			LAITINES 05-51-2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0146	Peri od: From 01/01/2016 To 12/31/2016	Date/Time Prepared
			E /22 /2017 0. 40 cm

					10	12/31/2016	5/22/2017	
PART I - COST	REPORT	STATUS						
Provi der	1. [X] Electronically filed	cost report		Da	te: 5/22/20	17 Tim∈	e: 9:40 aı
use only	2. [] Manually submitted co	ost report					
			report enter the number Enter "F" for full or "L		resubmi t	ted this co	ost report	
Contractor use only	(1) (2) (3)		6. Date Received: 7. Contractor No. 8. [N] Initial Report fo 9. [N] Final Report for	r this Provider CCN 12.	.[0]If	tor's Vendo	lumn 1 is	

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPT. OF NOBLE CTY, INC. (15-0146) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)_______Officer or Administrator of Provider(s)

Title

Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	58, 995	-20, 066	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	58, 995	-20, 066	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0146 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/22/2017 9:39 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 401 SAWYER ROAD P0 Box: 728 1.00 Zip Code: 46755-0728 County: NOBLE 2.00 City: KENDALLVILLE State: IN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPT. OF 150146 99915 1 05/30/2000 Ν 3.00 NOBLE CTY, INC. Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2016 12/31/2016 20.00 21.00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3. 00 4.00 5.00 6.00 29 24.00 If this provider is an IPPS hospital, enter the 217 609 462 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

0. od

0.00

o. od

0.00

61.04

61.05

instructions)

61.04

Enter the number of unweighted primary care/or

61.04 minus line 61.03). (see instructions)

surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).
61.05 Enter the difference between the baseline primary

and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line

Health Financial Systems COMMUNITY HOS					u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	·A	Provi der Co	F	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Pre 5/22/2017 9:39	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4.00	5. 00	
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.0	O		61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. 00		61. 10
					1.00	
ACA Provisions Affecting the Health Resources and Serv						
62.00 Enter the number of FTE residents that your hospital to your hospital received HRSA PCRE funding (see instruct		in this cost	reporting per	iod for which	0. 00	62. 00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progr	Teachi			your hospital	0. 00	62. 01
Teaching Hospitals that Claim Residents in Nonprovider						1
63.00 Has your facility trained residents in nonprovider set						

MCRI F32 - 10. 5. 160. 2

N

Ν

N

94.00

applicable column.

94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the

Health Financial Systems COMMUNITY HOSPT. OF	NOBLE CTY, IN	IC.	Li	n Lieu	ı of Forr	n CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti	et S-2 me Prepared:
			V		5/22/20	17 9:39 am
			1. 00		2. 0	
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N		0. 0 N	
97.00 If line 96 is "Y", enter the reduction percentage in the appl Rural Providers	licable column	٦.	0.00		0.0	97. 00
105.00 Does this hospital qualify as a critical access hospital (CAI 106.00 of this facility qualifies as a CAH, has it elected the all-ifor outpatient services? (see instructions)		nod of payment	N t			105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see instr	ructions) If	t			107. 00
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.			N			108. 00
	Physi cal 1.00	0ccupati onal 2.00	Speec 3. 00		Respi ra 4. 0	
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	2.00	3.30			109. 00
					1.0	0
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" 1		on project (4°	10A Demo)fo	r	N	110. 00
				1. 00	2.00	3. 00
Miscellaneous Cost Reporting Information	"N" 6					115.00
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or 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 providers Pub. 15-1, chapter 22, §2208.1.	If column 2 i t for long ter	s "E", enter rm care (inclu	in column udes	N		0 115.00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insura	-		"N" for	N Y		116. 00 117. 00
no. 118.00 Is the mal practice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	f the policy	is	1		118. 00
eranii iiiaac. Enter 2 ii the porrey 13 decarrence.		Premi ums	Losse	S	Insura	ance
		1.00	2.00		2.0	0
118.01 List amounts of malpractice premiums and paid losses:		1. 00 35, 11	2. 00 12 1	4, 887	3. 0 1	32, 140 118. 01
			1.00		2.0	0
118.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			1. 00 Y		2. 0	118. 02
119.00 DO 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 qual	column 1, "Y' alifies for th	' for yes or ne Outpatient	N		Υ	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	ntable devices	s charged to	Y			121. 00
122.00 Does the cost report contain state health or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.			N			122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N"	for no. If	N			125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 on this is a Medicare certified kidney transplant center, enter the column 1 and termination date if applicable in column 2.		fication date				126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, entering in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date				127. 00
128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date				128. 00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	r the certific		ו			129. 00
130.00 f this is a Medicare certified pancreas transplant center, and date in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date.	umn 2.					130. 00
131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1						11.51 ()()
132.00 If this is a Medicare certified islet transplant center, entering in column 1 and termination date, if applicable, in column 2.	umn 2. er the certifi					132. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	COMMUNITY HOSPT. O	Provi der CC		Peri od: From 01/01/2016 To 12/31/2016		-2 repared:
				1. 00	2. 00	
133.00 If this is a Medicare certified other			cation date			133. 00
in column 1 and termination date, if 134.00 If this is an organ procurement organ and termination date, if applicable,	nization (OPO), enter t		n column 1			134. 00
All Providers 140.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the ho	for no in column 1. If	yes, and home	office cost	S Y	15H032	140. 00
1.00	2.		1 0113)	3. 00		
If this facility is part of a chain				name and address	of the	
home office and enter the home office 141.00 Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: W			tor's Number: 081	01	141. 00
142.00 Street: 10501 CORPORATE DRIVE		600				142. 00
143.00 City: FORT WAYNE	State: I	N	Zi p Code	e: 468	45	143. 00
					1.00	
144.00 Are provider based physicians' costs	included in Worksheet	A?			Y	144. 00
145 001 f costs for ronal occident	nod on Wks+ A li 7:	1 and the!	for	1.00	2.00	145.00
inpatient services only? Enter "Y" fo no, does the dialysis facility include period? Enter "Y" for yes or "N" for	or yes or "N" for no ir de Medicare utilization	column 1. If o	column 1 is	N	N	145. 00
146.00 Has the cost allocation methodology of Enter "Y" for yes or "N" for no in co yes, enter the approval date (mm/dd/	changed from the previo Dlumn 1. (See CMS Pub.			N f		146. 00
					1.00	_
147.00 Was there a change in the statistical	basis? Enter "Y" for	yes or "N" for	no.		N N	147. 00
148.00 Was there a change in the order of al	location? Enter "Y" fo	or yes or "N" fo	or no.		N	148. 00
149.00 Was there a change to the simplified	cost finding method? E				N Title VIV	149. 00
		Part A 1.00	Part B 2.00	7i tle V 3.00	Title XIX 4.00	
Does this facility contain a provide	r that qualifies for a					
or charges? Enter "Y" for yes or "N"	for no for each compor					
155.00 Hospi tal 156.00 Subprovi der - IPF		N N	l N l N	N N	N N	155. 00 156. 00
157.00 Subprovider - TRF		N	N N	N N	N	157. 00
158. 00 SUBPROVI DER						158. 00
159. 00 SNF		N	N	N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N N	N	N	160.00
161. 00 CMHC			N N	N	N	161.00
					1.00	
Multicampus						
165.00 Is this hospital part of a Multicampu Enter "Y" for yes or "N" for no.	·	<u> </u>			N FTE (Compute	165. 00
	Name O	County 1.00	2. 00	i p Code	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each	U	1. 00	2.00	1.00		00 166. 00
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)						
		D-	-l D-: :		1.00	
Health Information Technology (HIT) 1 167.00 s this provider a meaningful user un				nt Act	Y	167. 00
168.00 If this provider is a CAH (line 105 i reasonable cost incurred for the HIT	s "Y") and is a meanir	ngful user (line), enter the	r	0168.00
168.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)? E	a meaningful user, doe nter "Y" for yes or "N"	es this provider ' for no. (see i	nstructi ons)		168. 01
169.00 If this provider is a meaningful used transition factor. (see instructions)		d is not a CAH ((line 105 is	"N"), enter the	9.	99169.00

Health Financial Systems	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CCN: 15-0146	Peri od:	Worksheet S-2	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre	
				5/22/2017 9:3	9 am
	Begi nni ng	Endi ng			
	1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR b	01/01/2016	12/31/2016	170. 00		
period respectively (mm/dd/yyyy)					
			1. 00	2.00	1
171.00 If line 167 is "Y", does this prov	N	0	171. 00		
section 1876 Medicare cost plans r					
"Y" for yes and "N" for no in colu	ımn 1. If column 1 is yes, e	enter the number of section	n		
1876 Medicare days in column 2. (s	ee instructions)				

	Financial Systems COMMUNITY HOSPT. (u of Form CMS-	-2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0146	Peri od: From 01/01/2016 To 12/31/2016		epared:
		'		Y/N	Date	1
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	sponses. Ent	er all dates in t	:he	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N)		1.00
	<u> </u>		Y/N	Date	V/I	
			1.00	2. 00	3. 00	
 2.00 3.00 	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary. Is the provider involved in business transactions, includi	umn 3, "V" for ng management	N N			3.00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	der or its of the board				
			Y/N	Туре	Date	
			1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av	for Compiled,	Y	A		4.00
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N	V (1)		5. 00
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	e provider i	s N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see i	nstructions.		N		7. 00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	d and/or renewed	during the	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	he current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.		roved	N		11. 00
					Y/N 1. 00	
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye				Y	12.00
	period? If yes, submit copy.	. , ,	3	, 3	N	13.00
	If line 12 is yes, were patient deductibles and/or co-paym	nents waived? If	yes, see in	STructi ons.	N	14.00
14. 00	Bed Complement					
	Did total beds available change from the prior cost report				N	15. OC
			yes, see ins t A Date		N Tt B Date	15. 00

		11.00	2.00	0.00	11.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	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 Report for	Υ	05/01/2017	Υ	05/01/2017	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		Y		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
40.00	cost report? If yes, see instructions.					40.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.				l	I

Heal th	Financial Systems COMMUNITY HOSPT. 0	F NOBLE CTY, II	NC.	In Lie	u of Form CMS	-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0146	Period: From 01/01/2016 To 12/31/2016	Worksheet S- Part II	2 epared:		
			i pti on	Y/N	Y/N	o an		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00		
20.00	Report data for Other? Describe the other adjustments:			IN IN	IV	20.00		
		Y/N	Date	Y/N	Date			
21 00	Was the east report propored only using the provider's	1.00	2.00	3.00	4. 00	21.00		
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 HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)					
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	e instructions				22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense		als made duri	ng the cost		23. 00		
	reporting period? If yes, see instructions.							
24. 00	Were new leases and/or amendments to existing leases entered of the property of the second of the se	· ·	·			24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? If	yes, see		26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit		27. 00		
28. 00	Interest Expense ON Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting							
29. 00								
30. 00								
31. 00	instructions. On Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.							
32. 00	Purchased Servi ces	rvices furnishe	ed through con	itractual		32. 00		
33. 00	arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 approximately appro	uctions. olied pertainir	ng to competit	ive bidding? If		33. 00		
	Provi der-Based Physi ci ans			ı				
34. 00	Are services furnished at the provider facility under an arlf yes, see instructions.	rrangement with	n provi der-bas	sed physicians?		34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the p	rovi der-based		35. 00		
				Y/N	Date			
	Home Office Costs			1.00	2. 00			
36. 00						36. 00		
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?			37. 00		
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end					38. 00		
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compor	nents? If yes,			39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00		
		1.	00					
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report	PARKVIEW HEALT	H SYSTEM, INC			42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	260-373-8406		ERI C. NI CKESON@F	PARKVI EW. COM	43. 00		

Heal th	Financial Systems COM	MMUNITY HOSPT.	OF N	NOBLE CTY, I	NC.		In Lie	u of Form C	MS-2	552-10
HOSPI 7	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE		Provi der	CCN: 15-0146	Peri		Worksheet	S-2	
						To	n 01/01/2016 12/31/2016			
				3	. 00					
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the tit	le/position	DI	RECTOR REIM	BURSEMENT					41.00
	held by the cost report preparer in columns	1, 2, and 3,								
	respecti vel y.									
42.00	Enter the employer/company name of the cost	report								42.00
	preparer.									
43.00	Enter the telephone number and email addres	s of the cost								43.00
	report preparer in columns 1 and 2, respect	i vel y.								

