This report is required by law (42 USC 1395g; 42 CF payments made since the beginning of the cost report	R 413.20(b)). F ting period bei	ailure to repo ng deemed over	rt can result i payments (42 US	n all interim SC 1395g).	FORM APPROVED OMB NO. 0938-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Fail ure to report an result in all interim FORM APPROVED TAL MAD MSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150146 Provider CCN: 15014 Provider CCN: 150 Provide					
PART I – COST REPORT STATUS						
Provider 1. [X] Electronically filed cost rep	ort			Date: 5/22/20	15 Time: 1	:36 pm
use only 2. [] Manually submitted cost repor	`t					
3.[0] If this is an amended report 4.[F] Medicare Utilization. Enter "	enter the numbe F" for full or	er of times the "L" for low.	e provider resul	omitted this c	ost report	
use only (1) As Submitted 7. Contr (2) Settled without Audit 8. [N] (3) Settled with Audit 9. [N] (4) Reopened	actor No. Initial Report	for this Provi or this Provide	der CCN 12. [0	ractor's Vendo]lfline 5, co	olumn 1 is 4: E	
PART II - CERTIFICATION						
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O	ER FEDERAL LAW. R INDIRECTLY OF	FURTHERMORE,	IF SERVICES ID	ENTIFIED IN TH	HIS REPORT WERE	
CERTIFICATION BY OFFICER OR ADMINI	STRATOR OF PROV	IDER(S)				
electronically filed or manually submitted Expenses prepared by COMMUNITY HOSPT. OF NC 01/01/2014 and ending 12/31/2014 and to the correct, complete and prepared from the boo instructions, except as noted. I further of provision of health care services, and that	cost report and BLE CTY, INC. (best of my kno ks and records certify that I a	the Balance S (150146) for wledge and bel of the provide m familiar wit	Sheet and Stater the cost report ief, this report er in accordance th the laws and	nent of Revenue ting period be rt and stateme with applical regulations re	e and ginning nt are true, ble egarding the	
compirance with such raws and regulations.						
	(-)					
	(Si gn					
		Offi ce	er or Administr	ator of Provid	ler(s)	
		litle				
			M/IIII			
Cost Center Description	TitleV			ні т	Title XIX	
Cost center beschiption						
PART III - SETTLEMENT SUMMARY		2100	0100		0100	
	0	12, 055	-25, 204	-2,865	0	1.00
	0				0	
	0	0			0	
	0	0	0		0	
6.00 Swing bed - NF	0				0	6.00
200. 00 Total	0	12, 055	-25, 204	-2, 865	0	200.00
The above amounts represent "due to" or "due from"	the applicable	program for th	e element of th	e above comple	ex indicated.	
						it
displays a valid OMB control number. The valid OMB						
required to complete and review the information col				5		
instructions, search existing resources, gather the						
have any comments concerning the accuracy of the ti 7500 Security Boulevard, Attn: PRA Report Clearance						, Civio
Please do not send applications, claims, payments,						PRA
Reports Clearance Office. Please note that any cor						
under the associated OMB control number listed on t						
or concerns regarding where to submit your document	s , please cont	act 1-800-MEDI	CARE.		-	

PLL	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENITFICATION DATA	L .	Provi d	der CCN:	150146	Period: From 01/C	1/2014	Workshe Part I	et S-2	
								1/2014	Date/Ti		
	1.00	2.00	o C	3	. 00			4.00	5/22/20	<u>) 15 1:0</u>	5 pr
	Hospital and Hospital Health Care Cor										
	Street: 401 SAWYER ROAD	P0 Box: 728				200 000					1
0	City: KENDALLVILLE	State: IN Component Name		p Code: CN	46755-0 CBSA	Provi dei	ty: NOBLE Date	Paym	ent Syst	em (P	2
		component Name			Number	Type	Certifie		, 0, or		
								V	XVIII	XIX]
	Uponital and Uponital Decod Company	1.00	2	. 00	3.00	4.00	5.00	6.00	7.00	8.00	
	<u>Hospital and Hospital-Based Componen</u> Hospital	COMMUNITY HOSPT. 0	F 15	0146	21140	1	05/30/20	N OC	Р	Р	3
	•	NOBLE CTY, INC.			21110		00,00,20				
	Subprovider - IPF										4
	Subprovider - IRF Subprovider - (Other)										5
	Swing Beds - SNF										7
	Swing Beds - NF										8
	Hospital-Based SNF										9
00 00	Hospi tal -Based NF Hospi tal -Based OLTC										10 11
	Hospi tal -Based HHA										12
	Separately Certified ASC										13
00 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14 15
	Hospital-Based Health Clinic - FQHC										16
00	Hospital-Based (CMHC) I										17
	Renal Dialysis										18
00	Other						Fro	m.	То		19
							1.		2. (1
	Cost Reporting Period (mm/dd/yyyy)						01/01		12/31/	/2014	20
00	Type of Control (see instructions) Inpatient PPS Information							2			21
00	Does this facility qualify and is it	currently receivir	ng pavment	s for	di sprop	ortionate	e Y	,	N		22
	share hospital adjustment, in accorda										
	for yes or "N" for no. Is this facili				.06(c)(2	2) (Pi ckl e	•				
01	amendment hospital?) In column 2, en Did this hospital receive interim und				cost re	eportina	N		N		22
	period? Enter in column 1, "Y" for ye		2			. 0					
	reporting period occurring prior to (
	for no for the portion of the cost re (see instructions)	eporting period occ	curring or	i or ar	ter octo	bber I.					
02	Is this a newly merged hospital that	requires final uno	compensate	ed care	paymen [.]	ts to be	N	I	N		22
	determined at cost report settlement						s				
	or "N" for no, for the portion of the in column 2, "Y" for yes or "N" for r	1 01					n				
	or after October 1.			.03110	portring	periodie					
	Did this hospital receive a geographi							I	N		22
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for r										
	prior to October 1. Enter in column 2						e				
	cost reporting period occurring on or										
	hospital contain at least 100 but not 42 CFR 412.105)? Enter in column 3, '			inted i	n accord	dance wit	ih				
	Which method is used to determine Med	,		'or 25	below?	n columr	1	3	N		23
	1, enter 1 if date of admission, 2 if	2			0						
	method of identifying the days in thi used in the prior cost reporting peri										
	ased in the piror cost reporting peri		n-State	In-Sta		ut-of	Out-of	Medi ca	id 0	ther	
			ledi cai d	Medi ca		state	State	HMO da	~	li cai d	
		p	aid days	eligib unpai			Medicaid eligible		C	lays	
				days			unpai d				
			1.00	2.00		3.00	4.00	5.00		. 00	
00	If this provider is an IPPS hospital,		382		39	0	0		734	42	24
	in-state Medicaid paid days in column Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in co	olumn 3,									
	out-of-state Medicaid eligible unpaid										
	4, Medicaid HMO paid and eligible but column 5, and other Medicaid days in										
00	If this provider is an IRF, enter the	e in-state	0		o	о	0		0		25
	Medicaid paid days in column 1, the i	n-state									
	Medicaid eligible unpaid days in colu out-of-state Medicaid days in column										
	iour-or-state weurodiu udvs fil COLUMA	J, UUL-UI-SLALE									1
	Medicaid eligible unpaid days in colu	umn 4, Medicaid									

			NOBLE CTY, IN	IC.	I	n Lieu	ı of For	m CMS-2	2552-10
HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der		eriod: com 01/01, o 12/31,		Workshe Part I Date/Ti 5/22/20	me Pre	
				·	Urban/Rui 1.00			Geogr	
26.00	Enter your standard geographic classification (not			ginning of the	1.00	2	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban	wage) sta or "2" fo	atus at the end or rural. If ap			2	10/01/	/2013	27.00
35.00	enter the effective date of the geographic reclass If this is a sole community hospital (SCH), enter effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00		Endi 2. (
36.00	Enter applicable beginning and ending dates of SCH		Subscript line	36 for number			2.1		36.00
	of periods in excess of one and enter subsequent da If this is a Medicare dependent hospital (MDH), en in effect in the cost reporting period.	ter the nu				0			37.00
38.00	Enter applicable beginning and ending dates of MDH of periods in excess of one and enter subsequent dates and enter subsequent dates and enter subsequent dates are subsequent dates and enter subsequent dates are subsequent and enter subsequent dates are subsequent as a subsequent dates are subsequent as a subsequent dates are subsequent as a subseq		Subscript line	38 for number					38.00
					Y/N 1.00		Y/ 2.0		
39.00	Does this facility qualify for the inpatient hospi hospitals in accordance with 42 CFR §412.101(b)(2) or "N" for no. Does the facility meet the mileage CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for y	(ii)? Ente requiremen	er in column 1 nts in accordar	"Y" for yes nce with 42	Y	,	<u> </u>		39.00
40.00	Is this hospital subject to the HAC program reduct "N" for no in column 1, for discharges prior to Oc no in column 2, for discharges on or after October	ion adjust tober 1. E	tment? Enter "\ Enter "Y" for y	/" for yes or	N		Ν		40. 00
	· · · · · ·					V 1.00	XVIII 2.00	XI X 3.00	
45.00	Prospective Payment System (PPS)-Capital								45.00
45.00	Does this facility qualify and receive Capital pay with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment e					N N	N	N N	45. 00 46. 00
47 00	pursuant to 42 CFR §412.348(f)? If yes, complete W Pt. III.				0	N		N	47.00
47.00 48.00	Is this a new hospital under 42 CFR §412.300 PPS ca Is the facility electing full federal capital paym Teaching Hospitals					N N	N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents or "N" for no.	in approve	ed GME programs	s? Enter "Y" f	or yes	N			56.00
57.00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first mu	for yes or onth of th	r "N" for no ir nis cost report	n column 1. If ting period? E	column 1 inter "Y"	N			57.00
58.00	for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. If line 56 is yes, did this facility elect cost re	II, if a	oplicable.			N			58.00
	defined in CMS Pub. 15-1, § 2148? If yes, complete Are costs claimed on line 100 of Worksheet A? If	Wkst. D-5	ō.			N			59.00
	Are you claiming nursing school and/or allied heal	th costs 1	for a program t	that meets the	+: `	N			60.00
	provider-operated criteria under §413.85? Enter "	Y/N	s or "N" for no IME	<u>p. (see instruc</u> Direct GME	I ME		Di rect	t GME	
		1.00	2.00	3.00	4.00)	5.0	00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00			61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61. 01
61. 02	instructions) Enter the current year total unweighted primary ca FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of	re	0.00	0.00					61. 02
61.03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used fo determining compliance with the 75% test. (see	r	0.00	0.00					61. 03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61.04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (lin	ne	0.00	0.00					61. 05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00					61.06

HOSPITAL AND H	OSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA	Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/22/2015 1:0	pared:
			Program	n Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. (00	2.00	3.00	4.00	
specialt for each column 1 program unweight FTE unwe b1.20 Of the F program resident instruct enter ir	TEs in line 61.05, speci y, if any, and the numbe new program. (see instr t, the program name, ente code, enter in column 3, ted count and enter in co sighted count. TEs in line 61.05, speci specialty, if any, and t sfor each expanded prog tions) Enter in column 1, n column 2, the program c	r of FTE residents uctions) Enter in r in column 2, the the IME FTE Jumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column				0.00		61. 1
	ME FTE unweighted count							
4, di rec	t GME FTE unweighted cou	nτ.						
							1.00	
ACA Prov	visions Affecting the Hea	I th Resources and Ser	rvices Admir	nistrati on	(HRSA)			
2.00 Enter th	ne number of FTE resident	s that your hospital	trained in			od for which	0.00	62. C
	spital received HRSA PCRE							
during i	ne number of FTE resident n this cost reporting pe Hospitals that Claim Re	riod of HRSA THC prop	gram. (see i			your nospitai	0.00	62.0
3.00 Has your	facility trained reside	nts in nonprovider se	ettings duri			period? Enter	N	63.0
"Y" for	yes or "N" for no in col	umn 1. If yes, comple	ete lines 64	-67. (see		Upweighted	Ratio (col. 1/	
					Unweighted FTEs	Unweighted FTEs in	(col. 1 + col.	
					Nonprovi der	Hospi tal	2))	
					Si te			
					1.00	2.00	3.00	
	5504 of the ACA Base Yea hat begins on or after J				This base year	is your cost r	eporting	
4.00 Enter in in the b resident settings resident	national segnals of of a filter of n column 1, if line 63 is pase year period, the num FTEs attributable to ro Enter in column 2 the FTEs that trained in you mn 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	trained r primary ca all nonprov non-primar column 3 t	residents re ider ycare heratio	0. OC	0. 00	0. 000000	64. C
		Program Name	Program	n Code	Unwei ghted		Ratio (col. 3/	
					FTEs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
		1.00	2. (00	3.00	4.00	5.00	
is yes, trained year per associat FTEs for program resident the prog column 3 unweight resident rotatior non-prov column 4 unweight	n column 1, if line 63 or your facility residents in the base riod, the program name eed with primary care r each primary care in which you trained s. Enter in column 2, gram code, enter in 8, the number of eed primary care FTE s attributable to ns occurring in all vider settings. Enter in 1, the number of eed primary care f. Enter in the settings. Enter in 1, the number of er primary care f. FTEs that trained in				O. OC	0.00	0. 000000	65.0

	Financial Systems	COMMUNI TY HO		LE CTY, IN	IC.	1	n Lie	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA	Provi der	CCN: 150146	Period: From 01/01	/2014	Workshe Part I	et S-2	
						To 12/31		Date/Ti 5/22/20		
					Unweighted	Unwei gh		Ratio (c	:ol. 1/	
					FTEs Nonprovider	FTEs Hospit		(col. 1 2)		
					Site					
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovid	er Settina	1.00 sEffective	2.00 for cost re		<u> </u>		
() 00	beginning on or after July 1, 20)10	•		1		·			
66.00	Enter in column 1 the number of FTEs attributable to rotations o				0.0	00	0.00	0.	000000	66.00
	Enter in column 2 the number of FTEs that trained in your hospit									
	(column 1 divided by (column 1 +	column 2)). (see ins	structions)							
		Program Name	Progra	n Code	Unwei ghted FTEs	Unwei gh FTEs		Ratio (c (col. 3		
					Nonprovi der			(0011 0		
		1.00	2.	00	Si te 3. 00	4.00)	5.0	0	
67.00	Enter in column 1, the program	1.00	2		0.0		0.00		000000	67.00
	name associated with each of your primary care programs in									
	which you trained residents.									
	Enter in column 2, the program code. Enter in column 3, the									
	number of unweighted primary									
	care FTE residents attributable to rotations occurring in all									
	non-provider settings. Enter in column 4, the number of									
	unweighted primary care									
	resident FTEs that trained in your hospital. Enter in column									
	5, the ratio of (column 3									
	divided by (column 3 + column 4)). (see instructions)									
							1.00) 2.00	3.00	
	Inpatient Psychiatric Facility P						1.00	5 2.00	3.00	
70.00	ls this facility an Inpatient Ps Enter "Y" for yes or "N" for no		IPF), or doe	es it cont	ain an IPF su	oprovi der?	N			70.00
71.00	If line 70 yes: Column 1: Did th	e facility have an ap							0	71.00
	recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co									
	program in accordance with 42 CF	R 412.424 (d)(1)(iii))(D)?Enter	"Y" for y	es or "N" for	no.				
	Column 3: If column 2 is Y, ente reporting period covers the begi									
	or subsequent academic years of instructions) For cost reporting	the new teaching proc	gram in exis	stence, en	ter 5. (see	s cost				
	reporting period covers the begi									
	teaching program in existence, e Inpatient Rehabilitation Facilit		(see instruc	ctions)						
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or	does it c	ontain an IRF		N			75.00
76 00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th		pproved GMF	teachi ng	program in th	e most			0	76.00
	recent cost reporting period end	ling on or before Nove	ember 15, 20	04? Enter	"Y" for yes	or "N" for			-	
	no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente									
	1, 2, or 3, in column 3. (see in	structions) If this o	cost reporti	ng period	covers the b	egi nni ng				
	of the fourth year, enter 4 in c teaching program in existence, e									
	on or after October 1, 2012, if any subsequent academic year of									
	instructions)	the new teaching proj		stence, en		III 3. (See				
								1.0	0	
	Long Term Care Hospital PPS									
	Is this a long term care hospita Is this a LTCH co-located within					n neriod? E	nter	N N		80. 00 81. 00
01.00	"Y" for yes and "N" for no.			, or the						01.00
85 00	TEFRA Providers Is this a new hospital under 42	CER Section 8413 40(1	f)(1)(i) TFF	RA? Ente	r "Y" for ves	or "N" for	no	N		85.00
	Did this facility establish a ne	w Other subprovider ((excluded ur							86.00
	§413.40(f)(1)(ii)? Enter "Y" fo	or yes and "N" for no.								

Health Financial Systems COMMUNITY HOSPT. OF	F NOBLE CTY, IN	IC.	In	Lieu	ı of Form CM	MS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	F	Period: From 01/01/2 To 12/31/2		Worksheet S Part I Date/Time 5/22/2015	Prepared:
			V		XI X	
Title V and XIX Services			1.00		2.00	
90.00 Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.			N		Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N		N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (di instructions) Enter "Y" for yes or "N" for no in the applications of the application of the applic	ual certificati				Ν	92.00
93.00 Does this facility operate an ICF/MR facility for purposes of "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.			N	0.00	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			Ν	0. 00	N	. 00 95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	plicable column	n.		0. 00	0	. 00 97. 00
105.00 Does this hospital qualify as a Critical Access Hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	N			105.00 106.00
107.00 Column 1: If this facility qualifies as a CAH, is it eligit for I &R training programs? Enter "Y" for yes or "N" for m instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educ. CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or	o in column 1. kst. B, Pt. I, D-2, Pt. II. (ation program f	(see col. 25 and Column 2: If train in the				107.00
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee schee	dul e? See 42	Ν			108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00		Respirator 4.00	гу
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N					109.00
110.00 Did this hospital participate in the Rural Community Hospit: the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for		1.00 N	110.00
				1.00	2.00 3.	00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, \$2208.1. 116 001e this facility classified as a referral conter? Enter "Y"	. If column 2 i nt for long ten rs) based on th	is "E", enter rm care (inclu he definition	in column des	N	C	
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur- no.			"N" for	N Y		116.00 117.00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i			1		118.00
		Premi ums	Losses		l nsurance	2
		1.00	2.00		3.00	
118.01 List amounts of malpractice premiums and paid losses:		49,70	9 187	, 521	22,	390 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost	contor other	than the	1.00 Y		2.00	118.02
Administrative and General? If yes, submit supporting scher and amounts contained therein.			Y			
119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y ualifies for th	" for yes or he Outpatient	Ν		Y	119.00 120.00
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y			121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N"	for no. If	N			125.00
126.00 If this is a Medicare certified kidney transplant center, en		fication date				126.00
in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 1	ter the certifi	ication date				127.00

lealth Financial Systems	COMMUNI TY HOSPT.						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX		Provi der	CCN: 150146			Worksheet S	-2
					01/01/2014 12/31/2014	Part I Date/Time Pi	repared:
						5/22/2015 1:	
					1.00	2.00	_
128.00 If this is a Medicare certified liv			cation dat	te			128.00
in column 1 and termination date, i 129.00 If this is a Medicare certified lu			ation date	. in			129.00
column 1 and termination date, if a				5 1 11			129.00
130.00 <mark>1f this is a Medicare certified par</mark>	ncreas transplant center	r, enter the cert	i fi cati on				130.00
date in column 1 and termination da I31.00 If this is a Medicare certified in			rtificatio	on			131.00
date in column 1 and termination da	ate, if applicable, in c	column 2.					
32.00 If this is a Medicare certified is			cation dat	te			132.00
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in column 1 and termination date, i							
34.00 If this is an organ procurement organd termination date, if applicable		the OPO number i	n column 1				134.00
All Providers							
40.00 Are there any related organization					Y	15H032	140. 00
chapter 10? Enter "Y" for yes or "I are claimed, enter in column 2 the		J		sts			
1.00	2	. 00			3.00	I	
If this facility is part of a chai				e name a	nd address	of the	
home office and enter the home off 41.00 Name: PARKVIEW HEALTH SYSTEM, INC				nctor's M	lumber 0810)1	141.00
		SERVI CES					
42.00 Street: 10501 CORPORATE DRIVE 43.00 City: FORT WAYNE		5600 I N	Zip Co	do	4684	c	142.00
43.00ptity. Toki wanne	jstate.			ue.	4004	5	143.00
						1.00	
44.00 Are provider based physicians' cos			ooto for i	nnoti oni		Y	144.00
45.00 If costs for renal services are cla		ne 74, are the c	USIS I OF I	npatren	t services	N	145.00
only? Enter "Y" for yes or "N" for	no.						
only? Enter "Y" for yes or "N" for	no.						
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 46.00 Has the cost allocation methodology. Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in of 47.00 Was there a change in the statistic 48.00 Was there a change in the order of 49.00 Was there a change to the simplific no. Does this facility contain a provious or charges? Enter "Y" for yes or "1 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 	y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method? der that qualifies for a N" for no for each compo mpus hospital that has c Name 0	15-2, § 4020) I - yes or "N" for For yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from onent for Part A N N N N N N N N N N N N N	f yes, ent no. r no. s or "N" f Part E 2.00 h the appli and Part I N N N N N N Ses in dif	For a ication B. (See Ferent (Zip Code 3.00	N N N N 3.00 of the lowe 42 CFR \$413 N N N N N N N CBSAs? ⇒ CBSA 4.00	Title XIX 4.00 r of costs 3.13) N N N N N N N N N N N FTE/Campus 5.00	147. 00 148. 00 149. 00 155. 00 156. 00 157. 00 158. 00 159. 00 160. 00 161. 00 161. 00
 46. 00 Has the cost allocation methodology. Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in of 47. 00 Was there a change in the statistic 48. 00 Was there a change in the order of 49. 00 Was there a change to the simplific no. Does this facility contain a provid or charges? Enter "Y" for yes or "I 55. 00 Hospital 56. 00 Subprovider - IPF 57. 00 Subprovider - IPF 57. 00 Subprovider - IRF 58. 00 SUBPROVIDER 59. 00 SNF 60. 00 HOME HEALTH AGENCY 61. 00 CMHC Multicampus 65. 00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no. 66. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67. 00 Is this provider a meaningful user 	y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method? der that qualifies for a N" for no for each compo mpus hospital that has c <u>Name</u> 0) incentive in the Ameri under Section §1886(n)?	15-2, § 4020) I r yes or "N" for for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from onent for Part A N N N N N N N N N N N N N	f yes, ent no. r no. s or "N" f Part E 2.00 h the appli and Part I N N N N N N N N Ses in dif State 2.00	For a i cati on B. (See a ferent (Zi p Code 3.00 ment Act	N N N N N N Of the lowe 100 42 CFR \$413 N N N N N N CBSAs? E CBSAs 4.00	Title XIX 4.00 r of costs 3.13) N N N N N N N N N N N FTE/Campus 5.00 0.1	147. 00 148. 00 149. 00 155. 00 156. 00 157. 00 157. 00 159. 00 160. 00 161. 00 165. 00 165. 00 00 166. 00
 46.00 Has the cost all ocation methodology Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in of 47.00 Was there a change in the statistic 48.00 Was there a change in the order of 49.00 Was there a change to the simplific no. Does this facility contain a provi- or charges? Enter "Y" for yes or "I 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 105) 	y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method? der that qualifies for a <u>N" for no for each compo</u> mpus hospital that has cont <u>Name</u> 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15-2, § 4020) I r yes or "N" for for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from onent for Part A N N N N N N N N N N N N N	f yes, ent no. r no. s or "N" f Part E 2.00 h the appli and Part I N N N N N N N N Ses in dif State 2.00	For a i cati on B. (See a ferent (Zi p Code 3.00 ment Act	N N N N N N Of the lowe 100 42 CFR \$413 N N N N N N CBSAs? E CBSAs 4.00	Ti tl e XI X 4.00 er of costs .13) N N N N N N N N N N N N N N N N N N N	147.00 148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 165.00
 46. 00 Has the cost allocation methodology. Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in of 47. 00 Was there a change in the statistic 48. 00 Was there a change in the order of 49. 00 Was there a change to the simplific no. Does this facility contain a provid or charges? Enter "Y" for yes or "I 55. 00 Hospital 56. 00 Subprovider - IPF 57. 00 Subprovider - IPF 57. 00 Subprovider - IRF 58. 00 SUBPROVIDER 59. 00 SNF 60. 00 HOME HEALTH AGENCY 61. 00 CMHC Multicampus 65. 00 If Line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67. 00 Is this provider a meaningful user 	y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method? der that qualifies for a <u>N" for no for each compo</u> mpus hospital that has cont <u>Name</u> 0) incentive in the Ameri under Section §1886(n)? 5 is "Y") and is a meani IT assets (see instructi	15-2, § 4020) I r yes or "N" for for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from onent for Part A N N N N N N N N N N N N N	f yes, ent no. r no. s or "N" f Part E 2.00 h the appli and Part I N N N N N N N Ses in dif State 2.00 State 2.00	For a ication B. (See a Control (See a a a a a a a a a a a a a	N N N N N Title V 3.00 of the lowe 42 CFR §413 N N N N N N N N N N N N N	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. 00 148. 00 149. 00 155. 00 156. 00 157. 00 158. 00 159. 00 160. 00 161. 00 165. 00 00 166. 00 00 166. 00

Health Financial Systems	COMMUNITY HOSPT. OF NO	BLE CTY, INC.	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 150146	Period: From 01/01/2014	Worksheet S-2 Part I	
			To 12/31/2014		
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	inning date and ending date	e for the reporting	10/01/2013	09/30/2014	170.00
				1.00	
171.00 If line 167 is "Y", does this provid Medicare cost plans reported on Wkst (see instructions)				Ν	171.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150146 Peri od: Worksheet S-2 From 01/01/2014 Part II Date/Time Prepared: То 12/31/2014 5/22/2015 1:05 pm Y/N Date 1.00 2.00 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 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 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) Y/N Date Туре 3.00 1.00 2.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Intern-Resident programs claimed on the current cost report? If Ν 9.00 ves. see instructions. 10.00 Was an Intern-Resident program been initiated or renewed in the current cost reporting Ν 10.00 period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Υ 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. Ν 15.00 Part B Part A Description Y/N Date Y/N 0 1.00 2.00 3.00 PS&R Data Ν 16.00 Ν 16.00 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) 17.00 Was the cost report prepared using the PS&R γ 04/30/2013 Υ 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional 18.00 Ν Υ 18.00 claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments 19.00 Ν Ν 19.00 made to PS&R Report data for corrections of other PS&R Report information? If yes, see

Ν

Ν

20.00

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

Heal th	Financial Systems COMM	UNITY HOSPT. O	F NOBLE CTY, I	NC.	In Lie	eu of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE			CCN: 150146 F	Period:	Worksheet S-2	
				F	From 01/01/2014	Part II	
				1	To 12/31/2014	Date/Time Pre 5/22/2015 1:0	eparea: D5 nm
				Par	rt A	Part B	
		Descr	iption	Y/N	Date	Y/N	
			0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21.00
				•			
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)			-
	Capital Related Cost						
	Have assets been relifed for Medicare purpose						22.00
23.00	Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.	ation expense	due to apprais	sars made durin	ig the cost		23.00
24.00	Were new leases and/or amendments to existing	n Leases enter	ed into durina	this cost rend	orting period?		24.00
21.00	If yes, see instructions		cu into uuring	1113 0031 1000	in this period.		21.00
25.00	Have there been new capitalized leases entered instructions.	ed into during	the cost repo	rting period? I	f yes, see		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during tl	he cost reporti	ing period? If	yes, see		26.00
	instructions.						
27.00	Has the provider's capitalization policy char	nged during the	e cost reporti	ng period? If y	ves, submit		27.00
	copy. Interest Expense						-
28 00	Were new Loans, mortgage agreements or Letter	cs of credit e	ntered into du	ring the cost r	eporting		28.00
20.00	period? If yes, see instructions.	3 OF CIEUTE		ing the cost i	eportring		20.00
29.00	Did the provider have a funded depreciation a	account and/or	bond funds (De	ebt Service Res	serve Fund)		29.00
	treated as a funded depreciation account? If	yes, see inst	ructions				
30.00	Has existing debt been replaced prior to its	schedul ed mat	urity with new	debt? If yes,	see		30.00
21 00	instructions.						21 00
31.00	Has debt been recalled before scheduled matur instructions.	T LY WI LHOUL IS	ssuance of new	debt? IT yes,	See		31.00
	Purchased Services						
32.00	Have changes or new agreements occurred in pa	atient care se	rvi ces furni sh	ed through cont	ractual		32.00
	arrangements with suppliers of services? If			5			
33.00	If line 32 is yes, were the requirements of S	Sec. 2135.2 ap	plied pertaini	ng to competiti	ve bidding? If		33.00
	no, see instructions.						-
24 00	Provider-Based Physicians Are services furnished at the provider facili	ty under on a	rrangamant with	h providor baca	d physicians?		34.00
34.00	If yes, see instructions.	ty under an a	i i angement with	ii providei -base	u physicians?		34.00
35.00	If line 34 is yes, were there new agreements	or amended exi	isting agreeme	nts with the pr	rovi der-based		35.00
	physicians during the cost reporting period?	lf yes, see i	nstructions.	•			
					Y/N	Date	
					1.00	2.00	
	Home Office Costs	10					
	Were home office costs claimed on the cost re If line 36 is yes, has a home office cost sta		repared by the	home office?			36.00
37.00	If yes, see instructions.	atement been p	repared by the	nome office?			37.00
38.00	If line 36 is yes, was the fiscal year end of	of the home of	fice different	from that of			38.00
	the provider? If yes, enter in column 2 the 1						
39.00	If line 36 is yes, did the provider render se	ervices to othe	er chain compo	nents? If yes,			39.00
	see instructions.						
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	If yes, see			40.00
	instructions.				-		
			1	. 00	2	00	-
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title	e/position	ERI C		NI CKESON		41.00
	held by the cost report preparer in columns ?	1, 2, and 3,					
	respectively.						
42.00	Enter the employer/company name of the cost i	report	PARKVI EW HEAL	TH SYSTEM, INC			42.00
43.00	preparer. Enter the telephone number and email address	of the cost	260-373-8406		ERI C. NI CKESON@		43.00
	report preparer in columns 1 and 2, respectiv		200 070-0400		LIN O. NI OKESUN®	T ANTEN COM	-5.00
		2	•				

OSPITAL AND HOSPITAL	HEALTH CARE REIMBURSEMENT QUES		Provi der	CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet S- Part II Date/Time Pr 5/22/2015 1:	epared
		Part B	-				
		Date	-				
		4.00					_
PS&R Data	port prepared using the PS&R		1				11/
Report only? If enter the paid-	either column 1 or 3 is yes, through date of the PS&R columns 2 and 4 .(see						16.
7.00 Was the cost re Report for tota for allocation?	bort prepared using the PS&R s and the provider's records If either column 1 or 3 is baid-through date in columns petructions	04/30/2013					17.
3.00 If line 16 or 1 made to PS&R Re claims that hav included on the	7 is yes, were adjustments port data for additional e been billed but are not PS&R Report used to file t? If yes, see instructions.						18.
0.00 If line 16 or 1 made to PS&R Re	7 is yes, were adjustments bort data for corrections of rt information? If yes, see						19
	7 is yes, were adjustments port data for Other? Describe tments:						20
.00 Was the cost re	oort prepared only using the ds? If yes, see			_			21.
				00			
Cost Depart Der	anan Contact Information		3	. 00			
.00 Enter the first	parer Contact Information name, last name and the title t report preparer in columns 1		DIRECTOR REIM	BURSEMENT			41
2.00 Enter the employ	yer/company name of the cost r	report					42
	none number and email address in columns 1 and 2, respectiv						43

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 150146		eriod: com 01/01/2014 o 12/31/2014	Worksheet S Part I Date/Time F 5/22/2015	Pre	pare
								I/P Days / C)/P	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	<u>Visits / Tri</u> Title V	ps	
		Line Number			Avai I abl e					
		1.00		2.00	3.00		4.00	5.00		
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00		31	11, 3	15	0.00		0	1
00 00 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider									2 3 4
00 00 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			31	11, 3	15	0.00	-	0 0 0	5 6 7
00 00 . 00 . 00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT									8 9 10 11
00 00 00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00		31	11.2	15	0.00		0	12 13
00	Total (see instructions) CAH visits SUBPROVIDER - IPF			31	11, 3	15	0.00		0	14
00 00 00	SUBPROVIDER – IRF SUBPROVIDER SKILLED NURSING FACILITY									17 18 19
00 00	NURSI NG FACILITY OTHER LONG TERM CARE									20 21
00 00 00	HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE									22 23 24
10 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00								24 25
00 25 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)			31						26 26 27
00 00	Observation Bed Days Ambulance Trips								0	28 29
00 00 00	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)			0		0				30
. 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days			0		0				32

