26,330	401		158,590	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	114,418				114,418	63
65 RESPIRATORY THERAPY	621,640		74,937	116,209	835,429	65
66 PHYSICAL THERAPY	550,591	116,442	13,175	116,032	796,240	66
67 OCCUPATIONAL THERAPY	189,050			31,621	220,671	67
68 SPEECH PATHOLOGY	58,161			9,728	67,889	68
69 ELECTROCARDIOLOGY	88,093	1,884			89,977	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	644,484				644,484	71
72 IMPL. DEV. CHARGED TO PATIENT	78,923				78,923	72
73 DRUGS CHARGED TO PATIENTS	1,563,481				1,563,481	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	27,161			5,513	32,674	90
91 EMERGENCY	1,191,972	83,334	30,998	234,991	1,541,295	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,515,643		91,298	261,998	1,868,939	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	27,740,001	1,390,312	2,123,285	3,074,618	27,586,695	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,225	10,523	3,770	5,475	45,993	190
192 PHYSICIANS' PRIVATE OFFICES	73,542	74,844	3,896	15,130	167,412	192
194 OTHER NONREIMBURSABLE						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	2,598,923	19,530		6,575	2,625,028	194.04
194.05 COMMUNITY & VOLUNTEER SERVICES	213,191			9,990	223,181	194.05
194.06 VACANT SPACE		3,573			3,573	194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	30,731,886	1,498,782	2,130,951	3,111,788	30,731,886	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	4,884,230					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	212,203	1,335,197				7
8 LAUNDRY & LINEN SERVICE	31,897	14,872	215,571			8
9 HOUSEKEEPING	84,371	21,511	15,320	567,700		9
10 DIETARY	76,683	44,284	513	19,356	546,649	10
11 CAFETERIA	20,258	28,647	513	12,521		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	103,300	6,024		2,633		13
14 CENTRAL SERVICES & SUPPLY	92,903	55,325	5,514	24,182		14
15 PHARMACY	329,874	16,314		7,131		15
16 MEDICAL RECORDS & LIBRARY	122,751	24,921		10,893		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	528,818	255,880	72,535	111,843	546,649	30
43 NURSERY	24,736	3,740	242	1,635		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	430,219	194,923	57,124	85,199		50
52 DELIVERY ROOM & LABOR ROOM	85,445	24,020	242	10,499		52
53 ANESTHESIOLOGY	8,360					53
54 RADIOLOGY-DIAGNOSTIC	623,938	175,169	21,818	76,565		54
54.01 CAT SCAN						54.01
60 LABORATORY	29,967	34,430	509	15,049		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	21,621					63
65 RESPIRATORY THERAPY	157,864	29,608	1,468	12,941		65
66 PHYSICAL THERAPY	150,459	152,261		66,552		66
67 OCCUPATIONAL THERAPY	41,698					67
68 SPEECH PATHOLOGY	12,828					68
69 ELECTROCARDIOLOGY	17,002	2,464		1,077		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	121,783					71
72 IMPL. DEV. CHARGED TO PATIENT	14,913					72
73 DRUGS CHARGED TO PATIENTS	295,438					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	6,174					90
91 EMERGENCY	291,246	108,968	37,603	47,629		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	353,158					95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	4,289,907	1,193,361	213,401	505,705	546,649	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,691	13,760		6,014		190
192 PHYSICIANS' PRIVATE OFFICES	31,635	97,867	2,170	42,777		192
194 OTHER NONREIMBURSABLE						194
194.01 PAIN CLINIC						194.01
194.02 OCC HEALTH						194.02
194.03 FOUNDATION	15,118					194.03
194.04 PHYSICIAN OFFICES	496,031	25,537		11,162		194.04
194.05 COMMUNITY & VOLUNTEER SERVICES	42,173					194.05
194.06 VACANT SPACE	675	4,672		2,042		194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,884,230	1,335,197	215,571	567,700	546,649	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	169,148					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	5,769	664,395				13
14 CENTRAL SERVICES & SUPPLY	6,856		676,427			14
15 PHARMACY	4,439		10,709	2,114,184		15
16 MEDICAL RECORDS & LIBRARY	8,551				816,724	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	34,144	298,146	63,094	6,309	57,985	30
43 NURSERY	1,624	14,181			3,504	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,360	142,856	107,592	1,253	77,421	50
52 DELIVERY ROOM & LABOR ROOM	5,456	47,641			13,382	52
53 ANESTHESIOLOGY					10,123	53
54 RADIOLOGY-DIAGNOSTIC	19,962		32,679	2,663	255,673	54
54.01 CAT SCAN						54.01
60 LABORATORY					80,128	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.					2,171	63
65 RESPIRATORY THERAPY	8,217		26,486		23,560	65
66 PHYSICAL THERAPY	6,664		5,767	486	12,938	66
67 OCCUPATIONAL THERAPY	2,090				4,385	67
68 SPEECH PATHOLOGY	643				1,913	68
69 ELECTROCARDIOLOGY			22		14,646	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			298,688		31,947	71
72 IMPL. DEV. CHARGED TO PATIENT					3,505	72
73 DRUGS CHARGED TO PATIENTS			12,745	2,084,949	65,922	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	443		86		288	90
91 EMERGENCY	18,503	161,571	49,669	5,009	116,015	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	25,652		67,716	4,310	41,218	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	165,373	664,395	675,253	2,104,979	816,724	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	500		124			190
192 PHYSICIANS' PRIVATE OFFICES	1,590		1,006	280		192
194 OTHER NONREIMBURSABLE						194
194.01 PAIN CLINIC						194.01
194.02 OCC HEALTH						194.02
194.03 FOUNDATION	829					194.03
194.04 PHYSICIAN OFFICES						194.04
194.05 COMMUNITY & VOLUNTEER SERVICES	856		44	8,925		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)	169,148	664,395	676,427	2,114,184	816,724	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				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 SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	4,773,947		4,773,947	30
43 NURSERY	180,564		180,564	43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	3,389,698		3,389,698	50
52 DELIVERY ROOM & LABOR ROOM	638,868		638,868	52
53 ANESTHESIOLOGY	62,724		62,724	53
54 RADIOLOGY-DIAGNOSTIC	4,510,344		4,510,344	54
54.01 CAT SCAN				54.01
60 LABORATORY	318,673		318,673	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRANS.	138,210		138,210	63
65 RESPIRATORY THERAPY	1,095,573		1,095,573	65
66 PHYSICAL THERAPY	1,191,367		1,191,367	66
67 OCCUPATIONAL THERAPY	268,844		268,844	67
68 SPEECH PATHOLOGY	83,273		83,273	68
69 ELECTROCARDIOLOGY	125,188		125,188	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,096,902		1,096,902	71
72 IMPL. DEV. CHARGED TO PATIENT	97,341		97,341	72
73 DRUGS CHARGED TO PATIENTS	4,022,535		4,022,535	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	39,665		39,665	90
91 EMERGENCY	2,377,508		2,377,508	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES	2,360,993		2,360,993	95
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	26,772,217		26,772,217	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	75,082		75,082	190
192 PHYSICIANS' PRIVATE OFFICES	344,737		344,737	192
194 OTHER NONREIMBURSABLE				194
194.01 PAIN CLINIC				194.01
194.02 OCC HEALTH				194.02
194.03 FOUNDATION	95,951		95,951	194.03
194.04 PHYSICIAN OFFICES	3,157,758		3,157,758	194.04
194.05 COMMUNITY & VOLUNTEER SERVICES	275,179		275,179	194.05
194.06 VACANT SPACE	10,962		10,962	194.06
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	30,731,886		30,731,886	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL		345,477	30,317	375,794	375,794	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		132,204	49,912	182,116	16,327	7
8 LAUNDRY & LINEN SERVICE		11,373		11,373	2,454	8
9 HOUSEKEEPING		16,451	7,744	24,195	6,492	9
10 DIETARY		33,867	13,763	47,630	5,900	10
11 CAFETERIA		21,908		21,908	1,559	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		4,607	1,465	6,072	7,948	13
14 CENTRAL SERVICES & SUPPLY		42,310	1,956	44,266	7,148	14
15 PHARMACY		12,476	144,593	157,069	25,381	15
16 MEDICAL RECORDS & LIBRARY		19,059		19,059	9,445	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		195,687	102,027	297,714	40,688	30
43 NURSERY		2,861	7,676	10,537	1,903	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		149,068	409,981	559,049	33,102	50
52 DELIVERY ROOM & LABOR ROOM		18,369	29,310	47,679	6,574	52
53 ANESTHESIOLOGY			10,729	10,729	643	53
54 RADIOLOGY-DIAGNOSTIC		133,962	1,103,003	1,236,965	48,001	54
54.01 CAT SCAN						54.01
60 LABORATORY		26,330	401	26,731	2,306	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.					1,664	63
65 RESPIRATORY THERAPY		22,643	74,937	97,580	12,146	65
66 PHYSICAL THERAPY		116,442	13,175	129,617	11,577	66
67 OCCUPATIONAL THERAPY					3,208	67
68 SPEECH PATHOLOGY					987	68
69 ELECTROCARDIOLOGY		1,884		1,884	1,308	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					9,370	71