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2016 | Part I | Date/Time Prepared: | Provider CCN: 15-0146

					12/31/2010	5/22/2017 9: 3	
						I/P Days / 0/P	, cann
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2. 00	3, 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00		11, 346	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and			,			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					l ol	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					ol	6.00
7. 00	Total Adults and Peds. (exclude observation		31	11, 346	0.00	o	7. 00
	beds) (see instructions)			,			
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		31	11, 346	0.00		14. 00
15. 00	CAH visits			,		0	15. 00
16. 00	SUBPROVIDER - IPF					_	16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	31			Ĭ	27. 00
28. 00	Observation Bed Days		0.			0	28. 00
29. 00	Ambul ance Tri ps					Ĭ	29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	o			32. 00
32. 01	Total ancillary labor & delivery room						32. 00
JZ. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days						33. 00
55. 55	1=155 55 54 44	ı		1		1	55. 00

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 COMMUNITY HO

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0146

Peri od: Worksheet S-3
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/22/2017 9: 39 am

		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	7 alli
	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, 089	116	5, 050			1. 00
2. 00 3. 00 4. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	1, 071 0 0	1, 070 0 0				2. 00 3. 00 4. 00
5. 00 6. 00 7. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	0 2, 089	0 0 116	0 0 5, 050			5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY		85	492			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 23. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	2, 089 0	201 0	5, 542 0	0.00	216. 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. 00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0	0	0			24. 00 24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambul ance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)	0 1, 630 0	0 254 46	0 1, 401 50 0 67	0. 00 0. 00	0. 00 216. 00	27. 00 28. 00 29. 00 30. 00 31. 00 32. 00
32. 01 33. 00	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0		0			32. 01

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 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-0146

Peri od: Worksheet S-3
From 01/01/2016
To 12/31/2016 Date/Ti me Prepared: 5/22/2017 9:39 am

						5/22/2017 9: 3	9 am
		Full Time Equivalents	·	Di sch	arges		
	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)			647	422	1, 789	1. 00
2.00	HMO and other (see instructions)			326	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00		647	422	1, 789	14.00
15.00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0146

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2016 | Part II | Date/Time Prepared: | From 2/2/2017 | Prepared: | From 2

					To	12/31/2016	Date/Time Pre 5/22/2017 9:3	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from	(col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
	+	1.00	2.00	Worksheet A-6) 3.00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	14, 711, 722	3, 634, 114	18, 345, 836	606, 744. 00	30. 24	1.00
2. 00	instructions) Non-physician anesthetist Part	200.00	0		0	0. 00		
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
4. 00	B Physician-Part A - Administrative		54, 000	0	54, 000	488. 00	110. 66	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0		0	0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6.00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7.00
7. 01	Contracted interns and residents (in an approved programs)		0	0	О	0.00	0.00	7.0
8.00	Home office and/or related organization personnel		3, 634, 403	0	3, 634, 403	119, 634. 00	30. 38	8.00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 1, 889, 742	0 187, 057	0 2, 076, 799	0. 00 89, 704. 00	l .	
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		0	0	0	0. 00	0. 00	11.00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0. 00	13.00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		3, 634, 403	0	3, 634, 403	119, 634. 00	30. 38	14.00
14. 01	Home office salaries		0	О	0	0.00		14. 0
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		
16. 00	- Administrative Home office and Contract		0	_		0.00		
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		3, 844, 409	0	3, 844, 409			17. 00
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 0
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		631, 905 0	0	631, 905 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part B		0	О	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 0
22. 01	Physician Part A - Teaching		0	0	0			22. 0 23. 0
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00
25. 50	approved program) Home office wage-related		1, 044, 196	0	1, 044, 196			25. 50
25. 5125. 52	Related orgainzation wage-related Home office: Physician Part A		0	0	0			25. 5° 25. 5°
20. 52	- Administrative - wage-related		0					25. 5.
25. 53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25. 5
26 00	OVERHEAD COSTS - DIRECT SALARIE	4. 00	2 050 214	_2 OE0 214	0	0. 00	0.00	26. 00
26.00	Employee Benefits Department Administrative & General	4. 00 5. 00	2, 058, 314 676, 522					26.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0146

Peri od: Worksheet S-3 From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared:

5/22/2017 9:39 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number on of Salaries Sal ari es Related to Wage (col. 4 Reported (col . 2 ± col . col . 5) (from Salaries in col. 4 Worksheet A-6) 3) 1.00 2.00 6.00 4.00 5.00 3.00 28.00 Administrative & General under 0.00 0.00 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 29.00 0.00 Operation of Plant 30.00 7.00 378, 580 38, 457 417, 037 16, 530. 00 25. 23 30.00 31.00 8.00 0.00 Laundry & Linen Service 31.00 0.00 32.00 Housekeepi ng 9.00 267, 369 27, 166 294, 535 24, 538. 00 12.00 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 14. 62 15, 994. 00 34.00 10.00 344, 380 -110, 588 233, 792 34.00 Di etary 35.00 Di etary under contract (see 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 10, 969. 00 12. 43 136, 350 136, 350 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 38.00 Nursing Administration 13.00 440, 930 44, 790 485, 720 12, 627. 00 38. 47 38.00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 Pharmacy 51. 35 40.00 15.00 536, 281 54, 476 590, 757 11, 504. 00 40.00 Medical Records & Medical 41.00 16.00 0 0.00 0.00 41.00 Records Library Social Service 42.00 17.00 0 0 0 0.00 0.00 42.00 0.00 43.00 43.00 Other General Service 18.00 0 0 0.00

Total overhead cost (see

instructions)

7.00

31.86

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2016 To 12/31/2016 Part III Date/Time Prepared: 5/22/2017 9:39 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) Salaries in (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 11, 077, 319 3, 634, 114 14, 711, 433 487, 110. 00 30. 20 1.00 instructions) 2.00 1, 889, 742 187, 057 2, 076, 799 89, 704. 00 23. 15 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 9, 187, 577 3, 447, 057 12, 634, 634 397, 406. 00 31.79 3.00 minus line 2) 4.00 Subtotal other wages & related 3, 634, 403 3, 634, 403 119, 634. 00 30. 38 4.00 costs (see inst.) Subtotal wage-related costs 5.00 4, 888, 605 Ω 4, 888, 605 0.00 38.69 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 17, 710, 585 3, 447, 057 21, 157, 642 517, 040. 00 40 92

4, 702, 376

2, 614, 006

7, 316, 382

229, 633. 00

Health Financial Systems
HOSPITAL WAGE RELATED COSTS Provider CCN: 15-0146

	To 12/31/2016	Date/Time Prep 5/22/2017 9:39	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	242, 906	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	574, 068	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	2, 874	6. 00
7.00	Employee Managed Care Program Administration Fees	56, 297	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2, 437, 843	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	23, 851	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	64, 327	13. 00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	17, 632	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16, 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	981, 308	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	40, 023	21. 00
	instructions))		
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	35, 185	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4, 476, 314	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	COMMUNITY HOSPT. OF NOBLE CTY, INC.	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0146	Period: Worksheet S-3

		Го 12/31/2016	Date/Time Prep 5/22/2017 9:39	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	4, 476, 314	1.00
2.00	Hospi tal	0	4, 476, 314	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			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	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
14. 00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17.00
18. 00	Other	0	0	18. 00

	Financial Systems COMMUNITY HOSPT. OF NOBLE CTY,			u of Form CMS-2	
HOSPI 7	FAL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 15-0146	Peri od: From 01/01/2016	Worksheet S-10)
			To 12/31/2016	Date/Time Prep 5/22/2017 9:39	
				1. 00	
	Uncompensated and indigent care cost computation			1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	line 202 colum	n 8)	0. 201402	1. 00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			667, 913	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	6 N !! !	10	Y	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payment		a?	N 1 242 (71	4.00
5. 00 6. 00	If line 4 is "no", then enter DSH or supplemental payments from Medicai Medicaid charges	a		1, 243, 671	5. 00 6. 00
7. 00	Medicald charges Medicald cost (line 1 times line 6)			17, 843, 232 3, 593, 663	7. 00
8. 00	Difference between net revenue and costs for Medicaid program (line 7 m	inus sum of Li	nos 2 and 5: if	1, 682, 079	8. 00
6.00	<pre>< zero then enter zero)</pre>	illus sulli 01 11	nes 2 and 5, 11	1,002,079	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each I	ine)			
9.00	Net revenue from stand-alone CHIP	,		0	9. 00
10. 00	Stand-alone CHIP charges			0	10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11	minus line 9;	if < zero then	0	12.00
	enter zero)				
	Other state or local government indigent care program (see instructions				
13. 00	Net revenue from state or local indigent care program (Not included on			2, 926, 669	
14. 00	Charges for patients covered under state or local indigent care program 10)	(Not included	in lines 6 or	19, 234, 236	14. 00
15. 00	State or local indigent care program cost (line 1 times line 14)			3, 873, 814	15. 00
16.00	Difference between net revenue and costs for state or local indigent ca	re program (li	ne 15 minus line	947, 145	16.00
	13; if < zero then enter zero)				
	Uncompensated care (see instructions for each line)				
17. 00	Private grants, donations, or endowment income restricted to funding ch			0	17. 00
18. 00	Government grants, appropriations or transfers for support of hospital			0	18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigen 8, 12 and 16)	t care program	s (sum of lines	2, 629, 224	19. 00
		Uni nsured	Insured	Total (col. 1	
		pati ents	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
	Charity care charges for the entire facility (see instructions)	1, 432, 0			
21. 00	Cost of patients approved for charity care (line 1 times line 20)	288, 4			
22. 00	Partial payment by patients approved for charity care		12 1, 834		
23. 00	Cost of charity care (line 21 minus line 22)	288, 3	10 214, 274	502, 584	23. 00
				1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient days be		of stay limit		24. 00
0= -	imposed on patients covered by Medicaid or other indigent care program?				
	If line 24 is "yes," charges for patient days beyond an indigent care		th of stay limit	0	25. 00
	Total bad debt expense for the entire hospital complex (see instructions)	S)		7, 979, 518	

27.00 Medicare bad debts for the entire hospital complex (see instructions)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)