	Financial Systems COMMM	JNITY HOSPT. OF AL DATA		CCN: 150146	Period: From 01/01/2014 To 12/31/2014		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2, 133	306				1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	1, 520 0	773 0				2.00 3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0	0 0		0		5.00 6.00
7.00 8.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT	2, 133	306	5, 57	9		7.00 8.00
9.00 10.00 11.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						9.00 10.00 11.00
12.00 13.00	OTHER SPECIAL CARE (SPECIFY) NURSERY		76	55	5		12.00 13.00
14.00 15.00	Total (see instructions) CAH visits	2, 133 0	382 0		4 0.00 0	211.00	14.00 15.00
16. 00 17. 00 18. 00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER						16.00 17.00 18.00
19.00 20.00 21.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE						19.00 20.00 21.00
22.00 23.00 24.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE						22.00 23.00 24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	0	0	(o		24. 10 25. 00
26.00 26.25 27.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)				0.00	211.00	26.00 26.25 27.00
28. 00 29. 00 30. 00	Observation Bed Days Ambulance Trips Employee discount days (see instruction)	1, 525	186	7	1		28.00 29.00 30.00
 31.00 32.00 32.01 	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	О	42	7	0 1 0		31.00 32.00 32.01
33. 00	outpatient days (see instructions) LTCH non-covered days	0					33.00

HOSPI -	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part I Date/Time Pre 5/22/2015 1:0	pared:
		Full Time Equivalents		Di s	scharges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0		78 383	1, 632	
2.00 3.00 4.00 5.00 6.00 7.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			3	62 0		2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY	0.00	0	5	78 383	1, 632	14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00
23.00 24.00 24.10 25.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00					23. 00 24. 00 24. 10 25. 00 26. 00 26. 20 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 0

From 0.02014 Decksbert A mount Neural Net Statistication (Science) Neural Science (Science) Neural Science (Science) Neural Science (Science) Neural Science (Science) Neural Science (Science) Neural Science (Science) Neural Science (Science) Neural Science (Science) Neural Science (Science) Neural Science Neural S		Financial Systems	COMML	JNITY HOSPT. O	F NOBLE CTY, IN			eu of Form CMS-2	
Uncentre Uncentre Percent Percent Percent Percent Salation Parage Result MAX_11	SPI TA	L WAGE INDEX INFORMATION			Provi der	F	rom 01/01/2014	Date/Time Pre	pared:
PART II - RACE DATA I.00 2.00 3.00 4.00 5.00 6.00 MART IS SAMARIS 200 Non-physic Lan anesthetist Part 0 0 0 0.00 <th></th> <th></th> <th></th> <th></th> <th>on of Salaries (from</th> <th>Salaries (col.2 ± col.</th> <th>Related to Salaries in</th> <th>Average Hourly Wage (col. 4 ÷</th> <th></th>					on of Salaries (from	Salaries (col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷	
BALARY ES Source Sour		-	1.00	2.00				6.00	
1.00 Total salaries (see line survey) 200.00 13,192.087 3,585.915 16,778.002 485.023.00 34.5 2.00 Mon-physic in a mesthetist Part in the survey is in a mesthetist (in a method is its a survey is in a mesthetist (in a survey is in a mesthetist (in a method is (in a me									-
2.00 Non-physician anesthetist Part 0 0 0 0.00 0.00 3.00 Non-physician anesthetist Part 0 0 0 0.00	00 1	Total salaries (see	200. 00	13, 192, 087	3, 585, 915	16, 778, 002	485, 023. 00	34. 59	1.00
3.00 Mon-physic lan anesthetist Part A 0 0 0 0.00 0.00 0.00 4.00 Physic lan-Part A 51, 338 0 51, 338 490.00 104.7 Admin firstrative 0 0 0 0 0.00 0.00 0.00 5.00 Physic lan-Part B 0 0 0 0.00 0.00 0.00 0.00 0.00 Northysic lan-Part B 0 0 0 0.00	1 00	Non-physician anesthetist Part		C	0	С	0.00	0.00	2.00
Admin is strative Admin is strative Admin is strative Admin is strative 4.00 Physicians - Part A - Teaching 0 0 0.00 0.00 0.00 5.00 Physicians - Part B 0 0 0 0.00 0.00 0.00 6.00 Response 0 0 0 0 0.00 0.00 0.00 7.00 Interns & residents (in an paroved programs) 0 0 0 0.00 <t< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td>C</td><td>0.00</td><td>0.00</td><td>3.00</td></t<>				0	0	C	0.00	0.00	3.00
4.01 Physicians - Part & - Teaching 0 0 0.00 0.00 0.00 0.00 6.00 Non-physician -Part B 0 0 0 0.00		5		51, 338	0	51, 338	490.00	104. 77	4.00
6.00 Non-physician-Part B 0 0 0 0.00 0.00 0.00 7.00 Interns & residents (in an approved program) 21.00 0 0 0 0.00 <td>01 F</td> <td>Physicians - Part A - Teaching</td> <td></td> <td>C</td> <td>0</td> <td>c</td> <td></td> <td></td> <td>•</td>	01 F	Physicians - Part A - Teaching		C	0	c			•
7.00 Interins & residents (in an proved program) 0 0 0 0.00 0.00 7.01 Contracted Interns and proved programs) 0 0 0 0.00 0.00 0.00 8.01 End office personnel 4.00 0 0 0 0.00 <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>-</td> <td></td> <td></td> <td></td>				0	0	-			
approved program) operation operatin operation operation			21 00	0		-			
8.00 Home office personnel 9.00 44.00 0 0 4.550, 428 0 4.550, 428 10.00 0.00	01 (approved program) Contracted interns and	2.1.00	C	0	_			
9.00 SNF 44.00 0 0 0 0 0.00				4 550 429	0	4 550 429	122 470 00	24.25	8.00
instructions) instructions 0THER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient Care 0 0 0 0.00 0.00 12.00 Contract labor: Top level management and other management and admin istrative services 0 <t< td=""><td></td><td></td><td>44.00</td><td>4, 550, 428</td><td>0</td><td></td><td></td><td></td><td></td></t<>			44.00	4, 550, 428	0				
11.00 Contract labor: Direct Patient care 0 0 0 0.00 0.00 12.00 Contract labor: Top level management and administrative services 0 <t< td=""><td>i</td><td>instructions)</td><td></td><td>1, 707, 183</td><td>171, 880</td><td>1, 879, 063</td><td>87, 562. 00</td><td>21.46</td><td>10.00</td></t<>	i	instructions)		1, 707, 183	171, 880	1, 879, 063	87, 562. 00	21.46	10.00
12.00 Contract labor: Top level management and administrative services 0 0 0 0.00 0.00 13.00 Contract labor: Physician-Part A- Administrative 0 0 0 0.00 0.00 14.00 Home office salaries & Mage-rel ated costs 4,550,428 0 4,550,428 132,479.00 34.3 15.00 Home office and Contract 0 0 0 0.00 0.00 16.00 Home office: Physician Part A - Administrative 0 0 0 0.00 0.00 17.00 Wage-rel ated costs (score) (see instructions) 4,603,954 0 4,603,954 0 0.00 0.00 18.00 Wage-rel ated costs (other) (see instructions) 0 0 0 0 0 0 19.00 Excluded areas 751,948 0 51,338 0 51,338 0 1 4 20.00 Physician Part A - administrative 51,338 0 51,338 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td>. 00 0</td><td>Contract Labor: Direct Patient</td><td></td><td>0</td><td>0</td><td>C</td><td>0.00</td><td>0.00</td><td>11.00</td></t<>	. 00 0	Contract Labor: Direct Patient		0	0	C	0.00	0.00	11.00
services o<	. 00 (r	Contract Labor: Top Level management and other		C	0	С	0.00	0.00	12.00
13.00 Contract labor: Physician-Part A - Administrative 0 0 0 0.00 0.00 14.00 Home office sal aries & wage-related costs tradin istrative 4,550,428 0 4,550,428 132,479.00 34.3 15.00 Home office sintrative 0 0 0 0.00 0.00 16.00 Home office sintrative 0 0 0 0.00 0.00 16.00 Home office sintrative 0 0 0 0.00 0.00 17.00 Wage-related costs (core) (see instructions) 4,603,954 0 4,603,954 0 0 0 0 18.00 Non-physician anesthetist Part A 0									
wage-related costs 0	. 00 0	Contract Labor: Physician-Part		0	0	C	0.00	0.00	13.00
15.00 Home office: Physician Part A - Administrative 0 0 0 0.00 0.00 0.00 16.00 Home office: and Contract Physicians Part A - Teaching 0 0 0 0 0.00 0.00 0.00 Wage-related costs (Core) (see instructions) 4, 603, 954 0 4, 603, 954 0 0 0 0 0 18.00 Wage-related costs (other) (see instructions) 0				4, 550, 428	0	4, 550, 428	132, 479. 00	34.35	14.00
16.00 Home office and Contract Physicians Part A - Teaching 0 0 0.00 0.00 WAGE-RELATED COSTS Wage-related costs (core) (see instructions) 4,603,954 0 4,603,954 0 <td>. 00 H</td> <td>Home office: Physician Part A</td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td>0.00</td> <td>0.00</td> <td>15.00</td>	. 00 H	Home office: Physician Part A		0	0	C	0.00	0.00	15.00
WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see instructions) 4,603,954 0 4,603,954 18.00 Wage-related costs (other) (see instructions) 0 0 0 19.00 Excluded areas 751,948 0 751,948 20.00 Non-physic ian anesthetist Part B 0 0 0 21.00 Non-physic ian anesthetist Part B 0 0 0 22.00 Physic ian Part A - Admin istrative 51,338 0 51,338 22.01 Physic ian Part A - Exeld costs (RHC/FOHC) 0 0 0 23.00 Physic ian Part B 0 0 0 24.00 Wage-rel ated costs (RHC/FOHC) 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 0 0 0 0 0 26.00 Employee Benefits Department Cortract (see inst.) 5.00 705,917 4,511,575 5,217,492 153,415.00 34.0	. 00 H	Home office and Contract		C	0	C	0.00	0.00	16.00
Instructions) Image of the second secon	W	VAGE-RELATED COSTS			1			1	
18.00 Wage-related costs (other) (see instructions) 0 0 0 19.00 Excluded areas 751,948 751,948 20.00 Non-physician anesthetist Part A 0 0 0 21.00 Non-physician anesthetist Part A 0 0 0 22.00 Physician Part A - Administrative 51,338 0 51,338 22.01 Physician Part A - Teaching 0 0 0 22.02 Physician Part B 0 0 0 22.01 Physician Part A Teaching 0 0 0 23.00 Physician Part B 0 0 0 0 24.00 Wage-related costs (REC/FOHC) 0 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 26.00 Employee Benefits Department contract (see inst.) 5.00 705, 917 4, 511, 575 5, 217, 492 153, 415.00 34.0 29.00 Administrative & General unterance & Repairs 6.00 0 0 0 0.00 <t< td=""><td></td><td></td><td></td><td>4, 603, 954</td><td>0</td><td>4, 603, 954</td><td></td><td></td><td>17.00</td></t<>				4, 603, 954	0	4, 603, 954			17.00
20.00 Non-physician anesthetist Part A 0 0 0 0 21.00 Non-physician anesthetist Part B 0 0 0 0 22.00 Physician Part A - Administrative 51,338 0 51,338 0 22.01 Physician Part A - Teaching 0 0 0 0 22.01 Physician Part A - Teaching 0 0 0 0 23.00 Physician Part B 0 0 0 0 24.00 Wage-related costs (RHC/FOHC) 0 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 0 0 0 0 0 26.00 Employee Benefits Department contract (see inst.) 5.00 705,917 4,511,575 5,217,492 153,415.00 34.0 29.00 Main itenance & Repairs 6.00 0 0 0 0 0 0 20.01 Maintenance & Repairs 6.00 0 0 0 0 0 0	. 00 🛛	Wage-related costs (other)		C	_	_			18.00
B C 22.00 Physician Part A - Administrative 51,338 0 51,338 22.01 Physician Part A - Teaching 0 0 0 23.00 Physician Part A - Teaching 0 0 0 23.00 Physician Part B 0 0 0 24.00 Wage-related costs (RHC/FOHC) 0 0 0 25.01 Interns & residents (in an approved program) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 26.00 Employee Benefits Department 4.00 1,953,743 -1,953,743 0 0.00 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td></td><td>751, 948 0</td><td></td><td></td><td></td><td></td><td>19.00 20.00</td></t<>				751, 948 0					19.00 20.00
Admin is strative Admin is strative Admin is strative Admin is strative 22.01 Physician Part A - Teaching 0 0 0 23.00 Physician Part B 0 0 0 23.00 Physician Part B 0 0 0 24.00 Wage-related costs (RHC/FQHC) 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 0VERHEAD COSTS - DIRECT SALARIES 0 1,953,743 -1,953,743 0 0.00 0.00 26.00 Employee Benefits Department 4.00 1,953,743 -1,953,743 0 0.00 0.00 28.00 Admin istrative & General 5.00 705,917 4,511,575 5,217,492 153,415.00 34.00 29.00 Maintenance & Repairs 6.00 0 0 0.00 0.00 29.00 Maintenance & Repairs 6.00 0 0 0.00 0.00 31.00 Laundry & Linen Service 8.00 0 0 0.00 0.00 32.00 Housekeeping under contract (see <td>. 00</td> <td>A Non-physician anesthetist Part</td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td></td> <td></td> <td>21.00</td>	. 00	A Non-physician anesthetist Part		0	0	C			21.00
22.01 Physician Part A - Teaching 0 0 0 23.00 Physician Part B 0 0 0 24.00 Wage-related costs (RHC/FQHC) 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 0 0VERHEAD COSTS - DIRECT SALARIES 0 1,953,743 -1,953,743 0 0.00 0.00 26.00 Employee Benefits Department 4.00 1,953,743 -1,953,743 0 0.00 0.00 27.00 Administrative & General 5.00 705,917 4,511,575 5,217,492 153,415.00 34.0 28.00 Administrative & General under contract (see inst.) 0 0 0 0.00 0.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 0.00 30.00 Operation of Plant 7.00 324,422 31,968 356,390 17,271.00 20.6 31.00 Laundry & Linen Service 8.00 0 <td></td> <td></td> <td></td> <td>51, 338</td> <td>0</td> <td>51, 338</td> <td></td> <td></td> <td>22.00</td>				51, 338	0	51, 338			22.00
23.00 Physician Part B 0 0 0 24.00 Wage-related costs (RHC/FQHC) 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 0VERHEAD COSTS - DIRECT SALARIES 0 1,953,743 -1,953,743 0 0.00 0.00 26.00 Employee Benefits Department 4.00 1,953,743 -1,953,743 0 0.00 0.00 27.00 Administrative & General 5.00 705,917 4,511,575 5,217,492 153,415.00 34.0 28.00 Administrative & General under contract (see inst.) 0 0 0 0 0.00 0.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 30.00 Operation of Plant 7.00 324,422 31,968 356,390 17,271.00 20.6 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 0.00 32.00 Housekeeping 9.00 262,324 25,849 288,173 23,642.00				0	0	c			22.01
25.00 Interns & residents (in an approved program) 0 0 0 OVERHEAD COSTS - DIRECT SALARIES 0 1,953,743 -1,953,743 0 0.00 0.00 26.00 Employee Benefits Department 4.00 1,953,743 -1,953,743 0 0.00 0.00 27.00 Administrative & General 5.00 705,917 4,511,575 5,217,492 153,415.00 34.00 28.00 Administrative & General under contract (see inst.) 0 0 0 0.00 0.00 0.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 30.00 Operation of Plant 7.00 324,422 31,968 356,390 17,271.00 20.6 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 0.00 33.00 Housekeeping 9.00 262,324 25,849 288,173 23,642.00 12.1 33.00 Housekeeping under contract (see 0 0 0 0.00 0.00 34.00 Di etary	. 00 F	Physician Part B		0	0	-			23.00
approved program) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 1,953,743 -1,953,743 0 0.00 0.00 27.00 Administrative & General 5.00 705,917 4,511,575 5,217,492 153,415.00 34.0 28.00 Administrative & General under contract (see inst.) 0 0 0 0.00 0.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 30.00 Operation of Plant 7.00 324,422 31,968 356,390 17,271.00 20.6 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 32.00 Housekeeping 9.00 262,324 25,849 288,173 23,642.00 12.1 33.00 Housekeeping under contract (see 0 0 0 0.00 0.00 0.00 34.00 Dietary 10.00 333,141 -100,636 232,505 16,079.00 14.4<				0					24.00 25.00
26.00 Employee Benefits Department 4.00 1,953,743 -1,953,743 0 0.00 0.00 27.00 Administrative & General 5.00 705,917 4,511,575 5,217,492 153,415.00 34.0 28.00 Administrative & General under contract (see inst.) 0 <td>a</td> <td>approved program)</td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>	a	approved program)		-					
27.00 Administrative & General 5.00 705,917 4,511,575 5,217,492 153,415.00 34.0 28.00 Administrative & General under contract (see inst.) 0 0 0 0 0.00 0.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 0.00 30.00 Operation of Plant 7.00 324,422 31,968 356,390 17,271.00 20.6 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 32.00 Housekeeping 9.00 262,324 25,849 288,173 23,642.00 12.1 33.00 Housekeeping under contract (see 0 0 0 0.00 0.00 34.00 Di etary 10.00 333,141 -100,636 232,505 16,079.00 14.4 35.00 Di etary under contract (see 0 0 0 0.00 0.00				1 953 743	_1 953 743	0	0.00	0.00	26.00
29.00 Maintenance & Repairs 6.00 0 0 0 0.00	.00 / .00 /	Administrative & General Administrative & General under					153, 415. 00	34. 01	27.00
30.00 Operation of Plant 7.00 324,422 31,968 356,390 17,271.00 20.6 31.00 Laundry & Linen Service 8.00 0 0 0 0 0.00			6.00	0	о	c	0.00	0.00	29.00
32.00 Housekeeping 9.00 262, 324 25, 849 288, 173 23, 642.00 12.1 33.00 Housekeeping under contract (see instructions) 0 0 0 0 0.00 34.00 Dietary 10.00 333, 141 -100, 636 232, 505 16, 079.00 14.4 35.00 Dietary under contract (see 0 0 0 0.00 0.00	. 00 0	Operation of Plant	7.00	324, 422	31, 968	356, 390			
33.00 Housekeeping under contract (see instructions) 0 0 0 0.00 0.00 34.00 Dietary 10.00 333,141 -100,636 232,505 16,079.00 14.4 35.00 Dietary under contract (see 0 0 0 0.00 0.00				0 262 201	0 25 8/0	C 288 172			
34. 00 Di etary 10. 00 333, 141 -100, 636 232, 505 16, 079. 00 14. 4 35. 00 Di etary under contract (see 0 0 0 0.00 0.00	. 00 H	Housekeeping under contract	2.00	202, 024	0				
	. 00 [. 00 [Dietary Dietary under contract (see	10. 00	333, 141 0	-100, 636 0	232, 505 C			34.00 35.00
i nstructi ons) 36. 00 Cafeteri a 11. 00 0 131, 014 131, 014 10, 811. 00 12. 1			11.00	C	131.014	131.014	10, 811.00	12. 12	36.00
37. 00 Maintenance of Personnel 12. 00 0 0 0 0.00 0.00	. 00	Maintenance of Personnel	12.00	0	0	C	0.00	0.00	37.00
				407, 110	40, 116	447, 226			38.00 39.00
40. 00 Pharmacy 15. 00 517, 577 51, 001 568, 578 12, 271. 00 46. 3				517, 577	51,001	568, 578			40.00

Health Financial Systems	COMMU	JNI TY HOSPT.	0F 1	NOBLE CTY, IN	IC.	In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION				Provi der	CCN: 150146	Peri od:	Worksheet S-3	
						From 01/01/2014		
						To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
	Worksheet A	Amount	Re	eclassi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on	n of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col	. Salaries in	col. 5)	
			Wo	orksheet A-6)	3)	col. 4		
	1.00	2.00		3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical	16.00		0	0		0 0.00	0.00	41.00
Records Library								
42.00 Social Service	17.00		0	0		0 0.00	0.00	42.00
43.00 Other General Service	18.00		0	0		0 0.00	0.00	43.00

Heal th	Financial Systems	COMM	JNITY HOSPT. O	F NOBLE CTY, IN	IC.	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION					Period: From 01/01/2014 Fo 12/31/2014		
		Worksheet A		Reclassi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
		4.00		Worksheet A-6)		<u>col.</u> 4	(00	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				1		
1.00	Net salaries (see		8, 641, 659	3, 585, 915	12, 227, 57	4 352, 544. 00	34.68	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		1, 707, 183	171, 880	1, 879, 06	87, 562. 00	21.46	2.00
3.00	Subtotal salaries (line 1		6, 934, 476	3, 414, 035	10, 348, 51	1 264, 982. 00	39. 05	3.00
4 00	minus line 2)		4 550 400		4 550 40	400 470 00	0.4.05	4 00
4.00	Subtotal other wages & related costs (see inst.)		4, 550, 428	0	4, 550, 42	3 132, 479. 00	34.35	4.00
5.00	Subtotal wage-related costs (see inst.)		4, 655, 292	0	4, 655, 293	2 0.00	44. 99	5.00
6.00	Total (sum of lines 3 thru 5)		16, 140, 196	3, 414, 035	19, 554, 23	1 397, 461. 00	49, 20	6,00
7.00	Total overhead cost (see		4, 504, 234					
	instructions)		.,,	,,	,			

	Financial Systems COMMUNITY HOSPT. OF N AL WAGE RELATED COSTS	Provi der CCN: 150		eu of Form CMS-2 Worksheet S-3	
			From 01/01/2014	Part IV	
			To 12/31/2014		
				5/22/2015 1:0	5 pm
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			0	1.0
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			322, 386	2.0
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			573, 600	3.0
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.0
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	
. 00	Legal/Accounting/Management Fees-Pension Plan			0	6. C
. 00	Employee Managed Care Program Administration Fees			55, 496	7.0
	HEALTH AND INSURANCE COST				
. 00	Health Insurance (Purchased or Self Funded)			2, 953, 303	
. 00	Prescription Drug Plan			0	
0.00	Dental, Hearing and Vision Plan			0	
1.00	Life Insurance (If employee is owner or beneficiary)			25, 762	
2.00	Accident Insurance (If employee is owner or beneficiary)			0	
3.00	Disability Insurance (If employee is owner or beneficiary)			54, 245	
4.00	Long-Term Care Insurance (If employee is owner or beneficiary	<i>(</i>)		0	1
5.00	'Workers' Compensation Insurance			86, 904	
6.00	Retirement Health Care Cost (Only current year, not the extra	iordinary accrual rec	quired by FASB 106.	0	16. (
	Non cumulative portion) TAXES				-
7.00	FICA-Employers Portion Only			1, 222, 669	17.0
8.00	Medicare Taxes - Employers Portion Only				
8.00 9.00	Unemployment Insurance			0	
	State or Federal Unemployment Taxes			0	
0.00	OTHER			0	20.0
1 00	Executive Deferred Compensation (Other Than Retirement Cost R	Poported on Lines 1 d	brough 4 above (see	29, 390	21 0
1.00	instructions))	tepor ted on Thes Th	in ough 4 above. (see	29, 390	21.0
2.00	Day Care Cost and Allowances			0	22.0
	Tui ti on Rei mbursement			32, 147	
	Total Wage Related cost (Sum of lines 1 -23)			5, 355, 902	
	Part B - Other than Core Related Cost			0,000,702	2
E 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.0

Heal th	Financial Systems	COMMUNI TY HOSPT. OF	NOBLE CTY, INC.	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150146	Peri od:	Worksheet S-3	
				From 01/01/2014	Part V	
				To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
	Cost Center Description			Contract Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Cos	t			2100	
	Hospital and Hospital-Based Component I	denti fi cati on:				1
1.00	Total facility's contract labor and ben			0	0	1.00
2.00	Hospi tal			0	0	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospi tal -Based Hospi ce					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems COMMUNITY HOSPT. OF NOBLE	CTY, INC.		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN		eriod:	Worksheet S-1	0
				rom 01/01/2014 o 12/31/2014		narod
			1	0 12/31/2014	5/22/2015 1:0	
					1.00	
4 00	Uncompensated and indigent care cost computation			0)	0.004000	1 1 00
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide Medicaid (see instructions for each line)	ea by line 4		8)	0. 224289	1.00
2.00	Net revenue from Medicaid				1, 817, 609	2.00
2.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental pa	avments from	n Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Me		i mear ear a.		1, 184, 566	
6.00	Medi cai d charges	sar sar a			19, 121, 828	
7.00	Medicaid cost (line 1 times line 6)				4, 288, 816	
8.00	Difference between net revenue and costs for Medicaid program (lin	ne 7 minus s	sum of line	s 2 and 5; if	1, 286, 641	
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructions	ns for each	line)			
9.00	Net revenue from stand-alone SCHIP				0	
10.00	Stand-alone SCHIP charges				0	
	Stand-alone SCHIP cost (line 1 times line 10)				0	1 1 1 0 0
12.00	Difference between net revenue and costs for stand-alone SCHIP (II)	ne 11 minus	sline 9; i	f < zero then	0	12.00
	enter zero)	+: 6				-
12 00	Other state or local government indigent care program (see instruct Net revenue from state or local indigent care program (Not include				314, 804	13.00
13.00 14.00	Charges for patients covered under state or local indigent care program (Not include				2, 470, 579	
14.00	10)		The udeu T	II THES 0 OF	2,470,579	14.00
15.00	State or local indigent care program cost (line 1 times line 14)				554, 124	15.00
16.00	Difference between net revenue and costs for state or local indige	ent care pro	ogram (line	15 minus line		
	13; if < zero then enter zero)		- g (
	Uncompensated care (see instructions for each line)					
	Private grants, donations, or endowment income restricted to fundi				9, 359	17.00
18.00					0	
19.00		ndi gent car	re programs	(sum of lines	1, 525, 961	19.00
	8, 12 and 16)	U	ni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00			1, 279, 331	791, 885	2, 071, 216	20.00
	charges excluding non-reimbursable cost centers) for the entire fa					
21.00	Cost of initial obligation of patients approved for charity care ((line 1	286, 940	177, 611	464, 551	21.00
22.00	times line 20)		1 771	1/ 707	10 470	22.00
22.00 23.00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)		1, 771 285, 169			
23.00			200, 109	100, 904	440, 073	23.00
					1.00	-
24 00	Does the amount in line 20 column 2 include charges for patient da	avs beyond a	length of	stav limit	1.00	24.00
21100	imposed on patients covered by Medicaid or other indigent care pro		. Foligti of	otaj mint		2
25.00	If line 24 is "yes," charges for patient days beyond an indigent		am's length	of stay limit	0	25.00
	Total bad debt expense for the entire hospital complex (see instru		5	-	9, 128, 000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instruction	ons)			33, 466	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line				9, 094, 534	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense	se (line 1 t	imes line	28)	2, 039, 804	
30.00					2, 485, 877	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			4, 011, 838	31.00

CLAS	Financial Systems COMM SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	NUNITY HOSPT. OF DF EXPENSES		CCN: 150146	Peri od:	u of Form CMS- Worksheet A	
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	T T	0 11/ 475	2 11/ 47	- 444 440	1 ((0 00)	1 1.
00	00200 CAP REL COSTS-BLDG & FIXT		2, 116, 475 0		5 -446,669 0 608,885	1, 669, 806 608, 885	2.
00	00300 OTHER CAP REL COSTS		0		0 000,000	000,009	3.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 953, 743	4, 129, 967	6, 083, 71	-1, 953, 743	4, 129, 967	4.
00	00500 ADMINI STRATI VE & GENERAL	705, 917	13, 270, 455	13, 976, 37	2 793, 748		
00	00700 OPERATION OF PLANT	324, 422	996, 961				
00 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	290 110		D 155, 319		
). 00	01000 DI ETARY	262, 324 333, 141	280, 110 191, 606			412, 572 328, 592	
	01100 CAFETERIA	0	4, 177				
2.00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	12.
8.00	01300 NURSING ADMINISTRATION	407, 110	5, 459	412, 56	9 39, 765	452, 334	13.
. 00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14.
. 00	01500 PHARMACY	517, 577	72, 313	589, 89	50, 648		
. 00 . 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0			0	16. 17.
	01900 NONPHYSICIAN ANESTHETISTS	0	0			0	19.
	02000 NURSI NG SCHOOL	0	0		0 0	0	20.
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.
. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.
. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0) (0 0	0	23.
00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2 2/0 527	204 024	2 (5(47)	2 221 102	2 225 200	1 20
. 00 . 00	03000 ADULTS & PEDIATRICS 04300 NURSERY	2, 269, 537 0	386, 936 0		3 -321, 193 0 84, 228		
. 00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0	1	04,220	04,220	43.
. 00	05000 OPERATI NG ROOM	894, 689	385, 030	1, 279, 71	9 11, 751	1, 291, 470	50.
. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 444, 585	444, 585	52.
. 00	05300 ANESTHESI OLOGY	0	948, 288			948, 288	
. 00	05400 RADI OLOGY-DI AGNOSTI C 05401 CAT SCAN	1, 260, 075	686, 033			1, 981, 563	
. 01 . 00	06000 LABORATORY	0	1, 749, 097		0 0 7 -2,493	0 1, 746, 604	54. 60.
. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	1, 749, 097	1, 749, 09	0 0	1, 740, 004	62.
. 00	06500 RESPI RATORY THERAPY	469, 639	78, 351	547, 99	43,059	591,049	
. 00	06600 PHYSI CAL THERAPY	987, 088	195, 068	1, 182, 15	6 -453, 329	728, 827	66.
. 00	06700 OCCUPATI ONAL THERAPY	0	1,000	1, 00		378, 081	
. 00	06800 SPEECH PATHOLOGY	0	0		0 135, 803		
. 00 . 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	10, 002			10,002	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	733, 675	1	324,079	407, 372 324, 079	
	07300 DRUGS CHARGED TO PATIENTS	0	1, 915, 021				
. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0		
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0		
. 99		0	0	(0 0	0	76.
. 00	OUTPATIENT SERVICE COST CENTERS	23, 133	3, 305	26, 43	8 4, 729	31, 167	90.
	09100 EMERGENCY	1, 076, 509	218, 179				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,0,0,00,	210, 177	1,2,1,00	10,000	1, 270, 002	92.
	OTHER REIMBURSABLE COST CENTERS	11				I	1
. 00	09500 AMBULANCE SERVI CES	1, 577, 813	295, 257	1, 873, 07	0 152, 837	2, 025, 907	95.
	SPECIAL PURPOSE COST CENTERS	L					
8.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	13, 062, 717	28, 672, 765	41, 735, 48	2 -345, 599	41, 389, 883	1118.
<u>)</u> 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23, 637	724	24, 36	1 1, 986	26, 347	190
	19200 PHYSI CLANS' PRI VATE OFFI CES	33, 897	6, 255				
4.00	07950 OTHER NONREI MBURSABLE	0	0, 200		0 0		194.
4.01	07951 PAIN CLINIC	0	0		0 0		194.
	07952 OCC HEALTH	0	-259, 974	-259, 97			194.
	07953 FOUNDATION	0	0		80, 004		
	07954 PHYSICIAN OFFICES	1, 573	0	1, 57			
	07955 COMMUNITY & VOLUNTEER SERVICES 07956 VACANT SPACE	70, 263 0	379, 170 2, 170				
		1 UI	2,1/0	ין ∠, ו /י	0 0	ı ∠, i/U	1174.