72 IMPL. DEV. CHARGED TO PATIENT					1,147	72
73 DRUGS CHARGED TO PATIENTS					22,731	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					475	90
91 EMERGENCY		83,334	30,998	114,332	22,409	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES			91,298	91,298	27,173	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)		1,390,312	2,123,285	3,513,597	330,066	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		10,523	3,770	14,293	669	190
192 PHYSICIANS' PRIVATE OFFICES		74,844	3,896	78,740	2,434	192
194 OTHER NONREIMBURSABLE						194
194.01 PAIN CLINIC						194.01
194.02 OCC HEALTH						194.02
194.03 FOUNDATION					1,163	194.03
194.04 PHYSICIAN OFFICES		19,530		19,530	38,165	194.04
194.05 COMMUNITY & VOLUNTEER SERVICES					3,245	194.05
194.06 VACANT SPACE		3,573		3,573	52	194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		1,498,782	2,130,951	3,629,733	375,794	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	198,443					7
8 LAUNDRY & LINEN SERVICE	2,210	16,037				8
9 HOUSEKEEPING	3,197	1,140	35,024			9
10 DIETARY	6,582	38	1,194	61,344		10
11 CAFETERIA	4,258	38	772		28,535	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	895		162		973	13
14 CENTRAL SERVICES & SUPPLY	8,223	410	1,492		1,157	14
15 PHARMACY	2,425		440		749	15
16 MEDICAL RECORDS & LIBRARY	3,704		672		1,443	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	38,032	5,397	6,902	61,344	5,761	30
43 NURSERY	556	18	101		274	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	28,970	4,250	5,256		2,760	50
52 DELIVERY ROOM & LABOR ROOM	3,570	18	648		920	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	26,034	1,623	4,724		3,368	54
54.01 CAT SCAN						54.01
60 LABORATORY	5,117	38	928			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY	4,400	109	798		1,386	65
66 PHYSICAL THERAPY	22,630		4,106		1,124	66
67 OCCUPATIONAL THERAPY					353	67
68 SPEECH PATHOLOGY					108	68
69 ELECTROCARDIOLOGY	366		66			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						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
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC					75	90
91 EMERGENCY	16,195	2,797	2,938		3,121	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES					4,327	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	177,364	15,876	31,199	61,344	27,899	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,045		371		84	190
192 PHYSICIANS' PRIVATE OFFICES	14,545	161	2,639		268	192
194 OTHER NONREIMBURSABLE						194
194.01 PAIN CLINIC						194.01
194.02 OCC HEALTH						194.02
194.03 FOUNDATION					140	194.03
194.04 PHYSICIAN OFFICES	3,795		689			194.04
194.05 COMMUNITY & VOLUNTEER SERVICES					144	194.05
194.06 VACANT SPACE	694		126			194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	198,443	16,037	35,024	61,344	28,535	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	16,050					13
14 CENTRAL SERVICES & SUPPLY		62,696				14
15 PHARMACY		993	187,057			15
16 MEDICAL RECORDS & LIBRARY				34,323		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 ADULTS & PEDIATRICS	7,202	5,848	558	2,441	471,887	30
43 NURSERY	343			148	13,880	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,451	9,972	111	3,259	650,180	50
52 DELIVERY ROOM & LABOR ROOM	1,151			563	61,123	52
53 ANESTHESIOLOGY				426	11,798	53
54 RADIOLOGY-DIAGNOSTIC		3,029	236	10,703	1,334,683	54
54.01 CAT SCAN						54.01
60 LABORATORY				3,373	38,493	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.				91	1,755	63
65 RESPIRATORY THERAPY		2,455		992	119,866	65
66 PHYSICAL THERAPY		535	43	545	170,177	66
67 OCCUPATIONAL THERAPY				185	3,746	67
68 SPEECH PATHOLOGY				81	1,176	68
69 ELECTROCARDIOLOGY		2		617	4,243	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		27,685		1,345	38,400	71
72 IMPL. DEV. CHARGED TO PATIENT				148	1,295	72
73 DRUGS CHARGED TO PATIENTS		1,181	184,470	2,775	211,157	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		8		12	570	90
91 EMERGENCY	3,903	4,604	443	4,884	175,626	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		6,276	381	1,735	131,190	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	16,050	62,588	186,242	34,323	3,441,245	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					17,473	190
192 PHYSICIANS' PRIVATE OFFICES		93	25		98,905	192
194 OTHER NONREIMBURSABLE						194
194.01 PAIN CLINIC						194.01
194.02 OCC HEALTH						194.02
194.03 FOUNDATION					1,303	194.03
194.04 PHYSICIAN OFFICES					62,179	194.04
194.05 COMMUNITY & VOLUNTEER SERVICES		4	790		4,183	194.05
194.06 VACANT SPACE					4,445	194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	16,050	62,696	187,057	34,323	3,629,733	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS		TOTAL	
	25	26		
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				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 SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS		471,887		30
43 NURSERY		13,880		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM		650,180		50
52 DELIVERY ROOM & LABOR ROOM		61,123		52
53 ANESTHESIOLOGY		11,798		53
54 RADIOLOGY-DIAGNOSTIC		1,334,683		54
54.01 CAT SCAN				54.01
60 LABORATORY		38,493		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRANS.		1,755		63
65 RESPIRATORY THERAPY		119,866		65
66 PHYSICAL THERAPY		170,177		66
67 OCCUPATIONAL THERAPY		3,746		67
68 SPEECH PATHOLOGY		1,176		68
69 ELECTROCARDIOLOGY		4,243		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		38,400		71
72 IMPL. DEV. CHARGED TO PATIENT		1,295		72
73 DRUGS CHARGED TO PATIENTS		211,157		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		570		90
91 EMERGENCY		175,626		91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES		131,190		95
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)		3,441,245		118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		17,473		190
192 PHYSICIANS' PRIVATE OFFICES		98,905		192
194 OTHER NONREIMBURSABLE				194
194.01 PAIN CLINIC				194.01
194.02 OCC HEALTH				194.02
194.03 FOUNDATION		1,303		194.03
194.04 PHYSICIAN OFFICES		62,179		194.04
194.05 COMMUNITY & VOLUNTEER SERVICES		4,183		194.05
194.06 VACANT SPACE		4,445		194.06
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)		3,629,733		202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	130,465					1
2 CAP REL COSTS-MVBLE EQUIP		1,120,205				2
4 EMPLOYEE BENEFITS			14,592,676			4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	30,073	15,937	3,664,253	-4,884,230	25,847,656	5
7 OPERATION OF PLANT	11,508	26,238	293,524		1,122,994	7
8 LAUNDRY & LINEN SERVICE	990				168,802	8
9 HOUSEKEEPING	1,432	4,071	288,408		446,498	9
10 DIETARY	2,948	7,235	224,010		405,813	10
11 CAFETERIA	1,907		127,115		107,209	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	401	770	439,791		546,669	13
14 CENTRAL SERVICES & SUPPLY	3,683	1,028	262,099		491,647	14
15 PHARMACY	1,086	76,010	484,817		1,745,717	15
16 MEDICAL RECORDS & LIBRARY	1,659		384,969		649,608	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	17,034	53,634	1,863,548		2,798,544	30
43 NURSERY	249	4,035	90,589		130,902	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,976	215,520	1,028,966		2,276,751	50
52 DELIVERY ROOM & LABOR ROOM	1,599	15,408	304,437		452,183	52
53 ANESTHESIOLOGY		5,640			44,241	53
54 RADIOLOGY-DIAGNOSTIC	11,661	579,830	1,322,363		3,301,877	54
54.01 CAT SCAN						54.01
60 LABORATORY	2,292	211			158,590	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.					114,418	63
65 RESPIRATORY THERAPY	1,971	39,393	544,962		835,429	65
66 PHYSICAL THERAPY	10,136	6,926	544,132		796,240	66
67 OCCUPATIONAL THERAPY			148,287		220,671	67
68 SPEECH PATHOLOGY			45,620		67,889	68
69 ELECTROCARDIOLOGY	164				89,977	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					644,484	71
72 IMPL. DEV. CHARGED TO PATIENT					78,923	72
73 DRUGS CHARGED TO PATIENTS					1,563,481	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			25,851		32,674	90
91 EMERGENCY	7,254	16,295	1,101,989		1,541,295	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		47,994	1,228,634		1,868,939	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	121,023	1,116,175	14,418,364	-4,884,230	22,702,465	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	916	1,982	25,676		45,993	190
192 PHYSICIANS' PRIVATE OFFICES	6,515	2,048	70,954		167,412	192
194 OTHER NONREIMBURSABLE						194
194.01 PAIN CLINIC						194.01
194.02 OCC HEALTH						194.02
194.03 FOUNDATION					80,004	194.03
194.04 PHYSICIAN OFFICES	1,700		30,833		2,625,028	194.04
194.05 COMMUNITY & VOLUNTEER SERVICES			46,849		223,181	194.05
194.06 VACANT SPACE	311				3,573	194.06