1, 587, 763 29. 00 2, 090, 347 30. 00 4, 719, 571 31. 00

27. 00

28.00

95, 968

7, 883, 550

Heal th	Financial Systems COMM	IUNI TY HOSPT. OF	NOBLE CTY, IN	VC.	In Lie	u of Form CMS-	<u> 2552-10</u>
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Period: From 01/01/2016 To 12/31/2016	Worksheet A Date/Time Pre 5/22/2017 9:3	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT		2, 216, 437	2, 216, 43		1, 624, 199	1.00
2. 00 3. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO300 OTHER CAP REL COSTS		0		0 764, 496	764, 496 0	2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 058, 314	4, 492, 776	6, 551, 09	0 -2, 058, 314	4, 492, 776	
5. 00	00500 ADMINISTRATIVE & GENERAL	676, 522	13, 300, 683			14, 772, 136	
7. 00	00700 OPERATION OF PLANT	378, 580	1, 022, 211			1, 437, 834	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 169, 560	169, 560	8. 00
9.00	00900 HOUSEKEEPI NG	267, 369	348, 283			473, 098	
10.00	01000 DI ETARY	344, 380	207, 558	1		344, 773	
11.00	01100 CAFETERI A	0	0		0 231, 362		1
12. 00 13. 00	O1200 MAI NTENANCE OF PERSONNEL O1300 NURSI NG ADMI NI STRATI ON	440, 930	21, 512	462, 44	2 44, 592	0 507, 034	
14. 00	01400 CENTRAL SERVICES & SUPPLY	440, 730	21, 312	402, 44	0 44, 372	0 0 0 0 0	14. 00
15. 00	01500 PHARMACY	536, 281	75, 294	611, 57	50, 208	661, 783	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0 0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0		0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	21.00
22. 00 23. 00	02300 PARAMED ED PRGM-(SPECIFY)		0		0 0	0	22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u>ا</u>		1	0 0		23.00
30.00	03000 ADULTS & PEDIATRICS	2, 508, 203	444, 159	2, 952, 36	2 -369, 917	2, 582, 445	30.00
43.00	04300 NURSERY	0	0		0 123, 380	123, 380	43. 00
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	1, 275, 837	838, 312	2, 114, 14		2, 233, 055	1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	0	40E 027	405 00	0 489, 525	489, 525	
54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1, 338, 587	685, 827 781, 630			685, 827 2, 176, 647	
54. 01	05401 CAT SCAN	1, 330, 307	701,030	2, 120, 21	0 0	2, 170, 047	
60.00	06000 LABORATORY	0	2, 317, 353	2, 317, 35	-248	2, 317, 105	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	494, 832	64, 273				
66.00	06600 PHYSI CAL THERAPY	1, 143, 678	188, 094	1		848, 201	
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	0		0 383, 278 0 211, 038		1
69. 00	06900 ELECTROCARDI OLOGY		5, 510	5, 51		5, 339	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1, 419, 892			852, 401	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	, , , , ,	0 567, 289		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 801, 456	2, 801, 45	6 -1, 721	2, 799, 735	
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	
	07698 HYPERBARI C OXYGEN THERAPY	645	578, 887				
76. 99	O7699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0	0	76. 99
90. 00	09000 CLINIC	30, 523	4, 508	35, 03	1 12, 322	47, 353	90.00
91. 00	09100 EMERGENCY	1, 327, 299	278, 484				1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				·		92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00		1, 576, 841	312, 505	1, 889, 34	6 156, 759	2, 046, 105	95. 00
110 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	14, 398, 821	22 405 444	14 904 44	5 -49, 799	14 7E1 444	110 00
118. 00	NONREI MBURSABLE COST CENTERS	14, 398, 821	32, 405, 644	46, 804, 46	5 -49, 799	46, 754, 666] 118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	24, 141	33, 460	57, 60	1 1, 828	59, 429	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	32, 682	2, 855				192. 00
	07950 OTHER NONREIMBURSABLE	0	0	1	0	0	194. 00
	07951 PAIN CLINIC	0	0	1	0 0		194. 01
	07952 OCC HEALTH	0	-29, 964	1			194. 02
	07953 FOUNDATION	29	1	3			194. 03 194. 04
	07954 PHYSICIAN OFFICES 07955 COMMUNITY & VOLUNTEER SERVICES	256, 049	430, 421		0 0 16, 354	702, 824	
	07956 VACANT SPACE	230, 049	130, 421	000, 47	0 0		194. 06
200.00		14, 711, 722	32, 842, 417	47, 554, 13			
				•			•

Health Financial Systems COMMUNITY HOSPT RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0146

| Period: | Worksheet A | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: 5/22/2017 9:39 am

				5/22/2017 9: 3	9 am
	Cost Center Description	Adjustments	Net Expenses		
	•		For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-1, 259, 400	364, 799		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	764, 496		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 923, 289	2, 569, 487		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 900, 505	11, 871, 631		5.00
7.00	00700 OPERATION OF PLANT	-2, 113	1, 435, 721		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	169, 560		8.00
9.00	00900 HOUSEKEEPI NG	-50	473, 048		9. 00
10.00	01000 DI ETARY	-5, 717	339, 056		10.00
11. 00		-184, 451	46, 911		11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0		12. 00
13. 00	1 1	0	507, 034	l .	13. 00
14. 00	1 1	0	307, 034 O		14. 00
15. 00		-661, 783	0		15. 00
16. 00	I I	0	0		16. 00
17. 00	I I	0	0		17. 00
17.00		0	0		19.00
	I I	0	0		1
20.00	+ +	0	0		20.00
21. 00		0	0		21. 00
22. 00		0	0	l .	22. 00
23. 00		0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	47.000	0 (00 770	T T T T T T T T T T T T T T T T T T T	
30. 00		47, 333	2, 629, 778	·	30.00
43. 00		0	123, 380		43. 00
	ANCILLARY SERVICE COST CENTERS				1
50. 00	I I	0	2, 233, 055		50.00
52. 00		0	489, 525		52. 00
53. 00		-667, 020	18, 807		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-12, 632	2, 164, 015		54.00
54. 01	05401 CAT SCAN	0	0		54. 01
60.00	06000 LABORATORY	0	2, 317, 105		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65.00	06500 RESPI RATORY THERAPY	-2, 088	604, 446		65.00
66.00	06600 PHYSI CAL THERAPY	-149, 725	698, 476		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	383, 278		67.00
68.00	06800 SPEECH PATHOLOGY	0	211, 038		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	5, 339		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	852, 401		71.00
72. 00		0	567, 289		72.00
73. 00	I I	0	2, 799, 735		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76. 98		0	579, 598		76. 98
76. 99		0	0		76. 99
	OUTPATIENT SERVICE COST CENTERS			I	1
90.00		0	47, 353		90.00
91. 00	1 1	0	1, 720, 760	·	91.00
92. 00	· · · · · · · · · · · · · · · · · · ·	ĺ	.,,20,,00		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
95 00	09500 AMBULANCE SERVICES	-51, 491	1, 994, 614		95. 00
73.00	SPECIAL PURPOSE COST CENTERS	31, 471	1, 774, 014		75.00
118. 00		-7, 772, 931	38, 981, 735		118. 00
110.00	NONREI MBURSABLE COST CENTERS	-1,112,731	30, 701, 733		1110.00
100 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-33, 460	25, 969		190. 00
		-33, 400			
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	37, 158 0		192. 00 194. 00
	007950 OTHER NONREIMBURSABLE 107951 PAIN CLINIC				1
	I I	0	0		194. 01 194. 02
	2 07952 0CC HEALTH 3 07953 FOUNDATI ON	0	0	l .	
	I I	0	62	l .	194. 03
	4 07954 PHYSI CI AN OFFI CES	174 740	0		194. 04
	5 07955 COMMUNITY & VOLUNTEER SERVICES	-174, 742	528, 082		194. 05
	6 07956 VACANT SPACE	0	0		194. 06
200.00	TOTAL (SUM OF LINES 118-199)	-7, 981, 133	39, 573, 006		200. 00

					5/22/2017 9:3	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3.00	4. 00	5. 00		
4 00	B - REHAB THERAPY	(7.00	200 0/0	E4 440		1 00
1.00	OCCUPATIONAL THERAPY	67.00	329, 263	54, 149		1.00
2. 00	SPEECH PATHOLOGY		181, 233	2 <u>9, 8</u> 05		2. 00
	C - I NSURANCE		510, 496	83, 954		-
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	O	25, 249		1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	2.00	o	9, 864		2. 00
2.00	n REE COSTS-MVDEE EQUIT			35, 113		2.00
	D - EQUIPMENT LEASE		<u> </u>	00, 110		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	64, 578		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	72, 567		2. 00
3.00		0.00	o	0		3. 00
4.00		0.00	o	0		4. 00
5.00		0.00	o	0		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	О	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11. 00		0.00	0	0		11. 00
12. 00		0. 00	0	0		12. 00
13. 00		0. 00	0	0		13. 00
14.00		0. 00	0	0		14. 00
15. 00		0. 00	0	0		15. 00
16. 00		0.00	0	0		16. 00
	O		0	137, 145		-
1 00	F - CLINIC DIETICIAN	00.00	0.221	0		1 00
1. 00	CLINIC	9000	9, 221	0		1.00
	G - PTO		9, 221	U		1
1. 00	ADMINISTRATIVE & GENERAL	5.00	847, 555	0		1. 00
2. 00	OPERATION OF PLANT	7. 00	38, 457	0		2. 00
3. 00	HOUSEKEEPI NG	9.00	27, 166	0		3. 00
4. 00	DI ETARY	10.00	34, 983	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	44, 790	0		5. 00
6.00	PHARMACY	15. 00	54, 476	0		6. 00
7. 00	ADULTS & PEDIATRICS	30.00	253, 836	0		7. 00
8.00	OPERATING ROOM	50.00	129, 601	0		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	135, 955	0		9. 00
10.00	RESPI RATORY THERAPY	65.00	50, 266	0		10.00
11.00	PHYSI CAL THERAPY	66.00	116, 176	0		11. 00
12.00	CLINIC	90.00	3, 101	0		12.00
13.00	EMERGENCY	91. 00	134, 829	0		13. 00
14.00	AMBULANCE SERVICES	95. 00	160, 178	0		14. 00
15. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	2, 452	0		15. 00
	CANTEEN					
16. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	3, 320	0		16. 00
17. 00	COMMUNITY & VOLUNTEER	194. 05	21, 104	0		17. 00
40	SERVICES					40
18. 00	HYPERBARI C OXYGEN THERAPY	76. 98	66	0		18. 00
19. 00	FOUNDATI ON	1 <u>94.</u> 03	3	0		19. 00
	O H - CAFETERIA		2, 058, 314	0		1
1. 00	CAFETERIA	11. 00	136, 350	95, 012		1. 00
1.00	0		136, 350	95, 012 95, 012		1.00
	I - DEPRECIATION		130, 330	75, 012		1
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	674, 012		1. 00
1.00	0			674, 012		1.00
	J - HOME OFFICE SALARY		O _I	574, 512		1
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	3, 634, 114	0		1. 00
	0		3, 634, 114			
	K - LAUNDRY			<u>'</u>		1
1.00	LAUNDRY & LINEN SERVICE	8.00	0	169, 560		1.00
			0	169, 560]
	L - OCCH HEALTH					
1.00	OCC HEALTH	194. 02	0	29, 964		1. 00
2.00		0.00	O	0		2. 00
3.00		0. 00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00

Health Financial Systems	COMMUNITY HOSPT. OF NOBLE CTY, INC.	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0146	Peri od: Worksheet A-6
		From 01/01/2016 Date/Time Prepared:

					5/22/2017 9:	ерагец. 39 am
		Increases		·		
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	0		0	29, 964		
	M - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO	72.00	0	567, 289		1. 00
	PATI ENTS					
	0		0	567, 289		
	N - OB					
1.00	NURSERY	43.00	112, 370	11, 010		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	445, 843	43, 682		2. 00
	0 — — — — —		558, 213	54, 692		
	P - OTHER					
1.00	FOUNDATI ON	194. 03	0	29		1. 00
		- $ +$		₂₉		
	Q - PERSONAL PROPERTY TAX					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8, 053		1. 00
	TOTALS			8, 053		1
500.00	Grand Total: Increases		6, 906, 708	1, 854, 823		500.00