	Financial Systems COMM SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		NOBLE CTY, INC Provider C	C. In Lieu of Form C CCN: 150146 Period: Worksheet	
				From 01/01/2014 To 12/31/2014 Date/Time	
	Cost Center Description	Adjustments	Net Expenses	5/22/2015	
		(See A-8) 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-1, 310, 127	359, 679		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	46, 232	655, 117		2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 609, 118	2, 520, 849		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-3, 556, 665	11, 213, 455		5.00
7.00	00700 OPERATION OF PLANT	-4, 502	1, 347, 453		7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 -102	155, 319		8.00 9.00
9.00 10.00	01000 DI ETARY	-4, 171	412, 470 324, 421		10.00
11.00	01100 CAFETERI A	-175, 314	53, 099		11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	00,077		12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	452, 334		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500 PHARMACY	-700, 859	-60, 321		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700 SOCIAL SERVICE	0	0		17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		19.00
20.00	02000 NURSING SCHOOL	0	0		20.00
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0		22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	V	U		23.00
30.00	03000 ADULTS & PEDIATRICS	14, 396	2, 349, 676		30.00
43.00	04300 NURSERY	0			43.00
	ANCI LLARY SERVI CE COST CENTERS				
50.00	05000 OPERATING ROOM	0	1, 291, 470		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	444, 585		52.00
53.00	05300 ANESTHESI OLOGY	-934, 857	13, 431		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-18, 173	1, 963, 390		54.00
54.01 60.00	05401 CAT SCAN 06000 LABORATORY	0	1 744 404		54.01 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	1, 746, 604		62.30
65.00	06500 RESPI RATORY THERAPY	-2, 716	588, 333		65.00
66.00	06600 PHYSI CAL THERAPY	-136, 638	592, 189		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	378, 081		67.00
68.00	06800 SPEECH PATHOLOGY	0	135, 803		68.00
69.00	06900 ELECTROCARDI OLOGY	0	10, 002		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	407, 372		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	324, 079		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 898, 995		73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		76.97
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0		76.98
10.77	OUTPATIENT SERVICE COST CENTERS	0	0		/0.79
90.00	09000 CLINIC	-289	30, 878		90.00
91.00	09100 EMERGENCY	0	1, 278, 082		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-1, 810	2, 024, 097		95.00
	SPECIAL PURPOSE COST CENTERS		00.577		
118.00		-8, 394, 713	32, 995, 170		118.00
100 00	NONREIMBURSABLE COST CENTERS	0	26 217		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 347 41, 824		190.00 192.00
	07950 OTHER NONREI MBURSABLE		41, 024		192.00
194 1	07951 PAIN CLINIC	0	0		194.00
			0		194.02
194.01	207952 OCC HEALTH	0	U		
194.01 194.02		0	80, 004		194.03
194. 02 194. 02 194. 03	07952 OCC HEALTH	0 0 0	-		
194. 01 194. 02 194. 03 194. 04 194. 05	2 07952 OCC HEALTH 3 07953 FOUNDATI ON 4 07954 PHYSI CI AN OFFI CES 5 07955 COMMUNI TY & VOLUNTEER SERVI CES	0 0 0 -137, 680	80, 004 1, 728 313, 561		194. 03 194. 04 194. 05
194.01 194.02 194.03 194.04 194.05	2 07952 OCC HEALTH 3 07953 FOUNDATI ON 4 07954 PHYSI CLAN OFFI CES 5 07955 COMMUNI TY & VOLUNTEER SERVI CES 6 07956 VACANT SPACE	0	80, 004 1, 728 313, 561 2, 170		194. 03 194. 04

	Financial Systems	COMMU	NITY HOSPT. OF	NOBLE CTY, INC.		eu of Form CMS-2552-1
ULA2	SI FI CATI ONS			Provider CCN: 1	50146 Peri od: From 01/01/2014 To 12/31/2014	Worksheet A-6 Date/Time Prepared: 5/22/2015 1:05 pm
		Increases	Color	Othors		
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
00	B - REHAB THERAPY OCCUPATI ONAL THERAPY	67.00	200 500	94 044		1.00
00	SPEECH PATHOLOGY	67.00 68.00	308, 598 106, 188	86, 066 29, 615		2.00
			414, 786	115, 681		
00	C - INSURANCE CAP REL COSTS-BLDG & FIXT	1.00	0	24, 812		1.00
00	CAP REL COSTS-MVBLE EQUIP	2.00	<u>o</u>	<u> </u>		2.00
	0 D - EQUIPMENT LEASE		0	34, 956		
00	CAP REL COSTS-BLDG & FIXT	1.00	0	67, 966		1.0
00 00	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	0	59, 294		2.0
00 00		0.00	0	0 0		3.0
00		0.00	0	0		5.0
00 00		0.00 0.00	0	0 0		6. 0 7. 0
00		0.00	0	0		8.0
00		0.00	0	0		9.0
00		0.00 0.00	0	0		10.0
00		0.00	0	0		12.0
00		0.00	0	0		13. C
00 00		0.00 0.00	0	0		14. C
00		0.00	0	0		16.0
	0		0	127, 260		
00	E - DRUGS CHARGED TO PATIENTS	0.00	0	0		1.0
	0		0	<u>0</u>		
0	F - CLINIC DIETICIAN CLINIC	90.00	2, 449	0		1.0
0			2, 449	- <u> </u>		1.0
0	G – PTO ADMI NI STRATI VE & GENERAL	5.00	925, 660	0		1.0
0	OPERATION OF PLANT	7.00	31, 968	0		2.0
0	HOUSEKEEPING	9.00	25, 849	0		3.0
0 0	DI ETARY NURSI NG ADMI NI STRATI ON	10.00 13.00	32, 827 40, 116	0 0		4. C
0	PHARMACY	15.00	51, 001	0		6.0
0	ADULTS & PEDIATRICS	30.00	210, 216	0		7.0
)0)0	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	88, 161 124, 165	0 0		8. C 9. C
00	RESPIRATORY THERAPY	65.00	46, 277	0		10.0
00	PHYSICAL THERAPY	66.00	97, 266	0		11.0
00 00	CLINIC EMERGENCY	90.00 91.00	2, 280 106, 077	0 0		12. C 13. C
00	AMBULANCE SERVICES	95.00	155, 474	0		14. C
00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	2, 329	0		15. C
00	PHYSICIANS' PRIVATE OFFICES	192.00	3, 340	0		16.0
00	COMMUNITY & VOLUNTEER	194.05	10, 582	0		17.0
00	SERVICES PHYSICIAN OFFICES	194.04	155	0		18.0
	0		1, 953, 743	<u>0</u>		
~	H - CAFETERIA	11 00	121 014	02 222		1.0
0	CAFETERI A	<u>11.00</u>	<u>131, 014</u> 131, 014	9 <u>3, 222</u> 93, 222		1.0
~			· · ·			
0	CAP REL COSTS-MVBLE EQUIP		0	<u>539, 447</u> 539, 447		1.0
	J - HOME OFFICE SALARY		- 1			
0	ADMI NI STRATI VE & GENERAL	5.00	<u>3, 585, 915</u> 3, 585, 915	<u>0</u>		1.0
	K - LAUNDRY		3, 565, 915	0		
0	LAUNDRY & LINEN SERVICE	8.00	0	155, 319		1.0
	O L - OCCH HEALTH		0	155, 319		
0	OCC HEALTH	194.02	0	259, 974		1.0
0		0.00	0	0		2.0
0		0.00	0	0		3.0
0 0		0.00 0.00	0	0 0		4. 0 5. 0
0		0.00	0	0		6.0
00	1	0.00	0	0		7.0

Heal th	Financial Systems	COM	UNITY HOSPT. O	F NOBLE CTY, I	NC.	In Lie	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provi der	CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet A- Date/Time Pr 5/22/2015 1:	epared:
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
	<u> </u>		o	259, 974				
	M - IMPLANTS	г I			1			1
1.00	IMPL. DEV. CHARGED TO	72.00	0	324, 079				1.00
	PATI ENTS							
	0		0	324, 079				
	N - OB							
1.00	NURSERY	43.00	76, 839	7, 389				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	405, 586	38, 999				2.00
	0 — — — — — — —		482, 425	46, 388				
	P - OTHER							
1.00	FOUNDATI ON	194.03	0	<u> </u>				1.00
	0		0	80, 004				
500.00	Grand Total: Increases		6, 570, 332	1, 776, 330				500.00

CLASSI FI (ancial Systems CATIONS			Provi der			sheet A-6
							/Time Prepare
		Decreases				5/22	2/2015 1:05 pr
	Cost Center	Line #	Salary		Wkst. A-7 Ref.		
	6.00 REHAB THERAPY	7.00	8.00	9.00	10.00		
	SI CAL THERAPY	66.00	414, 786	115, 681	9		1
00		0.00	0	0	0		2
0			414, 786	115, 681			
		F 00	ol	24.057	10		1
DO ADMI	I NI STRATI VE & GENERAL	5.00 0.00	0 0	34, 956 0	12 12		1
0		0.00	0	34, 956			
D –	EQUIPMENT LEASE						
	INISTRATIVE & GENERAL	5.00	0	16, 952	10		1
	RATION OF PLANT	7.00	0	1, 396	10		2
	SEKEEPI NG TARY	9.00 10.00	0	392 2, 297	0		3
	SING ADMINISTRATION	13.00	0	351	0		5
	RMACY	15.00	0	353	0		6
	LTS & PEDIATRICS	30.00	0	2, 596	0		7
	RATING ROOM	50.00	0	76, 139	0		8
	I OLOGY-DI AGNOSTI C	54.00	0	3,046	0		9
	PI RATORY THERAPY SI CAL THERAPY	65.00 66.00	0	3, 042 3, 567	0		10
	RGENCY	91.00	0	3, 707	0		12
	ULANCE SERVICES	95.00	0	2, 637	0		13
	T, FLOWER, COFFEE SHOP &	190.00	0	343	0		14
	TEEN	100.00					
	SICIANS' PRIVATE OFFICES	192.00 194.05	0	1, 668	0		15
	MUNITY & VOLUNTEER VICES	194.05	0	8, 774	0		10
0		+		127, 260			
E -	DRUGS CHARGED TO PATIENTS						
00		0.00	0	0			1
0			0	0			
	CLINIC DIETICIAN	10.00	2, 449	0	0		1
		10.00	2, 449	⁰ 0	<u> </u>		
G -	PTO	I	_,]		11		
	LOYEE BENEFITS DEPARTMENT	4.00	1, 953, 743	0	0		1
00		0.00	0	0			2
		0.00 0.00	0	0	0		3
		0.00	0	0	0		5
00		0.00	0	0	0		6
00		0.00	О	0	0		7
00		0.00	0	0	0		8
00		0.00	0	0	0		9
00 00		0. 00 0. 00	0	0	0		10
00		0.00	0	0	0		12
00		0.00	0	0	0		13
00		0.00	0	0	0		14
00		0.00	0	0	0		15
00		0.00	0	0	0		16
00		0.00	0	0	0		17
00		0.00	1, 953, 743	0	<u> </u>		18
0 Н -	CAFETERI A		1,755,745	0			
	TARY	10.00	131, 014	93, 222	0		1
0			131, 014	93, 222			
	DEPRECIATION						
00 <u>CAP</u>	REL_COSTS_BLDG_&_FI_XT	1.00	0	539, 447	9		1
0	HOME OFFICE SALARY		0	539, 447			
	INI STRATI VE & GENERAL	5.00	0	3, 585, 915	0		1
0			— — <u> </u>	3, 585, 915			'
К –	LAUNDRY						
	SEKEEPING	9.00	0	15 <u>5, 3</u> 19			1
0			0	155, 319			
	OCCH HEALTH	F0 00		077	~		
	RATING ROOM I OLOGY-DI AGNOSTI C	50.00 54.00	0	271 85, 664	0		1
	ORATORY	54.00 60.00	0	85, 664 2, 493	0		2
	PIRATORY THERAPY	65.00	0	2, 493	0		4
	SI CAL THERAPY	66.00	0	16, 561	0		5
	UPATI ONAL THERAPY	67.00			0		

Heal th	Financial Systems	COMM	IUNI TY HOSPT. O	F NOBLE CTY, I	NC.	In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provi der	- CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet A- Date/Time Pr 5/22/2015 1:	repared:
		Decreases				I		1
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2, 224		0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	16, 026		0		8.00
9.00	EMERGENCY	91.00	0	118, 976		0		9.00
	0		0	259, 974				
	M - IMPLANTS							
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	324, 079		0		1.00
	PATI ENT							
	0		0	324, 079				_
	N - OB	-			T	- 1		
1.00	ADULTS & PEDIATRICS	30.00	482, 425	46, 388		0		1.00
2.00		0.00	0	0	·	0		2.00
	0		482, 425	46, 388				_
	P - OTHER				1			_
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	<u> </u>		0		1.00
	0		0	80, 004				
500.00	Grand Total: Decreases		2, 984, 417	5, 362, 245				500.00

Heal th	Financial Systems COMM	IUNI TY HOSPT. OF	NOBLE CTY, IN	IC.	In Lie	eu of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150146	Period: From 01/01/2014 To 12/31/2014		pared:
				Acqui si ti on	S	0,22,2010 110	
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	0	0		0 0		
2.00	Land Improvements	314, 996	322, 239		0 322, 239		2.00
3.00	Buildings and Fixtures	2, 889, 131	219, 913		0 219, 913	0	3.00
4.00	Building Improvements	57, 402	0		0 0	, o	4.00
5.00	Fixed Equipment	262, 844	13, 958		0 13, 958		5.00
6.00	Movable Equipment	12, 395, 455	69, 231		0 69, 231	1, 072, 845	6.00
7.00	HIT designated Assets	2, 291, 849	330, 679		0 330, 679	0	7.00
8.00	Subtotal (sum of lines 1-7)	18, 211, 677	956, 020		0 956, 020	1, 072, 845	8.00
9.00	Reconciling Items	2, 117, 527	505, 001		0 505, 001	0	9.00
10.00	Total (line 8 minus line 9)	16, 094, 150	451, 019		0 451,019	1, 072, 845	10.00
		Endi ng Bal ance	Fully				
		, i i i i i i i i i i i i i i i i i i i	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	637, 235	89, 216				2.00
3.00	Buildings and Fixtures	3, 109, 044	67, 079				3.00
4.00	Building Improvements	57, 402	1, 000				4.00
5.00	Fixed Equipment	276, 802	25, 227				5.00
6.00	Movable Equipment	11, 391, 841	7, 560, 237				6.00
7.00	HIT designated Assets	2, 622, 528	0				7.00
8.00	Subtotal (sum of lines 1-7)	18, 094, 852	7, 742, 759				8.00
9.00	Reconciling Items	2, 622, 528	0				9.00
10.00	Total (line 8 minus line 9)	15, 472, 324	7, 742, 759				10.00

Heal th	Financial Systems COMM	UNITY HOSPT. OF	NOBLE CTY, IN	NC.	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150146	Peri od:	Worksheet A-7	
					From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
			SL	JMMARY OF CAP	PI TAL	072272010 1.0	
					–		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 116, 475	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	2, 116, 475			0 0	0	3.00
		SUMMARY O	F CAPITAL				
				-			
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	15.00	-			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	14.00	15.00	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	SHEEL A, CULUM		1			1.00
2.00	CAP REL COSTS-BLDG & FIXT	0	2, 116, 475				2.00
2.00	Total (sum of lines 1-2)	0	0 114 47E				2.00
3.00	Total (Sum of Times 1-2)	1 0	2, 116, 475	1			3.00

Health Financial Systems COMM	UNITY HOSPT. OI	F NOBLE CTY, IN	IC.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prep 5/22/2015 1:05	pared: 5 pm
	COM	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	4, 080, 483 11, 391, 842 15, 472, 325	398, 959	10, 992, 88 15, 073, 36	3 0. 729292		1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-				
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0			266, 901 585, 679 852, 580		1.00 2.00 3.00
		SL	IMMARY OF CAPI		1277 200	0.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-	04.010			050 (72	1 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 0 0	10, 144		0 0 0 0	359, 679 655, 117 1, 014, 796	1.00 2.00 3.00

COMMUNI TY	HOSPT.	0F	NOBLE	CTY.	INC.

403031	MENTS TO EXPENSES				eriod: rom 01/01/2014	Worksheet A-8	
				To		Date/Time Prep 5/22/2015 1:05	
				Expense Classification on To/From Which the Amount is		10/22/2010 1100	5 1011
					· · · · · · · · · · · · · · · · · · ·		
			A	Cost Conton	1.1.7.7. //		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		C	CAP REL COSTS-BLDG & FIXT	1.00	0	1. C
2.00	Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
8.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	-3, 965	PHARMACY	15.00	0	3. (
00	(chapter 2)				0.00	0	
. 00	Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4. (
. 00	Refunds and rebates of		C		0.00	0	5.0
. 00	expenses (chapter 8) Rental of provider space by		C		0.00	о	6. (
. 00	suppliers (chapter 8) Telephone services (pay	А	-8 527	ADMI NI STRATI VE & GENERAL	5.00	0	7. (
. 00	stations excluded) (chapter 21)	~	-0, 327		5.00	0	7.0
8. 00	Television and radio service (chapter 21)	A	-1, 641	OPERATION OF PLANT	7.00	0	8. (
. 00	Parking lot (chapter 21)		C		0.00	0	9. (
0.00	Provider-based physician adjustment	A-8-2	-934, 857			0	10. (
1.00	Sale of scrap, waste, etc.		C		0.00	0	11. (
2.00	(chapter 23) Related organization	A-8-1	-344, 288			0	12. (
3. 00	transactions (chapter 10) Laundry and linen service		C		0.00	0	13.
4.00	Cafeteria-employees and guests	A	-51, 968	CAFETERI A	11.00	0	14.0
5.00	Rental of quarters to employee and others		Ĺ		0.00	0	15.0
6. 00	Sale of medical and surgical supplies to other than		C		0.00	0	16. (
7.00	patients Sale of drugs to other than		C		0.00	0	17. (
8 00	patients Sale of medical records and		C		0.00	0	18. (
	abstracts						
9.00	Nursing school (tuition, fees, books, etc.)		C		0.00	0	19. (
0.00	Vendi ng machi nes		C		0.00	0	20.
1. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		Ĺ		0.00	0	21.
2. 00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.
3. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
-	therapy costs in excess of		-				
4.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.
F 0-	limitation (chapter 14)						<u> </u>
5.00	Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.
6. 00	(chapter 21)	А	-50 707	CAP REL COSTS-BLDG & FIXT	1.00	9	26. (
	COSTS-BLDG & FIXT						
/. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	47, 234	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.0
8.00	Non-physician Anesthetist		C	NONPHYSI CI AN ANESTHETI STS	19.00	_	28.
9.00 0.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 30.
	limitation (chapter 14)						<i>.</i> -
0. 99	Hospice (non-distinct) (see instructions)		C	ADULTS & PEDIATRICS	30.00		30.
1. 00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31. (
2 00	limitation (chapter 14) CAH HIT Adjustment for		ſ		0.00	0	32. (
	Depreciation and Interest		C				
3.00	OTHER ADJUSTMENTS (SPECIFY) (3)		C		0.00	0	33.0

	Financial Systems MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
				Expense Classification o	n Worksheet A	0,22,2010 110	
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	· · · ·	1.00	2.00	3.00	4.00	5.00	
33.01	TELEPHONE	A		CAP REL COSTS-MVBLE EQUIP	2.00		33.01
33.02	TELEPHONE	A	-1, 282	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.02
33.03	TELEVISION OFFSET - DEPR	A		CAP REL COSTS-MVBLE EQUIP	2.00		33.03
33.04	PHYSICIAN RECRUITMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.05	PHARMACY SALES	В		PHARMACY	15.00		33.0
33.06	SELF INSURANCE	A		EMPLOYEE BENEFITS DEPARTMEN			
33.07	COMMUNITY HEALTH	A	-83, 664	ADMI NI STRATI VE & GENERAL	5.00	0	33.0
33. 08	COMMUNITY HEALTH	A		CAFETERIA	11.00		33.0
33.09	LOBBY DUES	A		ADMI NI STRATI VE & GENERAL	5.00		33.0
33. 12	I NTERUNI T	A		PHYSICAL THERAPY	66.00		33.1
33. 13	I NTERUNI T	A		ADMI NI STRATI VE & GENERAL	5.00		
33.14	I NTERUNI T	A		CAP REL COSTS-BLDG & FIXT	1.00		33.1
33. 15	I NTERUNI T	A	-121, 692	COMMUNITY & VOLUNTEER	194.05	0	33.15
00.4/			40.004	SERVICES	54.00		00.4
33.16		A		RADI OLOGY-DI AGNOSTI C	54.00		
33.17	OTHER OPERATING REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00		33.1
33.18	OTHER OPERATING REVENUE	В		OPERATION OF PLANT	7.00		
	OTHER OPERATING REVENUE	В		HOUSEKEEPING	9.00		
33.20	OTHER OPERATING REVENUE	B B			10.00		33.20
33.21	OTHER OPERATING REVENUE	В			11.00		33.2
33.22	OTHER OPERATING REVENUE				15.00		
33.23	OTHER OPERATING REVENUE	B B		ADULTS & PEDIATRICS	30.00		
33.24	OTHER OPERATING REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00		
33.25	OTHER OPERATING REVENUE	В			65.00		33.2
33. 26 33. 27	OTHER OPERATING REVENUE OTHER OPERATING REVENUE	В		PHYSI CAL THERAPY CLI NI C	66.00 90.00		33.2 33.2
	OTHER OPERATING REVENUE	В			90.00		33.2
33. 28 33. 29	OTHER OPERATING REVENUE	В		AMBULANCE SERVICES COMMUNITY & VOLUNTEER	194.05		
JJ. 27	UTHER OFERALING REVENUE	D	- 10, 988	ISERVICES	194.05		33.25
33, 30	TELEMETRY	А	33 846	ADULTS & PEDIATRICS	30.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49)		-8, 532, 393		30.00		50.00
55.00	(Transfer to Worksheet A,		0,002,070]			00.00
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

A. Costs - If Cost, find during appreciate overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of								
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 150146	Period:	Worksheet A-8	-1			
OFFICE	COSTS			From 01/01/2014 To 12/31/2014					
	Line No.	Cost Center	Expense Items	Amount of	Amount				
				Allowable Cost					
					Wks. A, column				
					5				
	1.00	2.00	3. 00	4.00	5.00				
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:								
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	8, 244, 712	8, 589, 000	1.00			
2.00	0.00			0	0	2.00			
3.00	0.00			0	0	3.00			
3.01	0.00			0	0	3. 01			
4.00	0.00			0	0	4.00			
5.00	TOTALS (sum of lines 1-4).			8, 244, 712	8, 589, 000	5.00			
	Transfer column 6, line 5 to			-, -,					
	Worksheet A-8, column 2,								
	line 12.								

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

			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1.00	2.00	3.00	4.00	5.00				
 B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

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

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	COMMUNITY HOSPT. OF NOB	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED OFFICE COSTS	ORGANIZATIONS AND HOME	Provider CCN: 150146	From 01/01/2014	Worksheet A-8-1 Date/Time Prepared:

								5/22/2015 1:0	<u>75 pm</u>
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6.00	7.00							
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED	AS A RESULT OF	TRANSACTI 0	NS WITH RELATED (ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:							
1.00	-344, 288	0							1.00
2.00	0	0							2.00
3.00	0	0							3.00
3.01	0	0							3.01
4.00	0	0							4.00
5.00	-344, 288								5.00

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

nas not	been posted to worksheet A,	corumns r a	nu/01 Z,	the amount	allowable sho	iui cateu i	II COLUMIT 4 OI	this part.	
	Rel ated Organi zati on(s)								
	and/or Home Office								
	Type of Business]							
	5.								
	6.00	1							
-	B INTERRELATIONSHIP TO RELAT	TED ORGANI 74	TLON(S)	AND/OR HOME	OFFLCE:				

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

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

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

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

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10 PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 150146 Peri od: Worksheet A-8-2 From 01/01/2014 12/31/2014 Date/Time Prepared: То 5/22/2015 1:05 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er Component ider Component Remunerati on Component Hours 1.00 2.00 3.00 4.00 5.00 6.00 7.00 53. 00 ANESTHESI OLOGY 1.00 926, 904 21, 338 1.00 200, 300 139 948.242 2.00 91.00 EMERGENCY 30, 000 0 30,000 200, 300 351 2.00 3.00 0.00 3.00 0 0 С С 0 4.00 0.00 0 0 0 0 0 4.00 0 С 0.00 5.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 0 0 0 0 7.00 0.00 0 7.00 8.00 0.00 0 0 8.00 0 0 0 9.00 0.00 0 0 0 0 9.00 10.00 0.00 0 0 0 C 0 10.00 490 978, 242 926, 904 51, 338 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice . Limit Conti nui ng Share of col. Insurance Educati on 12 1.00 2.00 8.00 9.00 12.00 13.00 14.00 53. 00 ANESTHESI OLOGY 13, 385 1.00 1.00 669 0 С 0 2.00 91.00 EMERGENCY 33, 801 1,690 0 0 0 2.00 3.00 0.00 0 0 0 3.00 0 0 0 4.00 0.00 0 0 4.00 0 0 5.00 0.00 0 0 0 5 00 6.00 0.00 0 0 0 6.00 0 7.00 0.00 0 0 0 0 7.00 01 0 0 8.00 0.00 8.00 0 0.00 0 0 0 9.00 0 9.00 10.00 0.00 0 0 0 10.00 0 0 200.00 47, 186 2,359 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adj ustment I denti fi er Component Limit Di sal I owance Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 53. 00 ANESTHESI OLOGY 13, 385 934, 857 1.00 1.00 7,953 0 2.00 91.00 EMERGENCY 0 33, 801 0 0 2.00 3.00 0.00 0 0 0 0 3.00 0 4.00 0.00 0 0 4.00 0 0.00 5.00 0 0 0 5 00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 0 0.00 0 0 8.00 0 8.00 0.00 0 9.00 0 0 9.00 10.00 0.00 0 0 0 10.00 0 0 7,953 200.00 47, 186 934, 857 200.00

Heal th Financial Systems COM COST ALLOCATION - GENERAL SERVICE COSTS COM	MMUNITY HOSPT. OF			In Lie eriod:	u of Form CMS- Worksheet B	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		FIOVICEI	Fi	rom 01/01/2014	Part I	
			T	b 12/31/2014	Date/Time Pre 5/22/2015 1:0	
		CAPI TAL REI	ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
cost center bescription	for Cost	DEDG & TIXI	WVDEL EQUIT	BENEFITS	50510121	
	Allocation			DEPARTMENT		
	(from Wkst A col. 7)					
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	359, 679	359, 679				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	655, 117 2, 520, 849	0	655, 117 0	2, 520, 849		2.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	11, 213, 455	92, 273	-	783, 917	12, 099, 323	5.00
7.00 00700 OPERATION OF PLANT	1, 347, 453			53, 547	1, 516, 131	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	155, 319	3, 038		0	158, 357	8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY	412, 470 324, 421	4, 394 9, 045		43, 297 34, 933	464, 169 374, 738	1
11. 00 01100 CAFETERIA	53, 099	5, 851	0, 339	19, 684	78, 634	
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSI NG ADMI NI STRATI ON	452, 334	1, 230		67, 194	521, 708	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	11, 300		0	11, 300	
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	-60, 321	3, 332 5, 090	85, 823 0	85, 427	114, 261 5, 090	15.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00 02100 I & SERVICES-SALARY & FRINGES APPRV 22.00 02200 I & SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0		0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDIATRICS	2, 349, 676			300, 093		30.00
43.00 04300 NURSERY	84, 228	764	0	11, 545	96, 537	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1, 291, 470	39, 814	89, 686	147, 670	1, 568, 640	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	444, 585	4, 906		60, 938		
53.00 05300 ANESTHESI OLOGY	13, 431	0	5, 059	0	18, 490	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 963, 390	23, 844		207, 978		
54. 01 05401 CAT SCAN 60. 00 06000 LABORATORY	1, 746, 604	7,032	0	0	0 1, 753, 636	54.01 60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	588, 333	6, 048	28, 661	77, 515	700, 557	65.00
66. 00 06600 PHYSI CAL THERAPY	592, 189	2, 412	9, 521	100, 601	704, 723	1
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	378, 081 135, 803	0	0	46, 366 15, 954	424, 447 151, 757	
69. 00 06900 ELECTROCARDI OLOGY	10, 002	503	0	13, 754	10, 505	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	407, 372	0		0	407, 372	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	324,079	0	0	0	324, 079	
73. 00 07300 DRUGS CHARGED TO PATLENTS 76. 97 07697 CARDLAC REHABLITATION	1, 898, 995			0	1, 898, 995 0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0	0	76.99
OUTPATIENT SERVICE COST CENTERS	1	-	-			
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	30, 878 1, 278, 082	0 22, 257		4, 186 177, 680		90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 270, 002	22,237	15,055	177,000	1, 491, 034	1
OTHER REI MBURSABLE COST CENTERS						12.00
95.00 09500 AMBULANCE SERVICES	2, 024, 097	0	34, 028	260, 421	2, 318, 546	95.00
SPECIAL PURPOSE COST CENTERS	22.005.170	220 700	(51 1/4	2 400 044	22 040 242	1110 00
SUBTOTALS SUBTOTALS <t< td=""><td>32, 995, 170</td><td>330, 708</td><td>651, 164</td><td>2, 498, 946</td><td>32, 940, 343</td><td></td></t<>	32, 995, 170	330, 708	651, 164	2, 498, 946	32, 940, 343	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	26, 347	2, 811	2, 043	3, 901	35, 102	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	41, 824	19, 990		5, 595	69, 195	192.00
194. 00 07950 OTHER NONREI MBURSABLE	0	0	0	0		194.00
194. 01 07951 PALN CLINIC 194. 02 07952 0CC HEALTH	0	0	0	0		194.01 194.02
194. 02 07952 0CC_HEALTH 194. 03 07953 FOUNDATI ON	80, 004		0	0		194.02
194. 04 07954 PHYSI CI AN OFFI CES	1, 728	5, 216	-	260		194.04
194.0507955COMMUNITY & VOLUNTEER SERVICES	313, 561	954		12, 147	326, 786	194.05
194. 06 07956 VACANT SPACE	2, 170	0	0	0		194.06
200.00Cross Foot Adjustments201.00Negative Cost Centers		^		0		200.00
202.00 TOTAL (sum lines 118-201)	33, 460, 804	359, 679	655, 117	2, 520, 849		
				_, 020, 017	1 12, 188, 901	,