PROVIDER CCN: 15-0146 COMMUNITY HOSPT. OF NOBLE CTY,
PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
05/28/2013 09:04

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,498,782	2,130,951	3,111,788		4,884,230	202
203 UNIT COST MULT-WS B PT I	11.488001	1.902287	0.213243		0.188962	203
204 COST TO BE ALLOC PER B PT II					375,794	204
205 UNIT COST MULT-WS B PT II					0.014539	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET 7	POUNDS OF LAUNDRY 8	SQUARE FEET 9	MEALS SERVED 10	HOURS WORKED 11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	88,884					7
8 LAUNDRY & LINEN SERVICE	990	290,138				8
9 HOUSEKEEPING	1,432	20,619	86,462			9
10 DIETARY	2,948	691	2,948	32,634		10
11 CAFETERIA	1,907	690	1,907		419,313	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	401		401		14,301	13
14 CENTRAL SERVICES & SUPPLY	3,683	7,421	3,683		16,996	14
15 PHARMACY	1,086		1,086		11,003	15
16 MEDICAL RECORDS & LIBRARY	1,659		1,659		21,198	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	17,034	97,624	17,034	32,634	84,642	30
43 NURSERY	249	326	249		4,025	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,976	76,884	12,976		40,556	50
52 DELIVERY ROOM & LABOR ROOM	1,599	326	1,599		13,525	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	11,661	29,365	11,661		49,486	54
54.01 CAT SCAN						54.01
60 LABORATORY	2,292	685	2,292			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY	1,971	1,976	1,971		20,370	65
66 PHYSICAL THERAPY	10,136		10,136		16,519	66
67 OCCUPATIONAL THERAPY					5,181	67
68 SPEECH PATHOLOGY					1,594	68
69 ELECTROCARDIOLOGY	164		164			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						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
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC					1,097	90
91 EMERGENCY	7,254	50,610	7,254		45,869	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES					63,591	95
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	79,442	287,217	77,020	32,634	409,953	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	916		916		1,240	190
192 PHYSICIANS' PRIVATE OFFICES	6,515	2,921	6,515		3,941	192
194 OTHER NONREIMBURSABLE						194
194.01 PAIN CLINIC						194.01
194.02 OCC HEALTH						194.02
194.03 FOUNDATION					2,056	194.03
194.04 PHYSICIAN OFFICES	1,700		1,700			194.04
194.05 COMMUNITY & VOLUNTEER SERVICES					2,123	194.05
194.06 VACANT SPACE	311		311			194.06