RECLASSI FI CATIONS

Provi der CCN: 15-0146

Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Ti me Prepared:

5/22/2017 9:39 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 B - REHAB THERAPY 66.00 1.00 PHYSI CAL THERAPY 510, 496 83, 954 0 1.00 0 2.00 0.00 2.00 510, 496 83, 954 - I NSURANCE 1.00 ADMINISTRATIVE & GENERAL 5.00 0 35, 113 12 1.00 2.00 0.00 0 12 2.00 ō 35, 113 D - EQUIPMENT LEASE ADMINISTRATIVE & GENERAL 1.00 5.00 17, 482 10 1.00 2 00 OPERATION OF PLANT 7 00 0 1, 414 10 2 00 3.00 HOUSEKEEPI NG 9.00 0 160 0 3.00 4.00 DI ETARY 10.00 o 1, 565 0 4.00 5.00 NURSING ADMINISTRATION 13.00 0 198 0 5.00 0 PHARMACY 4. 268 6.00 15 00 0 6 00 ADULTS & PEDIATRICS 0 7.00 30.00 0 10,848 7.00 8.00 OPERATING ROOM 50.00 o 10, 695 0 8.00 9.00 RADI OLOGY-DI AGNOSTI C 54.00 0 67, 926 0 9.00 Ol 0 RESPIRATORY THERAPY 65.00 10.00 2.809 10.00 11.00 PHYSICAL THERAPY 66.00 0 4, 745 0 11.00 EMERGENCY 91.00 o 0 12.00 4,543 12.00 AMBULANCE SERVICES 95.00 0 0 3.419 13.00 13.00 14.00 GIFT, FLOWER, COFFEE SHOP & 190.00 0 624 0 14.00 CANTEEN 1, 699 15.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 0 15.00 COMMUNITY & VOLUNTEER 16.00 194.05 4, 750 16.00 SERVI CES 0 137, 145 - CLINIC DIETICIAN 10. 00 1.00 1.00 DI ETARY 9, 221 0 9, 221 0 G - PTO 1.00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 2, 058, 314 0 0 1.00 2.00 0.00 0 0 2.00 0 3 00 0 00 0 0 3 00 4.00 0.00 0 0 0 4.00 0 0 0 5.00 0.00 5.00 ol 6.00 0.00 0 0 6.00 0 0 7.00 0.00 0 7.00 8.00 0.00 0 0 0 8.00 9.00 0.00 o 0 0 9.00 0 0 10.00 0.00 0 10.00 11.00 0.00 0 0 11.00 12.00 0.00 0 0 12.00 13.00 0.00 0 0 13.00 0 0 14.00 0.00 0 14.00 0 15.00 0.00 0 0 15.00 16.00 0.00 0 0 16.00 0 17.00 0.00 0 0 17.00 18.00 0.00 0 0 18.00 19.00 19.00 0.00 0 2, 058, 314 H - CAFETERIA 1.00 DI ETARY 10.00 13<u>6, 3</u>50 9<u>5, 0</u>12 0 1.00 136, 350 95, 012 - DEPRECIATION 1.00 CAP REL COSTS-BLDG & FIXT 1.00 674, 012 9 1.00 0 674, 012 J - HOME OFFICE SALARY 1.00 ADMINISTRATIVE & GENERAL 5.00 0 3, 634, 114 0 1.00 ō 3, 634, 114 K - LAUNDRY 1.00 HOUSEKEEPI NG 9. 00 169, 560 1.00 0 0 169, 560 - OCCH HEALTH 1.00 RADI OLOGY-DI AGNOSTI C 54.00 0 11, 599 0 1.00 2.00 LABORATORY 60.00 0 248 0 2.00 RESPIRATORY THERAPY 0 0 3 00 65.00 3 00 28 4.00 PHYSICAL THERAPY 66.00 0 552 0 4.00 OCCUPATIONAL THERAPY 0 0 5.00 67.00 134 5.00 6.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 202 0 6.00 IPATI ENT DRUGS CHARGED TO PATIENTS 7 00 73 00 0 1, 721 0 7 00 8.00 **EMERGENCY** 91.00 15, 309 0 8.00

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

Provider CCN: 15-0146 In Lieu of Form CMS-2552-10

Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

						5/22/2017 9:	<u>39 am</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref		
	6. 00	7. 00	8. 00	9. 00	10.00		
9. 00	ELECTROCARDI OLOGY	69. 00	0	171		0	9. 00
	0		0	29, 964			
	M - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	567, 289		0	1. 00
	PATI ENT						
	0		0	567, 289			
	N - OB						
1.00	ADULTS & PEDIATRICS	30.00	558, 213	54, 692		0	1. 00
2.00		0.00	0	0		0	2. 00
	0		558, 213	54, 692			
	P - OTHER						
1.00	ADMINISTRATIVE & GENERAL	5. 00		29		0	1. 00
	0		0	29			
	Q - PERSONAL PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		<u>8, 0</u> 53	1	3	1. 00
	TOTALS		0	8, 053			
500.00	Grand Total: Decreases		3, 272, 594	5, 488, 937			500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0146 Peri od: Worksheet A-7 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/22/2017 9:39 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements Bal ances 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 685, 510 0 69, 882 2.00 Land Improvements 69, 882 0 2.00 3, 469, 806 0 3.00 181, 480 181, 480 3.00 Buildings and Fixtures 0 57, 402 0 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 301, 535 90, 745 0 90, 745 0 5.00 0 6.00 Movable Equipment 12, 544, 614 2, 065, 028 2, 065, 028 838, 396 6.00 0 7.00 2, 839, 753 HIT designated Assets 35, 419 35, 419 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 19, 898, 620 2, 442, 554 2, 442, 554 838, 396 8.00 9.00 Reconciling Items 2, 839, 753 35, 419 0 35, 419 9.00 Total (line 8 minus line 9) 17, 058, 867 2, 407, 135 2, 407, 135 838, 396 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1.00 2.00 Land Improvements 755, 392 152, 865 2.00 524, 088 3.00 Buildings and Fixtures 3, 651, 286 3.00 57, 402 1, 000 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 392, 280 27, 208 5.00 13, 771, 246 6.00 Movable Equipment 8, 647, 430 6.00 7. 00 7.00 HIT designated Assets 2, 875, 172 Ω

21, 502, 778

2, 875, 172

18, 627, 606

9, 352, 591

9, 352, 591

Health Financial Systems	COMMUNITY HOSPT. OF N	OBLE CTY, INC.	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Peri od: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part II Date/Time Prepared: 5/22/2017 9:39 am

				0 12/31/2016	Date/lime Pre 5/22/2017 9:3		
	SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
	9. 00	10.00	11. 00	instructions) 12.00	instructions) 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 & FLXT	2, 216, 437	0	C	0	0	1. 00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	C	0	0	2. 00	
3.00 Total (sum of lines 1-2)	2, 216, 437	0	C	0	0	3. 00	
SUMMARY OF CAPITAL							
Cost Center Description		Total (1) (sum					
	Capi tal -Rel ate						
	d Costs (see	through 14)					
	instructions)	15.00					
DART II DECONCILIATION OF AMOUNTS FROM WORK	14.00	15. 00	nd 2				
PART II - RECONCILIATION OF AMOUNTS FROM WORK 1.00 CAP REL COSTS-BLDG & FLXT	SHEET A, CULUMI					1.00	
2.00 CAP REL COSTS-BLDG & FIXT	0	2, 216, 437				2.00	
3.00 Total (sum of lines 1-2)		2, 216, 437				3.00	
3.00 Total (3ull of 111les 1-2)	ı Y	2,210,437	I			J 5.00	

Heal	th Financial Systems COMM	IUNITY HOSPT. O	F NOBLE CTY, IN	NC.	In Lie	u of Form CMS-2	2552-10		
RECO	NCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7			
					From 01/01/2016 Fo 12/31/2016		narod:		
					10 12/31/2010	5/22/2017 9:3	pareu. 9 am		
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL			
			_						
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance			
			Leases	for Ratio	instructions)				
				(col . 1 - col .					
		1.00	2.00	2) 3. 00	4. 00	5. 00			
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00			
1 00				4 057 277	0 071017	0	1 00		
1.00		4, 856, 360	l .	4, 856, 360		0	1.00		
2.00		13, 771, 246				0	2.00		
3.00	Total (sum of lines 1-2)	18, 627, 606		<u> </u>			3. 00		
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY O	OF CAPITAL			
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease			
	cost center bescription		Capi tal -Rel ate		Depi eci ati on	Lease			
			d Costs	through 7)					
		6, 00	7.00	8. 00	9. 00	10.00			
	PART III - RECONCILIATION OF CAPITAL COSTS CI		7.00	0.00	7. 00	10.00			
1. 00		0	0	(283, 025	64, 578	1.00		
2.00			٥		674, 012	72, 567	2. 00		
3.00	= = = = = = = = = = = = = = = = = = = =	0	l o		957, 037		•		
			Sl	JMMARY OF CAPI					

| Period: | Worksheet A-8 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES COMMUNITY HOSPT. OF NOBLE CTY, INC.

Provider CCN: 15-0146

				T	o 12/31/2016	Date/Time Prep 5/22/2017 9:39	
				Expense Classification on To/From Which the Amount is			9 4111
					,		
						WI . A 7 D C	
	Cost Center Description	Basi s/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)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	A	-2, 499	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)	А	-1, 843	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -667, 020		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.	7 0 2	007, 020		0. 00		11. 00
	(chapter 23)	A O 1	-		0.00	0	
12.00	Related organization transactions (chapter 10)	A-8-1	-2, 930, 931		0.00		
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	А	-56, 131	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
. 23	therapy costs in excess of limitation (chapter 14)				22.00		
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00		27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30. 00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00			0		0. 00	0	32. 00
33. 00	Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 00
	(3)						