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part I Date/Time Pre 5/22/2015 1:0	pared: 5 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	·
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	12, 099, 323					5.00
7.00	00700 OPERATION OF PLANT	858, 749	2, 374, 880				7.00
B. 00	00800 LAUNDRY & LINEN SERVICE	89, 695					8.00
9.00	00900 HOUSEKEEPI NG	262, 909					9.00
10.00	01000 DI ETARY	212, 255			31, 544	711, 489	10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	44, 539			20, 405 0	0	11. 00 12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	295, 500	-		4, 291	0	12.00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 400		1		0	14.00
	01500 PHARMACY	64, 718			11, 621	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	2, 883		1	17, 752	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 23.00	02200 I & SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY)	0		0	0	0	22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	<u> </u>	0	0	23.00
30. 00	03000 ADULTS & PEDIATRICS	1, 573, 644	534, 792	97, 380	182, 270	711, 489	30.00
43.00	04300 NURSERY	54, 679			2, 664	0	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	888, 490			138, 847	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	289, 111	50, 201	1	17, 110	0	52.00
53.00	05300 ANESTHESI OLOGY	10, 473		0	02 152	0	53.00 54.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 CAT SCAN	1, 361, 039	243, 974	27, 820	83, 152	0	54.00 54.01
60.00	06000 LABORATORY	993, 273	71, 958	691	24, 525	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62.30
65.00	06500 RESPI RATORY THERAPY	396, 801	61, 880	1, 704	21, 090	0	65.00
66.00	06600 PHYSI CAL THERAPY	399, 161	24, 677	0	8, 410	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	240, 410			0	0	67.00
68.00	06800 SPEECH PATHOLOGY	85, 956		-	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	5, 950			1, 755	0	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	230, 739 183, 561	0	0	0	0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 075, 606		0	0	0	72.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS			1			
90.00	09000 CLINIC	19, 861			0	0	90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	844, 885	227, 743	53, 701	77, 620	0	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	1, 313, 243	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS				1	-	
118.00	SUBTOTALS (SUM OF LINES 1-117)	11, 804, 530	2, 078, 444	275, 958	682, 465	711, 489	118.00
	NONREI MBURSABLE COST CENTERS		-	1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 882			9, 801		190.00
			204, 542	3, 176	69, 712	0	192. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	39, 193	201/012		~	0	101 00
192.00 194.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE	0	0	0	0		194.00 194.01
192.00 194.00 194.01	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OTHER NONREI MBURSABLE 07951 PAI N CLI NI C		0		0	0	194.01
92.00 94.00 94.01 94.02	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OTHER NONREI MBURSABLE 07951 PAI N CLI NI C 07952 OCC HEALTH	0 0 0	0 0 0		0 0 0 0	0	194. 01 194. 02
192.00 194.00 194.01 194.02 194.03	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OTHER NONREI MBURSABLE 07951 PAI N CLI NI C	0	0 0 0 0	0 0 0	0 0 0 18, 190	0 0 0	194.01
192.00 194.00 194.01 194.02 194.03 194.04	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATION	0 0 45, 315	0 0 0 53, 372	0 0 0	0 0 0 18, 190 3, 328	0 0 0 0 0	194. 01 194. 02 194. 03 194. 04 194. 05
92.00 94.00 94.01 94.02 94.03 94.03 94.05 94.05	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATION 07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES 07956 VACANT SPACE	0 0 45, 315 4, 080	0 0 0 53, 372 9, 764	0 0 0 0 0		0 0 0 0 0 0	194. 01 194. 02 194. 03 194. 04 194. 05 194. 06
192.00 194.00 194.01 194.03 194.03 194.04 194.06 194.06	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATION 07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES 07956 VACANT SPACE Cross Foot Adjustments	0 0 45, 315 4, 080 185, 094 1, 229	0 0 53, 372 9, 764 0	0 0 0 0 0	3, 328	0 0 0 0 0 0	194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 200. 00
192.00 194.00 194.01 194.02 194.03 194.04 194.04	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE 07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATION 07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES 07955 VACANT SPACE Cross Foot Adjustments Negative Cost Centers	0 0 45, 315 4, 080 185, 094	0 0 53, 372 9, 764 0		3, 328 0 0	0 0 0 0 0 0 0	194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 200. 00 201. 00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: fom 01/01/2014 0 12/31/2014	Worksheet B Part I Date/Time Pre 5/22/2015 1:0	epared: 05 pm
	Cost Center Description	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.00 7.00 8.00 9.00	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						2.00 4.00 5.00 7.00 8.00 9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	202 046					10.00
12.00	01200 MAINTENANCE OF PERSONNEL	203, 846	0				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	7, 257	0	841, 346			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	181, 189		14.00
15.00	01500 PHARMACY	6, 312	0	0	3, 086	234, 093	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS		0	0	0	0	
20.00	02000 NURSI NG SCHOOL		0	0	0	0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	•
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	38, 416	0	351, 527	24, 099	228	30.00
43.00	04300 NURSERY	1, 593			24, 099	228	
	ANCI LLARY SERVI CE COST CENTERS	.,	-				
50.00	05000 OPERATING ROOM	18, 626			23, 937	3, 313	
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 409			0	0	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	25, 952	0	0	0 7, 371	0 35	
54.00	05401 CAT SCAN	23, 732	0	0	,, 3, 1	0	
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
65.00		10, 440		0	6, 795	0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	9,024		0	3, 003	12 0	
68.00	06800 SPEECH PATHOLOGY	1, 881	0	0	0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	77, 570	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00 76.97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION		0	0	3, 607	229, 172 0	1
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	•
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
~~ ~~	OUTPATIENT SERVICE COST CENTERS				107		
90.00 91.00	09000 CLINIC 09100 EMERGENCY	529 24, 901	0		137 13, 652	0 67	•
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 901	0	227,039	13, 032	07	92.00
/2/00	OTHER REIMBURSABLE COST CENTERS			<u> </u>			/2/00
95.00	09500 AMBULANCE SERVI CES	39, 847	0	0	15, 428	1, 216	95.00
	SPECIAL PURPOSE COST CENTERS	100 (50			470 (05		
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	198, 652	0	841, 346	178, 685	234, 043	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	667		0	27	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 177	0	0	328		192.00
	07950 OTHER NONREI MBURSABLE	0	0	0	0		194.00
	07951 PAIN CLINIC 07952 OCC HEALTH			0	0		194. 01 194. 02
		1, 111	0	0	0	50	194.02
194.02	U/953 FOUNDATION			0	0		194.04
194. 02 194. 03	07953 FOUNDATI ON 07954 PHYSI CI AN OFFI CES	0	0	0	U U	0	1174.04
194.02 194.03 194.04 194.05	07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES	0 2, 239	0	0	2, 149	0	194.05
194. 02 194. 03 194. 04 194. 05 194. 06	07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES 07956 VACANT SPACE	0 2, 239 0	0	0	2, 149 0	0	194. 05 194. 06
194.02 194.03 194.04 194.05	07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES 07956 VACANT SPACE Cross Foot Adjustments	0 2, 239 0		0	2, 149 0	0 0	194.05

ST ALLOC	ATI ON - GENERAL SERVI CE COSTS		Provi der	F	Period: From 01/01/2014 Fo 12/31/2014	Worksheet B Part I Date/Time Pre 5/22/2015 1:0	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY 16. 00	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS 19.00	NURSING SCHOOL	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES APPRV 21.00	
GEN	ERAL SERVICE COST CENTERS						
00 0010 00 0024 00 0044 00 0054 00 0070 00 0070 00 0070 00 0070 00 0070 00 0070 00 0100 00 0110 00 0113 00 0144 00 0156 00 0166 00 01770 00 0120 00 0200 00 0200 00 0200 00 0200	DO CAP REL COSTS-BLDG & FIXT DO CAP REL COSTS-MVBLE EQUIP DO EMPLOYEE BENEFITS DEPARTMENT DO ADMINISTRATIVE & GENERAL DO OPERATION OF PLANT DO LAUNDRY & LINEN SERVICE DO HOUSEKEEPING DO DI ETARY DO CAFETERIA DO NURSING ADMINISTRATION DO CENTRAL SERVICES & SUPPLY DO PHARMACY DO MEDICAL RECORDS & LI BRARY DO SOCIAL SERVICE DO NONPHYSICIAN ANESTHETISTS DO NURSING SCHOOL DO I & SERVICES-OTHER PRGM COSTS APPRV DO I & SERVICES-OTHER PRGM COSTS APPRV DO I & SERVICES-OTHER PRGM COSTS APPRV DO I & SERVICES-OTHER PRGM DED PARAMED D D D D D D D D D D D	77, 810 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0			0 0	
I NP/	ATIENT ROUTINE SERVICE COST CENTERS		-				
	DO ADULTS & PEDIATRICS DO NURSERY	4, 740	0			0	1
ANCI	LLARY SERVICE COST CENTERS		-		-		
	DO OPERATING ROOM	7,899	0		-	0	50.0
	DO DELIVERY ROOM & LABOR ROOM DO ANESTHESIOLOGY	1, 277	0		-	0	52. 0 53. 0
	DO RADI OLOGY-DI AGNOSTI C	24, 759	0	0	-	0	54.
	D1 CAT SCAN	0	0		-	0	54.
	DO LABORATORY 50 BLOOD CLOTTING FOR HEMOPHILIACS	7,861			-	0	60. 62.
	DO RESPIRATORY THERAPY	2,775	0		-	0	65.
. 00 0660	DO PHYSI CAL THERAPY	1, 361	0	0	0 0	0	66.
	DO OCCUPATI ONAL THERAPY	507	0	(-	0	67.
	DO SPEECH PATHOLOGY DO ELECTROCARDI OLOGY	187				0	68. 69.
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	2, 502	0	0	0 0	0	71.
	DO I MPL. DEV. CHARGED TO PATIENTS	1,094	0	(-	0	72.
	DO DRUGS CHARGED TO PATIENTS 97 CARDIAC REHABILITATION	6, 213	0			0	73.
	98 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
	29 LI THOTRI PSY	0	0	0	00	0	76.
	PATIENT SERVICE COST CENTERS	18	0		0	0	90.
	DO EMERGENCY	11, 286		1		0	
	OO OBSERVATION BEDS (NON-DISTINCT PART						92.
	ER REIMBURSABLE COST CENTERS	2 (05				0	
	DO AMBULANCE SERVICES CIAL PURPOSE COST CENTERS	3, 695	0	(0 0	0	95.
8.00	SUBTOTALS (SUM OF LINES 1-117)	77, 810	0	(0 0	0	118.
	REIMBURSABLE COST CENTERS						100
	DO GIFT, FLOWER, COFFEE SHOP & CANTEEN DO PHYSICIANS' PRIVATE OFFICES	0	0		-		190. 192.
	50 OTHER NONREI MBURSABLE	0	0				194.
4.01079	51 PAIN CLINIC	0	0	C C	0 0	0	194.
	52 OCC HEALTH	0	0		0		194
	53 FOUNDATION 54 PHYSICIAN OFFICES						194. 194.
	55 COMMUNITY & VOLUNTEER SERVICES	0	0				194.
4.06079	56 VACANT SPACE	0	0	i c	o o	0	194.
0.00	Cross Foot Adjustments			0	0		200.
1.00	Negative Cost Centers TOTAL (sum lines 118-201)	0 77, 810	0			0	201.

OST ALLOCATION - GENERAL SERVICE COSTS	MUNITY HOSPT. OF	Provi der	CCN: 150146	Period [.]	Worksheet B	2552-
		i i ovi dei		From 01/01/2014	Part I	
				To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
	INTERNS &				1 37 227 2013 1.0	
	RESI DENTS					
Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
	PRGM COSTS	PRGM		Residents Cost		
	APPRV			& Post		
				Stepdown		
	22.00	23.00	24.00	Adjustments 25.00	26.00	-
GENERAL SERVICE COST CENTERS	22.00	20.00	21.00	20.00	20.00	
00 00100 CAP REL COSTS-BLDG & FIXT						1.
00 00200 CAP REL COSTS-MVBLE EQUIP						2.
00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.
00 00500 ADMINI STRATI VE & GENERAL						5.
00 00700 OPERATION OF PLANT						7.
00 00800 LAUNDRY & LINEN SERVICE						8.
00 00900 HOUSEKEEPI NG						9.
. 00 01000 DI ETARY						10.
						11.
00 01200 MAINTENANCE OF PERSONNEL						12.
00 01300 NURSING ADMINISTRATION						13.
00 01400 CENTRAL SERVICES & SUPPLY						14.
						15.
00 01600 MEDICAL RECORDS & LIBRARY						16.
. 00 01700 SOCIAL SERVICE . 00 01900 NONPHYSICIAN ANESTHETISTS						17.
						19.
00 02000 NURSI NG SCHOOL						20.
. 00 02100 I & SERVI CES-SALARY & FRI NGES APPRV . 00 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	0					21.
. 00 02200 PARAMED ED PRGM-(SPECIFY)	0	C				22.
INPATIENT ROUTINE SERVICE COST CENTERS	0		/			23.
. 00 03000 ADULTS & PEDIATRICS	0	C	6, 296, 85	6 0	6, 296, 856	30.
. 00 04300 NURSERY	0	C	178, 37	/3 0	178, 373	43.
ANCI LLARY SERVI CE COST CENTERS			.			
. 00 05000 OPERATING ROOM	0	C				
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	C				
00 05300 ANESTHESI OLOGY	0	0				
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	., ,			
. 01 05401 CAT SCAN	0	0		0 0		
	0	0	_,, .		1	
30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0		
00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY	0	0	., 202, 0			
00 06600 PHYSI CAL THERAPY 00 06700 OCCUPATI ONAL THERAPY	0	0	.,			
00 06800 SPEECH PATHOLOGY	0	0				1
00 06900 ELECTROCARDI OLOGY	0	0	20///0			1
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				
00 07200 IMPL. DEV. CHARGED TO PATIENT	0		508, 73		508, 734	
. 00 07200 TRUEL DEV. CHARGED TO PATTENTS	0	0				
97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0		
98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0		
99 07699 LI THOTRI PSY	0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS						1.0.
00 09000 CLINIC	0	0	55, 60)9 0	55, 609	90.
00 09100 EMERGENCY	0	0				
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		-	, , , , , , , , , , , , , , , , , , ,	0		92.
OTHER REIMBURSABLE COST CENTERS	· · ·					1
00 09500 AMBULANCE SERVICES	0	C	3, 691, 97	75 0	3, 691, 975	95.
SPECIAL PURPOSE COST CENTERS						1
B. 00 SUBTOTALS (SUM OF LINES 1-117)	0	0	32, 237, 15	59 0	32, 237, 159	118.
NONREI MBURSABLE COST CENTERS						1
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	94, 23	37 0	94, 237	190.
00 19200 PHYSICIANS' PRIVATE OFFICES	0	C				
4. 00 07950 OTHER NONREI MBURSABLE	1		1	0 0		194.

70.00 10		U 0	0	00,007	0	00,007	70.00
91.00 0	9100 EMERGENCY	0	0	2, 973, 368	0	2, 973, 368	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
0	THER REIMBURSABLE COST CENTERS						
95.00 0	19500 AMBULANCE SERVI CES	0	0	3, 691, 975	0	3, 691, 975	95.00
S	PECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	32, 237, 159	0	32, 237, 159	118.00
N	ONREIMBURSABLE COST CENTERS						
190.001	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	94, 237	0	94, 237	190. 00
192.001	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0	387, 323	0	387, 323	192.00
194.000	7950 OTHER NONREI MBURSABLE	0	0	0	0	0	194.00
194.010	7951 PAIN CLINIC	0	0	0	0	0	194.01
194.020	07952 OCC HEALTH	0	0	0	0	0	194. 02
194.030	7953 FOUNDATI ON	0	0	126, 480	0	126, 480	194.03
194.040	7954 PHYSICIAN OFFICES	0	0	82, 846	0	82, 846	194.04
194.050	7955 COMMUNI TY & VOLUNTEER SERVI CES	0	0	529, 360	0	529, 360	194.05
194.060	17956 VACANT SPACE	0	0	3, 399	0	3, 399	194.06
200.00	Cross Foot Adjustments	0	0	0	0	0	200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	33, 460, 804	0	33, 460, 804	202.00

	Financial Systems COM TION OF CAPITAL RELATED COSTS	MUNITY HOSPT. OF		CCN: 150146 Pe	eri od:	u of Form CMS-: Worksheet B	2002-10
				Fr Tc	com 01/01/2014 12/31/2014	Part II Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/22/2015 1:0	5 pm
				LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	
5.00	00500 ADMINISTRATIVE & GENERAL	2, 013, 291	92, 273	9,678	2, 115, 242	0	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	35, 310 3, 038	79, 821 0	115, 131 3, 038	0	
9.00	00900 HOUSEKEEPI NG	0	4, 394	4, 008	8, 402	0	
10.00	01000 DI ETARY	0	9, 045	6, 339	15, 384	0	10.00
11.00	01100 CAFETERIA	0	5, 851	0	5, 851	0	
12.00 13.00	01200 MAINTENANCE OF PERSONNEL	0	0	0 950	0	0	
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	1, 230 11, 300	950	2, 180 11, 300	0	
	01500 PHARMACY	0	3, 332	85, 823	89, 155	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	5, 090	0	5, 090	0	16.00
	01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
19.00 20.00	01900 NONPHYSI CLAN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0	19.00
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		50.0/5	74 007	400 500		1 00 00
30. 00 43. 00	03000 ADULTS & PEDIATRICS 04300 NURSERY	0	52, 265 764	76, 237 0	128, 502 764	0	
43.00	ANCI LLARY SERVICE COST CENTERS	0	704	0	704	0	43.00
50.00	05000 OPERATI NG ROOM	0	39, 814	89, 686	129, 500	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 906	0	4, 906	0	
53.00	05300 ANESTHESI OLOGY	0	0	5,059	5, 059	0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 CAT SCAN	0	23, 844	207, 718 0	231, 562	0	
60.00	06000 LABORATORY	0	7,032	0	7,032	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	6, 048	28, 661	34, 709	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	2, 412	9, 521	11, 933	0	66.00 67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	1
69.00	06900 ELECTROCARDI OLOGY	0	503	0	503	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	0	0	0	0	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
	07699 LI THOTRI PSY	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS		_				
		0	0	0 13, 635	25 002	0	
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	22, 257	13, 035	35, 892	0	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVI CES	0	0	34, 028	34, 028	0	95.00
	SPECIAL PURPOSE COST CENTERS			I			
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	2, 013, 291	330, 708	651, 164	2, 995, 163	0	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 811	2,043	4, 854	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	19, 990	1, 786	21, 776		192.00
194.00	07950 OTHER NONREI MBURSABLE	0	0	0	0		194.00
	07951 PAIN CLINIC	0	0	0	0		194.01
	07952 OCC HEALTH 07953 FOUNDATI ON	0	0	0	0		194.02 194.03
	07953 FOUNDATION 07954 PHYSICIAN OFFICES	0	5, 216	0	0 5, 216		194.03
	07955 COMMUNITY & VOLUNTEER SERVICES	0	954	124	1, 078		194.04
194.06	07956 VACANT SPACE	0	0	0	0		194.06
200.00					0		200.00
201.00	5	2, 013, 291	0 359, 679	0 455 117	0 3, 028, 087		201.00 202.00
202.00	IUTAL (SUM ITTHES IT8-201)	2,013,291	339, 0/9	655, 117	3, 028, 087	0	1202.00

LLOCA	TION OF CAPITAL RELATED COSTS	MUNITY HOSPT. OF	Provi der	CCN: 150146 Pe Fr Tc	eriod: com 01/01/2014 o 12/31/2014	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/22/2015 1:0	pared:
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS				1		
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
. 00 . 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
. 00	00500 ADMINISTRATIVE & GENERAL	2, 115, 242					5.00
. 00	00700 OPERATION OF PLANT	150, 129	265, 260				7.00
. 00	00800 LAUNDRY & LINEN SERVICE	15, 681	3, 472	22, 191			8.00
. 00	00900 HOUSEKEEPI NG	45, 962	5, 022	911	60, 297		9.00
0.00	01000 DI ETARY	37, 107	10, 338	32	2, 428	65, 289	10.00
1.00 2.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	7, 786	6, 687 0	32 0	1, 570 0	0	11.00 12.00
2.00	01300 NURSI NG ADMI NI STRATI ON	51, 660	1, 406	0	330	0	12.00
4.00	01400 CENTRAL SERVICES & SUPPLY	1, 119	12, 915	672	3, 033	0	14.00
5.00	01500 PHARMACY	11, 314	3, 808	0	894	0	15.00
5. 00	01600 MEDI CAL RECORDS & LI BRARY	504	5, 818	0	1, 366	0	16.00
7.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
9.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
0.00 1.00	02000 NURSING SCHOOL 02100 I & SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0	20.00
2.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21.00
3.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
0.00	03000 ADULTS & PEDIATRICS	275, 115	59, 733	7, 741	14, 028	65, 289	30.00
3. 00	04300 NURSERY	9, 559	873	22	205	0	43.00
D. 00	ANCI LLARY SERVI CE COST CENTERS	155, 328	45, 503	5, 835	10, 686	0	50.00
2.00	05200 DELIVERY ROOM & LABOR ROOM	50, 543	43, 503	22	1, 317	0	52.00
3.00	05300 ANESTHESI OLOGY	1,831	0,007	0	0	0	53.00
4.00	05400 RADI OLOGY-DI AGNOSTI C	237, 941	27, 250	2, 212	6, 399	0	54.00
4. 01	05401 CAT SCAN	0	0	0	0	0	54.01
). 00	06000 LABORATORY	173, 647	8, 037	55	1, 887	0	60.00
2.30 5.00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0 69, 370	0 6, 912	0 135	0 1, 623	0	62.30 65.00
5.00	06600 PHYSI CAL THERAPY	69, 370	2, 756	0	647	0	66.00
7.00	06700 OCCUPATI ONAL THERAPY	42, 029	2,700	0	0	0	67.00
3. 00	06800 SPEECH PATHOLOGY	15, 027	0	0	0	0	68.00
9.00	06900 ELECTROCARDI OLOGY	1, 040	575	0	135	0	69.00
I. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40, 338	0	0	0	0	71.00
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	32, 091	0	0	0	0	72.00
3.00 5.97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	188, 040 0	0	0	0	0	73.00
5. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
5. 99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS				1		
). 00	09000 CLINIC	3, 472	0	0	0	0	90.00
1.00	09100 EMERGENCY	147, 705	25, 438	4, 269	5, 974	0	91.00
2.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REIMBURSABLE COST CENTERS						92.00
5.00	09500 AMBULANCE SERVICES	229, 585	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS			I	-1	-	
18.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	2,063,705	232, 150	21, 938	52, 522	65, 289	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 476	3, 212	0	754		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	6, 852	22, 846	253	5, 365		192.00
	07950 OTHER NONREI MBURSABLE	0	0	0	0		194.00
	07951 PAIN CLINIC 07952 OCC HEALTH	0	0	0	0		194.01 194.02
	07953 FOUNDATI ON	7, 922	0	0	0		194.02
	07954 PHYSICIAN OFFICES	7, 722	5, 961	0	1, 400		194.03
	07955 COMMUNITY & VOLUNTEER SERVICES	32, 359	1, 091	0	256		194.05
94.06	07956 VACANT SPACE	215	0	0	0		194.06
00.00							200. 00
01.00	8	0	0	0	0		201.00
02.00	TOTAL (sum lines 118-201)	2, 115, 242	265, 260	22, 191	60, 297	65, 289	202.00

Health Financial Systems COMMU	JNITY HOSPT. 0	F NOBLE CTY, IN	IC.	In Lieu	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		riod: com 01/01/2014 12/31/2014	Worksheet B Part II Date/Time Pre	pared:
Cost Center Description	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	5/22/2015 1:0 PHARMACY	5 pm
	11.00	12.00	13.00	SUPPLY 14.00	15.00	
GENERAL SERVICE COST CENTERS		12100			10100	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11.00 01100 CAFETERIA	21, 926					11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON	C 781	0	56, 357			12.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	, U 1 C	-	0	29, 039		14.00
15. 00 01500 PHARMACY	679		0	495	84, 556	
16.00 01600 MEDI CAL RECORDS & LI BRARY	C		0	0	0	16.00
17.00 01700 SOCIAL SERVICE	C		0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS 20.00 02000 NURSING SCHOOL		0	0	0	0	19.00 20.00
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRV		0	0	0	0	20.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	C	-	0	0	0	22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	C	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS	4, 132			3, 862	82	•
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	171	0	976	0	0	43.00
50. 00 05000 OPERATING ROOM	2,003	0	11, 416	3, 836	1, 197	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	905			0	0	52.00
53.00 05300 ANESTHESI OLOGY	C	-	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 791		0	1, 181	13	54.00
54. 01 05401 CAT SCAN	C		0	0	0	54.01
60.00 06000 LABORATORY 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	C	-	0	0	0	60.00 62.30
65. 00 06500 RESPIRATORY THERAPY	1, 123		0	1, 089	0	65.00
66. 00 06600 PHYSI CAL THERAPY	971		0	481	5	66.00
67.00 06700 OCCUPATI ONAL THERAPY	588		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	202		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	C		0	0 12, 433	0	69.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	-	0	12, 435	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	0	578	82, 778	
76. 97 07697 CARDI AC REHABI LI TATI ON	C	0	0	0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	C	0	0	0	0	
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	C	0	0	0	0	76.99
90. 00 09000 CLINIC	57	0	0	22	0	90.00
91.00 09100 EMERGENCY	2, 678			2, 188	24	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REI MBURSABLE COST CENTERS	4 205			2 472	420	
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	4, 285	0	0	2, 473	439	95.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	21, 366	0	56, 357	28, 638	84. 538	118.00
NONREI MBURSABLE COST CENTERS	,	-			,	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	72			4		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	127			53		192.00
194. 00 07950 0THER_NONREIMBURSABLE 194. 01 07951 PALN_CLINIC	C		0	0		194. 00 194. 01
194. 02 07952 OCC HEALTH	C	-	-	0		194.01
194. 03 07953 FOUNDATI ON	120		0	0		194.03
194.04 07954 PHYSI CI AN OFFI CES	C	0	0	0	0	194.04
194. 05 07955 COMMUNI TY & VOLUNTEER SERVICES	241		0	344		194.05
194.06 07956 VACANT SPACE 200.00 Cross Foot Adjustments	C	0	0	0	0	194.06 200.00
200.00 ICTOSS FOOT AUJUSTINENTS 201.00 Negative Cost Centers	C	0	0	0	21.789	200.00
202.00 TOTAL (sum lines 118-201)	21, 926		56, 357	29, 039	106, 345	

	ncial Systems COMM OF CAPITAL RELATED COSTS	MUNITY HOSPT. 0			In Lie Period:	u of Form CMS-2 Worksheet B	2552-10
ALLOCATION	OF CAPITAL RELATED COSTS		Provider	F	From 01/01/2014 o 12/31/2014	Part II	pared: 5 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	ANESTHETI STS	NURSI NG SCHOOL	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES APPRV	
GENER	AL SERVICE COST CENTERS	16.00	17.00	19.00	20.00	21.00	
$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV I&RAENT	12, 778 0 0 0 0 0 0 0 0		C	0	0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 22.\ 00\\ \end{array}$
I NPAT	ENT ROUTINE SERVICE COST CENTERS		-				23.00
	ADULTS & PEDIATRICS	780					30. 00 43. 00
	LARY SERVICE COST CENTERS	1 200		1			E0.00
52.00 05200 53.00 05300 54.00 05400 54.01 05401	OPERATING ROOM DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY RADIOLOGY-DIAGNOSTIC CAT SCAN LABORATORY	1, 299 210 186 4, 051 0 1, 293					50.00 52.00 53.00 54.00 54.01 60.00
65.00 06500 66.00 06600 67.00 06700	BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY	0 456 224 83					62.30 65.00 66.00 67.00
69.00 06900 71.00 07100 72.00 07200 73.00 07300) SPEECH PATHOLOGY ELECTROCARDI OLOGY MEDI CAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS CARDI AC REHABILITATION	31 46 412 180 1,022					68. 00 69. 00 71. 00 72. 00 73. 00 76. 97
76. 98 07698	HYPERBARI C OXYGEN THERAPY	0					76. 98 76. 99
0UTPA 90. 00 09000 91. 00 09100	TI ENT SERVICE COST CENTERS CLINIC EMERGENCY	3					90. 00 91. 00
	BOBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS						92.00
	AMBULANCE SERVICES AL PURPOSE COST CENTERS	608	C				95.00
118.00	SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	12, 778	C	(0 0	0	118.00
190. 00 19000 192. 00 19200 194. 00 07950 194. 01 07951 194. 02 07952 194. 03 07953 194. 04 07954 194. 05 07955	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE PAIN CLINIC OCC HEALTH		0		0 0		190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 200. 00
200.00 201.00 202.00	Negative Cost Centers TOTAL (sum lines 118-201)	0 12, 778	C	C	0	0	200.00 201.00 202.00