PROVIDER CCN: 15-0146 COMMUNITY HOSPT. OF NOBLE CTY,
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KPMG LLP COMPU-MAX MICRO SYSTEM
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED	HOURS WORKED	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,335,197	215,571	567,700	546,649	169,148	202
203	UNIT COST MULT-WS B PT I	15.021792	0.742995	6.565890	16.750904	0.403393	203
204	COST TO BE ALLOC PER B PT II	198,443	16,037	35,024	61,344	28,535	204
205	UNIT COST MULT-WS B PT II	2.232607	0.055274	0.405080	1.879757	0.068052	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					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	188,618				13
14 CENTRAL SERVICES & SUPPLY		1,643,926			14
15 PHARMACY		26,025	1,569,270		15
16 MEDICAL RECORDS & LIBRARY				123,663,467	16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	84,642	153,338	4,683	8,780,236	30
43 NURSERY	4,026			530,616	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	40,556	261,481	930	11,723,313	50
52 DELIVERY ROOM & LABOR ROOM	13,525			2,026,378	52
53 ANESTHESIOLOGY				1,532,925	53
54 RADIOLOGY-DIAGNOSTIC		79,419	1,977	38,707,299	54
54.01 CAT SCAN					54.01
60 LABORATORY				12,133,269	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63 BLOOD STORING, PROCESSING & TRANS.				328,768	63
65 RESPIRATORY THERAPY		64,368		3,567,516	65
66 PHYSICAL THERAPY		14,016	361	1,959,068	66
67 OCCUPATIONAL THERAPY				663,941	67
68 SPEECH PATHOLOGY				289,611	68
69 ELECTROCARDIOLOGY		54		2,217,698	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		725,905		4,837,592	71
72 IMPL. DEV. CHARGED TO PATIENT				530,681	72
73 DRUGS CHARGED TO PATIENTS		30,975	1,547,569	9,982,156	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		210		43,670	90
91 EMERGENCY	45,869	120,711	3,718	17,567,416	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		164,571	3,199	6,241,314	95
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	188,618	1,641,073	1,562,437	123,663,467	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		301			190
192 PHYSICIANS' PRIVATE OFFICES		2,445	208		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		107	6,625		194.05
194.06 VACANT SPACE					194.06