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0146 Peri od: Worksheet A-8 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 33. 01 SELF INSURANCE -1,922,836 EMPLOYEE BENEFITS DEPARTMENT 33. 01 4.00 Α -453 EMPLOYEE BENEFITS DEPARTMENT TELEPHONE 33.02 Α 4.00 0 33.02 33. 04 PHYSICIAN RECRUITMENT Α -25, 006 ADMINI STRATI VE & GENERAL 5.00 33.04 33.05 PHARMACY SALES В -659, 277 PHARMACY 15.00 33.05 LOBBY DUES -3, 735 ADMINISTRATIVE & GENERAL 33 09 5.00 ol 33 09 Α LIQUOR EXPENSE OFFSET -157 ADMINISTRATIVE & GENERAL 33.10 Α 5.00 33.10 33. 12 I NTERUNI T Α -125, 682 PHYSI CAL THERAPY 66.00 33.12 I NTERUNI T -1, 259, 400 CAP REL COSTS-BLDG & FIXT 33. 14 33 14 Α 1 00 -126, 402 COMMUNITY & VOLUNTEER 33.15 I NTERUNI T Α 194.05 33.15 SERVI CES 33. 16 I NTERUNI T Α -12, 632 RADI OLOGY-DI AGNOSTI C 54.00 33.16 33. 17 OTHER OPERATING REVENUE В -52, 291 ADMI NI STRATI VE & GENERAL 5.00 0 33. 17 -270 OPERATION OF PLANT OTHER OPERATING REVENUE 0 33.18 В 7.00 33.18 33.19 OTHER OPERATING REVENUE В -50 HOUSEKEEPI NG 9.00 33.19 OTHER OPERATING REVENUE -5, 717 DI ETARY 10.00 33.20 33.20 В OTHER OPERATING REVENUE 33. 21 В -128, 320 CAFETERI A 11.00 33. 21 -2, 506 PHARMACY 33. 23 OTHER OPERATING REVENUE В 15.00 0 33. 23 -552 ADULTS & PEDIATRICS 33. 24 OTHER OPERATING REVENUE В 30.00 ol 33. 24 33. 26 OTHER OPERATING REVENUE В -2, 088 RESPIRATORY THERAPY 65.00 33. 26 -24, 034 PHYSI CAL THERAPY 33. 27 OTHER OPERATING REVENUE 33. 27 В 66.00 33, 29 OTHER OPERATING REVENUE -51, 491 AMBULANCE SERVICES 95.00 ol В 33, 29 OTHER OPERATING REVENUE -33,460 GIFT, FLOWER, COFFEE SHOP & 190.00 33.30 33.30 В CANTEEN -48, 340 COMMUNITY & VOLUNTEER 33.31 OTHER OPERATING REVENUE В 194.05 33.31 SERVI CES 47, 885 ADULTS & PEDIATRICS 33.32 TELEMETRY Α 30.00 ol 33.32 33. 33 ADMIN PHYS SALARIES 115, 051 ADMINI STRATI VE & GENERAL 5.00 0 33.33 Α 33. 34 LOBBYING EXPENSE Α -9 PHYSI CAL THERAPY 66.00 33.34 -937 ADMINISTRATIVE & GENERAL LOBBYING EXPENSE 5.00 33.35 33.35 Α 50.00 TOTAL (sum of lines 1 thru 49) -7, 981, 133 50.00 (Transfer to Worksheet A, 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.

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.

OFFICE COSTS

line 12.

Provider CCN: 15-0146

Worksheet A-8-1

From 01/01/2016 12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 1. 00 3.00 4.00 5.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 5.00 ADMINISTRATIVE & GENERAL HOME OFFICE ALLOCATION 1.00 8, 573, 449 7, 609, 000 1.00 5. 00 ADMINISTRATIVE & GENERAL PPG SUBSIDY 3, 895, 380 2.00 2.00 3.00 0.00 0 0 3.00 3.01 0.00 0 0 3.01 4.00 0.00 4.00 5 00 TOTALS (sum of lines 1-4). 8 573 449 11 504 380 5 00 Transfer column 6, line 5 to Worksheet A-8, column 2,

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 par

111	as not	been posted to worksheet A,	corumns rand/or 2, the amoun	it allowable sil	oura de marcatea mi coranin 4	or this part.	
					Related Organization(s) and/	or Home Office	
		Symbol (1)	Name	Dorcontago of	Name	Dorcontago of	
		Syllibol (1)	Ivallie	Percentage of	Ivallie	Percentage of	
				Ownershi p		Ownershi p	
		1. 00	2. 00	3. 00	4. 00	5. 00	
		B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

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

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- 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.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

Heal th	Financial Syste	ems	COMMU	INITY HOSPT. OF N	NOBLE CTY,	I NC.	In Lie	eu of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZA	TIONS AND HOME	Provi der	CCN: 15-0146		Worksheet A-8	3-1
OFFICE	COSTS						From 01/01/2016 To 12/31/2016		narod:
							10 12/31/2010	5/22/2017 9:3	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS	A RESULT OF TRA	ANSACTI ONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED	
	HOME OFFICE CO	STS:							
1.00	964, 449	0							1.00
2.00	-3, 895, 380	0							2. 00
3.00	0	0							3. 00
3. 01	0	0							3. 01
4.00	0	0							4.00

* 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

5 00

1103 1101	been posted to worksheet A,	cordinate and or 2, the amount arrowable should be mareated in cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	3.		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
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.

-2. 930. 931

5.00

| Period: | Worksheet A-8-2 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0146

					-	Γο 12/31/201 <i>6</i>	Date/Time Pre 5/22/2017 9:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	, diii
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ANESTHESI OLOGY	685, 781	661, 781	24, 000			
2.00		EMERGENCY	30, 000			239, 400	325	
3.00	0. 00		0	1	0	0	0	
4.00	0. 00		0	0	0	0	0	
5. 00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	
7. 00	0.00		0	0	0	0	0	
8. 00	0.00		0	0	0	0	0	
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00	W . A	0 1 0 1 (D)	715, 781				488	
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	Unadjusted RCE	Cost of		Physician Cost of Malpractice	
		rdentiffer	LIIIII L	Limit	Continuing	Share of col.	Insurance	
				LIIIII	Education	12	i iisui ance	
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14.00	
1. 00		ANESTHESI OLOGY	18, 761	938				1. 00
2. 00		EMERGENCY	37, 406			1		2. 00
3. 00	0.00		0			l o	0	1
4.00	0.00		0	0	0	0	0	1
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10. 00
200.00			56, 167			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2. 00	14 15. 00	16. 00	17. 00	18.00		
1.00		ANESTHESI OLOGY	13.00		5, 239			1. 00
2. 00		EMERGENCY	0				1	2.00
3.00	0.00		0	0 0		0		3. 00
4. 00	0.00		0	0	_	0		4. 00
5. 00	0.00		l o	0	0	0		5. 00
6. 00	0.00		0	l o	0	l		6. 00
7. 00	0.00		Ö	0	0	0		7. 00
8.00	0. 00		0	0	0	0		8. 00
9.00	0.00		0	0	0	0		9. 00
10.00	0. 00		0	0	0	0		10. 00
200.00			0	56, 167	5, 239	667, 020		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/22/2017 9:39 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFLTS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 364, 799 364, 799 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 764, 496 764, 496 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 569, 487 2, 569, 487 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 11, 871, 631 92, 689 7 254 722 454 12 694 028 5 00 7.00 00700 OPERATION OF PLANT 1, 435, 721 35, 812 19,688 58, 409 1,549,630 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 169, 560 3, 081 172, 641 8.00 9.00 00900 HOUSEKEEPI NG 473,048 4, 456 1,582 41, 252 520, 338 9.00 01000 DI ETARY 388, 239 10 00 339,056 9 174 32 744 10 00 7, 265 11.00 01100 CAFETERI A 46, 911 5, 935 19,097 71, 943 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 507, 034 1, 248 694, 414 13.00 118, 103 68.029 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 11, 461 11, 461 14 00 15.00 01500 PHARMACY 0 3, 380 81, 779 82, 740 167, 899 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 5, 163 5, 163 16.00 0 01700 SOCIAL SERVICE 17.00 17.00 C 0 0 0 19 00 01900 NONPHYSICIAN ANESTHETISTS C 0 0 0 19 00 02000 NURSING SCHOOL 0 0 0 20.00 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 Ω 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 0 22.00 C 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 629, 778 53, 905 52, 684 308, 663 3, 045, 030 30.00 04300 NURSERY 3, 086 142, 979 43.00 123, 380 775 15, 738 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 2, 233, 055 40, 381 209, 416 196, 843 2, 679, 695 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 489, 525 4.976 12, 387 62.444 569, 332 52.00 05300 ANESTHESI OLOGY 53.00 18, 807 18, 807 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 164, 015 24, 183 160, 072 206, 521 2, 554, 791 54.00 54.01 05401 CAT SCAN 0 0 54.01 06000 LABORATORY 60.00 2, 317, 105 7, 133 0 0 2, 324, 238 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 0 06500 RESPIRATORY THERAPY 65.00 604, 446 6, 134 35, 368 76, 345 722, 293 65.00 06600 PHYSI CAL THERAPY 698, 476 104, 954 66.00 2.446 14, 190 820, 066 66.00 06700 OCCUPATIONAL THERAPY 383, 278 429, 394 67.00 0 46, 116 67.00 68.00 06800 SPEECH PATHOLOGY 211,038 0 25, 383 236, 421 68.00 69.00 06900 ELECTROCARDI OLOGY 5, 339 510 0 5,849 69.00 852, 401 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 852, 401 71 00 0 0 71 00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 567, 289 C 0 0 567, 289 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 799, 735 C 0 0 2, 799, 735 73.00 07697 CARDIAC REHABILITATION 76. 97 0 0 76.97 0 07698 HYPERBARI C OXYGEN THERAPY 585, 885 579, 598 100 76 98 76 98 5, 290 897 76. 99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 47, 353 6, 001 53, 354 90.00 09100 EMERGENCY 22, 574 91.00 1, 720, 760 9.527 204, 783 1, 957, 644 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES
SPECIAL PURPOSE COST CENTERS 1, 994, 614 27, 520 243, 283 2, 265, 417 95.00 0 95.00 SUBTOTALS (SUM OF LINES 1-117) 38, 981, 735 340, 706 760, 818 2, 521, 899 38, 906, 376 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 25.969 2.851 3.725 34, 583 190. 00 2.038 192.00 19200 PHYSICIANS' PRIVATE OFFICES 37, 158 20, 274 1, 321 5,042 63, 795 192. 00 194. 00 07950 OTHER NONREIMBURSABLE 0 194.00 0 C 0 0 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 0 0 194. 02 07952 OCC HEALTH 0 194.02 0 0 Ω 0 194. 03 07953 FOUNDATI ON 0 0 4 66 194. 03 62 194. 04 07954 PHYSICIAN OFFICES 0 194. 04 C 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 568, 186 194. 05 319 38, 817 528,082 968 194.06 07956 VACANT SPACE C 0 194, 06 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 39, 573, 006 364, 799 764, 496 2.569.487 39, 573, 006 202. 00 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: | 5/22/2017 9:39 am