From D14101020 Pri: L1	Heal th Financia ALLOCATION OF C	I Systems COMM CAPITAL RELATED COSTS	IUNITY HOSPT. OF			In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
Cost Contor Description Internet A BRS INPUS PARAED D PRAVED 20 Subtotal Prove A Subtotal Internet A BRS INPUS PARAED D PRAVED 20 Subtotal Internet A BRS INPUS PARAED 20 1.00 Option Sector Control Contro Control Contro Control Control Control Control Contro Control Con					F	rom 01/01/2014	Part II	narod
Loss Licenter Description RESIDENTS ERRIGES-BITUR PROVIDENTS PMARLE LD PROVIDENTS Subtratal Providents Internis Resident Stephtics Loss Environments 1.00 00100 CAP REL 0057 - RDD & FLAT 22.00 23.00 24.00 26.00 26.00 1.00 00100 CAP REL 0057 - RDD & FLAT 1.00 1.0						0 12/31/2014	5/22/2015 1:0	pareu: 15 pm
Internal. SERVICE COST CENTERS 22.00 23.00 24.00 25.00 26.00 1.00 DOUDQ CAP REL COST-BLUG & FIXT 1 <td>Cos</td> <td>st Center Description</td> <td>RESIDENTS SERVICES-OTHER PRGMCOSTS</td> <td></td> <td></td> <td>Residents Cost & Post Stepdown</td> <td>Total</td> <td></td>	Cos	st Center Description	RESIDENTS SERVICES-OTHER PRGMCOSTS			Residents Cost & Post Stepdown	Total	
1.00 DOTOD CAP REL COSTS-BLDG & FLYT 1.00 0.00 DOTOD CAP REL COSTS-BLDG & FLYT 2.0 4.00 DAUGO LIPLOYT I MAY ILS DEPARTIM MAT 2.0 0.00 DOLOD CAP REL COSTS-BLDG & FLYT 2.0 0.00 DOLOD CAP REL COSTS-MURPH MAT 1.0 0.00 DOLOD CAPEREL DISTS-MURPH MAT 1.0 0.00 DITOD CAPEREL DISTS MURPH MAT 1.0 0.00 DITOD CAPEREL DATS-MURPH CAPERATION 1.0 0.00 DITOD MARKENET IN STATION 1.0 1.00 DITOD CARESTER IN CR 1.0 0.00 DITOD MARKENET IN STATION 1.0 1.00 DITOD MARKENET IN STATION 1.0			22.00	23.00	24.00		26.00	
2.00 DOOD CAP RL COSTS-WHLF EQUIP 2.00 0.00 GOOD CAP RL COSTS-WHLF EQUIP 4.0 5.00 DOOD CAP RL COSTS-WHLF EQUIP 5.00 7.00 DOOD CAP RL COSTS-WHLF EQUIP 5.00 7.00 DOOD CAP RL COSTS-WHLF EQUIP 7.00 7.00 DOOD DOOD 7.00 7.00 DOOD DOOD 7.00 7.00 DOOD DO								
30:0 00 03000 ADULTS & PEDI ATRICS 52, 812 00 582, 812 00 430 ANO 04300 MRSERY 12, 607 0 12, 607 43.0 ANO 04300 MRSERY 562, 812 30.0 43.0 ANOLLLARY SERVICE COST CENTERS	1.00 00100 CAF 2.00 00200 CAF 4.00 00400 EMF 5.00 00500 AD 7.00 00700 OPE 8.00 00800 LAU 9.00 00900 HOL 10.00 01000 DI 11.00 01100 CAF 12.00 01200 MAI 13.00 01300 NUF 15.00 01400 CEN 15.00 01500 PHA 16.00 01900 NOF 20.00 02000 NUF 21.00 02000 NUF 21.00 02100 I & F 22.00 02200 I & F 23.00 02300 PAF	P REL COSTS-BLDG & FIXT P REL COSTS-MVBLE EQUI P PLOYEE BENEFITS DEPARTMENT MINISTRATIVE & GENERAL ERATION OF PLANT JNDRY & LINEN SERVICE JSEKEEPING ETARY FETERIA INTENANCE OF PERSONNEL RSING ADMINISTRATION VITRAL SERVICES & SUPPLY ARMACY DICAL RECORDS & LIBRARY CIAL SERVICE VPHYSICIAN ANESTHETISTS RSING SCHOOL R SERVICES-SALARY & FRINGES APPRV R SERVICES-OTHER PRGM COSTS APPRV RAMED ED PRGM-(SPECIFY)	0	0				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ \end{array}$
43.00 004300 NUESERY 12.607 0 12.607 43.00 ANCLLARY SERVICE COST CENTERS 366.603 0 366.603 0 68.664 0 68.664 0 68.664 52.00 53.00 00500 (PERTING ROM ALBOR ROM 68.664 0 68.664 0 68.664 0 68.664 0 68.664 52.00 53.00 00500 (PERTING ROM ALBOR ROM 53.00 0 513.400 0 513.400 0 64.01 54.01 513.400 0 0 0 62.3 66.00 0.0000 (PHS) (ALTSRAPY 115.417 0 115.417 66.02 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 65.00 15.26.00 15.26.00 15.26.00 15.26.00 15.26.00 65.06 66.00 66.00 66.00 66.00 65.01 67.00 0.00 65.03 67.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 <t< td=""><td></td><td></td><td></td><td></td><td>582 812</td><td>0</td><td>582 812</td><td>30.00</td></t<>					582 812	0	582 812	30.00
50. 00 050.00 0FEATING ROOM 366.603 0 366.603 50. 0 50. 00 60. 00 70. 70. 70. 70. 70 70. 70. 70. 70. 70. 70. 70. 70. 70. 70.								1
52.00 052.00 DELUVERY ROOM & LABOR ROOM 68.664 0 66.664 52.0 53.00 DS5400 RADIOLOGY-DI AGNOSTI C 513.400 0 54.0 54.01 DS401 RADIOLOGY-DI AGNOSTI C 513.400 0 0 0 54.0 54.01 DS401 CAT SCAN 0 0 0 0 0 0 54.0 60.00 GEORD LLEDRY THERAPY 1119.1951 0 0 0 62.2 0 0 0 62.2 0 0 0 62.2 0 0 0 62.2 0 0 0 62.2 0 64.70 66.0 68.00 68.00 68.00 68.00 66.0 68.00 66.0 68.00 66.0 68.00 66.0 68.00 66.0 68.00 66.0 68.00 66.0 68.00 68.00 68.00 68.00 68.00 68.00 68.00 70.00 70.00 72.00 72.00 72.00 72.00 <td></td> <td></td> <td></td> <td></td> <td><u> </u></td> <td></td> <td></td> <td>1 50.00</td>					<u> </u>			1 50.00
53.00 Dis300 ANESTHESI OLOGY 7,076 0 7,076 53.0 7,076 53.0 53.00 0 54.00 54.00 54.00 54.00 513.400 0 54.00 56.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00						-		
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60.00 0x000 LABORATORY 191, 951 00 191, 951 60.00 62.30 0x250 BLODD CLOTTING FOR HEMOPHILIACS 0 0 62.30 62.30 0x250 BLODD CLOTTING FOR HEMOPHILIACS 0 0 62.30 66.00 0x500 RESPI RATORY THERAPY 115, 417 0 115, 417 66.00 0x500 OCUPATIONAL THERAPY 42, 700 0 42, 700 67.00 0x500 OLLONAL THERAPY 42, 700 0 42, 700 69.00 0x600 ELECTROCARDIOLOCY 2, 299 0 2, 299 0 2, 299 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 32, 271 0 32, 271 72.0 73.00 07300 DRUGS CHARGED TO PATIENTS 272, 418 0 272, 418 73.0 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.5 9 0x698 HYREBRARIC COXYGEN THERAPY 0 2141, 288 0 241, 288	54.00 05400 RAE	DI OLOGY-DI AGNOSTI C			513, 400	0	513, 400	54.00
62.30 0c250 BLODD CLOTTING FOR HEMOPHILIACS 0 0 62.30 0 0 65.00 0 0 65.00 0 0 65.00 0 115,417 0 115,417 65.00 0 66.00 0 42,700 0 42,700 67.00 67.00 0 42,700 0 42,700 67.00 67.00 65.00 86.799 0 42,700 0 42,700 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.07 </td <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>-</td> <td></td> <td></td>					0	-		
65.00 06500 PESPI RATORY THERAPY 115, 417 0 115, 417 65.05 66.00 06600 PHYSI CAL THERAPY 86, 799 0 86, 799 66.05 67.00 06700 OCUPATIONAL THERAPY 42, 700 0 42, 700 67.05 68.00 06800 SPECH PATHOLOGY 15, 260 0 45, 209 62.05 69.00 69000 ECCROCARDIOLOGY 2, 299 0 2, 299 0 2, 299 0 2, 299 0 2, 299 0 2, 291 0 32, 211 0 32, 211 72.05 72.06 76.55 76.57 76.57 76.57 76.57 76.57 76.57 76.59					191, 951	-		
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71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 53, 183 0 53, 183 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 32, 271 0 32, 371 0	68.00 06800 SPE	EECH PATHOLOGY			15, 260	0	15, 260	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 32,271 0 32,271 72.00 73.00 07300 DRGS CHARGED TO PATIENTS 272,418 0 272,418 0 272,418 73.00 67.97 OR767 CARDIA C REHABILITATION 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.97 90.00 07609 LITHOTRI PSY 0 0 0 76.97 90.00 09000 CLI NI C 0 3,554 0 3,554 0 76.97 91.00 09000 CLI NI C 241,288 0 241,288 0 241,288 91.00 92.00 92501/AMBULANCE SERVI CES 91.00 92.01 92.00 92.01/AL PURPOSE COST CENTERS 92.00 92.01/AL PURPOSE COST CENTERS 92.01 92.01 92.01/AL PURPOSE COST CENTERS 92.01 92.01 92.01 92.01 92.01/AL PURPOSE COST CENTERS 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td></t<>						-		
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OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 3,554 0 3,554 90.0 91.00 09000 CLINIC 241,288 0 241,288 90.0 92.00 09500 AMBURSABLE COST CENTERS 0 241,288 0 241,288 90.0 0THER REI MBURSABLE COST CENTERS 0 271,418 0 271,418 95.00 09500 AMBULANCE SERVICES 0 2,879,720 0 2,879,720 118.00 NONREI MBURSABLE COST CENTERS 12,372 0 12,372 12,372 12,372 190.0 190.0 190.0 190.0 190.0 12,372 0 12,372 190.0 190.0 190.0 190.0 190.0 140.0 0 0 194.00 0 0 194.00 194.00 0 0 0 194.00 194.00 194.00 194.00 0 0 0 194.00 194.00 194.00 194.00 194.00 194.00 194.00					0	0	0	
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91.00 09100 EMERGENCY 241, 288 0 241, 288 91.0 92.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.0 92.0 92.0 0750 AMBULANCE SERVICES 271, 418 0 271, 418 92.0 92.0 09500 AMBULANCE SERVICES 271, 418 0 271, 418 92.0 95.0 09500 AMBURSABLE COST CENTERS 95.00 0 2, 879, 720 0 2, 879, 720 118.0 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 2, 879, 720 0 2, 879, 720 118.0 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12, 372 0 12, 372 190.0 190.0 12, 372 190.0 194.0 0 0 194.00 194.00 194.00 194.00 0 0 194.00 0 194.00 194.00 194.00 194.00 194.00 0 0 194.00 194.00 194.00 0 0 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 <t< td=""><td></td><td></td><td></td><td></td><td>2 554</td><td>0</td><td>2 55/</td><td></td></t<>					2 554	0	2 55/	
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 271,418 0 271,418 95.0 95.00 OPSOO AMBULANCE SERVICES 0 271,418 0 271,418 95.0 SPECI AL PURPOSE COST CENTERS 271,418 0 2,879,720 0 2,879,720 118.0 NONREI MBURSABLE COST CENTERS 0 2,879,720 0 2,879,720 12,372 190.0 12,372 190.0 12,372 190.0 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 194.01 0 0 0 0 194.02 194.00 0 0 0 194.00 194.00 194.00 0 0 0 194.00 194.00 194.00 0 0 0 194.00 194.00 0 0 0 0 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 0 0 0 194.00 194.00 194.00 194.00								
OTHER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 271,418 0 271,418 95.00 SPECIAL PURPOSE COST CENTERS TI8.00 SUBTOTALS SUBTOTALS SUM OF LINES 1-117) 0 0 2,879,720 0 2,879,720 118.00 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12,372 0 12,372 190.00 194.01 194.00 07950 OTHER NONREI MBURSABLE 0 0 0 194.00 194.00 0 0 0 194.00 194.01 07951 PAI N CLI NI C 0 0 0 194.00 194.02 07952 0CC HEALTH 0 0 0 194.02 07953 FOUNDATI ON 8,060 0 8,060 13,290 194.02 194.02 07955 0 35,369 0 35,369 13,290 194.02 194.02 07955 0 215 0 215					2,200			92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 2,879,720 0 2,879,720 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 2,879,720 0 2,879,720 118.00 NONREL MBURSABLE COST CENTERS 12,372 0 12,372 190.0 190.00 19200 PHYSI CI ANS' PRI VATE OFFICES 57,272 0 57,272 192.0 194.00 07950 OTHER NONREI MBURSABLE 0 0 0 194.0 194.01 07951 PAI N CLINIC 0 0 0 194.0 194.02 07952 OCC HEALTH 0 0 0 194.0 194.02 07953 FOUNDATION 8,060 0 8,060 194.0 194.04 07954 PHYSI CI AN OFFICES 13,290 0 13,290 194.0 194.05 07955 COMMUNITY & VOLUNTEER SERVICES 35,369 0 35,369 194.0 194.06 07956 VACANT S	OTHER REI	IMBURSABLE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 2,879,720 18.0 NONREI MEURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12,372 0 12,372 190.0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 57,272 0 57,272 192.0 194.0 194.00 07950 OTHER NONREI MBURSABLE 0 0 0 194.0 194.02 07952 OCC HEALTH 0 0 0 194.0 194.02 07953 FOUNDATION 8,060 0 8,060 194.0 194.03 07953 FOUNDATION 8,060 0 8,060 194.0 194.0 194.04 07954 PHYSI CI AN OFFICES 13,290 0 13,290 194.0 194.0 194.05 07955 COMMUNITY & VOLUNTEER SERVICES 35,369 0 35,369 194.0 194.00 215 0 215 194.00 200.00 205.00 205.00 2					271, 418	0	271, 418	95.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12, 372 0 12, 372 190. 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 57, 272 0 57, 272 192. 0 194. 00 07950 OTHER NONREI MBURSABLE 0 0 0 194. 0 194. 01 07951 PAI N CLI NI C 0 0 0 194. 0 194. 02 07952 OCC HEALTH 0 0 0 194. 0 194. 03 07953 FOUNDATION 8, 060 0 8, 060 194. 0 194. 04 07954 PHYSI CI AN OFFICES 13, 290 0 13, 290 194. 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 35, 369 0 35, 369 194. 0 194. 06 07956 VACANT SPACE 215 0 215 194. 0 194. 06 07956 VACANT SPACE 215 0 215 194. 0 200. 00 Cross Foot A					2 070 700		2 070 720	1110 00
190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12,372 0 12,372 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 57,272 0 57,272 192.00 194.00 07950 OTHER NONREI MBURSABLE 0 0 0 194.00 194.01 07951 PAI N CLI NI C 0 0 0 194.00 194.02 07952 OCC HEALTH 0 0 0 194.00 194.03 07953 FOUNDATI ON 8,060 0 8,060 194.00 194.04 07954 PHYSI CLAN OFFICES 13,290 0 13,290 194.00 194.05 07955 COMMUNITY & VOLUNTEER SERVICES 35,369 0 35,369 194.00 194.06 07956 VACANT SPACE 215 0 215 194.00 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 21,789 0 21,789 21,00			0	0	2,879,720	0	2, 879, 720	1118.00
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 57,272 0 57,272 192.0 194.00 07950 OTHER NONREI MBURSABLE 0 0 0 194.0 194.01 07951 PAIN CLINIC 0 0 0 194.0 194.02 07952 OCC HEALTH 0 0 0 194.0 194.03 07953 FOUNDATION 8,060 0 8,060 194.0 194.04 07954 PHYSI CLAN OFFICES 13,290 0 13,290 194.0 194.05 07955 COMMUNITY & VOLUNTEER SERVICES 35,369 0 35,369 194.00 194.06 07956 VACANT SPACE 215 0 215 194.00 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 0 21,789 201.00 21,789 201.00 21,789 201.00 21,789 201.00 21,789 201.00 0 21,789 201.00 0 0 0 0 0 0 0 0 0 0					12, 372	0	12, 372	190.00
194. 01 07951 PAIN CLINIC 0 0 194. 02 194. 02 07952 OCC HEALTH 0 0 194. 02 194. 03 07953 FOUNDATION 8,060 0 8,060 194. 02 194. 04 07954 PHYSI CLAN OFFICES 13, 290 0 13, 290 194. 02 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 35, 369 0 35, 369 194. 02 194. 05 07955 Cross Foot Adjustments 0 0 0 0 200. 00 Cross Foot Adjustments 0 0 0 201. 00 0 21, 789 0 21, 789 201. 00 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 0 21, 789 201. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0		
194. 02 07952 OCC HEALTH 0 0 194. 02 194. 03 07953 FOUNDATION 8, 060 0 8, 060 194. 02 194. 04 07954 PHYSI CI AN OFFICES 13, 290 0 13, 290 194. 02 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 35, 369 0 35, 369 194. 02 194. 06 07956 VACANT SPACE 215 0 215 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 0 21, 789 201. 00 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 21, 789 201. 00 0 0 21, 789 0 21, 789 0 21, 789 0 21, 789 0 21, 789 0 21, 789					0	0		
194. 03 07953 FOUNDATION 8,060 0 8,060 194. 0 194. 04 07954 PHYSICIAN OFFICES 13,290 0 13,290 194. 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 35,369 0 35,369 194. 0 194. 06 07956 VACANT SPACE 215 0 215 194. 0 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 21, 789 201. 00					0	0		
194.04 07954 PHYSI CLAN OFFICES 13,290 0 13,290 194.02 194.05 07955 COMMUNITY & VOLUNTEER SERVICES 35,369 0 35,369 194.02 194.06 07956 VACANT SPACE 215 0 215 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.02 201.00 Negative Cost Centers 0 0 21,789 21,789 21,789					0	0		
194.05 07955 COMMUNITY & VOLUNTEER SERVICES 35,369 0 35,369 194.0 194.06 07956 VACANT SPACE 215 0 215 194.0 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 21,789 0 21,789 21,789						0		
194.06 07956 VACANT SPACE 215 0 215 194.0 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 21,789 0 21,789 21,789						0		
201.00 Negative Cost Centers 0 0 21,789 0 21,789 201.0	194.0607956 VAC	CANT SPACE				0	215	194.06
			0	0	, °	0		200.00
		gative Cost Centers TAL (sum lines 118-201)	0					

ST ALLO	CATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	l
					To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
		CAPI TAL RE	LATED COSTS			0,22,2010 1.0	
	Cast Contar Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
	Cost Center Description		(DOLLAR VALUE)		Reconcination	& GENERAL	-
			(DOLLAR VALUE)	DEPARTMENT		(ACCUM COST)	
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	IERAL SERVICE COST CENTERS	L	-	1			÷.,
	00 CAP REL COSTS-BLDG & FIXT	117, 225					1
	200 CAP REL COSTS-MVBLE EQUI P		795, 567				2
	00 EMPLOYEE BENEFITS DEPARTMENT 00 ADMINISTRATIVE & GENERAL	30, 073) (2) 11,753			21 2/1 401	4
	00 OPERATION OF PLANT	11, 508					
	BOO LAUNDRY & LINEN SERVICE	990			0 0		
	POO HOUSEKEEPI NG	1, 432				464, 169	
	DOO DI ETARY	2, 948				374, 738	
00 011	00 CAFETERI A	1, 907				78, 634	11
00 012	200 MAINTENANCE OF PERSONNEL	C			0 0	0	12
	BOO NURSING ADMINISTRATION	401	1, 154	447, 22	6 0	521, 708	13
	OO CENTRAL SERVICES & SUPPLY	3, 683			0 0		
		1,086					
	00 MEDICAL RECORDS & LIBRARY	1,659				5, 090	
	700 SOCIAL SERVICE 200 NONPHYSICIAN ANESTHETISTS					0	
	000 NURSI NG SCHOOL						
	00 I &R SERVICES-SALARY & FRINGES APPRV					0	
	200 I &R SERVICES-OTHER PRGM COSTS APPRV				0 0	-	
	BOO PARAMED ED PRGM-(SPECIFY)				0 0		
	ATIENT ROUTINE SERVICE COST CENTERS						
00 030	000 ADULTS & PEDI ATRI CS	17, 034	92, 582	1, 997, 32	8 0	2, 778, 271	30
00 043	300 NURSERY	249) (76, 83	9 0	96, 537	43
	ILLARY SERVICE COST CENTERS	1	1		-1		
	DOO OPERATING ROOM	12, 976				1	
	200 DELIVERY ROOM & LABOR ROOM	1, 599					
	300 ANESTHESI OLOGY	0	0,110		0 0		
	100 RADI OLOGY-DI AGNOSTI C	7,771					
	IO1 CAT SCAN DOO LABORATORY	2 202					
	250 BLOOD CLOTTING FOR HEMOPHILIACS	2, 292				1, 753, 636 0	
	500 RESPIRATORY THERAPY	1, 971			0	700, 557	
	00 PHYSI CAL THERAPY	786				704, 723	
	OO OCCUPATIONAL THERAPY	0				424, 447	
	BOO SPEECH PATHOLOGY	0		106, 18		151, 757	
00 069	POO ELECTROCARDI OLOGY	164	t C		0 0	10, 505	69
	OO MEDICAL SUPPLIES CHARGED TO PATIENT	C			0 0		2 71
	200 IMPL. DEV. CHARGED TO PATIENTS	C) (0 0	021/077	
	BOO DRUGS CHARGED TO PATIENTS	C	0 0		0 0	1, 898, 995	
	97 CARDI AC REHABI LI TATI ON	C			0 0	0	
	98 HYPERBARI C OXYGEN THERAPY	0			0 0		
	999 LITHOTRIPSY PATIENT SERVICE COST CENTERS	L C	<u>и (</u>	<u>и</u> (0 0	0	76
	DOO CLINIC			27, 86	2 0	35, 064	90
00 090	00 EMERGENCY	7, 254					
	200 OBSERVATION BEDS (NON-DISTINCT PART	1,204	10,000	1, 102, 00		1, 171, 004	92
	IER REI MBURSABLE COST CENTERS						1 .
. 00 095	OO AMBULANCE SERVI CES	C	41, 323	1, 733, 28	7 0	2, 318, 546	95
SPE	CIAL PURPOSE COST CENTERS						
3. 00	SUBTOTALS (SUM OF LINES 1-117)	107, 783	3 790, 766	16, 632, 22	6 -12, 099, 323	20, 841, 020	118
	IREI MBURSABLE COST CENTERS			1	-1		
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	916					
	200 PHYSI CLANS' PRI VATE OFFI CES	6, 515	2, 169	37, 23	7 0		
	250 OTHER NONREIMBURSABLE 251 PAIN CLINIC) 194) 194
	252 OCC HEALTH						194
	253 FOUNDATION					80, 004	
	254 PHYSICIAN OFFICES	1, 700		1, 72	8 N	7, 204	
	255 COMMUNITY & VOLUNTEER SERVICES	311				326, 786	
	256 VACANT SPACE	()		00,04	- 	2, 170	
D. 00	Cross Foot Adjustments					2, 0	200
1.00	Negative Cost Centers	1					201
2.00	Cost to be allocated (per Wkst. B,	359, 679	655, 117	2, 520, 84	9	12, 099, 323	
	Part I)						
3.00	Unit cost multiplier (Wkst. B, Part I)	3. 068279	0. 823459	0. 15024	7	0. 566408	
4.00	Cost to be allocated (per Wkst. B,	1	1	1 (2, 115, 242	1204

Health Financial Systems COM	MUNITY HOSPT. OF	NOBLE CTY, IN	IC.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
				Γο 12/31/2014	Date/Time Pre 5/22/2015 1:0	pared: 5 pm
	CAPITAL RELA	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET) (I	MVBLE EQUIP DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM COST)	
	1.00	2.00	4.00	5A	5.00	
205.00 Unit cost multiplier (Wkst. B, Part			0.00000		0. 099021	205.00

JST AL	LOCATION - STATISTICAL BASIS		F NOBLE CTY, IN Provider	CCN: 150146 P	eriod:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2014 o 12/31/2014	Date/Time Pre	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	5/22/2015 1:0 CAFETERIA (HOURS WORKED)	5 pm
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	75, 644 990 1, 432 2, 948 1, 907 0 401 3, 683	291, 335 11, 961 415 414 0 0	73, 222 2, 948 1, 907 0 401		396, 286 0 14, 108 0	1. 2. 4. 5. 7. 8. 9. 10. 11. 12. 13. 14.
5.00 6.00 7.00 9.00 0.00 1.00 2.00 3.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0,086 1,086 0 0 0 0 0 0 0 0 0	0	1, 086 1, 659 0 0 0 0 0 0 0	Ű	12, 271 0 0 0 0 0 0 0	15. 16. 17. 19. 20. 21. 22. 23.
o. oo 🛛	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	17,034				74, 682	30. 43.
0. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	12, 976	76, 602	12, 976		3, 097 36, 209 16, 348	50.
3.00 4.00 4.01	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 CAT SCAN	0 7, 771 0	0 29, 036 0	0 7, 771 0	0 0 0	0 50, 451 0	53. 54. 54.
2.30	06000 LABORATORY 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS	2, 292	0	0	0	0 0	60. 62.
6. 00 7. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1,971 786 0	0	786 0		20, 296 17, 543 10, 624	66. 67.
9.00 1.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0 164 0	0		0 0 0	3, 656 0 0 0	68 69 71 72
3.00 5.97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY		0		0	0 0 0	73 76
	07699 LITHOTRIPSY DUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76
0.00 1.00 2.00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 7, 254				1, 029 48, 409	
5.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	0	77, 465	95
18.00	SUBTOTALS (SUM OF LINES 1-117)	66, 202	288, 020	63, 780	30, 945	386, 188	118
90.00 92.00 94.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFICES 07950 OTHER NONREI MBURSABLE 07951 PAIN CLINIC	916 6, 515 0		916 6, 515 0			
4.02 4.03 4.04	07951 PAIN CLINIC 07952 OCC HEALTH 07953 FOUNDATION 07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES	0 0 0 1, 700 311		0 0 0 1, 700 311		0 2, 160	194 194 194
4.06 0.00 1.00	07956 VACANT SPACE Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	194 200 201
)2.00)3.00)4.00	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	2, 374, 880 31. 395484 265, 260	0. 958120	10. 700281	22. 992050	203, 846 0. 514391 21, 926	203
04.00 05.00	Part II) Unit cost multiplier (Wkst. B, Part II)	3. 506689				0. 055329	

OST ALI	Financial Systems COMM LOCATION - STATISTICAL BASIS		F NOBLE CTY, IN Provider	CCN: 150146	Peri od:	Worksheet B-1	2552-
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL (MEALS SERVED)	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	
			(DIRECT NRSING	(COSTED	REGUIS. J	(GROSS	
			HRS)	REQUIS.)		REVENUE)	
-		12.00	13.00	14.00	15.00	16.00	
	ENERAL SERVICE COST CENTERS						1 1
	0200 CAP REL COSTS-BEDG & FIXT						1.
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
	00500 ADMI NI STRATI VE & GENERAL						5.
. 00 0	00700 OPERATION OF PLANT						7.0
	00800 LAUNDRY & LINEN SERVICE						8.
	00900 HOUSEKEEPI NG 01000 DI ETARY						9.0
	01000 DIETARI 01100 CAFETERIA						10.
	1200 MAINTENANCE OF PERSONNEL	C					12.
	1300 NURSING ADMINISTRATION	C	178, 745				13.
	1400 CENTRAL SERVICES & SUPPLY	C	0	1, 713, 76			14.
	1500 PHARMACY	C	0	29, 19			15.0
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0		0 0	143, 730, 561	16.
	1700 SOCIAL SERVICE 1900 NONPHYSICIAN ANESTHETISTS		0			0	17. 19.
	2000 NURSI NG SCHOOL		0		0 0	0	20.
	22100 I &R SERVICES-SALARY & FRINGES APPRV	C	0		0 0	0	21.
	2200 I&R SERVICES-OTHER PRGM COSTS APPRV	C	0		0 0	0	22.
	2300 PARAMED ED PRGM-(SPECIFY)	C	0		0 0	0	23.
	NPATIENT ROUTINE SERVICE COST CENTERS		7. (00)			0.7/4.040	1
	3000 ADULTS & PEDIATRICS			227, 94		8, 761, 810	
-	04300 NURSERY NCI LLARY SERVI CE COST CENTERS		3, 097		0 0	416, 426	43.
	15000 OPERATI NG ROOM	C	36, 209	226, 40	4 27, 103	14, 600, 777	50.
	05200 DELIVERY ROOM & LABOR ROOM	C			0 0	2, 359, 572	
3. 00 0	5300 ANESTHESI OLOGY	C	0		0 0	2, 090, 381	53.
	05400 RADI OLOGY-DI AGNOSTI C	C	0	69, 72		45, 671, 482	54.
	05401 CAT SCAN	C	0		0 0	0	54.
	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0		0 0 0 0	14, 530, 656 0	60. 62.
	6500 RESPIRATORY THERAPY		0	64, 27	0	5, 128, 817	
	06600 PHYSI CAL THERAPY	C	0	28, 40		2, 514, 815	
7.00 0	06700 OCCUPATI ONAL THERAPY	C	0		0 0	936, 652	67.
	06800 SPEECH PATHOLOGY	C	0		0 0	346, 342	
		C	0	700 (7	0 0	516, 673	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		0	733, 67	5 0	4, 625, 006 2, 022, 277	
	7300 DRUGS CHARGED TO PATIENTS		0	34, 11	7 1, 874, 763	11, 485, 153	
	07697 CARDI AC REHABI LI TATI ON		0	0.1, 1.1	0 0		76.
	7698 HYPERBARI C OXYGEN THERAPY	C	0		0 0	0	
	07699 LI THOTRI PSY	C	0		0 0	0	76.
-	UTPATIENT SERVICE COST CENTERS	-	-1				
	99000 CLI NI C 99100 EMERGENCY	C	1	1, 29		33, 442	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	C	48, 409	129, 12	9 548	20, 860, 509	91. 92.
	THER REIMBURSABLE COST CENTERS		<u> </u>				/2.
	99500 AMBULANCE SERVICES	C	0	145, 92	5 9, 948	6, 829, 771	95.
S	PECIAL PURPOSE COST CENTERS	-					
18.00	SUBTOTALS (SUM OF LINES 1-117)	C	178, 745	1, 690, 07	6 1, 914, 617	143, 730, 561	118.
	ONREI MBURSABLE COST CENTERS						1
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1	25			190.
	9200 PHYSI CLANS' PRI VATE OFFI CES 07950 OTHER NONRELMBURSABLE			3, 10			192. 194.
	77951 PAIN CLINIC		0		0 0		194.
	07952 OCC HEALTH		0		0 0		194.
4.030	7953 FOUNDATI ON	C	0		0 410		194.
	7954 PHYSI CI AN OFFI CES	C	0		0 0		194.
	07955 COMMUNITY & VOLUNTEER SERVICES		0	20, 32	9 0		194.
4.060 0.00	07956 VACANT SPACE Cross Foot Adjustments	C	0		0	0	194.
1.00	Negative Cost Centers						200.
2.00	Cost to be allocated (per Wkst. B,	C	841, 346	181, 18	9 234, 093	77, 810	
	Part I)		,			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
03.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	1 1	0. 10572		0.000541	
04.00	Cost to be allocated (per Wkst. B,	C	56, 357	29, 03	9 106, 345	12, 778	204.
05.00	Part II) Unit cost multiplier (Wkst. B, Part	0.000000	0.045000	0.04/01		0 000000	205
	LUDIT COST MULTIDULER (WKST – B. Part	0. 000000	0. 315293	0.01694	5 0.044154	0.000089	1205

T AL	Financial Systems COMM LOCATION - STATISTICAL BASIS		Provi der		eriod:	Worksheet B-1	
				F	rom 01/01/2014 o 12/31/2014		
		_			0 12/31/2014	5/22/2015 1:0	
					INTERNS &	RESI DENTS	
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN		SERVI CES-SALAR		
	cost center bescription	SUCIAL SERVICE	ANESTHETI STS	NURSING SCHOOL	Y & FRINGES	PRGM COSTS	
		(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
			TIME)	TIME)	(ASSI GNED	(ASSI GNED	
		17.00	19.00	20.00	TIME) 21.00	TI ME) 22.00	-
0	GENERAL SERVICE COST CENTERS	17.00	19.00	20.00	21.00	22.00	
	DO100 CAP REL COSTS-BLDG & FIXT						1 -
0 0	DO200 CAP REL COSTS-MVBLE EQUIP						:
	DO400 EMPLOYEE BENEFITS DEPARTMENT						
	DO500 ADMINISTRATIVE & GENERAL						
	DO700 OPERATION OF PLANT DO800 LAUNDRY & LINEN SERVICE						
	DO900 HOUSEKEEPING						
	D1000 DI ETARY						1
	D1100 CAFETERI A						1
	D1200 MAINTENANCE OF PERSONNEL						12
	D1300 NURSING ADMINISTRATION						13
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14
	D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY						1!
	D1700 SOCIAL SERVICE	0					1
	D1900 NONPHYSICIAN ANESTHETISTS	0	C				10
	D2000 NURSI NG SCHOOL	0		0			20
	D2100 I &R SERVICES-SALARY & FRINGES APPRV	0			0		2
	D2200 I &R SERVICES-OTHER PRGM COSTS APPRV	0				0	1
	D2300 PARAMED ED PRGM-(SPECIFY)	0					2:
	NPATIENT ROUTINE SERVICE COST CENTERS	0		0	0	0	30
	04300 NURSERY	0		0		0	
-	ANCI LLARY SERVICE COST CENTERS			-	-	-	
00 0	D5000 OPERATING ROOM	0	C			0	50
	D5200 DELIVERY ROOM & LABOR ROOM	0	C	-		0	52
	05300 ANESTHESI OLOGY	0	C	0	-	0	5
	D5400 RADI OLOGY-DI AGNOSTI C D5401 CAT SCAN	0				0	54 54
	D6000 LABORATORY	0			-	0	6
	D6250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	-	0	6
00 0	06500 RESPI RATORY THERAPY	0	C	0	0	0	6
	D6600 PHYSI CAL THERAPY	0	C	0	0	0	66
	06700 OCCUPATI ONAL THERAPY	0	C	0	0	0	6
	06800 SPEECH PATHOLOGY	0		0	0	0	68
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			0	0	6º
	07200 IMPL. DEV. CHARGED TO PATIENTS				-	0	
	D7300 DRUGS CHARGED TO PATIENTS	0			0	0	
	D7697 CARDI AC REHABI LI TATI ON	0	c	0	0	0	70
	07698 HYPERBARI C OXYGEN THERAPY	0	C	0	0	0	7
	07699 LI THOTRI PSY	0	C	0	0	0	70
	DUTPATIENT SERVICE COST CENTERS					0	
	D9000 CLINIC D9100 EMERGENCY	0		0	0	0	
	D9200 OBSERVATION BEDS (NON-DISTINCT PART			, 		0	9
	OTHER REIMBURSABLE COST CENTERS				I		1
00	09500 AMBULANCE SERVICES	0	C	0	0	0	9!
	SPECIAL PURPOSE COST CENTERS						Ι.
. 00	SUBTOTALS (SUM OF LINES 1-117)	0	C	0	0	0	118
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES				0		19
	07950 OTHER NONREIMBURSABLE	0			0		194
	D7951 PAIN CLINIC	0		o o	0		194
. 02	07952 OCC HEALTH	0	C	0	0	0	194
	07953 FOUNDATION	0	C	0	0		194
	07954 PHYSI CI AN OFFI CES	0	L C	0	0		194
	07955 COMMUNITY & VOLUNTEER SERVICES	0		0	0		194
. 06 (07956 VACANT SPACE Cross Foot Adjustments	0	C	ין ⁰	0		194 200
. 00	Negative Cost Centers						200
. 00	Cost to be allocated (per Wkst. B,	0	r		0		201
	Part I)			Ĭ	Ĭ	0	[⁻³²
00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000	0. 000000	0.00000	203
. 00		0.000000	0.000000	0.000000	0.000000	0.000000	1-00

Health Financial Systems CC	MMUNITY HOSPT. O	F NOBLE CTY, I	NC.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014		
					5/22/2015 1:0	5 pm
				INTERNS &	RESI DENTS	
Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	
		ANESTHETI STS		Y & FRINGES	PRGM COSTS	
	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
		TIME)	TIME)	(ASSI GNED	(ASSI GNED	
		, í	í í	TIME)	TIME)	
	17.00	19.00	20.00	21.00	22.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0.00000	0. 000000	0.000000	205.00
1)						

ST ALLOCA	TION - STATISTICAL BASIS		Provider CCN: 150146	Period: From 01/01/2014	Worksheet B-1
				To 12/31/2014	Date/Time Prepare 5/22/2015 1:05 pt
	Cost Center Description	PARAMED ED PRGM			<u>- 372272013 1.03 p</u>
		(ASSI GNED			
		TI ME) 23.00			
	RAL SERVICE COST CENTERS				1
00 0020	CAP REL COSTS-MVBLE EQUIP				2
	D EMPLOYEE BENEFITS DEPARTMENT				4
) ADMINISTRATIVE & GENERAL) OPERATION OF PLANT				5
	D LAUNDRY & LINEN SERVICE				8
	D HOUSEKEEPI NG				9
	D DI ETARY D CAFETERI A				10
	MAINTENANCE OF PERSONNEL				12
	D NURSING ADMINISTRATION				13
	D CENTRAL SERVI CES & SUPPLY				14
	D MEDICAL RECORDS & LIBRARY				16
	D SOCIAL SERVICE				17
	D NONPHYSI CI AN ANESTHETI STS D NURSI NG SCHOOL				19
	DI&R SERVICES-SALARY & FRINGES APPRV				20
	0 I&R SERVICES-OTHER PRGM COSTS APPRV				22
	O PARAMED_ED_PRGM-(SPECIFY) TIENT_ROUTINE_SERVICE_COST_CENTERS	0			23
	D ADULTS & PEDIATRICS	0			30
	D NURSERY	0			43
	LARY SERVICE COST CENTERS	0			EC
) OPERATING ROOM) DELIVERY ROOM & LABOR ROOM	0			50 52
	ANESTHESI OLOGY	0			53
	D RADI OLOGY-DI AGNOSTI C	0			54
	1 CAT SCAN D LABORATORY	0			54 60
	BLOOD CLOTTING FOR HEMOPHILIACS	0			62
		0			65
1	D PHYSI CAL THERAPY D OCCUPATI ONAL THERAPY	0			66
	SPEECH PATHOLOGY	0			68
	D ELECTROCARDI OLOGY	0			69
	D MEDICAL SUPPLIES CHARGED TO PATIENT DIMPL. DEV. CHARGED TO PATIENTS	0			71
	D DRUGS CHARGED TO PATIENTS	0			73
	7 CARDI AC REHABI LI TATI ON	0			76
	B HYPERBARI C OXYGEN THERAPY 9 LI THOTRI PSY	0			76
	ATIENT SERVICE COST CENTERS	0			
. 00 0900		0			90
	D EMERGENCY D OBSERVATION BEDS (NON-DISTINCT PART	0			91 92
	R REIMBURSABLE COST CENTERS				
	D AMBULANCE SERVICES	0			95
8. 00	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	0			118
	EI MBURSABLE COST CENTERS	0			
	D GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190
	D PHYSI CLANS' PRI VATE OFFI CES D OTHER NONREI MBURSABLE	0			192 194
	PAIN CLINIC	0			194
		0			194
	3 FOUNDATION 4 PHYSICIAN OFFICES	0			194 194
	5 COMMUNITY & VOLUNTEER SERVICES	0			194
4.060795	6 VACANT SPACE	0			194
0.00	Cross Foot Adjustments				200
1.00 2.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	o			201 202
	Part I)				
3.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000			203
4.00	Cost to be allocated (per Wkst. B, Part II)				204
5.00	Unit cost multiplier (Wkst. B, Part	0. 000000			205