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	COST TO BE ALLOC PER B PT I	664,395	676,427	2,114,184	816,724	202
203	UNIT COST MULT-WS B PT I	3.522437	0.411470	1.347240	0.006604	203
204	COST TO BE ALLOC PER B PT II	16,050	62,696	187,057	34,323	204
205	UNIT COST MULT-WS B PT II	0.085093	0.038138	0.119200	0.000278	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,773,947		4,773,947		4,773,947	30
43 NURSERY	180,564		180,564		180,564	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,389,698		3,389,698		3,389,698	50
52 DELIVERY ROOM & LABOR ROOM	638,868		638,868		638,868	52
53 ANESTHESIOLOGY	62,724		62,724	39,844	102,568	53
54 RADIOLOGY-DIAGNOSTIC	4,510,344		4,510,344		4,510,344	54
54.01 CAT SCAN						54.01
60 LABORATORY	318,673		318,673		318,673	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	138,210		138,210		138,210	63
65 RESPIRATORY THERAPY	1,095,573		1,095,573		1,095,573	65
66 PHYSICAL THERAPY	1,191,367		1,191,367		1,191,367	66
67 OCCUPATIONAL THERAPY	268,844		268,844		268,844	67
68 SPEECH PATHOLOGY	83,273		83,273		83,273	68
69 ELECTROCARDIOLOGY	125,188		125,188		125,188	69
71 MEDICAL SUPPLIES CHRGED TO	1,096,902		1,096,902		1,096,902	71
72 IMPL. DEV. CHARGED TO PATIE	97,341		97,341		97,341	72
73 DRUGS CHARGED TO PATIENTS	4,022,535		4,022,535		4,022,535	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	39,665		39,665		39,665	90
91 EMERGENCY	2,377,508		2,377,508	4,096	2,381,604	91
92 OBSERVATION BEDS	860,484		860,484		860,484	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	2,360,993		2,360,993		2,360,993	95
200 SUBTOTAL (SEE INSTRUCTIONS)	27,632,701		27,632,701	43,940	27,676,641	200
201 LESS OBSERVATION BEDS	860,484		860,484		860,484	201
202 TOTAL (SEE INSTRUCTIONS)	26,772,217		26,772,217		26,816,157	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,053,590		7,053,590			30
43 NURSERY	530,616		530,616			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,446,359	9,276,954	11,723,313	0.289142	0.289142	0.289142 50
52 DELIVERY ROOM & LABOR ROOM	1,783,214	243,164	2,026,378	0.315276	0.315276	0.315276 52
53 ANESTHESIOLOGY	329,209	1,203,716	1,532,925	0.040918	0.040918	0.066910 53
54 RADIOLOGY-DIAGNOSTIC	3,105,668	35,601,631	38,707,299	0.116524	0.116524	0.116524 54
54.01 CAT SCAN						54.01
60 LABORATORY	2,273,326	9,859,943	12,133,269	0.026264	0.026264	0.026264 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	147,207	181,561	328,768	0.420388	0.420388	0.420388 63
65 RESPIRATORY THERAPY	1,374,129	2,193,387	3,567,516	0.307097	0.307097	0.307097 65
66 PHYSICAL THERAPY	187,905	1,771,163	1,959,068	0.608129	0.608129	0.608129 66
67 OCCUPATIONAL THERAPY	19,494	644,447	663,941	0.404922	0.404922	0.404922 67
68 SPEECH PATHOLOGY	34,617	254,994	289,611	0.287534	0.287534	0.287534 68
69 ELECTROCARDIOLOGY	615,566	1,602,132	2,217,698	0.056450	0.056450	0.056450 69
71 MEDICAL SUPPLIES CHRGED TO	1,067,878	3,769,714	4,837,592	0.226745	0.226745	0.226745 71
72 IMPL. DEV. CHARGED TO PATIE	292,169	238,512	530,681	0.183427	0.183427	0.183427 72
73 DRUGS CHARGED TO PATIENTS	3,870,586	6,111,570	9,982,156	0.402973	0.402973	0.402973 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	1,743	41,927	43,670	0.908289	0.908289	0.908289 90
91 EMERGENCY	2,141,562	15,425,854	17,567,416	0.135336	0.135336	0.135569 91
92 OBSERVATION BEDS		1,726,646	1,726,646	0.498356	0.498356	0.498356 92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		6,241,314	6,241,314	0.378285	0.378285	0.378285 95
200 SUBTOTAL (SEE INSTRUCTIONS)	27,274,838	96,388,629	123,663,467			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	27,274,838	96,388,629	123,663,467			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL	REDUCED	TOTAL	PER	INPAT	INPAT PGM	
	COST	CAP-REL		DIEM			CAP COST
	(FROM WKST	COST	(COL.1 MINUS	(COL.3 +	PGM	(COL.5 x	
	B, PT. II,	SWING-BED	COL.2)	COL.4)	DAYS	COL.6)	
	COL. 26)	ADJUSTMENT					
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	471,887		471,887	6,419	73.51	2,209	162,384 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	13,880		13,880	611	22.72		43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	485,767		485,767	7,030		2,209	162,384 200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-0146) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	650,180	11,723,313	0.055460	639,400	35,461	50
52 DELIVERY ROOM & LABOR ROOM	61,123	2,026,378	0.030164			52
53 ANESTHESIOLOGY	11,798	1,532,925	0.007696	87,468	673	53
54 RADIOLOGY-DIAGNOSTIC	1,334,683	38,707,299	0.034481	1,709,941	58,960	54
54.01 CAT SCAN						54.01
60 LABORATORY	38,493	12,133,269	0.003173	1,150,315	3,650	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T	1,755	328,768	0.005338	59,480	318	63
65 RESPIRATORY THERAPY	119,866	3,567,516	0.033599	689,915	23,180	65
66 PHYSICAL THERAPY	170,177	1,959,068	0.086866	111,245	9,663	66
67 OCCUPATIONAL THERAPY	3,746	663,941	0.005642	12,208	69	67
68 SPEECH PATHOLOGY	1,176	289,611	0.004061	19,232	78	68
69 ELECTROCARDIOLOGY	4,243	2,217,698	0.001913	343,131	656	69
71 MEDICAL SUPPLIES CHRGD TO PA	38,400	4,837,592	0.007938	204,317	1,622	71
72 IMPL. DEV. CHARGED TO PATIENT	1,295	530,681	0.002440	154,290	376	72
73 DRUGS CHARGED TO PATIENTS	211,157	9,982,156	0.021153	1,531,917	32,405	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	570	43,670	0.013052			90
91 EMERGENCY	175,626	17,567,416	0.009997	980,230	9,799	91
92 OBSERVATION BEDS	85,055	1,726,646	0.049260			92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)	2,909,343	109,837,947		7,693,089	176,910	200