						5/22/2017 9:3	9 am
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		5. 00	7. 00	LINEN SERVICE 8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	1 2.22		2.00			
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						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	12, 694, 028					5. 00
7.00	00700 OPERATION OF PLANT	731, 838	2, 281, 468				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	81, 532	29, 746	283, 919			8. 00
9.00	00900 HOUSEKEEPI NG	245, 738	43, 026	11, 657	820, 759		9. 00
10.00	01000 DI ETARY	183, 352	88, 576	404	32, 915	693, 486	10.00
11. 00	01100 CAFETERI A	33, 976	57, 298	404	21, 292	0	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	O	0	0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	327, 948	12, 049	0	4, 477	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	5, 413	1	1	41, 122	0	14.00
15. 00	01500 PHARMACY	79, 293		l	12, 125	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 438	1	1	18, 523	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	l o	0	0	0	19.00
20. 00	02000 NURSI NG SCHOOL	0	l o	0	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	l o	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	l o	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	Ö	0	0	Ö	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		20.00
30. 00	03000 ADULTS & PEDI ATRI CS	1, 438, 066	520, 460	99, 050	193, 406	693, 486	30.00
43. 00	04300 NURSERY	67, 524	l ·	1		0	43.00
	ANCILLARY SERVICE COST CENTERS	1 2.7.2= 1	., ., .,		=/		
50.00	05000 OPERATING ROOM	1, 265, 529	389, 879	74, 652	144, 881	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	268, 876			17, 853	0	52.00
53.00	05300 ANESTHESI OLOGY	8, 882	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 206, 541	233, 489	28, 297	86, 765	0	54.00
54. 01	05401 CAT SCAN	0	0	0	0	0	54. 01
60.00	06000 LABORATORY	1, 097, 659	68, 866	703	25, 591	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	341, 114	59, 221	1, 733	22, 007	0	65.00
66. 00	06600 PHYSI CAL THERAPY	387, 289			8, 776	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	202, 788		0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	111, 654	l .	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 762	l	0	1, 831	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	402, 560	1	0	., 55.	Ö	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	267, 911	0	0	0	Ö	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 322, 220		0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	ł	0	0	Ö	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	276, 694	51, 079	0	18, 981	0	76. 98
76. 99		0	0.,0,,	1	0	Ö	76. 99
70.77	OUTPATIENT SERVICE COST CENTERS				٥,		70.77
90.00	09000 CLI NI C	25, 197	О	0	0	0	90.00
91.00	09100 EMERGENCY	924, 529		54, 621	80, 993	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				·		92.00
	OTHER REIMBURSABLE COST CENTERS	*		•			
95.00	09500 AMBULANCE SERVICES	1, 069, 879	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	12, 379, 202	2, 048, 851	280, 688	734, 318	693, 486	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 332	27, 522	0	10, 227		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	30, 128	195, 751	3, 231	72, 742	0	192. 00
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194. 00
194.0	1 07951 PAIN CLINIC	0	0	0	0		194. 01
	2 07952 0CC HEALTH	0	0	0	0	0	194. 02
194. 03	3 O7953 FOUNDATI ON	31	0	0	0		194. 03
	4 07954 PHYSICIAN OFFICES	0	0	0	0		194. 04
194. 0	07955 COMMUNITY & VOLUNTEER SERVICES	268, 335	9, 344	0	3, 472		194. 05
194.00	07956 VACANT SPACE	0	0	0	0	0	194. 06
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0	o		201. 00
202.00	TOTAL (sum lines 118-201)	12, 694, 028	2, 281, 468	283, 919	820, 759	693, 486	202. 00

0 194.06

296, 834 202. 00

200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

0

1, 042, 382

177, 250

Period: Worksheet B From 01/01/2016 Part I

12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** SERVICES & **PERSONNEL** ADMI NI STRATI ON **SUPPLY** 11. 00 12.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 184, 913 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 3.494 1,042,382 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 177, 250 14.00 15.00 01500 PHARMACY 0 1, 703 296, 834 15.00 3.184 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16.00 0 0 0 17.00 01700 SOCIAL SERVICE 0 0 0 Ω 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 19.00 0 02000 NURSI NG SCHOOL 0 0 20.00 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21 00 C Ω 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 C 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDI ATRI CS 19,606 0 421, 742 14, 282 191 43.00 04300 NURSERY 1,006 0 21,646 0 43.00 ANCILLARY SERVICE COST CENTERS 8, 233 50 00 05000 OPERATING ROOM 10 464 n 225, 091 43 424 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 3, 992 0 85, 881 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 3, 998 36 54.00 13, 716 05401 CAT SCAN 0 0 54.01 0 0 0 54.01 60.00 06000 LABORATORY 0 0 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 0 0 0 62.30 65 00 06500 RESPIRATORY THERAPY 5 294 Ω O 2 786 0 65 00 06600 PHYSI CAL THERAPY 0 66.00 18, 501 0 1, 268 33 66.00 06700 OCCUPATIONAL THERAPY 52,053 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 14, 986 0 0 68.00 06900 ELECTROCARDI OLOGY O 69 00 0 Ω 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 83, 815 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 4.580 287, 580 73.00 07697 CARDIAC REHABILITATION 76. 97 76.97 0 0 Ω 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 8 179 21 0 76.98 76.99 07699 LI THOTRI PSY 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 404 0 212 0 91.00 09100 EMERGENCY 13, 381 287, 843 11, 288 16 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 7, 594 95.00 20, 892 666 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 180, 981 0 1, 042, 382 174, 971 296, 755 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 345 n 1.553 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 584 0 0 58 0 192.00 194. 00 07950 OTHER NONREIMBURSABLE 0 194. 00 0 0 0 0 0 0 194. 01 194. 01 07951 PAIN CLINIC 0 0 0 194. 02 07952 OCC HEALTH 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 79 194. 03 582 0 0 194. 04 07954 PHYSICIAN OFFICES 0 194, 04 0 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 2, 421 C 0 668 0 194. 05

184, 913

194.06 07956 VACANT SPACE

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Provider CCN: 15-0146

Peri od:

From 01/01/2016

12/31/2016

Date/Time Prepared:

Part I

5/22/2017 9:39 am INTERNS & **RESI DENTS** NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR Cost Center Description MEDI CAL SOCIAL SERVICE Y & FRINGES RECORDS & ANESTHETI STS LI BRARY **APPRV** 19.00 16.00 17.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 75, 971 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19 00 0 0 02000 NURSING SCHOOL 20.00 0 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23 00 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 374 0 0 0 30.00 0 0 43.00 04300 NURSERY 0 o 0 43.00 213 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9.950 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 855 0 52.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 53.00 1.434 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 20.347 0 54.00 54.01 05401 CAT SCAN 0 0 0 54.01 06000 LABORATORY 0 60.00 7, 411 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62.30 06500 RESPIRATORY THERAPY 0 65 00 2.560 0 0 65.00 06600 PHYSI CAL THERAPY 66.00 1, 133 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 484 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 260 0 06900 ELECTROCARDI OLOGY 69.00 274 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 342 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 1, 105 Oı 0 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 569 Ω 73.00 0 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 125 0 0 o 0 76. 98 07699 LI THOTRI PSY 76. 99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMERGENCY 11,008 C 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 3, 457 0 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 75, 971 0 0 0 0 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 Ω 0 0 192.00 0 0 0 0 0 0 0 0 0 194.00 07950 OTHER NONREI MBURSABLE 0 0 0 0 194, 00 0 194. 01 07951 PAIN CLINIC 0 0 194. 01 194. 02 07952 OCC HEALTH 0 0 194. 02 0 0 0 194. 03 07953 FOUNDATI ON 0 194. 03 0 0 194. 04 07954 PHYSICIAN OFFICES 0 194. 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 0 194. 05 194.06 07956 VACANT SPACE 0 0 0 194. 06 0 Cross Foot Adjustments 0 200. 00 200.00 201.00 Negative Cost Centers 0 0 0 0 201. 00 TOTAL (sum lines 118-201) 75, 971 0 202.00 202.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/22/2017 9:39 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED Subtotal Intern & Total PRGM COSTS **PRGM** Residents Cost **APPRV** & Post Stepdown Adjustments 22.00 23. 00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 20.00 02000 NURSING SCHOOL 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 449, 693 6, 449, 693 30.00 04300 NURSERY 0 0 243, 916 243, 916 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 4, 851, 798 4, 851, 798 50.00 0 o 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 995, 120 995, 120 52.00 0000000000000 05300 ANESTHESI OLOGY 0 53.00 0 29, 123 29, 123 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 4, 147, 980 0 0 0 4, 147, 980 54.00 54.01 05401 CAT SCAN 0 Ω 54.01 06000 LABORATORY 0 60.00 3, 524, 468 3, 524, 468 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 65.00 1, 157, 008 0 0 0 1, 157, 008 65.00 06600 PHYSI CAL THERAPY 1, 260, 682 66.00 1, 260, 682 66.00 06700 OCCUPATIONAL THERAPY 684, 719 684, 719 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 363, 321 363, 321 68.00 69.00 06900 ELECTROCARDI OLOGY 15, 644 0 0 0 15, 644 69.00 1, 342, 118 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 342, 118 71 00 Ω 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 836, 305 836, 305 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 420, 684 4, 420, 684 73.00 07697 CARDIAC REHABILITATION 0 0 76. 97 0 76.97 0 07698 HYPERBARI C OXYGEN THERAPY 933, 972 933, 972 76 98 76 98 0 76. 99 07699 LI THOTRI PSY 0 0 C 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 79, 237 0 79, 237 90.00 09100 EMERGENCY 0 91.00 C 3, 559, 278 0 3, 559, 278 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 0 3, 367, 905 3, 367, 905 95.00 0 0 95.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 38, 262, 971 0 38, 262, 971 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 90, 562 190, 00 90.562 0 366, 289 192. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 366, 289 0 194. 00 07950 OTHER NONREI MBURSABLE 0 0 194. 00 0000000000 C 0 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 194. 02 07952 OCC HEALTH 01194.02 0 0 194. 03 07953 FOUNDATI ON 0 758 0 0 0 758 194. 03 194. 04 07954 PHYSICIAN OFFICES 0 194. 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 852, 426 194. 05 0 852, 426 194.06 07956 VACANT SPACE 0 C 0 194, 06 200.00 Cross Foot Adjustments 0 0 200.00 0 0 201.00 Negative Cost Centers 0 O 0 201.00 202.00 TOTAL (sum lines 118-201) 39, 573, 006 39, 573, 006 202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146

				To	12/31/2016	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		5/22/2017 9: 3	9 am
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	4. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	_	0	0	4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 933, 623	92, 689		2, 033, 566	0	5. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	0	35, 812 3, 081		55, 500 3, 081	0	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	4, 456	I	6, 038	0	9. 00
10.00	01000 DI ETARY	0	9, 174		16, 439	0	10. 00
11. 00	01100 CAFETERI A	0	5, 935	1	5, 935	0	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0 1, 248	_	0 119, 351	0	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11, 461	1	11, 461	0	14. 00
15. 00	01500 PHARMACY	0	3, 380	81, 779	85, 159	0	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	5, 163	1	5, 163	0	16. 00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0	Ö	Ö	ő	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	О	O	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	0	53, 905	52, 684	106, 589	0	30. 00
43.00	04300 NURSERY	0	775		3, 861	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS		40.201	200 41/	240 707		F0 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	40, 381 4, 976		249, 797 17, 363	0	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	12, 307	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	24, 183	160, 072	184, 255	0	54. 00
54. 01	05401 CAT SCAN	0	7 122	0	7 122	0	54. 01
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	7, 133 0	1	7, 133 0	0	60. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY	0	6, 134	35, 368	41, 502	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 446	1	16, 636	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	510	1	0 510	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	Ö	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 97 76. 98	07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY	0	5, 290	0 897	6, 187	0	76. 97 76. 98
	07699 LI THOTRI PSY	Ö	0, 2, 0	1	0, 107	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0	0 22, 574	0 9, 527	0 32, 101	0	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		22, 374	9, 527	32, 101	U	91.00
72.00	OTHER REIMBURSABLE COST CENTERS			<u> </u>	٩		72.00
95. 00	09500 AMBULANCE SERVI CES	0	0	27, 520	27, 520	0	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	1, 933, 623	340, 706	760, 818	3, 035, 147	0	118. 00
116.00	NONREI MBURSABLE COST CENTERS	1, 933, 023	340, 700	700, 616	3, 033, 147	0	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 851	2, 038	4, 889	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	20, 274	1	21, 595		192. 00
	07950 OTHER NONREI MBURSABLE 07951 PAIN CLINI C	0	0		0		194. 00 194. 01
	07951 PATN CETNIC	0	0		0		194. 01
	07953 FOUNDATI ON	O	Ö	ő	ő		194. 03
	07954 PHYSI CI AN OFFI CES	0	0	0	0		194. 04
	07955 COMMUNITY & VOLUNTEER SERVICES	0	968		1, 287		194. 05
200.00	07956 VACANT SPACE Cross Foot Adjustments		0	0	0		194. 06 200. 00
201.00			О	o	ő	0	201. 00
202.00	TOTAL (sum lines 118-201)	1, 933, 623	364, 799	764, 496	3, 062, 918	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am