Health Financial Systems COMM	UNITY HOSPT. 0	F NOBLE CTY, IN	VC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/22/2015 1:0	pared: 5 pm
		Titl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	i	-	1			
30. 00 03000 ADULTS & PEDI ATRI CS	6, 296, 856		6, 296, 8		6, 296, 856	
43. 00 04300 NURSERY	178, 373		178, 3	73 0	178, 373	43.00
ANCI LLARY SERVICE COST CENTERS	i	1				
50.00 05000 OPERATING ROOM	3, 300, 968		3, 300, 90		3, 300, 968	
52.00 05200 DELIVERY ROOM & LABOR ROOM	953, 768		953, 76		953, 768	
53. 00 05300 ANESTHESI OLOGY	30, 094		30, 09		38, 047	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 177, 032		4, 177, 03	32 0	4, 177, 032	
54.01 05401 CAT SCAN	0			0 0	0	
60. 00 06000 LABORATORY	2, 851, 944		2, 851, 94	14 0	2, 851, 944	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	1, 202, 042				1, 202, 042	
66. 00 06600 PHYSI CAL THERAPY	1, 150, 371		1, 150, 3		1, 150, 371	
67.00 06700 OCCUPATI ONAL THERAPY	670, 829		670, 82		670, 829	
68.00 06800 SPEECH PATHOLOGY	239, 781		239, 78		239, 781	
69. 00 06900 ELECTROCARDI OLOGY	23, 639		23, 63		23, 639	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	718, 183		718, 18		718, 183	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	508, 734		508, 73		508, 734	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 213, 593		3, 213, 59	93 0	3, 213, 593	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
76. 99 07699 LI THOTRI PSY	0)		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	55, 609		55, 60		55, 609	
91.00 09100 EMERGENCY	2, 973, 368		2, 973, 30		2, 973, 368	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 169, 108		1, 169, 10	08	1, 169, 108	92.00
OTHER REI MBURSABLE COST CENTERS	1	1	1			
95. 00 09500 AMBULANCE SERVICES	3, 691, 975		3, 691, 9		3, 691, 975	
200.00 Subtotal (see instructions)	33, 406, 267				33, 414, 220	
201.00 Less Observation Beds	1, 169, 108		1, 169, 10		1, 169, 108	
202.00 Total (see instructions)	32, 237, 159	0	32, 237, 15	59 7, 953	32, 245, 112	202.00

	UNITY HOSPT. OF				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/22/2015 1:0	pared: 5 pm
		Ti tl	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 383, 473		7, 383, 4	73		30.00
43.00 04300 NURSERY	416, 426		416, 4	26		43.00
ANCI LLARY SERVI CE COST CENTERS			_			
50.00 05000 OPERATING ROOM	4, 268, 026	10, 332, 751	14, 600, 7	0. 226082	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 265, 627	93, 945	2, 359, 5	0. 404212	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	558, 848	1, 531, 533	2, 090, 3	0. 014396	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 081, 789	41, 589, 693	45, 671, 4	0. 091458	0.000000	54.00
54.01 05401 CAT SCAN	0	0		0 0.000000	0.000000	54.01
60. 00 06000 LABORATORY	2, 829, 089	11, 701, 567	14, 530, 6	56 0. 196271	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000	0.000000	62.30
65. 00 06500 RESPI RATORY THERAPY	1, 566, 299	3, 562, 518	5, 128, 8	0. 234370	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	254, 508	2, 260, 307	2, 514, 8	0. 457438	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	16, 979	919, 673	936, 6	52 0. 716199	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	25, 025	321, 317	346, 3	42 0. 692324	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	423, 707	92, 966			0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 443, 738	3, 181, 268	4, 625, 0	0. 155283	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 465, 802	556, 475	2, 022, 2	0. 251565	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 049, 179	6, 435, 974	11, 485, 1	53 0. 279804	0.000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0.000000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0.000000	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS			-			
90. 00 09000 CLINIC	3, 105	30, 337			0.00000	
91. 00 09100 EMERGENCY	2, 300, 732	18, 559, 777			0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 378, 337	1, 378, 3	0. 848202	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	6, 829, 771		0. 540571	0.000000	
200.00 Subtotal (see instructions)	34, 352, 352	109, 378, 209	143, 730, 5	51		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	34, 352, 352	109, 378, 209	143, 730, 5	61		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pr 5/22/2015 1:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS					30.0
3. 00 04300 NURSERY					43.0
ANCI LLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM	0. 226082				50. C
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 404212				52.0
3. 00 05300 ANESTHESI OLOGY	0. 018201				53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 091458				54.0
4.01 05401 CAT SCAN	0. 000000				54.0
0. 00 06000 LABORATORY	0. 196271				60.0
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.3
5. 00 06500 RESPI RATORY THERAPY	0. 234370				65.0
6. 00 06600 PHYSI CAL THERAPY	0. 457438				66. (
7. 00 06700 OCCUPATI ONAL THERAPY	0. 716199				67.0
8.00 06800 SPEECH PATHOLOGY	0. 692324				68.0
9. 00 06900 ELECTROCARDI OLOGY	0.045752				69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 155283				71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 251565				72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 279804				73.0
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.
6. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76.9
6. 99 07699 LI THOTRI PSY	0. 000000				76.9
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC	1. 662849				90.0
1. 00 09100 EMERGENCY	0. 142536				91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 848202				92.0
OTHER REIMBURSABLE COST CENTERS					-
5. 00 09500 AMBULANCE SERVICES	0, 540571				95.0
00.00 Subtotal (see instructions)					200.0
01.00 Less Observation Beds					201.0
02.00 Total (see instructions)					202.0

Health Financial Systems COMM	UNITY HOSPT. 0	F NOBLE CTY, IN	VC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/22/2015 1:0	pared: 5 pm
		Tit	le XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 03000 ADULTS & PEDI ATRI CS	6, 296, 856		6, 296, 8		6, 296, 856	•
43. 00 04300 NURSERY	178, 373		178, 3	73 0	178, 373	43.00
ANCI LLARY SERVI CE COST CENTERS	1	1	1	- i		
50.00 05000 OPERATING ROOM	3, 300, 968		3, 300, 90		3, 300, 968	
52.00 05200 DELIVERY ROOM & LABOR ROOM	953, 768		953, 76		953, 768	
53. 00 05300 ANESTHESI OLOGY	30, 094		30, 04		38, 047	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 177, 032		4, 177, 03	32 0	4, 177, 032	
54.01 05401 CAT SCAN	0			0 0	0	54.01
60. 00 06000 LABORATORY	2, 851, 944		2, 851, 94	14 0	2, 851, 944	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	1, 202, 042				1, 202, 042	
66. 00 06600 PHYSI CAL THERAPY	1, 150, 371		1, 150, 3		1, 150, 371	
67.00 06700 OCCUPATI ONAL THERAPY	670, 829		670, 82		670, 829	•
68.00 06800 SPEECH PATHOLOGY	239, 781		239, 78		239, 781	
69. 00 06900 ELECTROCARDI OLOGY	23, 639		23, 63		23, 639	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	718, 183		718, 18		718, 183	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	508, 734		508, 73		508, 734	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 213, 593		3, 213, 59	93 0	3, 213, 593	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	55, 609		55, 60		55, 609	
91. 00 09100 EMERGENCY	2, 973, 368		2, 973, 30		2, 973, 368	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 169, 108		1, 169, 10	08	1, 169, 108	92.00
OTHER REIMBURSABLE COST CENTERS	1	1				4
95. 00 09500 AMBULANCE SERVI CES	3, 691, 975		3, 691, 9		3, 691, 975	
200.00 Subtotal (see instructions)	33, 406, 267				33, 414, 220	
201.00 Less Observation Beds	1, 169, 108		1, 169, 10		1, 169, 108	
202.00 Total (see instructions)	32, 237, 159	0	32, 237, 1	59 7, 953	32, 245, 112	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGE	COMMUNI TY HOSE	PT. OF		IC. CCN: 150146	In Lie Period:	u of Form CMS- Worksheet C	2552-10
COMPUTATION OF RATIO OF CUSTS TO CHARGE	5		Provider	CCN: 150146	From 01/01/2014	Part I	
					To 12/31/2014	Date/Time Pre	epared:
			T: +	le XIX	lleonitel	5/22/2015 1:0 PPS)5 pm
			Charges		Hospi tal	PP5	
Cost Center Description	Inpatie	nt	Outpati ent	Total (col	6 Cost or Other	TEFRA	
cost center bescription	Theatre		outpatrent	+ col. 7	Ratio	Inpatient	
					nu tro	Ratio	
	6.00		7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST C							
30. 00 03000 ADULTS & PEDI ATRI CS	7, 38	3, 473		7, 383, 4	73		30.00
43.00 04300 NURSERY	41	6, 426		416, 4	26		43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATI NG ROOM	4, 26	8, 026	10, 332, 751	14, 600, 7	0. 226082	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 26	5, 627	93, 945	2, 359, 5	0. 404212	0.000000	52.00
53.00 05300 ANESTHESI OLOGY	55	8, 848	1, 531, 533	2, 090, 3	0. 014396	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4,08	1, 789	41, 589, 693	45, 671, 4	B2 0. 091458	0.000000	54.00
54.01 05401 CAT SCAN		0	0		0 0.000000	0.000000	54.01
60. 00 06000 LABORATORY	2,82	9, 089	11, 701, 567	14, 530, 6	56 0. 196271	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHIL	I ACS	0	0		0 0.000000	0.000000	62.30
65. 00 06500 RESPI RATORY THERAPY	1, 56	6, 299	3, 562, 518	5, 128, 8	0. 234370	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY		4, 508	2, 260, 307	2, 514, 8		0.00000	
67.00 06700 OCCUPATI ONAL THERAPY		6, 979	919, 673	936, 6		0.00000	
68.00 06800 SPEECH PATHOLOGY		5, 025	321, 317			0.00000	
69. 00 06900 ELECTROCARDI OLOGY		3, 707	92, 966			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO		3, 738	3, 181, 268			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIE		5, 802	556, 475			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 04	9, 179	6, 435, 974	11, 485, 1		0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON		0	0		0 0. 000000	0. 000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0	0		0 0. 000000	0. 000000	
76. 99 07699 LI THOTRI PSY		0	0		0 0.000000	0. 000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C		3, 105	30, 337			0.00000	
91.00 09100 EMERGENCY		0, 732	18, 559, 777			0.00000	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI	NCT PART	0	1, 378, 337	1, 378, 3	0. 848202	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS							-
95.00 09500 AMBULANCE SERVICES		0	6, 829, 771			0.00000	
200.00 Subtotal (see instructions)	34, 35	2, 352	109, 378, 209	143, 730, 5	61		200.00
201.00 Less Observation Beds							201.00
202.00 Total (see instructions)	34, 35	2,352	109, 378, 209	143, 730, 5	61		202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/22/2015 1:0	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
0.00 03000 ADULTS & PEDIATRICS					30.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM	0. 226082				50. C
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 404212				52. C
3. 00 05300 ANESTHESI OLOGY	0. 018201				53. C
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 091458				54. C
4. 01 05401 CAT SCAN	0. 000000				54.0
0. 00 06000 LABORATORY	0. 196271				60.0
2. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.3
5. 00 06500 RESPI RATORY THERAPY	0. 234370				65.0
6. 00 06600 PHYSI CAL THERAPY	0. 457438				66.0
7.00 06700 OCCUPATI ONAL THERAPY	0. 716199				67.0
8.00 06800 SPEECH PATHOLOGY	0. 692324				68.0
9. 00 06900 ELECTROCARDI OLOGY	0. 045752				69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 155283				71.0
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 251565				72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 279804				73.0
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.
6. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76.9
6. 99 07699 LI THOTRI PSY	0. 000000				76.9
OUTPATIENT SERVICE COST CENTERS	0.000000				
0. 00 09000 CLINIC	1. 662849				90.0
1. 00 09100 EMERGENCY	0. 142536				91.0
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 848202				92.0
OTHER REIMBURSABLE COST CENTERS	0.010202				
5. 00 09500 AMBULANCE SERVICES	0, 540571				95.0
00.00 Subtotal (see instructions)	0. 540571				200.0
01.00 Less Observation Beds					200.0
02.00 Total (see instructions)					1201.0

Health Financial Systems COM	MUNITY HOSPT. OF	F NOBLE CTY, I	NC.	In Lie	eu of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provi der	CCN: 150146	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICALD ONLY				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
		Ti t	le XIX	Hospi tal	PPS	5 piii
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1	- 1		
50. 00 05000 OPERATI NG ROOM	3, 300, 968				0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	953, 768				0	52.00
53. 00 05300 ANESTHESI OLOGY	30, 094				0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 177, 032				0	54.00
54.01 05401 CAT SCAN	0			0 0	0	54.01
60. 00 06000 LABORATORY	2, 851, 944		1	03 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	1, 202, 042				0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 150, 371				0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	670, 829				0	67.00
68.00 06800 SPEECH PATHOLOGY	239, 781				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	23, 639				0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	718, 183				0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	508, 734				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 213, 593	272, 418	2, 941, 17	/5 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C	D	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	()	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	55 (00	0.55	50.05			
90. 00 09000 CLINIC	55, 609					90.00
91.00 09100 EMERGENCY	2, 973, 368					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1, 169, 108	108, 208	1, 060, 90	0 0	0	92.00
	2 (01 075	071 446	2 420 55	7		05 00
95. 00 09500 AMBULANCE SERVICES	3, 691, 975					95.00
200.00 Subtotal (sum of lines 50 thru 199)	26, 931, 038					200.00
201.00 Less Observation Beds	1, 169, 108					201.00
202.00 Total (line 200 minus line 201)	25, 761, 930	2, 284, 301	23, 477, 62	[9] 0	1 0	202.00

Health Financial Systems COM	MUNITY HOSPT. OF	NOBLE CTY, IN	VC.	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RAREDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provi der	CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Prepared: 5/22/2015 1:05 pm
		Tit	le XIX	Hospi tal	PPS
Cost Center Description	Capital and	Total Charges (Worksheet C,	Cost to Charg		
	Operating Cost	8)		0	
	Reduction 6.00	7.00	/ col . 7) 8.00	_	
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00		
50. 00 05000 OPERATING ROOM	3, 300, 968	14, 600, 777	0. 22608	22	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	953, 768				52.00
53. 00 05300 ANESTHESI OLOGY	30, 094				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 177, 032	45, 671, 482			54.00
54. 01 05401 CAT SCAN	4, 177, 032	43, 071, 402	0.0000		54.00
60. 00 06000 LABORATORY	2, 851, 944	14, 530, 656			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	2,031,744	14, 550, 650			62.30
65. 00 06500 RESPIRATORY THERAPY	1, 202, 042	5, 128, 817			65.00
66. 00 06600 PHYSI CAL THERAPY	1, 150, 371	2, 514, 815			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	670, 829				67.00
68. 00 06800 SPEECH PATHOLOGY	239, 781	346, 342			68.00
69. 00 06900 ELECTROCARDI OLOGY	23, 639				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	718, 183				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	508, 734				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 213, 593	11, 485, 153			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0,210,0,0	0	0.0000		76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.0000		76.98
76. 99 07699 LI THOTRI PSY	0	0	0.0000		76. 99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	55, 609	33, 442	1.66284	19	90.00
91.00 09100 EMERGENCY	2, 973, 368	20, 860, 509	0. 14253	36	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 169, 108	1, 378, 337	0.84820	02	92.00
OTHER REI MBURSABLE COST CENTERS			•		
95. 00 09500 AMBULANCE SERVICES	3, 691, 975	6, 829, 771	0. 5405	71	95.00
200.00 Subtotal (sum of lines 50 thru 199)	26, 931, 038				200.00
201.00 Less Observation Beds	1, 169, 108				201.00
202.00 Total (line 200 minus line 201)	25, 761, 930	135, 930, 662			202.00

Health Financial Systems COMM	IUNITY HOSPT. OI	F NOBLE CTY, I	In Lie	eu of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/22/2015 1:0	pared:
		Ti +I	e XVIII	Hospi tal	PPS	5 pili
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
Cost center bescription	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	Aujustment	Related Cost		3 / COL. 4)	
	Part II, col.		(col. 1 - col			
	26)		2)	•		
	1.00	2.00	3,00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	E00.010		 	2 (051	05.07	20.00
30. 00 ADULTS & PEDIATRICS	582, 812		582, 81			1
43.00 NURSERY	12, 607		12, 60			1
200.00 Total (lines 30-199)	595, 419		595, 41	9 7,406	L	200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 133	181, 454				30.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	2, 133	181, 454				200.00

Health Financial Systems COMM	IUNI TY HOSPT. OI	NOBLE CTY, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	0		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	366, 603	14, 600, 777	0. 02510	1, 274, 376	31, 997	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	68, 664	2, 359, 572	0. 02910	0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	7,076	2, 090, 381	0. 00338	152, 963	518	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	513, 400	45, 671, 482	0. 01124	1, 751, 297	19, 686	54.00
54.01 05401 CAT SCAN	0	0	0. 00000	0 0	0	54.01
60. 00 06000 LABORATORY	191, 951	14, 530, 656	0. 01321	0 1, 149, 991	15, 191	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	115, 417	5, 128, 817	0. 02250	701, 844	15, 794	65.00
66. 00 06600 PHYSI CAL THERAPY	86, 799	2, 514, 815	0. 03451	5 126, 800	4, 377	66.00
67.00 06700 OCCUPATI ONAL THERAPY	42,700	936, 652	0. 04558	7, 224	329	67.00
68.00 06800 SPEECH PATHOLOGY	15, 260	346, 342	0.04406	0 13, 563	598	68.00
69.00 06900 ELECTROCARDI OLOGY	2, 299	516, 673	0.00445	337, 952	1, 504	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	53, 183	4, 625, 006	0.01149	278, 690	3, 205	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 271	2, 022, 277	0. 01595	646, 684	10, 320	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	272, 418			9 1, 865, 914	44, 258	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000		0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	3, 554	33, 442	0. 10627	4 966	103	90.00
91.00 09100 EMERGENCY	241, 288	20, 860, 509	0. 01156	1, 049, 277	12, 137	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	108, 208	1, 378, 337	0. 07850	06 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	•			•		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	2, 121, 091	129, 100, 891		9, 357, 541	160, 017	200. 00

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-255								
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS	TS	Provi der	CCN: 150146	Period: From 01/01/2014 To 12/31/2014		pared [.]	
						5/22/2015 1:0		
	_			e XVIII	Hospi tal	PPS		
Cost Center Description	Nursing School	ALLI	ed Health	All Other	Swi ng-Bed	Total Costs		
			Cost	Medi cal	Adjustment	(sum of cols.		
				Education Cos	st Amount (see	1 through 3,		
					instructions)	minus col. 4)		
	1.00		2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS		_						
30. 00 03000 ADULTS & PEDIATRICS	C		0		0 0	0	30.00	
43. 00 04300 NURSERY	C		0		0	0	43.00	
200.00 Total (lines 30-199)	C		0		0	0	200.00	
Cost Center Description	Total Patient	Per [Diem (col.	Inpati ent	Inpati ent			
	Days	5 ÷	col. 6)	Program Days	Program			
					Pass-Through			
					Cost (col. 7 x			
					col. 8)			
	6.00		7.00	8.00	9.00]		
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 03000 ADULTS & PEDIATRICS	6, 851		0.00	2, 13	33 0		30.00	
43.00 04300 NURSERY	555	5	0.00		0 0		43.00	
200.00 Total (lines 30-199)	7,406			2, 13	33 O		200. 00	

Health Financial Systems COM	MUNITY HOSPT. O	F NOBLE CTY, I	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS	S Provi der		Period: From 01/01/2014 To 12/31/2014		
		. Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Health		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	9	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		•		-1		
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01 05401 CAT SCAN	0	0		0 0	0	54.01
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0 0)	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	-	1	1			
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0)	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1			
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50-199)	0	0 0		0 0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150146 Period: From 01/01/2014 To 12/31/2014 Worksheet D Bate/Time Prepared: 5/22/3015 1:05 pm 5/22/3015 1:05 pm 5/22/3015 1:05 pm 5/22/3015 1:05 pm 5/22/3015 1:05 pm 5/22/3015 1:05 pm 5/22/3016 0 foot ANCILLARY SERVICE COST CENTERS Total Outpatient Cost (sum of col. 2, 3 and 4) Total Outpatient Cost (sum of col. 2, 3 and 4) Total Cost (sum of col. 2, 3 and 4) Inpatient Cost (sum of col. 2, 359, 572 Inpatient Cost (sum of col. 2, 299, 381 Inpatient Cost (sum of col. 2, 359, 572 Inpatient Cost (sum of col. 2, 299, 381 Inpatient Cost (sum of cost (sum of	Health Financial Systems COMM	UNITY HOSPT. O	F NOBLE CTY, I	NC.	In Lie	u of Form CMS-:	2552-10
Interview To 12/31/2014 Date/Time Prepared: 22/2015 Date/Time Prepared: 22/2015 Cost Center Description Total Outpatient Cost (sum of 4) Total Outpatient Cost (sum of 4) Total Outpatient Cost Total Outpatient Cost Total Outpatient Cost Total Part I, col. Program (col. 5 + col. Program Cost Program Charges ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 50.00 05000 0PERATING ROM 0 14,600,777 0.000000 0.000000 1.274,376 50.00 52.00 052000 DELIVERY ROM & LABOR ROM 0 2,990,381 0.000000 0.000000 1.274,376 50.00 54.01 Ofsodi (Car Schward) 0 14,600,777 0.000000 0.000000 1.274,376 50.00 54.01 Ofsodi (Car Schward) 0 14,530,656 0.000000 1.751,297 54.00 60.00 06000 RESPIRATORY THERAPY 0 51.28,817 0.000000 0.000000 1.264,500 66.00 60.00 06000 RESPIRATORY THERAPY 0		RVICE OTHER PAS	S Provi der				
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ANCI LLARY SERVICE Outpatient Cost (sum of 4) (from West C Part I, col. 8) to Charges (col. 7) Ratio of Cost (col. 7) Program (col. 7) Charges (col. 7) C			Titl	e XVIII	Hospi tal		
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200.00 Total (Lines 50-199) 0 129, 100, 891 9, 357, 541 200.00							
	200.00 Total (lines 50-199)	0	129, 100, 891			9, 357, 541	200. 00

Health Financial Systems COMM	IUNITY HOSPT. OF	NOBLE CTY, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	5 Provi der	CCN: 150146	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2014	Part IV	
				To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
		Titl	e XVIII	Hospi tal	PPS	5 pili
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	n		
	Costs (col. 8	Ũ	Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS			·			
50.00 05000 OPERATI NG ROOM	0	2, 144, 508		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0		52.00
53.00 05300 ANESTHESI OLOGY	0	267, 474		0		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 251, 513		0		54.00
54.01 05401 CAT SCAN	0	0		0		54.01
60. 00 06000 LABORATORY	0	114, 752		0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62.30
65. 00 06500 RESPI RATORY THERAPY	0	505, 852		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0)	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0)	0		68.00
69.00 06900 ELECTROCARDI OLOGY	0	435, 684		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	224, 039		0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	79, 568		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 725, 809		0		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0		76.98
76. 99 07699 LI THOTRI PSY	0	0		0		76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	6, 969		0		90.00
91.00 09100 EMERGENCY	0	3, 911, 863		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	367, 157		0		92.00
OTHER REIMBURSABLE COST CENTERS		· · ·	•			1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	19, 035, 188		0		200.00
	•					

Health Financial Systems	COMMUNI TY HOSPT. OF				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SI	RVICES AND VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014	Part V Date/Time Pre	narod
				10 12/31/2014	5/22/2015 1:0)5 pm
		Titl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 226082			0 0	484, 835	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 404212			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 014396			0 0	3, 851	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 091458			0 0	846, 125	
54.01 05401 CAT SCAN	0. 000000			0 0	0	
60. 00 06000 LABORATORY	0. 196271	114, 752		0 0	22, 522	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILI		0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 234370	505, 852		0 0	118, 557	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 457438	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 716199	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 692324	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 045752	435, 684		0 0	19, 933	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO	PATI ENT 0. 155283	224, 039		0 0	34, 789	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIEN	TS 0. 251565	79, 568		0 0	20, 017	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 279804	1, 725, 809		0 0	482, 888	73.00
76.97 07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			•		•	
90. 00 09000 CLINIC	1. 662849	6, 969		0 0	11, 588	90.00
91.00 09100 EMERGENCY	0. 142536	3, 911, 863		0 0	557, 581	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTIN	CT PART 0. 848202	367, 157		0 0	311, 423	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0. 540571			0		95.00
200.00 Subtotal (see instructions)		19, 035, 188		0 0	2, 914, 109	200.00
201.00 Less PBP Clinic Lab. Service	s-Program			0 0		201.00
Only Charges	-					
202.00 Net Charges (line 200 +/- li	ne 201)	19, 035, 188		0 0	2, 914, 109	202.00

Health Fina	ancial Systems COMM	IUNI TY HOSPT. 0	F NOBLE CTY, I	NC.	In Lie	u of Form CMS.	-2552-10
APPORTI ONMI	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		- CCN: 150146	Period: From 01/01/2014 To 12/31/2014	5/22/2015 1:	epared: 05 pm
				le XVIII	Hospi tal	PPS	
			sts	_			
	Cost Center Description	Cost Reimbursed	Cost Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	7			
ANCI	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0		0			50.00
	O DELIVERY ROOM & LABOR ROOM	0		0			52.00
53.00 0530	0 ANESTHESI OLOGY	0		0			53.00
	0 RADI OLOGY-DI AGNOSTI C	0		0			54.00
54.01 0540	1 CAT SCAN	0		0			54.01
60.00 0600	0 LABORATORY	0		0			60.00
62.30 0625	O BLOOD CLOTTING FOR HEMOPHILIACS	0		0			62.30
	0 RESPI RATORY THERAPY	0		0			65.00
	0 PHYSI CAL THERAPY	0		0			66.00
67.00 0670	0 OCCUPATI ONAL THERAPY	0		0			67.00
	0 SPEECH PATHOLOGY	0		0			68.00
69.00 0690	0 ELECTROCARDI OLOGY	0		0			69.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	0		0			71.00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	0		0			72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0		0			73.00
76.97 0769	7 CARDIAC REHABILITATION	0		0			76.97
76.98 0769	8 HYPERBARI C OXYGEN THERAPY	0		0			76. 98
76.99 0769	9 LI THOTRI PSY	0		0			76.99
	ATIENT SERVICE COST CENTERS		-				
	DO CLINIC	0		0			90.00
	O EMERGENCY	0		0			91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
	R REIMBURSABLE COST CENTERS	1	1				
	O AMBULANCE SERVI CES	0					95.00
200.00	Subtotal (see instructions)	0		0			200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	0		o			202.00

Health Financial Systems COM	NUNITY HOSPT. OI	F NOBLE CTY, I	NC.	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/22/2015 1:0	pared:
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	582, 812	0	582, 81	2 6, 851	85.07	30.00
43.00 NURSERY	12, 607		12,60	7 555	22.72	43.00
200.00 Total (lines 30-199)	595, 419		595, 41	9 7,406		200.00
Cost Center Description	Inpati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	(00	6)	-			
	6.00	7.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0(001	1			00.00
30. 00 ADULTS & PEDIATRICS	306		•			30.00
43.00 NURSERY	76					43.00
200.00 Total (lines 30-199)	382	27, 758	5			200. 00

Health Financial Systems COMM	IUNITY HOSPT. OF	F NOBLE CTY, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	J		
	26)	í í	Í Í			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	366, 603	14, 600, 777	0. 02510	885, 541	22, 234	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	68, 664	2, 359, 572	0. 02910	0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	7,076	2, 090, 381	0. 00338	85 82, 331	279	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	513, 400	45, 671, 482	0. 01124	1 316, 993	3, 563	54.00
54.01 05401 CAT SCAN	0	0	0.00000	0 0	0	54.01
60. 00 06000 LABORATORY	191, 951	14, 530, 656	0. 01321	0 313, 770	4, 145	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	115, 417	5, 128, 817	0. 02250	134, 958	3, 037	65.00
66. 00 06600 PHYSI CAL THERAPY	86, 799	2, 514, 815	0. 03451	5 8, 573	296	66.00
67.00 06700 OCCUPATI ONAL THERAPY	42,700	936, 652	0. 04558	8 255	12	67.00
68.00 06800 SPEECH PATHOLOGY	15, 260	346, 342	0.04406	334	15	68.00
69.00 06900 ELECTROCARDI OLOGY	2, 299	516, 673	0.00445	36, 920	164	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	53, 183	4, 625, 006	0.01149	146, 368	1, 683	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	32, 271	2, 022, 277	0. 01595	54, 874	876	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	272, 418			9 621, 243	14, 735	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	3, 554	33, 442	0. 10627	4 621	66	90.00
91.00 09100 EMERGENCY	241, 288	20, 860, 509	0. 01156	7 191, 983	2, 221	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	108, 208	1, 378, 337	0. 07850	06 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				•		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	2, 121, 091	129, 100, 891		2, 794, 764	53, 326	200. 00

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-255								
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS	Provi der	CCN: 150146	Period: From 01/01/2014			
					To 12/31/2014	Date/Time Pre 5/22/2015 1:0		
			Ti t	le XIX	Hospi tal	PPS		
Cost Center Description	Nursing School	ALLI	ed Health	All Other	Swi ng-Bed	Total Costs		
	-		Cost	Medi cal	Adjustment	(sum of cols.		
				Education Cos	st Amount (see	1 through 3,		
					instructions)	minus col. 4)		
	1.00		2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS		_						
30. 00 03000 ADULTS & PEDIATRICS	C)	0		0 0	0	30.00	
43.00 04300 NURSERY	0		0		0	0	43.00	
200.00 Total (lines 30-199)	0		0		0	0	200.00	
Cost Center Description	Total Patient	Per [Diem (col.	Inpati ent	Inpati ent			
	Days	5 ÷	col. 6)	Program Days	s Program			
	-				Pass-Through			
					Cost (col. 7 x			
					col. 8)			
	6.00		7.00	8.00	9.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 03000 ADULTS & PEDI ATRI CS	6, 851		0.00	30	06 0		30.00	
43. 00 04300 NURSERY	555	5	0.00	-	76 O		43.00	
200.00 Total (lines 30-199)	7,406			38	32 0		200. 00	

Health Financial Systems COM	MUNITY HOSPT. O	F NOBLE CTY, I	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provi der		Period: From 01/01/2014 To 12/31/2014		
		. Ti t	le XIX	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Health		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	5	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		•		-1		
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01 05401 CAT SCAN	0	0		0 0	0	54.01
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0 0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	-	1				
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	1		-		
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0 0	1	0 0	0	200.00