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					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 (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-0146 COMMUNITY HOSPT. OF NOBLE CTY,
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	6,419		2,209		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	611				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	7,030		2,209		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
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 HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						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
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO				
	(FROM WKST	CHARGES	CHARGES	INPAT	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 ÷	(COL. 6 ÷	PGM	(COL. 8 x		(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	COL. 12)	COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	11,723,313			639,400		1,864,938	50
52 DELIVERY ROOM & LABOR ROOM	2,026,378						52
53 ANESTHESIOLOGY	1,532,925			87,468		196,922	53
54 RADIOLOGY-DIAGNOSTIC	38,707,299			1,709,941		8,032,756	54
54.01 CAT SCAN							54.01
60 LABORATORY	12,133,269			1,150,315		122,778	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
63 BLOOD STORING, PROCESSING &	328,768			59,480		88,983	63
65 RESPIRATORY THERAPY	3,567,516			689,915		525,238	65
66 PHYSICAL THERAPY	1,959,068			111,245			66
67 OCCUPATIONAL THERAPY	663,941			12,208			67
68 SPEECH PATHOLOGY	289,611			19,232			68
69 ELECTROCARDIOLOGY	2,217,698			343,131		470,180	69
71 MEDICAL SUPPLIES CHRGED TO P	4,837,592			204,317		268,159	71
72 IMPL. DEV. CHARGED TO PATIEN	530,681			154,290		9,119	72
73 DRUGS CHARGED TO PATIENTS	9,982,156			1,531,917		1,702,983	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	43,670					3,569	90
91 EMERGENCY	17,567,416			980,230		2,985,025	91
92 OBSERVATION BEDS	1,726,646					543,624	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	109,837,947			7,693,089		16,814,274	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.289142	1,864,938			539,232		50
52 DELIVERY ROOM & LABOR ROOM	0.315276						52
53 ANESTHESIOLOGY	0.040918	196,922			8,058		53
54 RADIOLOGY-DIAGNOSTIC	0.116524	8,032,756			936,009		54
54.01 CAT SCAN							54.01
60 LABORATORY	0.026264	122,778			3,225		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63 BLOOD STORING, PROCESSING & TRA	0.420388	88,983			37,407		63
65 RESPIRATORY THERAPY	0.307097	525,238			161,299		65
66 PHYSICAL THERAPY	0.608129						66
67 OCCUPATIONAL THERAPY	0.404922						67
68 SPEECH PATHOLOGY	0.287534						68
69 ELECTROCARDIOLOGY	0.056450	470,180			26,542		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.226745	268,159			60,804		71
72 IMPL. DEV. CHARGED TO PATIENT	0.183427	9,119			1,673		72
73 DRUGS CHARGED TO PATIENTS	0.402973	1,702,983			686,256		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	0.908289	3,569			3,242		90
91 EMERGENCY	0.135336	2,985,025			403,981		91
92 OBSERVATION BEDS	0.498356	543,624			270,918		92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.378285						95
200 SUBTOTAL (SEE INSTRUCTIONS)		16,814,274			3,138,646		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		16,814,274			3,138,646		202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (15-0146) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	650,180	11,723,313	0.055460	235,190	13,044	50
52	DELIVERY ROOM & LABOR ROOM	61,123	2,026,378	0.030164			52
53	ANESTHESIOLOGY	11,798	1,532,925	0.007696	25,573	197	53
54	RADIOLOGY-DIAGNOSTIC	1,334,683	38,707,299	0.034481	168,307	5,803	54
54.01	CAT SCAN						54.01
60	LABORATORY	38,493	12,133,269	0.003173	164,488	522	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	1,755	328,768	0.005338	7,269	39	63
65	RESPIRATORY THERAPY	119,866	3,567,516	0.033599	44,154	1,484	65
66	PHYSICAL THERAPY	170,177	1,959,068	0.086866	6,620	575	66
67	OCCUPATIONAL THERAPY	3,746	663,941	0.005642	248	1	67
68	SPEECH PATHOLOGY	1,176	289,611	0.004061	322	1	68
69	ELECTROCARDIOLOGY	4,243	2,217,698	0.001913	18,269	35	69
71	MEDICAL SUPPLIES CHRGD TO PA	38,400	4,837,592	0.007938	43,345	344	71
72	IMPL. DEV. CHARGED TO PATIENT	1,295	530,681	0.002440			72
73	DRUGS CHARGED TO PATIENTS	211,157	9,982,156	0.021153	265,375	5,613	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	570	43,670	0.013052			90
91	EMERGENCY	175,626	17,567,416	0.009997	105,669	1,056	91
92	OBSERVATION BEDS	85,055	1,726,646	0.049260			92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	2,909,343	109,837,947		1,084,829	28,714	200

PROVIDER CCN: 15-0146 COMMUNITY HOSPT. OF NOBLE CTY,
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/28/2013 09:04

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS
					(SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					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 (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-0146 COMMUNITY HOSPT. OF NOBLE CTY,
 PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 05/28/2013 09:04

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	6,419		307		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	611		92		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	7,030		399		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5
ANCILLARY SERVICE COST CENTERS						
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 HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						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
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO			
	(FROM WKST	CHARGES	CHARGES	INPAT	PASS-THRU	PASS-THRU
	C, PT. I,	(COL. 5 ÷	(COL. 6 ÷	PGM	(COL. 8 x	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	COL. 12)
	7	8	9	10	11	12
						13
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,723,313			235,190		50
52 DELIVERY ROOM & LABOR ROOM	2,026,378					52
53 ANESTHESIOLOGY	1,532,925			25,573		53
54 RADIOLOGY-DIAGNOSTIC	38,707,299			168,307		54
54.01 CAT SCAN						54.01
60 LABORATORY	12,133,269			164,488		60
62.30 BLOOD CLOTTING FOR HEMOPHILI						62.30
63 BLOOD STORING, PROCESSING &	328,768			7,269		63
65 RESPIRATORY THERAPY	3,567,516			44,154		65
66 PHYSICAL THERAPY	1,959,068			6,620		66
67 OCCUPATIONAL THERAPY	663,941			248		67
68 SPEECH PATHOLOGY	289,611			322		68
69 ELECTROCARDIOLOGY	2,217,698			18,269		69
71 MEDICAL SUPPLIES CHRGED TO P	4,837,592			43,345		71
72 IMPL. DEV. CHARGED TO PATIEN	530,681					72
73 DRUGS CHARGED TO PATIENTS	9,982,156			265,375		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	43,670					90
91 EMERGENCY	17,567,416			105,669		91
92 OBSERVATION BEDS	1,726,646					92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	6,241,314					95
200 TOTAL (SUM OF LINES 50-199)	109,837,947			1,084,829		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.289142		554,920			160,451		50
52 DELIVERY ROOM & LABOR ROOM	0.315276							52
53 ANESTHESIOLOGY	0.040918		53,710			2,198		53
54 RADIOLOGY-DIAGNOSTIC	0.116524		1,895,863			220,914		54
54.01 CAT SCAN								54.01
60 LABORATORY	0.026264		562,430			14,772		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63 BLOOD STORING, PROCESSING & TRA	0.420388		1,783			750		63
65 RESPIRATORY THERAPY	0.307097		138,938			42,667		65
66 PHYSICAL THERAPY	0.608129		98,083			59,647		66
67 OCCUPATIONAL THERAPY	0.404922		42,447			17,188		67
68 SPEECH PATHOLOGY	0.287534		8,340			2,398		68
69 ELECTROCARDIOLOGY	0.056450		79,109			4,466		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.226745		88,548			20,078		71
72 IMPL. DEV. CHARGED TO PATIENT	0.183427		21,995			4,034		72
73 DRUGS CHARGED TO PATIENTS	0.402973		608,442			245,186		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	0.908289		1,577			1,432		90
91 EMERGENCY	0.135336		1,160,212			157,018		91
92 OBSERVATION BEDS	0.498356							92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.378285		465,112			175,945		95
200 SUBTOTAL (SEE INSTRUCTIONS)			5,781,509			1,129,144		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			5,781,509			1,129,144		202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,419	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,419	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,262	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 (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL 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)	2,209	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)	4,773,947	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	4,773,947	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-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)	4,773,947	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0146) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 743.72 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,642,877 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) 1,642,877 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 43
 44 CORONARY CARE UNIT 44
 45 BURN INTENSIVE CARE UNIT 45
 46 SURGICAL INTENSIVE CARE UNIT 46
 47 OTHER SPECIAL CARE (SPECIFY) 47
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 1,579,399 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 3,222,276 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 162,384 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 176,910 51
 52 TOTAL PROGRAM EXCLUDABLE COST 339,294 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 2,882,982 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 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 (LINES 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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 1,157 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 743.72 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 860,484 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	471,887	4,773,947	0.098846	860,484	85,055 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,419	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,419	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,262	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 (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL 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)	307	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)	611	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	92	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)	4,773,947	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	4,773,947	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-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)	4,773,947	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0146) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 743.72 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 228,322 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) 228,322 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)	180,564	611	295.52	92	27,188 42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 43
 44 CORONARY CARE UNIT 44
 45 BURN INTENSIVE CARE UNIT 45
 46 SURGICAL INTENSIVE CARE UNIT 46
 47 OTHER SPECIAL CARE (SPECIFY) 47
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 246,604 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 502,114 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 24,658 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 28,714 51
 52 TOTAL PROGRAM EXCLUDABLE COST 53,372 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 448,742 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 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 (LINES 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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 1,157 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