				'	0 12/31/2010	5/22/2017 9: 3	
	Cost Center Description		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GEN	ERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
	00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 002	OO CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 004	OO EMPLOYEE BENEFITS DEPARTMENT						4. 00
	OO ADMINISTRATIVE & GENERAL	2, 033, 566					5. 00
	OO OPERATION OF PLANT	117, 239	172, 739				7. 00
	00 LAUNDRY & LINEN SERVICE	13, 061	2, 252	18, 394			8. 00
	00 HOUSEKEEPI NG	39, 367	3, 258			E. E.	9.00
	OO DI ETARY	29, 373	6, 706	26		54, 526	1
	OO CAFETERIA	5, 443	4, 338	26		0	1
	00 MAINTENANCE OF PERSONNEL	0	0	0	-	0	1
	00 NURSING ADMINISTRATION 00 CENTRAL SERVICES & SUPPLY	52, 537 867	912 8, 379	0 557		0	
	OO PHARMACY	12, 703	2, 471	557	2, 476 730	0	1
	00 MEDICAL RECORDS & LIBRARY	391	3, 774		1, 115	0	1
	00 SOCIAL SERVICE	0	3, 7,4	١	1, 119	0	
	00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
	00 NURSI NG SCHOOL		0	Ö	o	0	
	00 I&R SERVICES-SALARY & FRINGES APPRV	O	0	0	o	0	1
	00 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	o	0	22. 00
23. 00 023	OO PARAMED ED PRGM-(SPECIFY)	0	0	0	o	0	23. 00
INP	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	230, 382	39, 408	6, 417		54, 526	30. 00
	00 NURSERY	10, 817	566	19	167	0	43. 00
	ILLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	202, 735	29, 519	4, 836		0	
	OO DELIVERY ROOM & LABOR ROOM	43, 073	3, 638	19		0	
	OO ANESTHESI OLOGY	1, 423	17 (70	0	١	0	
	00 RADIOLOGY-DIAGNOSTIC 01 CAT_SCAN	193, 285	17, 678	1, 833	5, 224	0	
	OO LABORATORY	175, 843	5, 214	46	1, 541	0	
	50 BLOOD CLOTTING FOR HEMOPHILIACS	175, 645	3, 214 N	1 0	1, 541	0	
	00 RESPIRATORY THERAPY	54, 646	4, 484	112	1, 325	0	1
	00 PHYSI CAL THERAPY	62, 043	1, 788			0	
	OO OCCUPATI ONAL THERAPY	32, 486	0	0		0	
	00 SPEECH PATHOLOGY	17, 887	0	Ö	o	0	
	OO ELECTROCARDI OLOGY	443	373	0	110	0	1
71.00 071	OO MEDICAL SUPPLIES CHARGED TO PATIENT	64, 489	0	0	О	0	71.00
72.00 072	OO IMPL. DEV. CHARGED TO PATIENTS	42, 919	0	0	o	0	72. 00
73.00 073	OO DRUGS CHARGED TO PATIENTS	211, 817	0	0	0	0	73. 00
	97 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
	98 HYPERBARIC OXYGEN THERAPY	44, 326	3, 867	0	1, 143	0	
	99 LI THOTRI PSY	0	0	0	0	0	76. 99
	PATIENT SERVICE COST CENTERS						
	OO CLI NI C	4, 037	0	0		0	1
	OO EMERGENCY	148, 108	16, 502	3, 539	4, 877	0	
	OO OBSERVATION BEDS (NON-DISTINCT PART						92.00
	ER REIMBURSABLE COST CENTERS OO AMBULANCE SERVICES	171, 392	0	0	ol	0	95. 00
	CLAL PURPOSE COST CENTERS	171, 392	0		U U	0	95.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	1, 983, 132	155, 127	18, 185	44, 213	54 526	118. 00
	REI MBURSABLE COST CENTERS	1,700,102	100, 127	10, 100	11, 210	01,020	1110.00
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 616	2, 084	0	616	0	190. 00
	00 PHYSI CI ANS' PRI VATE OFFI CES	4, 826	14, 821	209			192. 00
	50 OTHER NONREIMBURSABLE	0	0	0	0		194.00
194. 01 079	51 PAIN CLINIC	0	0	0	o	0	194. 01
194. 02 079	52 OCC HEALTH	0	0	0	0		194. 02
194. 03 079	53 FOUNDATION	5	0	0	0		194. 03
	54 PHYSICIAN OFFICES	0	0	0			194. 04
	55 COMMUNITY & VOLUNTEER SERVICES	42, 987	707	0	209		194. 05
	56 VACANT_SPACE	0	0	0	0	0	194. 06
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118-201)	2, 033, 566	172, 739	18, 394	49, 418	54, 526	202. 00

0 194.06

101, 584 202. 00

200.00 0 201.00

In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2016 Part II 12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** SERVICES & **PERSONNEL** ADMI NI STRATI ON **SUPPLY** 11. 00 12.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 17,024 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 173, 392 13.00 322 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 23, 740 14.00 15.00 01500 PHARMACY 293 0 228 101, 584 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16.00 0 0 0 01700 SOCIAL SERVICE 17.00 0 C 0 0 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 02000 NURSI NG SCHOOL 0 20.00 0 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21 00 C 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 C 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 1,805 70, 153 1,913 65 43.00 04300 NURSERY 93 0 3,601 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 963 n 37 442 5, 816 2. 818 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 368 0 14, 286 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 12 54.00 1, 263 535 05401 CAT SCAN 0 0 54.01 0 0 0 54.01 60.00 06000 LABORATORY 0 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 0 0 0 62.30 06500 RESPIRATORY THERAPY 65 00 487 Ω 0 373 0 65 00 06600 PHYSI CAL THERAPY 0 66.00 1,703 0 170 11 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 791 0 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 1,380 0 0 68.00 06900 ELECTROCARDI OLOGY O 69 00 0 Ω 0 69 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 C 0 11, 227 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 613 98, 417 73.00 76. 97 07697 CARDIAC REHABILITATION 76. 97 0 0 Ω 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY C 30 3 0 76.98 76.99 07699 LI THOTRI PSY 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 37 28 0 91.00 09100 EMERGENCY 1, 232 47,880 1,512 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 1, 923 0 0 228 95.00 1, 017 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 101, 557 118. 00 16, 661 0 173, 392 23, 435 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 32 \cap 0 208 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 54 0 0 8 0 192.00 194. 00 07950 OTHER NONREIMBURSABLE 0 194. 00 0 0 0 0 0 0 194. 01 194. 01 07951 PAIN CLINIC 0 0 0 194. 02 07952 OCC HEALTH 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 27 194. 03 0 54 0 194. 04 194. 04 07954 PHYSICIAN OFFICES 0 0 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 223 C 0 89 0 194. 05

0

173, 392

23, 740

17.024

194.06 07956 VACANT SPACE

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Part II

From 01/01/2016 Date/Time Prepared: 12/31/2016 5/22/2017 9:39 am INTERNS & **RESI DENTS** NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR Cost Center Description MEDI CAL SOCIAL SERVICE Y & FRINGES RECORDS & ANESTHETI STS LI BRARY **APPRV** 17.00 19.00 16.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 10, 443 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19 00 Ω 0 02000 NURSING SCHOOL 20.00 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23 00 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 601 0 30.00 43.00 04300 NURSERY 0 43.00 29 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 368 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 118 52.00 05300 ANESTHESI OLOGY 53.00 197 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2.793 54.00 54.01 05401 CAT SCAN 0 54.01 06000 LABORATORY 60.00 1 019 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 06500 RESPIRATORY THERAPY 65 00 352 0 65 00 06600 PHYSI CAL THERAPY 66.00 156 66.00 06700 OCCUPATIONAL THERAPY 67.00 67 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 36 06900 ELECTROCARDI OLOGY 0 69.00 38 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 460 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 152 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 903 76. 97 07697 CARDIAC REHABILITATION 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 155 0 76. 98 07699 LI THOTRI PSY 76.99 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 10 90.00 91.00 09100 EMERGENCY 1,514 C 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 475 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 10, 443 0 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 Ω 192 00 194.00 07950 OTHER NONREI MBURSABLE 0 0 194.00 0 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 0 0 0 194.02 194. 03 07953 FOUNDATI ON 0 194 03 194. 04 07954 PHYSICIAN OFFICES 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194. 05 194.06 07956 VACANT SPACE 0 194. 06 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 0 201. 00 TOTAL (sum lines 118-201) 0 202.00 202.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPT. OF NOBLE CTY, INC. Provider CCN: 15-0146

			To		Date/Time Pre	pared:
	INTERNS &				5/22/2017 9: 3	9 am
	RESI DENTS					
Cost Center Description	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost	Total	
	APPRV	I KOW		& Post		
				Stepdown		
	22.00	22.00	24.00	Adjustments	24 00	
GENERAL SERVICE COST CENTERS	22. 00	23. 00	24. 00	25. 00	26. 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						5. 00 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 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE						16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS						17. 00 19. 00
20. 00 02000 NURSI NG SCHOOL						20. 00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV						21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	0					22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0				23. 00
30. 00 03000 ADULTS & PEDIATRICS			523, 504	ol	523, 504	30. 00
43. 00 04300 NURSERY			19, 153	О	19, 153	43. 00
ANCILLARY SERVICE COST CENTERS	1		F44 017	ما	F44 017	F0 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM			544, 017 79, 940	0	544, 017 79, 940	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY			1, 620	o	1, 620	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			406, 878	O	406, 878	54.00
54. 01 05401 CAT SCAN			0	0	0	54. 01
60.00 06000 LABORATORY 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS			190, 796 0	0	190, 796 0	60. 00 62. 30
65. 00 06500 RESPI RATORY THERAPY			103, 281	ő	103, 281	65. 00
66. 00 06600 PHYSI CAL THERAPY			83, 035	O	83, 035	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY			37, 344	0	37, 344	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY			19, 303 1, 474	0	19, 303 1, 474	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			76, 176	0	76, 176	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			43, 071	o	43, 071	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS			311, 750	0	311, 750	73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON 76. 98 O7698 HYPERBARI C OXYGEN THERAPY			0	0	0 EE 712	76. 97
76. 99 07699 LI THOTRI PSY			55, 712 0	-	55, 712 0	76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS			<u> </u>	٩	<u> </u>	, 0. , ,
90. 00 09000 CLI NI C			4, 112	0	4, 112	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART			257, 271	0	257, 271	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS				O _I		92.00
95. 00 09500 AMBULANCE SERVICES			202, 555	0	202, 555	95. 00
SPECIAL PURPOSE COST CENTERS			2 0/0 000	ما	2 0/0 002	110 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	0	2, 960, 992	0	2, 960, 992	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			10, 445	0	10, 445	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES			45, 893	O	45, 893	
194. 00 07950 OTHER NONREI MBURSABLE			0	0		194. 00
194. 01 07951 PALN CLINIC 194. 02 07952 OCC HEALTH			0	0		194. 01 194. 02
194. 03 07953 FOUNDATI ON			86	o o		194. 02
194. 04 07954 PHYSI CLAN OFFICES			0	o	0	194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES			45, 502	О	45, 502	
194.06 07956 VACANT SPACE 200.00 Cross Foot Adjustments		^	0	0		194. 06 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	1	0		200.00
202.00 TOTAL (sum lines 118-201)	0	0		ő	3, 062, 918	
			·			

Health Financial Systems

COMMUNITY HOSPT. OF NOBLE CTY, INC.