APPORT OWNENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150146 Period: From 01/01/2014 To 12/31/2014 Orcksheet D Pate/Time Prepared: 5/22/2015 1:05 pm 5/22/2015 1:05 pm 5/2/2015 1:05	Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-							
Introduct Gold State To 12/31/2014 Date/Time Prepared: Spare Title XIX Hospital PPS Total Outpatient Cost Center Description Total Outpatient Cost (sum of 4) Total Outpatient Cost (sum of 8) Post Intervention Ppst Total Cost (sum of 8) Ppst Total Total Cost Outpatient Cost Cost Outpatient Total Charges (col. 5 + col. Inpatient To Charges (col. 5 + col.			S Provider					
Cost Center Description Total Outpatient Cost (sum of col. 2, 3 and 4) Total (from Wkst. C, earl, 2, 3 and 4) Total (col. 5 + col. 7) Outpatient Ratio of Cost (sol. 6 + col. 7) Inpatient Program (col. 6 + col. 7) ANCILLARY SERVICE COST CENTERS	THROUGH COSTS						narad	
Cost Center Description Total Outpatient Cost (sum of ed. 2, 3 and 4) Total (from Wkst. C, ed. 2, 3 and 4) Total (from Wkst. C, ed. 5 + col. 7) Hospital Outpatient to Charges (col. 6 + col. 7) Outpatient Program (col. 6 + col. 7) ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.000 50.00 05000 (DPERATING ROOM 05000 (DPERATING ROOM 05000 (DPENATING ROOM 000000 0 14,600,777 0.000000 0.000000 0.000000 0.000000 0.000000 885,541 50.00 50.00 05000 (DPENATING ROOM 00000 (DELOTOLIA GNOSTIC 000000 (DABORATORY 000000 (DABORATORY 0000000 (DABORATORY 0000000 (DABORATORY 0000000 (DABORATORY 0000000 (DABORATORY 0000000 (DABORATORY 000000					10 12/31/2014		5 pm	
ANCI LLARY SERVICE COST CENTERS Outpatient Cost (sum 0) (4) (col. (col. 4) (col. (col. 8) (col. (col. 7) (col. (col. 7) (col. (col. 7) (col. (col. 7) (col. 7)			Ti t	le XIX	Hospital PPS		<u> </u>	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$	Cost Center Description							
Col. 2, 3 and 4) 8) 7) (col. 6 + col. 7) 7) (col. 6 + col. 7) ANCI LLARY SERVICE COST CENTERS								
4) 7) 6.00 7.00 8.00 9.00 10.00 S0.00 05000 0PERATING R00M 0 14,600,777 0.000000 0.000000 85,541 50.00 52.00 05200 DELIVERY ROM & LABOR R00M 0 2,359,572 0.000000 0.000000 82,331 53.00 54.00 05400 RADI OLCY-DI AGNOSTI C 0 45,671,482 0.000000 0.000000 0 54.00 54.01 05400 RADI OLCY-DI AGNOSTI C 0 41,530,656 0.000000 0.000000 0 54.01 65.00 06500 RESPI RATORY 0 14,530,656 0.000000 0.000000 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 5,128,817 0.000000 0.000000 2573 66.00 66.00 06600 PHYSI CAL THERAPY 0 2,514,815 0.000000 0.000000 255 67.00 6800 SPEECH PATHOLOGY 0 346,342 0.000000 0.000000 346 68.00 69.00 06900						Charges		
ANCI LLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROM 0 14,600,777 0.000000 0.000000 885,541 50.00 52.00 05200 DELI VERY ROM & LABOR ROM 0 2,359,572 0.000000 0.000000 82,331 53.00 54.00 05400 RADI OLOGY-DI AGNOSTIC 0 45,671,482 0.000000 0.000000 82,331 53.00 54.01 05401 CAT SCAN 0 0 0.000000 0.000000 0.000000 14,530,656 0.000000 0.000000 0 62.30 64.00 06250 BLODD CLOTTI NG FOR HEMOPHI LLACS 0 0 0.000000 0.000000 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 5,14,817 0.000000 0.000000 8,573 66.00 64.00 06600 PHYSI CAL THERAPY 0 34,652 0.000000 0.000000 2,556 67.00 65.00 06500 SPEECH PATHOLOGY 0 34,632			8)	7)				
ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM 0 14, 600, 777 0.000000 0.000000 885, 541 50.00 52.00 DELSZOD DELL VERY ROOM & LABOR ROOM 0 2, 359, 572 0.000000 0.000000 825, 200 53.00 05300 ANESTHESI OLOGY 0 2, 090, 381 0.000000 0.000000 82, 331 53.00 54.01 OS400 RADI LLGY-DI AGNOSTI C 0 45, 671, 482 0.000000 0.000000 0 54.01 60.00 06000 LABORATORY 0 14, 530, 656 0.000000 0.000000 0 65.01 65.00 0.000000 0 62.30 0.6250 BLOD CLOTTI NG FOR HEMOPHI LLI ACS 0 0 0.000000 0.000000 146, 50.00 65.00 0.65000 0.000000 134, 958 65.00 0.6500 0.000000 134, 958 66.00 67.00 0.6700 0.000000 3.648.00 69.00 69.00 0.600000 2.514, 815 0.0000000 0.000000 0.000000					.,			
50.00 05000 OPERATI NG ROM 0 14, 600, 777 0.000000 0.000000 885, 541 50.00 52.00 05200 DELI VERY ROM & LABOR ROM 0 2, 359, 572 0.000000 0.000000 62.00 53.00 05300 ANESTHESI DLOCGY 0 2, 909, 381 0.000000 0.000000 823, 31 53.00 54.01 OS400 RADI OLOGY-DI AGNOSTI C 0 45, 671, 482 0.000000 0.000000 316, 993 54.00 54.01 OS400 LABORATORY 0 14, 530, 656 0.000000 0.000000 0.000000 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 5, 128, 817 0.000000 0.000000 8, 573 66.00 66.00 06600 PHYSI CAL THERAPY 0 2, 514, 815 0.000000 0.000000 334, 958 65.00 67.00 06700 0C2000 0.000000 0.000000 346, 342 0.000000 0.000000 346, 860 69.00 69.00 0.000000 346, 342 0.000000 0.000000 346, 860 69.00 69.00 <td></td> <td>6.00</td> <td>7.00</td> <td>8.00</td> <td>9.00</td> <td>10.00</td> <td></td>		6.00	7.00	8.00	9.00	10.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 2, 359, 572 0.000000 0.000000 82.00 53.00 05300 ANESTHESI OLOGY 0 2, 090, 381 0.000000 0.000000 82, 331 53.00 54.00 05400 RADI DLOGY-DI AGNOSTI C 0 45, 671, 482 0.000000 0.000000 60.000000 60.000000 0 54.01 60.00 06400 LABORATORY 0 14, 530, 656 0.000000 0.000000 62.30 65.00 06500 RESPI RATORY HERAPY 0 5, 128, 817 0.000000 0.000000 62.30 65.00 06600 PHYSI CAL THERAPY 0 2, 514, 815 0.000000 0.000000 8, 573 66.00 66.00 06600 PHYSI CAL THERAPY 0 346, 342 0.000000 0.000000 2, 514, 815 0.000000 0.000000 2, 573 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0 346, 342 0.000000 0.000000 36, 920 69.00 69.00 06900 ELECT ROCARDI OLOGY 0 346, 532 0								
53.00 05300 ANESTHESI OLOGY 0 2,090,381 0.000000 0.000000 82,331 53.00 54.00 05401 CAT SCAN 0 0 0.000000 0.000000 316,993 54.00 54.01 CAT SCAN 0 0 0.000000 0.000000 0.000000 54.01 60.00 06000 LABORATORY 0 14,530,656 0.000000 0.000000 62.30 62.30 06500 RESPI RATORY THERAPY 0 5,128,817 0.000000 0.000000 8,573 66.00 65.00 06600 PHYSI CAL THERAPY 0 2,514,815 0.000000 0.000000 8,573 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 346,342 0.000000 0.000000 334 68.00 69.00 62800 SPEECH PATHOLOGY 0 346,342 0.000000 0.000000 346,86 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 4,625,006 0.000000 146,636 71.00 72.00 07300 INPL. DEV. CHARGED TO PATI ENTS 0		0						
54.00 05400 RADI OLOGY - DI AGNOSTI C 0 45, 671, 482 0.000000 0.000000 316, 993 54.00 54.01 05401 CAT SCAN 0 0.000000 0.000000 0.000000 0 54.01 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0.000000 0.000000 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 5,128,817 0.000000 0.000000 8,573 66.00 66.00 06700 0CUPATI ONAL THERAPY 0 2,514,815 0.000000 0.000000 2,556 7.00 06800 SPEECH PATHOLOGY 0 346,342 0.000000 0.000000 346,342 0.000000 36,923 64.00 69.00 06900 ELECTROCARDI OLOGY 0 516,673 0.000000 0.000000 36,920 69.00 71.00 MPL DEV. CHARGED TO PATI ENTS 2,022,277 0.000000 0.000000 64,947 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0.000000 0.000000 621,243 73.00 <tr< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></tr<>		0						
54. 01 05401 CAT SCAN 0 0 0 0.000000 0.000000 0 54. 01 60. 00 06000 LABORATORY 0 14, 530, 656 0.000000 0.000000 313, 770 60. 00 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0.000000 0.000000 0 62. 30 65. 00 06500 RESPI RATORY THERAPY 0 5, 128, 817 0.000000 0.000000 8, 573 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 2, 514, 815 0.000000 0.000000 255 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 346, 542 0.000000 0.000000 334 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 516, 673 0.000000 0.000000 36, 920 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 2, 022, 277 0.000000 0.000000 54, 874 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 1, 485, 153 0.000000 0.000000 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>		0						
60.00 06000 LABORATORY 0 14, 530, 656 0.000000 0.000000 313, 770 60.00 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LIACS 0 0 0.000000 0.000000 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 5, 128, 817 0.000000 0.000000 8, 573 66.00 66.00 06600 PHYSI CAL THERAPY 0 2, 514, 815 0.000000 0.000000 255 67.00 68.00 06600 PEECH PATHOLOGY 0 346, 342 0.000000 0.000000 334 68.00 69.00 06900 ELECTROCARDI OLOGY 0 516, 673 0.000000 0.000000 36, 920 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 2, 022, 277 0.000000 0.000000 54, 874 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 1, 485, 153 0.000000 0.000000 621, 243 73.00 76.97 07697 CARDI AC REHABI LITATI ON 0 0 0.0000000 0.000000 <		0	45, 671, 482					
62.30 06250 BLOOD CLOTTING FOR HEMOPHILLIACS 0 0 0.000000 0.000000 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 5,128,817 0.000000 0.000000 134,958 65.00 66.00 06600 PHYSICAL THERAPY 0 2,514,815 0.000000 0.000000 8,573 66.00 67.00 06700 0CCUPATIONAL THERAPY 0 936,652 0.000000 0.000000 334 68.00 68.00 06800 SPEECH PATHOLOGY 0 346,342 0.000000 0.000000 334 68.00 69.00 06900 ELECTROCARDIOLOGY 0 516,673 0.000000 0.000000 36,920 69.00 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 4,625,006 0.000000 0.000000 54,874 72.00 72.00 JMPL DEV. CHARGED TO PATIENTS 0 11,485,153 0.000000 0.000000 621,243 73.00 76.97 CARDIAC REHABILITATION 0 0 0.000000 0.000000 0 76.97		0	0					
65.00 06500 RESPIRATORY THERAPY 0 5, 128, 817 0.000000 0.000000 134, 958 65.00 66.00 06600 PHYSI CAL THERAPY 0 2, 514, 815 0.000000 0.000000 8, 573 66.00 67.00 0CCUPATI ONAL THERAPY 0 936, 652 0.000000 0.000000 235 67.00 68.00 06800 SPEECH PATHOLOGY 0 346, 342 0.000000 0.000000 334 68.00 69.00 06900 ELECTROCARDI OLOGY 0 516, 673 0.000000 0.000000 36, 920 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4, 625, 006 0.000000 0.000000 54, 874 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 2, 022, 277 0.000000 0.000000 621, 243 73.00 76.97 O7697 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 64.97 76.99 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0 0.000000 0		0	14, 530, 656					
66.00 06600 PHYSI CAL THERAPY 0 2, 514, 815 0.000000 0.000000 8, 573 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 936, 652 0.000000 0.000000 255 67.00 68.00 06800 SPEECH PATHOLOGY 0 346, 342 0.000000 0.000000 334 68.00 69.00 06900 ELECTROCARDI OLOGY 0 516, 673 0.000000 0.000000 36, 926 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 4, 625, 006 0.000000 0.000000 146, 388 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 2, 022, 277 0.000000 0.000000 621, 243 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 11, 485, 153 0.000000 0.000000 621, 243 73.00 76.97 OARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 76.97 76.98 07699 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0.000000		0	0					
67.00 06700 0CCUPATI 0NAL THERAPY 0 936,652 0.000000 0.000000 255 67.00 68.00 06800 SPEECH PATHOLOGY 0 346,342 0.000000 0.000000 334 68.00 69.00 06900 ELECTROCARDI OLOGY 0 516,673 0.000000 0.000000 36,920 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 4,625,006 0.000000 0.000000 146,368 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 2,022,277 0.000000 0.000000 621,243 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 11,485,153 0.000000 0.000000 621,243 73.00 76.97 07697 CARDI AC REHABI LI TATI 0N 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0 76.99 01700 D9000 CLI NI C 0 33,442 0.000000 0.000000 91.00		0	5, 128, 817				•	
68.00 06800 SPEECH PATHOLOGY 0 346, 342 0.000000 0.000000 334 68.00 69.00 06900 ELECTROCARDI OLOGY 0 516, 673 0.000000 0.000000 36, 920 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 4, 625, 006 0.000000 0.000000 146, 368 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 2, 022, 277 0.000000 0.000000 621, 243 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 11, 485, 153 0.000000 0.000000 621, 243 73.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 76.97 76.98 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 76.97 0000 09000 CLI NI C 0 33, 442 0.000000 0.000000 621 90.00 91.00 09100 EMERGENCY 0 33, 442 0.000000 0.000000 191, 983 91.00 <td></td> <td>0</td> <td>2, 514, 815</td> <td></td> <td></td> <td></td> <td></td>		0	2, 514, 815					
69.00 06900 ELECTROCARDI OLOGY 0 516, 673 0.000000 0.000000 36, 920 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 4, 625, 006 0.000000 0.000000 146, 368 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 2, 022, 277 0.000000 0.000000 54, 874 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 11, 485, 153 0.000000 0.000000 621, 243 73.00 76.97 7677 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 69.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0.000000 0 76.98 70.00 09000 CLI NI C 0 33, 442 0.000000 0.000000 621 90.00 91.00 09100 EMERGENCY 0 20, 860, 509 0.000000 0.000000 91.08 91.00 92.00		0	936, 652					
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 4, 625, 006 0.000000 0.000000 146, 368 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 2, 022, 277 0.000000 0.000000 54, 874 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 11, 485, 153 0.000000 0.000000 621, 243 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0.000000 0.000000 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 76.98 70.00 09000 CLI NI C 0 33, 442 0.000000 0.000000 621 90.00 91.00 09100 EMERGENCY 0 20, 860, 509 0.000000 0.000000 91.00 92.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 1, 378, 337 0.000000 0.000000		0	346, 342					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2,022,277 0.000000 0.000000 54,874 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 11,485,153 0.000000 0.000000 621,243 73.00 76.97 07697 CARDI AC REHABILITATION 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0.000000 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 76.98 70.00 09000 CLI NI C 0 33,442 0.000000 0.000000 621 90.00 91.00 09100 EMERGENCY 0 20,860,509 0.000000 0.000000 191,983 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 1,378,337 0.000000 0.000000 92.00 0 09500 AMBULANCE SERVICES 95.00 95.00 95.00		0	516, 673					
73.00 07300 DRUGS CHARGED TO PATIENTS 0 11,485,153 0.000000 0.000000 621,243 73.00 76.97 07697 CARDI AC REHABILITATION 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0.000000 0 76.98 76.99 07697 LITHOTRI PSY 0 0 0.000000 0.000000 0 76.98 70.00 09000 CLI NI C 0 0 0.000000 0.000000 621 90.00 90.00 09000 CLI NI C 0 33,442 0.000000 0.000000 621 90.00 91.00 09100 EMERGENCY 0 20,860,509 0.000000 0.000000 191,983 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 1,378,337 0.000000 0.000000 92.00 0 09500 AMBULANCE SERVICES 95.00 95.00 95.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 625, 006	0.00000	0 0.000000	146, 368	71.00	
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 76. 97 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0.000000 0 76. 99 0UTPATI ENT SERVICE COST CENTERS 0 33, 442 0.000000 0.000000 621 90. 00 91.00 09100 EMERGENCY 0 20, 860, 509 0.000000 0.000000 191, 983 91. 00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 1, 378, 337 0.000000 0.000000 92.00 0 09500 AMBULANCE SERVICES 95. 00 95. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 022, 277	0. 00000	0.000000	54, 874	72.00	
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0.000000 0 76.99 0UTPATI ENT SERVICE COST CENTERS 0 33,442 0.000000 0.000000 621 90.00 90.00 09100 EMERGENCY 0 20,860,509 0.000000 0.000000 191,983 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 1,378,337 0.000000 0.000000 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 485, 153	0.00000	0.000000	621, 243	73.00	
76.99 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 76.99 OUTPATI ENT SERVICE COST CENTERS 0 33,442 0.000000 0.000000 621 90.00 90.00 09100 EMERGENCY 0 20,860,509 0.000000 0.000000 191,983 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 0 1,378,337 0.000000 0.000000 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0.000000	0	76.97	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 33, 442 0.000000 621 90.00 91.00 09100 EMERGENCY 0 20, 860, 509 0.000000 191, 983 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 1, 378, 337 0.000000 0.000000 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0.000000	0	76.98	
90.00 09000 CLINIC 0 33,442 0.00000 0.00000 621 90.00 91.00 09100 EMERGENCY 0 20,860,509 0.000000 0.000000 191,983 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 1,378,337 0.000000 0.000000 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00		0	C	0.00000	0.000000	0	76.99	
91. 00 09100 EMERGENCY 0 20, 860, 509 0. 000000 0. 000000 191, 983 91. 00 92. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 1, 378, 337 0. 000000 0 000000 92. 00 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00								
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 1,378,337 0.000000 0 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90. 00 09000 CLINIC	0	33, 442	0. 00000	0.000000	621	90.00	
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	0	20, 860, 509	0.00000	0.000000	191, 983	91.00	
95. 00 09500 AMBULANCE SERVICES 95. 00		0	1, 378, 337	0.00000	0.000000	0	92.00	
200.00 Total (Lines 50-199) 0 129, 100, 891 2, 794, 764 200.00	95. 00 09500 AMBULANCE SERVICES						95.00	
	200.00 Total (lines 50-199)	0	129, 100, 891			2, 794, 764	200.00	

Health Financial Systems COMM	IUNI TY HOSPT. OF	NOBLE CTY, I	NC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150146	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C)	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
54.01 05401 CAT SCAN	0	0		0		54.01
60. 00 06000 LABORATORY	0	0		0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
66.00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69.00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0		76.97
76, 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		0		76, 98
76. 99 07699 LI THOTRI PSY	0	C		0		76, 99
OUTPATIENT SERVICE COST CENTERS	1		1			
90, 00 09000 CLINIC	0	0)	0		90.00
91.00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92,00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	C		0		200.00
	-1	-	1	1		1

		UNITY HOSPT. O	F NOBLE CTY, IN	VC.	In Lie	u of Form CMS-	2552-10
APPORTI ON	IMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
					From 01/01/2014 To 12/31/2014		nared
					10 12/01/2011	5/22/2015 1:0	
		1	Tit	le XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see		Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	0.00	(see inst.)	(see inst.)	F 00	
0.010		1.00	2.00	3.00	4.00	5.00	
	CILLARY SERVICE COST CENTERS	0.22(002		1 (00.01	(0	50.00
		0. 226082	0	1, 698, 81	0 0	Ű Ő	
	200 DELIVERY ROOM & LABOR ROOM 300 ANESTHESI OLOGY	0. 404212	0	210 5	0 0	0	
				219, 57		0	
	400 RADI OLOGY-DI AGNOSTI C	0. 091458		5, 744, 81	2 0	0	01100
	401 CAT SCAN	0.000000	0	1 500 44	0 0	0	
		0. 196271	0	1, 508, 44	8 0	0	
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		202.02	0 0	0	
	500 RESPI RATORY THERAPY 500 PHYSI CAL THERAPY	0. 234370		202, 82		0	
				324, 83		Ű	00.00
	700 OCCUPATIONAL THERAPY	0. 716199		195, 67		0	07100
	BOO SPEECH PATHOLOGY	0. 692324		148, 03		0	
		0. 045752		174, 21		0	07100
	100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 155283		230, 41		0	1 1 1 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 251565		54,96		0	
	300 DRUGS CHARGED TO PATIENTS 697 CARDIAC REHABILITATION	0. 279804		917, 59	0	0	
		0.000000			0 0	0	
	698 HYPERBARI C OXYGEN THERAPY	0. 000000			0 0	0	
	699 LI THOTRI PSY TPATI ENT SERVI CE COST CENTERS	0.00000	0		0 0	0	/0.99
	DOO CLINIC	1. 662849	0	2,69	0	0	90.00
	100 EMERGENCY	0. 142536				-	
	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 848202		4, 387, 03		-	
	HER REIMBURSABLE COST CENTERS	0. 040202	0	401, 22	.5 0	0	92.00
	500 AMBULANCE SERVICES	0. 540571	0	815, 05	2		95.00
200.00	Subtotal (see instructions)	0. 540571		17, 106, 80		0	200.00
200.00	Less PBP Clinic Lab. Services-Program			17,100,00		0	200.00
201.00	Only Charges				0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	17, 106, 80	0 0	0	202.00
				-			•

Health Financial Systems COMM	UNITY HOSPT. OI	F NOBLE CTY, IN	IC.	In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pr 5/22/2015 1:	
		Ti t	le XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	004.070					
50. 00 05000 OPERATING ROOM	384,072					50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	3, 161	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	525, 409					54.00
54. 01 05401 CAT SCAN	0	0				54.01
60. 00 06000 LABORATORY	296, 065					60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65. 00 06500 RESPI RATORY THERAPY	47, 535					65.00
66.00 06600 PHYSI CAL THERAPY	148, 592					66.00
67.00 06700 OCCUPATI ONAL THERAPY	140, 141					67.00
68.00 06800 SPEECH PATHOLOGY	102, 489					68.00
69. 00 06900 ELECTROCARDI OLOGY	7, 971					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 779					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 826					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	256, 746					73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	-				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	-				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	4, 475		•			90.00
91.00 09100 EMERGENCY	625, 396					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	408, 176	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	440, 593					95.00
200.00 Subtotal (see instructions)	3, 440, 426					200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	2 440 404					202.00
202.00 Net Charges (line 200 +/- line 201)	3, 440, 426	0				202.00

Heal th	Fi nan	ci al	Systems		
COMPUT	ATI ON	OF I	NPATI ENT	OPERATI NG	(

COMMUNI TY	HOSPT.	0F	NOBLE	CTY,	INC.	

In Lieu of Form CMS-2552-10

leal th	Financial Systems COMMUNITY HOSPT. OF NOE	BLE CTY, INC.	In Lie	u of Form CMS-2	<u>2552-1</u> 0
	TION OF INPATIENT OPERATING COST	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prep 5/22/2015 1:0	pared:
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	PART I – ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days,	excluding newborn)		6, 851	1.00
	Inpatient days (including private room days, excluding swing-be			6, 851	2.00
	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3.00
	do not complete this line.			5 570	
	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		r 21 of the east	5, 579 0	4.00 5.00
	reporting period	days) through becembe	I SI UI LINE CUST	0	5.00
	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.00
	reporting period				
	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	I OF THE COST	0	8.00
	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 133	9.00
	newborn days)		oming bour and	2, 100	,
	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10.00
	through December 31 of the cost reporting period (see instructi			_	
	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		oom days) after	0	11.00
	Swing-bed NF type inpatient days applicable to titles V or XIX		e room davs)	0	12.00
	through December 31 of the cost reporting period			-	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
	after December 31 of the cost reporting period (if calendar yea			_	
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	excluding swing-bed	days)	0	14.00 15.00
	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT			0	10.00
	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17.00
	reporting period				
	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18.00
	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19.00
	reporting period	0100			
	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00
	reporting period			(00(05(01 01
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing poriod (line	6, 296, 856 0	21.00 22.00
	5 x line 17)	ST OF THE COST TEPOL	ring period (inne	0	22.00
	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23.00
	x line 18)				
	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25.00
	x line 20)	er the cost roper trug	porrou (rrno o	J. J	20.00
	Total swing-bed cost (see instructions)			0	26.00
	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		6, 296, 856	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and obconvetion had ab	argoc)	0	20 00
	Private room charges (excluding swing-bed charges)	and observation bed ch	ai yes)	0	28.00 29.00
	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
22 00 1				0.00	
	Average private room per diem charge (line 29 ÷ line 3)				33.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	a line 20) (' '	tione)	0.00	
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu		tions)	0.00	34.00
33.00 34.00 35.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		tions)	0. 00 0. 00	34.00 35.00
33.00 34.00 35.00 36.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	31)		0.00 0.00 0	34.00 35.00 36.00
33.00 34.00 35.00 36.00 37.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36)	31)		0. 00 0. 00	34.00 35.00 36.00
33.00 34.00 35.00 36.00 37.00 E	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	a 31) d private room cost di		0.00 0.00 0	34.00 35.00 36.00
33. 00 / 34. 00 / 35. 00 / 36. 00 37. 00 (<u>F</u>	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	a 31) d private room cost di TMENTS		0. 00 0. 00 0 6, 296, 856	34.00 35.00 36.00 37.00
33. 00 / 34. 00 / 35. 00 / 36. 00 37. 00 (<u>F</u> 38. 00 /	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i	a 31) d private room cost di TMENTS nstructions)		0.00 0.00 0,296,856 919.11	34.00 35.00 36.00 37.00
33. 00 34. 00 35. 00 36. 00 37. 00 F 38. 00 39. 00 1 5 5 5 5 5 5 5 5 5 5 5 5 5	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	31) d private room cost di <u>TMENTS</u> nstructions) 8)		0. 00 0. 00 0 6, 296, 856	34.00 35.00 36.00 37.00

Heal th	Financial Systems COMM	NUNITY HOSPT. OF	NOBLE CTY,	INC.	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi de	er CCN: 150146	Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014		nared
					10 12/01/2011	5/22/2015 1:0	
				tle XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per		Program Cost (col. 3 x col.	
		Inpatient Cost	inpatrent bag		-	4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0		0 0.	00 0	0	42.00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1, 808, 512	48.00
	Total Program inpatient costs (sum of lines			i ons)		3, 768, 974	49.00
	PASS THROUGH COST ADJUSTMENTS					1	
50.00	Pass through costs applicable to Program inp	atient routine :	services (fr	om Wkst. D, su	m of Parts I and	181, 454	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (from Wkst. D,	sum of Parts II	160, 017	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				341, 471	52.00
	Total Program inpatient operating cost exclu		lated, non-p	hysician anest	hetist, and	3, 427, 503	53.00
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						F4 00
	Program discharges Target amount per discharge					0.00	54.00 55.00
	Target amount (line 54 x line 55)					0.00	56.00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount	(line 56 minus	line 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	60.00
	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that		s (lines 54	x 60), or 1% o	f the target		
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym		0	63.00			
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of t	he cost report	ing period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	a period (See	0	65.00
	instructions)(title XVIII only)					Ŭ	00.00
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line (64 plus line	65)(title XVI	II only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 o	f the cost rep	orting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + li	ne 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N					1	
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70.00 71.00
	Program routine service cost (line 9 x line			e 2)			72.00
73.00	Medically necessary private room cost applic	,	(line 14 x	line 35)			73.00
74.00	Total Program general inpatient routine serv	•					74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B,	Part II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital-related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovidor roco	rdc)			78.00 79.00
80.00	Total Program routine service costs for comp	• •		· · · · · · · · · · · · · · · · · · ·	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi			,	· ··- · · · ·		81.00
82.00	Inpatient routine service cost limitation (I		•				82.00
83.00	Reasonable inpatient routine service costs (s)				83.00
84.00 85.00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84.00 85.00
	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	<u> </u>				
	Total observation bed days (see instructions		Line 2			1, 272	87.00
88.00 89.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		rine 2)			919. 11 1, 169, 108	88.00 89.00
200						.,,	

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	582, 812	6, 296, 856	0. 09255	5 1, 169, 108	108, 208	90.00
91.00 Nursing School cost	0	6, 296, 856	0.00000	0 1, 169, 108	0	91.00
92.00 Allied health cost	0	6, 296, 856	0.00000	0 1, 169, 108	0	92.00
93.00 All other Medical Education	0	6, 296, 856	0.00000	1, 169, 108	0	93.00

COMMUNI TY	HOSPT.	0F	NOBLE	CTY,	INC.	