	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST		
90 CAPITAL-RELATED COST		90
91 NURSING SCHOOL COST		91
92 ALLIED HEALTH COST		92
93 ALL OTHER MEDICAL EDUCATION		93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		2,930,562		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.289142	639,400	184,877	50
52 DELIVERY ROOM & LABOR ROOM	0.315276			52
53 ANESTHESIOLOGY	0.066910	87,468	5,852	53
54 RADIOLOGY-DIAGNOSTIC	0.116524	1,709,941	199,249	54
54.01 CAT SCAN				54.01
60 LABORATORY	0.026264	1,150,315	30,212	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.420388	59,480	25,005	63
65 RESPIRATORY THERAPY	0.307097	689,915	211,871	65
66 PHYSICAL THERAPY	0.608129	111,245	67,651	66
67 OCCUPATIONAL THERAPY	0.404922	12,208	4,943	67
68 SPEECH PATHOLOGY	0.287534	19,232	5,530	68
69 ELECTROCARDIOLOGY	0.056450	343,131	19,370	69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.226745	204,317	46,328	71
72 IMPL. DEV. CHARGED TO PATIENT	0.183427	154,290	28,301	72
73 DRUGS CHARGED TO PATIENTS	0.402973	1,531,917	617,321	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	0.908289			90
91 EMERGENCY	0.135569	980,230	132,889	91
92 OBSERVATION BEDS	0.498356			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		7,693,089	1,579,399	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		7,693,089		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0146) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		638,458		30
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.289142	235,190	68,003	50
52 DELIVERY ROOM & LABOR ROOM	0.315276			52
53 ANESTHESIOLOGY	0.066910	25,573	1,711	53
54 RADIOLOGY-DIAGNOSTIC	0.116524	168,307	19,612	54
54.01 CAT SCAN				54.01
60 LABORATORY	0.026264	164,488	4,320	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.420388	7,269	3,056	63
65 RESPIRATORY THERAPY	0.307097	44,154	13,560	65
66 PHYSICAL THERAPY	0.608129	6,620	4,026	66
67 OCCUPATIONAL THERAPY	0.404922	248	100	67
68 SPEECH PATHOLOGY	0.287534	322	93	68
69 ELECTROCARDIOLOGY	0.056450	18,269	1,031	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.226745	43,345	9,828	71
72 IMPL. DEV. CHARGED TO PATIENT	0.183427			72
73 DRUGS CHARGED TO PATIENTS	0.402973	265,375	106,939	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	0.908289			90
91 EMERGENCY	0.135569	105,669	14,325	91
92 OBSERVATION BEDS	0.498356			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,084,829	246,604	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,084,829		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (15-0146)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	3,149,309	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	4,305	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	27.84	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) 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
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
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
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0499	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1987	31
32	SUM OF LINES 30 AND 31	0.2486	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0968	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	304,853	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
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)	3,458,467	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)	3,458,467	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	249,777	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (15-0146)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

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)	3,708,244	59
60	PRIMARY PAYER PAYMENTS	11,142	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	3,697,102	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	488,800	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	293	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	-8,151	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	-5,706	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	-41,659	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	3,202,303	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 PAYMENT ADJUSTMENT - 1	321,731	70.96
70.97	LOW VOLUME PAYMENT ADJUSTMENT - 2	87,882	70.97
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	3,611,916	71
72	INTERIM PAYMENTS	3,714,715	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-102,799	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	284,438	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (15-0146) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,699,615		2,954,442	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.		NONE		78,601	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.	.01 08/29/2012	15,100		NONE	3.01
	.02				3.02
	.03				3.03
	.04				3.04
	.05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	.52				3.52
	.53				3.53
	.54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99	15,100			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		15,100			
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		3,714,715		3,033,043	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01				6.01
	TO .02				
	PROVIDER .03				
	PROVIDER .04				
	TO .05				
	PROGRAM .06	-102,799		-924,263	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		3,611,916		2,108,780	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 15-0146 COMMUNITY HOSPT. OF NOBLE CTY,
PERIOD FROM 01/01/2012 TO 12/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
05/28/2013 09:04

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (15-0146) [] 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	1,751	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,209	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,195	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	5,262	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	123,663,467	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,396,422	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)	1,398,807	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	1,377,261	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	21,546	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (15-0146) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3		1,129,144	3
4		1,129,144	4
5			5
6			6
7		1,129,144	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
8			8
9	1,084,829	5,781,509	9
10			10
11			11
12	1,084,829	5,781,509	12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	1,084,829	5,781,509	16
17	1,084,829	4,652,365	17
18			18
19			19
20			20
21		1,129,144	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29		1,129,144	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31		1,129,144	31
32			32
33			33
34			34
35			35
36		1,129,144	36
37			37
38		1,129,144	38
39			39
40		1,129,144	40
41		1,129,144	41
42			42
43			43