In Lieu of Form CMS-2552-10

Heal th	Financial Systems COMMUNITY HOSPT. OF NOE	BLE CTY, INC.	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150146	Peri od:	Worksheet D-1	
			From 01/01/2014 To 12/31/2014	Date/Time Pre	nared
			10 12/31/2014	5/22/2015 1:0	
		Title XIX	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		6, 851	1.00
2.00	Inpatient days (including private room days, excluding swing-be	ed and newborn days)		6, 851	2.00
3.00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	rivate room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed			5, 579	4.00
4.00 5.00	Total swing-bed SNF type inpatient days (including private room		er 31 of the cost		5.00
0.00	reporting period			0	0.00
6.00	Total swing-bed SNF type inpatient days (including private room	n days) after December	31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)		04 6 11 1		7 00
7.00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	306	9.00
10 00	newborn days) Swing had SNE type inpatient days applicable to title XV/LL on	v (including privato r	soom davis)	0	10 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)			
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.00
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room dave)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar yea			0	13.00
14.00	Medically necessary private room days applicable to the Program			0	14.00
	Total nursery days (title V or XIX only)				15.00
16.00	Nursery days (title V or XIX only)			76	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 c	of the cost	0.00	17.00
17.00	reporting period	s thi dugh becember 51 c	in the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0, 00	20.00
	reporting period				
	Total general inpatient routine service cost (see instructions)			6, 296, 856	
22.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	- 31 of the cost report	ing period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportin	na period (line 6	0	23.00
201 00	x line 18)		ig poir ou (ir no o	J. J	20100
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
25 00	7 x line 19)			0	25 00
25.00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		6, 296, 856	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29.00 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	2		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minu		ctions)		34.00
35.00 36.00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	: 31)		0. 00 0	35.00 36.00
37.00	General inpatient routine service cost net of swing-bed cost an	nd private room cost di	fferential (line	6, 296, 856	
	27 minus line 36)	,			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			040.44	20.00
38. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i	nstructions)		919. 11 281 - 248	
38. 00 39. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	nstructions) 38)		919. 11 281, 248 0	39.00

	ATION OF INPATIENT OPERATING COST		Prov	uer	CCN: 150146	Period: From 01/01/2014		
						To 12/31/2014	Date/Time Pre 5/22/2015 1:0	epare D5 pm
		T 1 1		Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Davs	Average Per Diem (col 1		Program Cost (col. 3 x col.	
		inpatrent cost	Inpatront	Days	col . 2)		4)	
		1.00	2.00		3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	178, 373		555	321.3	39 76	24, 426	<u>5</u> 42.
. 00	INTENSIVE CARE UNIT							43.
. 00	CORONARY CARE UNIT							44.
. 00	BURN INTENSIVE CARE UNIT							45.
. 00	SURGICAL INTENSIVE CARE UNIT							46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47.
	cost center bescription						1.00	-
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200))			568, 690) 48.
. 00	Total Program inpatient costs (sum of lines 4	1 through 48)(see instru	ictio	ns)		874, 364	49.
00	PASS THROUGH COST ADJUSTMENTS	+! +		6	Wheet D area	C Davata I - and	07.75	
. 00	Pass through costs applicable to Program inpa	itient routine	services (Trom	WKST. D, SUN	for Parts I and	27, 758	3 50.
. 00	Pass through costs applicable to Program inpa	tient ancillar	ry services	s (fr	om Wkst. D, s	sum of Parts II	53, 326	51.
	and IV)		-		-			
. 00	Total Program excludable cost (sum of lines 5		lated -			ation and	81, 084	
8. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		erated, hor	i-pny	sician anestr	ietist, and	793, 280	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	(2)						
. 00	Program discharges						C	54
. 00	Target amount per discharge						0.00	
. 00	5) 56
. 00 . 00	Bonus payment (see instructions)	TThe 53)						
. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period	endi ng 199	96, u	pdated and co	ompounded by the		
	market basket		-			, ,		
. 00	Lesser of lines 53/54 or 55 from prior year of						0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than						C) 61
	amount (line 56), otherwise enter zero (see i		.5 (11165 .	,4 A		the target		
. 00	Relief payment (see instructions)	,					0	62.
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)				0) 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Dece	mbor 31 of	tho	cost reporti	na period (See		64
. 00	instructions) (title XVIII only)	.s through bece		the	cost reporti	ng period (see		04
. 00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of t	he c	ost reporting	g period (See	C	65
~~	instructions)(title XVIII only)			,				
. 00	Total Medicare swing-bed SNF inpatient routir CAH (see instructions)	ne costs (line	64 plus li	ne 6	5)(title XVII	I ONLY). FOR	C) 66
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December	31 o	f the cost re	eporting period	0	67
	(line 12 x line 19)	Ū.						
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 3	of	the cost repo	orting period	C	68
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r	routine costs (line 67 +	line	68)			69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU							
. 00	Skilled nursing facility/other nursing facili	5			• •			70
. 00	Adjusted general inpatient routine service co		ine 70 ÷ 1	i ne	2)			71
. 00 . 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14	v Li	ne 35)			72
. 00	Total Program general inpatient routine servi				ne 33)			74
. 00	Capital -related cost allocated to inpatient r				orksheet B, F	Part II, column		75
_	26, line 45)							
. 00	Per diem capital -related costs (line 75 ÷ lin Program capital related costs (line 0 × line							76
00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus							77
00	Aggregate charges to beneficiaries for excess		orovider re	ecord	s)			79
00	Total Program routine service costs for compa				•	nus line 79)		80
00	Inpatient routine service cost per diem limit							81
. 00	Inpatient routine service cost limitation (li		· .					82
00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		15)					83
. 00	Utilization review - physician compensation (ons)					85
. 00	Total Program inpatient operating costs (sum							86
	PART IV - COMPUTATION OF OBSERVATION BED PASS							
o -	Total observation bed days (see instructions)						1, 272	2 87
. 00	Adjusted general inpatient routine cost per o	liom (line 27 -	lino 2)				919. 11	00

Health Financial Systems COMM	IUNI TY HOSPT. 0	F NOBLE CTY, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/22/2015 1:0	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	582, 812	6, 296, 856	0. 092556	5 1, 169, 108	108, 208	90.00
91.00 Nursing School cost	C	6, 296, 856	0.00000	1, 169, 108	0	91.00
92.00 Allied health cost	C	6, 296, 856	0.00000	1, 169, 108	0	92.00
93.00 All other Medical Education	C	6, 296, 856	0.00000	1, 169, 108	0	93.00

Health Financial Systems COMMUNITY HOSPT. OF NOE INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150146	Peri od:	worksheet D-3	
	literider		From 01/01/2014		
			To 12/31/2014		pared:
	Ti +1	e XVIII	Hospi tal	5/22/2015 1:0 PPS	15 pm
Cost Center Description	1111	Ratio of Cos		Inpati ent	
cost center bescription		To Charges		Program Costs	
		10 ondriges	Charges	$(col \cdot 1 \times col \cdot$	
			ondrigoo	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			3, 086, 438		30.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2260		288, 113	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4042		-	
53. 00 05300 ANESTHESI OLOGY		0. 0182			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0914			
54. 01 05401 CAT SCAN		0.0000		-	
60. 00 06000 LABORATORY		0. 1962			
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 2343			
66. 00 06600 PHYSI CAL THERAPY		0. 4574			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 7161			
68.00 06800 SPEECH PATHOLOGY		0. 6923			
69. 00 06900 ELECTROCARDI OLOGY		0.0457			
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 1552			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2515			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2798			
76. 97 O7697 CARDIAC REHABILITATION		0.0000		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000		-	
76. 99 07699 LI THOTRI PSY		0.0000	00 0	0	76.9
		1 (() 0	40 044	1 (0)	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY		1.6628 0.1425			
		0. 1425			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0.8482	02 0	0	92.0
95. 00 09500 AMBULANCE SERVICES		1			95.0
200.00 Total (sum of lines 50-94 and 96-98)			9, 357, 541	1, 808, 512	
200.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		7, 337, 341	1,000,012	200.0
202.00 Net Charges (line 200 minus line 201)			9, 357, 541		201.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	CTY, I	CCN: 150146	Peri od:	u of Form CMS- Worksheet D-3	
			From 01/01/2014		
			To 12/31/2014		
	т; +	tle XIX	Hospi tal	5/22/2015 1:0 PPS	05 pm
Cost Center Description		Ratio of Cos		Inpati ent	
cost center bescription		To Charges		Program Costs	
		10 onarges	Charges	$(col \cdot 1 \times col \cdot)$	
			g	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 605, 706		30.0
13. 00 04300 NURSERY			290, 136		43.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 2260		200, 205	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4042		-	
53. 00 05300 ANESTHESI OLOGY		0. 0182		1, 499	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0914		28, 992	
54. 01 05401 CAT SCAN		0.0000		Ŭ	
50. 00 06000 LABORATORY		0. 1962		61, 584	
52.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
5. 00 06500 RESPI RATORY THERAPY		0. 2343			
6. 00 06600 PHYSI CAL THERAPY		0. 4574			
57. 00 06700 OCCUPATI ONAL THERAPY		0. 7161			
8.00 06800 SPEECH PATHOLOGY		0. 6923			
99. 00 06900 ELECTROCARDI OLOGY		0.0457			
11.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1552			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2515			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2798			
6. 97 07697 CARDIAC REHABILITATION		0.0000		0	
6. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	
6. 99 07699 LI THOTRI PSY		0.0000	00 0	0	76. 9
OUTPATIENT SERVICE COST CENTERS		1 4 4 4 9 9		1 000	1
0. 00 09000 CLINIC		1.6628			
1.00 09100 EMERGENCY		0. 1425			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 8482	02 0	0	92.0
OTHER REI MBURSABLE COST CENTERS		1		1	
05.00 09500 AMBULANCE SERVICES			2 704 774	F(0, (00)	95.0
100.00 Total (sum of lines 50-94 and 96-98)	- (1)		2, 794, 764		
201.00 Less PBP Clinic Laboratory Services-Program only charges (lin	ie 61)		0		201.0
202.00 Net Charges (line 200 minus line 201)		1	2, 794, 764		202.0

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	LE CTY, IN Provider	CCN: 150146	Period: From 01/01/2014	u of Form CMS Worksheet E Part A	
				To 12/31/2014	Date/Time Pr 5/22/2015 1:	repared 05 pm
		liti	e XVIII	Hospi tal	PPS	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2.00	_
00	DRG Amounts Other than Outlier Payments			0		1. (
01	DRG amounts other than outlier payments for discharges occurrin	g prior		2, 253, 310		1. (
02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	g on or		765, 215		1. (
0.2	after October 1 (see instructions)					1
03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0		1. (
04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1. (
00	Outlier payments for discharges. (see instructions)			30, 040		2.
01	Outlier reconciliation amount	n c)		0		2.
02 00	Outlier payment for discharges for Model 4 BPCI (see instructio Managed Care Simulated Payments	15)		0		2. 3.
00	Bed days available divided by number of days in the cost report	i ng		27. 52		4.
	period (see instructions) Indirect Medical Education Adjustment					-
00	FTE count for allopathic and osteopathic programs for the most			0.00		5.0
00	cost reporting period ending on or before 12/31/1996. (see instr FTE count for allopathic and osteopathic programs which meet th			0.00		6.
	criteria for an add-on to the cap for new programs in accordance					
00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7.
	CFR §412.105(f)(1)(iv)(B)(1)					
01	ACA Section 5503 reduction amount to the IME cap as specified u CFR 412.105(f)(1)(iv)(B)(2) If the cost report straddles July			0.00		7.
	then see instructions.					
00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8.
	413. 75(b), 413. 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8.
01	section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		0.
02	instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8.
02	closed teaching hospital under section 5506 of ACA. (see instru			0.00		0.
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8,01		0.00		9.
. 00	FTE count for allopathic and osteopathic programs in the curren	t year		0.00		10.
. 00	from your records FTE count for residents in dental and podiatric programs.			0.00		11.
	Current year allowable FTE (see instructions)			0.00		12.
. 00 . 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ondod on		0.00 0.00		13.
. 00	or after September 30, 1997, otherwise enter zero.	ended on		0.00		14.
	Sum of lines 12 through 14 divided by 3.			0.00		15.
. 00 . 00	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital closur	e		0.00 0.00		16.
	Adjusted rolling average FTE count			0.00		18.
	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000		19. 20.
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000		21.
	IME payment adjustment (see instructions)			0		22.
. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Sectio	n 422 of t	he MMA	0		22.
. 00	Number of additional allopathic and osteopathic IME FTE residen			0.00		23.
. 00	slots under 42 Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00		24.
	If the amount on line 24 is greater than $-0-$, then enter the lo	wer of		0.00		25.
. 00	line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000		26.
	IME payments adjustment factor. (see instructions)			0. 000000		20.
	IME add-on adjustment amount (see instructions)			0		28.
	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0		28. 29.
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.
00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	iont dave		<u> </u>		20
. 00	(see instructions)	ient udys		2.16		30.
. 00	Percentage of Medicaid patient days (see instructions)			19.07		31.
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			21.23 6.73		32.
-	Disproportionate share adjustment (see instructions)			50, 787		34.

ALCUL	Financial Systems COMMUNITY HOSPT. OF ATION OF REIMBURSEMENT SETTLEMENT	NOBLE CTY, INC. Provider CCN: 150146	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2014 To 12/31/2014	Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/22/2015 1:0 PPS	э рш
			Prior to	On/After	
			October 1	October 1	
	Uncomponented Caro Adjustment	0	1.00	2.00	
5.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		9 046 380 143	7, 647, 644, 855	35.00
5.01	Factor 3 (see instructions)		0. 000042081	0. 000035440	
5. 02	Hospital uncompensated care payment (If line 34 is zero,		380, 681	271, 033	35.0
	enter zero on this line) (see instructions)				
5. 03	Pro rata share of the hospital uncompensated care payment		284, 728	68, 315	35.03
6. 00	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line		353, 043		36.00
0.00	35. 03)		333, 043		00.00
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throug	h 46)		
0. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
1.00	682, 683, 684 an 685. (see instructions)		0		11.0
1. 01	Total ESRD Medicare covered and paid discharges excluding		0		41.0 ⁴
0.05	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
3. 00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
0.00	682, 683, 684 an 685. (see instructions)				
4.00	Ratio of average length of stay to one week (line 43		0. 000000		44.00
	divided by line 41 divided by 7 days)				
5.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
6. 00	Total additional payment (line 45 times line 44 times line		0		46.00
0.00	41.01)		0		10.0
7.00	Subtotal (see instructions)		3, 452, 395		47.00
8.00	Hospital specific payments (to be completed by SCH and		0		48.00
0 00	MDH, small rural hospitals only. (see instructions)		2 452 205		40.00
9.00	Total payment for inpatient operating costs (see instructions)		3, 452, 395		49.00
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		245, 681		50.00
	and Pt. II, as applicable)		,		
1. 00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
0 00	Pt. III, see instructions)				
2.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
3. 00	Nursing and Allied Health Managed Care payment		0		53.00
4.00	Special add-on payments for new technologies		0		54.00
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
(00	line 69)		0		56.00
6. 00	Cost of physicians' services in a teaching hospital (see intructions)		0		50.00
7.00	Routine service other pass through costs (from Wkst. D,		0		57.00
	Pt. III, column 9, lines 30 through 35).				
8.00	Ancillary service other pass through costs from Wkst. D,		0		58.00
9.00	Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58)		3, 698, 076		59.00
9.00 0.00	Total (sum of amounts on lines 49 through 58) Primary payer payments		3, 698, 076		60.00
1.00	Total amount payable for program beneficiaries (line 59		3, 680, 158		61.00
-	minus line 60)				
2.00	Deductibles billed to program beneficiaries		515, 036		62.00
3.00 4.00	Coinsurance billed to program beneficiaries		2,471		63.00 64.00
4.00 5.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		2, 198 1, 429		65.00
6.00	Allowable bad debts for dual eligible beneficiaries (see		-23, 258		66.00
	instructions)				
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3, 164, 080		67.00
8.00	Credits received from manufacturers for replaced devices		0		68.00
9. 00	for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
	96). (For SCH see instructions)				
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
0.50	RURAL DEMONSTRATION PROJECT		0		70.50
0. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70.8
0. 90	instructions) HSP bonus payment HVBP adjustment amount (see		_		70.90
0.70	instructions)		0		10.90
0. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 9 [.]
0. 92	Bundled Model 1 discount amount (see instructions)		0		70.9
0. 93	HVBP payment adjustment amount (see instructions)		13, 616		70.9
0.94	HRR adjustment amount (see instructions)		-10, 499		70.94

	Financial Systems COMMUNITY HOSPT. OF ATLON OF RELIMBURSEMENT SETTLEMENT	Provider CCN: 150146		eriod: com 01/01/2014 o 12/31/2014	5/22/2015 1:0	
		Title XVIII		Hospi tal	PPS	
				Prior to	On/After	
				October 1	October 1	
		0		1.00	2.00	
0.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	20)14	295, 356		70.96
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	20)15	101, 144		70.97
0. 98	Low Volume Payment-3			0		70.98
	HAC adjustment amount (see instructions)			0		70.99
1. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			3, 563, 697		71.00
	Sequestration adjustment (see instructions)			71, 274		71.0
	Interim payments			3, 480, 368		72.00
	Tentative settlement (for contractor use only)			0		73.00
	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			12, 055		74.0
5.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0		75.0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0		90.00
1.00	Capital outlier from Wkst. L, Pt. I, line 2			0		91.00
2.00	Operating outlier reconciliation adjustment amount (see instructions)			0		92.00
3.00	Capital outlier reconciliation adjustment amount (see instructions)			0		93.0
4.00	The rate used to calculate the time value of money (see instructions)			0.00		94.0
	Time value of money for operating expenses (see instructions)			0		95.00
6.00	Time value of money for capital related expenses (see instructions)			0		96.00
				Prior to 10/1	0n/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment		-		-	
	HVBP adjustment factor (see instructions)			0		101.0
	HVBP adjustment amount for HSP bonus payment (see instructio HRR Adjustment for HSP Bonus Payment	ns)		0	0	102.0
	HRR adjustment factor (see instructions)			0.0000	0,0000	103 0
	HRR adjustment amount for HSP bonus payment (see instruction			0.0000		103.0

N VO	Financial Systems			Provi der	CCN: 150146 F	Period:	Worksheet E	
					F	From 01/01/2014 To 12/31/2014	Part A Exhibi Date/Time Pre	pare
				T; +I	0 XV/111	Hocni tol	5/22/2015 1:0 PPS	5 pn
		W/S F Part A	Amounts (from	Pre/Post	e XVIII Period Prior	Hospi tal Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0			0	
1	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2, 253, 310	0	2, 253, 310	0	2, 253, 310	1
)2	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	765, 215	0	C	765, 215	765, 215	1
3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	C	0	0	1
4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	C	0	0	1
0	Outlier payments for discharges (see instructions)	2.00	30, 040	0	25, 706	4, 334	30, 040	2
)1	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	c	0	0	2
00	Operating outlier reconciliation	2.01	0	0	(0	0	
00	Managed care simulated payments	3.00	0	0	C	0 0	0	4
0	Indirect Medical Education Adju Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0.00000	0.000000		5
0	IME payment adjustment (see instructions)	22.00	0	0	C	0	0	
1	IME payment adjustment for managed care (see instructions)	22.01	0	0	(0	0	(
~	Indirect Medical Education Adju					0 000000		
0	IME payment adjustment factor (see instructions) IME adjustment (see	27.00 28.00	0. 000000	0. 000000		0.000000	0	8
1	instructions) IME payment adjustment add on	28.00	0	0			0	
	for managed care (see instructions)							
0	Total IME payment (sum of lines 6 and 8)	29.00	0	0	(0	0	
	Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustme	29.01	0	0		0	0	
	Allowable disproportionate share percentage (see	33.00	0. 0673	0.0673	0.0673	0.0673		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	50, 787	0	37, 912	2 12, 875	50, 787	11
	Uncompensated care payments Additional payment for high per	36.00 centage of ES	353, 043 RD benefi ci ary		284, 728	68, 315	353, 043	11
00	Total ESRD additional payment	46.00	0		C	0 0	0	12
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	3, 452, 395 0	0	2, 601, 656 (850, 739 0 0	3, 452, 395 0	13 14
00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see	49.00	3, 452, 395	0	2, 601, 656	850, 739	3, 452, 395	15
00	instructions) Payment for inpatient program	50.00	245, 681	0	182, 856	62, 825	245, 681	16
00	capital Special add-on payments for new technologies	54.00	0	0	C	0	0	17
01 02	Net organ aquisition cost Capital received from	55.00 68.00	0	0			0	17
	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see		0	0				18

	Financial Systems LUME CALCULATION EXHIBIT 4		UNI TY HOSPT. OF			Period: From 01/01/2014 To 12/31/2014		t 4 pared:
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E. Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3,00	4.00	5.00	
19.00	SUBTOTAL			0	2, 784, 51	2 913, 564	3, 698, 076	19.00
		W/S L, line	(Amounts from L)	-				
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	239, 609	0	177, 74	61, 868	239, 609	20.00
	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	6,072	0	5, 11	5 957	6,072	21.00
	Model 4 BPCI Capital DRG	2.01	0	0		0 0	0	21.01
	outlier payments						-	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0. 000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.00
24.00	Al lowable di sproporti onate share percentage (see i nstructi ons)	10.00	0. 0000	0. 0000	0.000	0.0000		24.00
25.00	Disproportionate share	11.00	0	0		0 0	0	25.00
	adjustment (see instructions)		-			-	-	
26.00	Total prospective capital payments (see instructions)	12.00	245, 681	0	182, 85	66 62, 825	245, 681	26.00
	payments (see instructions)	W/S E, Part A	(Amounts to E					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor	0	1.00	2.00	0, 10607			27.00
28.00	Low volume adjustment ractor	70, 96			295, 35		295, 356	
20.00	(transfer amount to Wkst. E, Pt. A, line)	70. 70			275, 55		275, 550	20.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				101, 144	101, 144	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

LOUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Pre 5/22/2015 1:0	
		Title XVIII	Hospi tal	PPS	, <u>, , , , , , , , , , , , , , , , , , </u>
				1.00	-
	PART B - MEDI CAL AND OTHER HEALTH SERVI CES			1.00	
00	Medical and other services (see instructions)			0	1
00	Medical and other services reimbursed under OPPS (see instruct	tions)		2, 914, 109	
00	PPS payments			2, 843, 271	
00 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruc	ati anc)		5, 763 0. 864	
00	Line 2 times line 5			2, 517, 790	
. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
. 00	Transitional corridor payment (see instructions)			0) e
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
	Organ acqui si ti ons			0	
1.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11
	Reasonabl e charges				1
2.00	Ancillary service charges			0	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, o	col. 4)		0	13
4.00	Total reasonable charges (sum of lines 12 and 13)			0	14
- 00	Customary charges	and the state of t			
	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for			0) 15) 16
5.00	had such payment been made in accordance with 42 CFR §413.13(in a chargebasis	0	
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17
	Total customary charges (see instructions)			0	18
9.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19
~ ~~	instructions)		10) (0	
J. 00	Excess of reasonable cost over customary charges (complete onl instructions)	Ty IT The IT exceeds IT	ne 18) (see	0	20
1.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		0	21
	Interns and residents (see instructions)			0	22
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
4.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			2, 849, 034	24
5 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			667, 995	25
6.00		r CAH, see instructions)		0	
7.00				2, 181, 039	27
	CAH, see instructions)				
	Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	
	ESRD direct medical education costs (from Wkst. E-4, line 36)			2 191 020	
	Subtotal (sum of lines 27 through 29) Primary payer payments			2, 181, 039 537	
	Subtotal (line 30 minus line 31)			2, 180, 502	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
3.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			49, 287	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		32, 037 30, 795	
	Subtotal (see instructions)			2, 212, 539	
	MSP-LCC reconciliation amount from PS&R			2, 212, 337	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39
	Pioneer ACO demonstration payment adjustment (see instructions			0	
	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0 2 212 520	
	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 212, 539 44, 251	
	Interim payments			2, 193, 492	
	Tentative settlement (for contractors use only)			0	
	Balance due provider/program (see instructions)			-25, 204	
4.00		nce with CMS Pub. 15-2,	chapter 1,	0	44
	§115.2 TO BE COMPLETED BY CONTRACTOR				-
	Original outlier amount (see instructions)			0	90
0.00					
	Outlier reconciliation adjustment amount (see instructions)			0	7 7
1. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150146	Period: From 01/ To 12/	′01/2014 ′31/2014		pared:
		Titl	e XVIII	Hosp	i tal	PPS	
		I npati en	nt Part A		Par	rt B	
		mm/dd/yyyy	Amount	mm/dc	l∕yyyy	Amount	
		1.00	2.00		00	4.00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		3, 480, 3	68 0		2, 156, 892 0	1.0 2.0
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3. 0
	Program to Provider		1				
01 02	ADJUSTMENTS TO PROVIDER			0 08/08	3/2014	36, 600 0	3.0 3.0
02				0		0	3.0
04				0		0	3.0
05				0		0	3.0
	Provider to Program						
50	ADJUSTMENTS TO PROGRAM			0		0	3.5
51				0		0	3.5
52 53				0		0	3.5 3.5
54				0		0	3.5
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0		36, 600	3. 9
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 480, 3	68		2, 193, 492	4. (
~~	TO BE COMPLETED BY CONTRACTOR		1				
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						5.0
01	TENTATI VE TO PROVI DER		1	0		0	5.0
02				0		0	5.0
03				0		0	5.0
50	Provider to Program						-
50 51	TENTATI VE TO PROGRAM			0		0	5. 5.
51 52				0		0	5. 5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0		0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)						6.
01	SETTLEMENT TO PROVIDER		12, 0			0	6.
02	SETTLEMENT TO PROGRAM			0		25, 204	6.
00	Total Medicare program liability (see instructions)		3, 492, 4			2, 168, 288	7.
					ractor nber	NPR Date (Mo/Day/Yr)	
			0		00	2.00	
00	Name of Contractor						8.

Heal th	Financial Systems COMMUNITY HOSPT. OF NOE	BLE CTY, INC.	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150146	Peri od:	Worksheet E-1	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
		Title XVIII	Hospi tal	PPS	<u>5 pili</u>
			10301 tui	115	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S	-3, Pt. I col. 15 line	e 14	1, 632	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1			2, 133	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1, 520	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		5, 579	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			143, 730, 561	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	e 20		2, 071, 216	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			696, 491	8.00
9.00	Sequestration adjustment amount (see instructions)			13, 930	9.00
10.00	Calculation of the HIT incentive payment after sequestration (s	ee instructions)		682, 561	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			685, 426	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and lin	e 31) (see instruction	is)	-2,865	32.00

nd_+	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl		CCN: 150146	Period: From 01/01/2014	Worksheet G	
iu-t	ype accounting records, comprete the General rund cordinin on	y)		To 12/31/2014	Date/Time Pre 5/22/2015 1:0	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS		1			
00	Cash on hand in banks	1, 879		0 0	0	
00	Temporary investments Notes receivable	0		0 0	0	
00	Accounts receivable	16, 531, 428		0 0	0	
00	Other receivable	4, 286, 344		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-9, 638, 366		0 0	0	
00	Inventory	224, 952		0 0	0	
00 00	Prepaid expenses Other current assets	26, 765		0 0	0	
00	Due from other funds	0		0 0	0	
00	Total current assets (sum of lines 1-10)	11, 433, 002		0 0	0	
	FIXED ASSETS					
00	Land	0		0 0	0	
00	Land improvements	637, 235		0 0	0	
00	Accumulated depreciation	-259, 285 3, 109, 044		0 0	0	
00	Buildings Accumulated depreciation	-939, 094		0 0	0	
00	Leasehold improvements	57, 402		0 0	0	
00	Accumulated depreciation	-11, 662		0 0	0	18
00	Fixed equipment	52, 820		0 0	0	
00	Accumulated depreciation	-31, 829		0 0	0	
00	Automobiles and trucks Accumulated depreciation	81, 334 -81, 334		0 0	0	
00	Major movable equipment	10, 792, 613		0 0	0	
00	Accumulated depreciation	-9, 638, 016		0 0	0	
00	Minor equipment depreciable	951, 470		0 0	0	25
00	Accumulated depreciation	-390, 125		0 0	0	
00	HIT designated Assets	0		0 0	0	
00	Accumulated depreciation Minor equipment-nondepreciable	0		0 0	0	
	Total fixed assets (sum of lines 12-29)	4, 330, 573		0 0	0	
	OTHER ASSETS	.,	1	-1 -1		
00	Investments	6, 366		0 0	0	31
00	Deposits on Leases	0		0 0	0	
00	Due from owners/officers	844, 675		0 0	0	
00	Other assets Total other assets (sum of lines 31-34)	851, 041		0 0	0	
00	Total assets (sum of lines 11, 30, and 35)	16, 614, 616		0 0	0	
	CURRENT LI ABI LI TI ES	10/011/010				1 00
00	Accounts payable	625, 949		0 0	0	37
00	Salaries, wages, and fees payable	732, 090		0 0	0	
00 00	Payroll taxes payable	124, 827 0		0 0	0	
00	Notes and Loans payable (short term) Deferred income	0		0 0	0	1 .0
00	Accel erated payments	0		0 0		42
00	Due to other funds	0		0 0	0	
00	Other current liabilities	997, 560		0 0	0	
00	Total current liabilities (sum of lines 37 thru 44)	2, 480, 426		0 0	0) 45
00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	46
00	Notes payable	0		0 0	0	
00	Unsecured Loans	0		0 0	0	
00	Other long term liabilities	301, 073		0 0	0	49
00	Total long term liabilities (sum of lines 46 thru 49	301, 073		0 0	0	
00	Total liabilites (sum of lines 45 and 50)	2, 781, 499		0 0	0	51
00	CAPI TAL ACCOUNTS General fund balance	13, 833, 117				52
00	Specific purpose fund	13,033,117		0		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	13, 833, 117		0 0	0	59
00			1	0		1 37

General 1.00 0 0 0 0 0 10, 151, 932		CCN: 150146	4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5/22/2015 1:0 Endowment Fund 5:00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5 pm 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
1.00 0 0 0 0 0 0 0	2.00 13,836,492 10,148,557 23,985,049	•		5.00 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
0 0 0 0 0 0	13, 836, 492 10, 148, 557 23, 985, 049 0	3.00		0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
0 0 0 0 0 0	13, 836, 492 10, 148, 557 23, 985, 049 0	3.00		0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
	10, 148, 557 23, 985, 049 0			0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
0 0 0 0	10, 151, 932			0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
					17.00
Endowment Fund	PI ant	Fund			
6.00	7.00	8.00			
0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
0 0 0	0 0 0 0 0 0		0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
	Endowment Fund 6.00 0 0 0	0 10, 151, 932 13, 833, 117 6. 00 7. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 10, 151, 932 13, 833, 117 Endowment Fund 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	0 0

STATE	I Financial Systems COMMUNITY HOSPT. OF NOBLE MENT OF PATIENT REVENUES AND OPERATING EXPENSES P		CCN: 150146	Peri od:		worksheet G-2	
				From 01/0 To 12/3	1/2014 1/2014	Date/Time Pre	
	Cost Center Description		Inpati ent	Outpat	ient	5/22/2015 1:0 Total	
			1.00	2.0		3.00	
	PART I - PATIENT REVENUES				<u> </u>	0100	
	General Inpatient Routine Services						1
1.00	Hospi tal		7, 255, 6	05		7, 255, 605	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 255, 6	05		7, 255, 605	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00 16.00	OTHER SPECIAL CARE (SPECIFY)			0		0	15.00 16.00
16.00	Total intensive care type inpatient hospital services (sum of line 11-15)	32		0		0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		7, 255, 6	05		7, 255, 605	17.00
18.00	Ancillary services		27, 560, 3		0		
19.00	Outpatient services		27, 300, 3		58, 529		
20.00	RURAL HEALTH CLINIC			0	00, 02,		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	-	
22.00	HOME HEALTH AGENCY			-	-		22.00
23.00	AMBULANCE SERVICES			0 6,8	69, 937	6, 869, 937	
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	OTHER (SPECIFY)			0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst.	34, 815, 9	80 114, 4	28, 466	149, 244, 446	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES					-	
29.00	Operating expenses (per Wkst. A, column 3, line 200)				93, 197		29.00
30.00	PROVISION FOR BAD DEBT		9, 127, 6				30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				27, 668		36.00
37.00	DEDUCT (SPECIFY)			0			37.00
38.00				0			38.00
39.00 40.00				0			39.00
40.00				0			40.00
41.00	Total deductions (sum of lines 37-41)			0	^		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	rancfor		Б1 1	0 20, 865		42.00
43.00	to Wkst. G-3, line 4)	01151 61		51, 1	20,000		43.00

Heal th	Financial Systems COMMUNITY HOSPT. OF	NOBLE CTY. INC.	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 150146 Period: From 0		Period: From 01/01/2014	Worksheet G-3		
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	149, 244, 446	1.00		
2.00	Less contractual al lowances and discounts on patients' accounts				2.00
3.00	Net patient revenues (line 1 minus line 2)			90, 006, 726 59, 237, 720	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		51, 120, 865	4.00
5.00	Net income from service to patients (line 3 minus line 4)	,		8, 116, 855	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			3, 965	7.00
8.00	Revenues from telephone and other miscellaneous communicatio	n services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			119, 863	14.00
15.00				0	15.00
16.00		than patients		0	16.00
17.00				0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	5			0	20.00
21.00				0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER (SPECIFY)			0	24.00
24.01				-10, 196	
24.02				168, 694	
24.03				1, 749, 376	24.03
25.00				2, 031, 702	
	Total (line 5 plus line 25)			10, 148, 557	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			10, 148, 557	29.00

LCULATION OF CAPITAL PAYMENT	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prep 5/22/2015 1:05			
	Title XVIII	Hospi tal	PPS	- 1		
			1.00			
PART I - FULLY PROSPECTIVE METHOD						
	CAPI TAL FEDERAL AMOUNT					
	Capital DRG other than outlier			1.		
01 Model 4 BPCI Capital DRG other than outlier			0 6, 072	1.		
	Capital DRG outlier payments			2.		
	Model 4 BPCI Capital DRG outlier payments			2.		
Total inpatient days divided by number of days in the cost reporting period (see instructions)				4		
00 Number of interns & residents (see instructions) 00 Indirect medical education percentage (see instructions)	Number of interns & residents (see instructions)					
				5		
Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line				7		
30) (see instructions)						
Percentage of Medicaid patient days to total days (see instructions)				8		
Sum of lines 7 and 8			0.00			
0 Allowable disproportionate share percentage (see instructions)			0.00			
.00 Disproportionate share adjustment (line 10 times the sum o			0			
.00 Total prospective capital payments (sum of lines 1, 1.01, 1	2, 2.01, 6 and 11)		245, 681	12		
			1.00			
PART II - PAYMENT UNDER REASONABLE COST			0			
	Program inpatient routine capital cost (see instructions)					
00 Program inpatient ancillary capital cost (see instructions 00 Total inpatient program capital cost (line 1 plus line 2))		0	2		
00 Capital cost payment factor (see instructions)			0	4		
00 Total inpatient program capital cost (line 3 x line 4)			0			
			0			
			1.00			
PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 1		
00 Program inpatient capital costs (see instructions) 00 Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	1		
00 Net program inpatient capital costs for extraordinary circumst 00 Net program inpatient capital costs (line 1 minus line 2)			0			
00 Applicable exception percentage (see instructions)			0.00	4		
Copital cost for comparison to payments (line 3 x line 4)			0			
00 Percentage adjustment for extraordinary circumstances (see	instructions)		0.00			
00 Adjustment to capital minimum payment level for extraording		line 6)	0	7		
00 Capital minimum payment level (line 5 plus line 7)	<u>,</u>		0	8		
00 Current year capital payments (from Part I, line 12, as ap	plicable)		0	9		
.00 Current year comparison of capital minimum payment level t			0			
.00 Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14)	r capital payment (from pri	or year	0	11.		
	payments (line 10 plus lin	e 11)	0	12		
.00 Net comparison of capital minimum payment level to capital	ter the amount on this line)	0	13		
	ter the unount of this fine		0	14		
.00 Current year exception payment (if line 12 is positive, en .00 Carryover of accumulated capital minimum payment level ove		ollowing period	0			
 .00 Current year exception payment (if line 12 is positive, en .00 Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line) 	r capital payment for the f	ollowing period	0	15		
.00 Current year exception payment (if line 12 is positive, en .00 Carryover of accumulated capital minimum payment level ove	r capital payment for the f instructions)	ollowing period	-			