SECTION 115.2

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	-66,546			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6,768,441			4
5	OTHER RECEIVABLES	4,295,495			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	207,539			7
8	PREPAID EXPENSES	136,493			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	11,341,422			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS	314,996			13
14	ACCUMULATED DEPRECIATION	-175,323			14
15	BUILDINGS	2,201,478			15
16	ACCUMULATED DEPRECIATION	-603,413			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	52,820			19
20	ACCUMULATED DEPRECIATION	-25,507			20
21	AUTOMOBILES AND TRUCKS	81,333			21
22	ACCUMULATED DEPRECIATION	-76,616			22
23	MAJOR MOVABLE EQUIPMENT	12,527,454			23
24	ACCUMULATED DEPRECIATION	-9,876,441			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	4,420,781			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	860,095			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	860,095			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	16,622,298			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	314,750			37
38	SALARIES, WAGES & FEES PAYABLE	650,971			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	66,558			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	1,499,389			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,531,668			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	246,873			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	246,873			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	2,778,541			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	13,843,757			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				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)	13,843,757			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	16,622,298			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		13,815,255							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		14,619,591							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		28,434,846							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)		28,434,846							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 ASSET TRANSFERS		14,591,089							13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		14,591,089							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		13,843,757							19

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	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	7,622,154		7,622,154	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				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)	7,622,154		7,622,154	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	7,622,154		7,622,154	18
19 ANCILLARY SERVICES	20,318,642		20,318,642	19
20 OUTPATIENT SERVICES		92,379,513	92,379,513	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE		6,269,153	6,269,153	25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	27,940,796	98,648,666	126,589,462	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		38,519,788	29
30 PROVISION FOR BAD DEBT	7,709,673		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		7,709,673	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 WKST G-3, LINE 4)		46,229,461	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	126,589,462	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	68,798,029	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	57,791,433	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	46,229,461	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	11,561,972	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	42,530	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		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	99,369	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP 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			24
24.01	OTHER (GAIN/(LOSS) ON SALE OF ASSETS)	67	24.01
24.02	OTHER (EMS SUBSIDY)	144,908	24.02
24.03	OTHER (OTHER REVENUE)	2,770,745	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,057,619	25
26	TOTAL (LINE 5 PLUS LINE 25)	14,619,591	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	14,619,591	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-014) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	249,003	1
2	CAPITAL DRG OUTLIER PAYMENTS	774	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	14.58	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (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 LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	249,777	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 FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (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 FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST 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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-014) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT	
1 CAPITAL DRG OTHER THAN OUTLIER	1
2 CAPITAL DRG OUTLIER PAYMENTS	2
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 (LINE 1 TIMES LINE 5)	6
7 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	7
8 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (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 LINE 1)	11
12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 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 FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)	3
4 APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)	4
5 CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)	5
6 PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	6
7 ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)	7
8 CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (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 FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST 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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL	SUBTOTAL	I&R COST &	TOTAL
	NARY CAP- REL COSTS 0	(COLS.0-4) 2A		POST STEP- DOWN ADJS 25	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					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 SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
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 HEMOPHILIAC					62.30
63 BLOOD STORING, PROCESSING & TR					63
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					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
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					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 LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3 Part IV, Line 4)

EXHIBIT 3

STEP 1: Determine the 3-Year Averaging Period		
1	Wage index fiscal year ending date	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	5
STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)		
6	Effective date of pension plan	6
7	First day of the provider cost reporting period containing the pension plan effective date	7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)	8
If this date occurs after the period shown on line 2, stop here and see instructions.		
STEP 3: Average Pension Contributions During the Averaging Period		
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	9
10	Ending date of averaging period from Line 5	10
11	Enter provider contributions made during averaging period on Lines 9 & 10	11
11.01		11.01
12	Total calendar months included in averaging period (36 unless Step 2 completed)	12
13	Total contributions made during averaging period	13
14	Average monthly contribution (Line 13 divided by Line 12)	14
15	Number of months in provider cost reporting period on Line 2	15
16	Average pension contributions (Line 14 times Line 15)	16
STEP 4: Total Pension Cost for Wage Index		
17	Annual prefunding installment (SEE INSTRUCTIONS)	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	19

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97)

EXHIBIT 4

	Amounts From E Part A (1)	Prior to 10/1/2010 or after 9/30/2013 Pre/Post Entitlement (2)	10/01/2011 through 09/30/2012 (3)	(3.01)	10/01/2012 through 09/30/2013 (4)	(4.01)	(Columns 2 through 4) TOTAL (5)	
1	DRG Amounts Other than Outlier Payments	3,149,309	2,328,910		776,304		3,105,214	1
2	Outlier payments for discharges	4,305	4,245				4,245	2
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments							4
INDIRECT MEDICAL EDUCATION ADJUSTMENT								
5	Amount from Worksheet E Part A, Line 21							5
6	IME payment adjustment							6
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								
7	Amount from Worksheet E Part A, Line 27							7
8	IME add-on adjustment							8
9	Total IME payment							9
DISPROPORTIONATE SHARE ADJUSTMENT								
10	Allowable disproportionate share percentage	0.0968	0.0968	0.0968	0.0968	0.0968	0.0968	10
11	Disproportionate share adjustment	304,853	229,707		75,146		304,853	11
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	Total ESRD additional payment							12
13	Subtotal	3,458,467	2,562,862		851,450		3,414,312	13
14	Hospital specific payments							14
15	Total payment for inpatient operating costs - E Part A Line 49	3,458,467	2,562,862		851,450		3,414,312	15
16	Payment for inpatient program capital	249,777						16
17	Special add-on payments for new technologies							17
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL		2,562,862		851,450		3,414,312	19
CAPITAL PAYMENTS								
20	Capital DRG other than outlier	249,003						20
21	Capital DRG outlier payments	774						21
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	249,777						26
LOW VOLUME ADJUSTMENT								
27	Low volume adjustment factor		0.125536		0.103214			27
28	Low Volume Adjustment		321,731				321,731	28
29	Low Volume Adjustment				87,882		87,882	29