In Lieu of Form CMS-2552-10

Provider CCN: 15-0146
From 01/01/2016
To 12/31/2016

CAPITAL RELATED COSTS

Cost Center Description

COMMUNITY HOSPT. OF NOBLE CTY, INC.

In Lieu of Form CMS-2552-10

Worksheet B-1

Date/Time Prepared: 5/22/2017 9: 39 am

CAPITAL RELATED COSTS

BLDG & FIXT MVBLE EQUIP EMPLOYEE Reconciliation ADMINISTRATIVE

Cost Center Description	epared: 39 am
COURT COUR	77 (3111
COUAND FEET COLLAR VALUE BENEFITS CACCUM COST)	-
CRORSS SALARIES SALARIE	
CENERAL SERVICE COST CENTERS	
CENERAL SERVICE COST CENTERS	
1.00	
2.00 00200 CAP REL COSTS-MUBLE EQUIP 0 694, 437 1 1 1 1 1 1 1 1 1	4
0.0400 EMPLOYEE BENEFITS DEPARTMENT 0 0 18, 345, 836 7, 20 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.0500 0.	1.00
5.00 0.0500 ADM IN STRATIVE & GENERAL 29, 785 6, 589 5, 158, 191 -12, 694, 028 26, 878, 97 7.00 0.000 ODERATION OF PLANT 11, 508 17, 884 417, 037 0 0 1, 549, 63 0 1, 22, 64 0 0 172, 64 0 122, 64 0 0 0 172, 64 0 0 0 172, 64 0 0 0 172, 64 0 0 0 0 172, 64 0 0 0 0 172, 64 0 0 0 0 172, 64, 028 0 5,88, 9 1 1,900 0 0 0 172, 64, 028 26, 218, 82, 92 0 388, 22 0 0 388, 22 1 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 11, 48 14	4.00
0.00800 LAUNDRY & LINEN SERVICE	
9.00 0.0900 HOUSEKEEPING	1
10.00 01000 DIETRRY 2, 948 6,599 233, 792 0 388, 25 12.00 01000 CAFETERIA 1,907 0 136, 350 0 71, 94 12.00 0100 CAFETERIA 1,907 0 136, 350 0 0 0 0 0 0 0 0 0	
12.00 01200 MAI NTEMANCE OF PERSONNEL 0 0 0 0 694, 41	
13.00 01300 NURSI NG ADMINISTRATION	
14. 00 01400 CENTRAL SERVI CES & SUPPLY 3, 683 0 0 0 11, 48	12. 00 1 13. 00
16. 00 0 10500 MEDICAL RECORDS & LIBRARY 1, 659 0 0 0 0 0 5, 16 17 17 17 10 17 17 10 17 17 10 17 17 10 17 17 10 17 17 10 17 17 1 15 1, 403 1, 474, 542 0 2, 544, 75 10 10 10 10 10 18 SERVI CE TO 10 10 10 10 18 SERVI CE STALARY & FRI NGES APPRV 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1
17.00 01700 01700 01 0 0 0 0 0 0 0 0	
19. DO 01990 NONPHYSICI AN AMESTHETISTS 0 0 0 0 0 0 0 0 0	16. 00 17. 00
20. 00 02000 NURSI NC SCHOOL 0 0 0 0 0 0 0 0 0	19.00
22 0.0 02200 LAR SERVI CES_OTHER PROM COSTS APPRV 0 0 0 0 0 0 0 0 0	20.00
23.00	21.00
INPATIENT ROUTI NE SERVI CE COST CENTERS 17, 322 47, 856 2, 203, 826 0 3, 045, 03 43, 00 300 ADURTS & PEDI ATRICS 249 2, 803 112, 370 0 142, 97 ANCI LLARY SERVI CE COST CENTERS	22. 00
43.00	25.00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 05000 05000 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 052	43.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 1,599 11,252 445,843 0 569,33	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 7,771 145,403 1,474,542 0 2,554,75 54. 01 05401 CAT SCAN 0 0 0 0 0 60. 00 06000 LABORATORY 2,292 0 0 0 0 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 1,971 32,127 545,098 0 722,29 66. 00 06600 PHYSI CAL THERAPY 786 12,890 749,358 0 820,00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 329,263 0 429,39 68. 00 06800 SPEECH PATHOLOGY 0 0 181,233 0 236,42 69. 00 06900 ELECTROCARDI OLOGY 164 0 0 0 0 72. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1,700 815 711 0 585,88 71. 00 09100 EMERGENCY 7,254 8,654 1,462,128 0 1,957,64 79. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS 79. 00 09200 CRANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 70. 00 SUBTOTALS (SUM OF LINES 1-117) 109,483 691,096 18,006,056 -12,694,028 26,212,34 70. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 916 1,851 26,593 0 34,558 70. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 916 1,851 26,593 0 34,558 70. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 916 1,851 26,593 0 34,558 70. 00 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 100000 100000 100000 100000 100000 100000 100000 100000 100000 100000 1000000 100000 100000 100000 100000 100000000	
54. 01	
60. 00 06000 LABORATORY 2, 292 0 0 0 0 2, 324, 235 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 1, 971 32, 127 545, 098 0 722, 297 66. 00 06600 PHYSI CAL THERAPY 786 12, 890 749, 358 0 820, 067 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 329, 263 0 429, 359 68. 00 06800 SPECCH PATHOLOGY 0 0 181, 233 0 236, 44 69. 00 06900 ELECTROCARDI OLOGY 164 0 0 0 0 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 69. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 69. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 69. 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 69. 07697 CARDI AC REHABI LI TATI ON 0 0 0 69. 09 07698 HYPERBARI C OXYGEN THERAPY 1,700 815 711 0 585, 88 69. 00 09000 CLI NI C 0 0 0 0 69. 00 09000 DEBERGENCY 7,254 8,654 1,462, 128 0 1,957, 64 69. 00 09000 DEBERGENCY 7,254 8,654 1,462, 128 0 1,957, 64 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 AMBULANCE SERVI CES 0 24,998 1,737,019 0 2,265,41 69. 00 09500 09500 09500 09500 09500 09500 09500 09500 09500	54. 00 54. 0
65. 00 06500 RESPI RATORY THERAPY 1, 971 32, 127 545, 098 0 722, 296 60. 00 06600 PHYSI CAL THERAPY 786 12, 890 749, 358 0 820, 066 700 0 0 0 0 0 0 0 0	
66. 00 06600 PHYSI CAL THERAPY 786 12,890 749,358 0 820,0667.00 06700 0CCUPATI ONAL THERAPY 0 0 0 329,263 0 429,38 68.00 06800 SPEECH PATHOLOGY 0 0 0 181,233 0 236,42 0 06900 ELECTROCARDI OLOGY 164 0 0 0 0 0 55,84 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 0 0 0	62. 30
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 329, 263 0 429, 39 68. 00 06800 SPEECH PATHOLOGY 0 0 181, 233 0 236, 42 69. 00 06900 ELECTROCARDI OLOGY 164 0 0 0 0 5, 44 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 55, 24 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 567, 28 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 2, 799, 73 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 700 815 711 0 585, 88 90. 00 09000 CLI NI C 0 0 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 42, 845 0 53, 35 91. 00 09100 EMERGENCY 7, 254 8, 654 1, 462, 128 0 1, 957, 64 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 24, 998 1, 737, 019 0 2, 265, 41 818. 00 SIGNARD AS SERVI CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 916 1, 851 26, 593 0 34, 58	
68. 00	
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76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 9
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC OUTPATIENT 91. 00 09100 EMERGENCY 7, 254 8, 654 1, 462, 128 OUTPATIENT 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 07THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES OUTPATIENT 95. 00 09500 AMBULANCE SERVICES OUTPATIENT 18. 00 SUBTOTALS (SUM OF LINES 1-117) 109, 483 691, 096 18, 006, 056 -12, 694, 028 26, 212, 348 18. 00 SUBTOTALS (SUM OF LINES 1-117) 109, 483 691, 096 18, 006, 056 -12, 694, 028 26, 212, 348 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 916 1, 851 26, 593 OUTPATIENT 190. 00 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000 19000	76. 98
91. 00	70. 7
92. 00	
OTHER REIMBURSABLE COST CENTERS 95.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97	91.00
95. 00	92.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 109, 483 691, 096 18, 006, 056 -12, 694, 028 26, 212, 34 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 916 1, 851 26, 593 0 34, 58	95.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 916 1,851 26,593 0 34,58	1110 0
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 916 1, 851 26, 593 0 34, 58	1118.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 6, 515 1, 200 36, 002 0 63, 79	190. 00
	192. 00
194. 00 07950 OTHER NONREI MBURSABLE 0 0 0 0	194.00
194. 01 07951 PAIN CLINIC 0 0 0 0 194. 02 07952 OCC HEALTH 0 0 0 0	194. 0° 194. 0°
194. 03 07953 FOUNDATION 0 0 32 0 6	194. 0
194. 04 07954 PHYSI CI AN OFFI CES 0 0 0 0	194. 0
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 311 290 277, 153 0 568, 18 194. 06 07956 VACANT SPACE 0 0 0	194. 0! 194. 0
200. 00 Cross Foot Adjustments	200. 00
201.00 Negative Cost Centers	201. 00
202.00 Cost to be allocated (per Wkst. B, 364,799 764,496 2,569,487 12,694,02	1202.00
203.00 Unit cost multiplier (Wkst. B, Part I) 3.111956 1.100886 0.140058 0.47226	203. 0
204.00 Cost to be allocated (per Wkst. B, 0 2,033,56	
Part II)	1

Health Financial Systems COM	MMUNITY HOSPT. OF	NOBLE CTY, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2016	Worksheet B-1	
				To 12/31/2016		
	CAPITAL REL	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	1.00	2. 00	4.00	5A	5. 00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 000000	0	0. 075656	205. 00

Provider CCN: 15-0146

			11	0 12/31/2016	Date/lime Pre 5/22/2017 9:3	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERI A	
	7. 00	LAUNDRY) 8. 00	9. 00	10. 00	11.00	
GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1. 00	75, 932 990 1, 432 2, 948 1, 907 0 401 3, 683 1, 086 1, 659 0 0	300, 212 12, 326 427 427 0 9, 087 0 0 0 0	73, 510 2, 948	34, 596 0 0 0 0 0 0 0 0	668, 166 0 12, 627 0 11, 504 0 0 0 0	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	17, 322	104, 736		34, 596	70, 843	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	249	302	249	0	3, 636	43. 00
50. 00 05000 OPERATING ROOM	12, 976	78, 936	12, 976	0	37, 810	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 599	303	1, 599	0	14, 426	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 CAT SCAN	7, 771	29, 921 0	7, 771	0	49, 562	1
60. 00 06000 LABORATORY	2, 292	743	2, 292	0	0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	1, 971	1, 832	1, 971	0	19, 130	1
66. 00 06600 PHYSI CAL THERAPY	786	0	786	0	66, 850	1
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	188, 085 54, 149	1
69. 00 06900 ELECTROCARDI OLOGY	164	0	164	0	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION	0	0	0	0	0	73. 00 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 700	0	1, 700	0	30	1
76. 99 07699 LI THOTRI PSY	0	0		0	l	1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	7, 254	0 57, 756		0		90. 00 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 234	57, 750	7, 254	0	40, 331	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	75, 493	95. 00
SPECIAL PURPOSE COST CENTERS	(0.400	201 701	/5.7/0	24.504	/50.055	1110 00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	68, 190	296, 796	65, 768	34, 596	653, 955	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	916	0	916	0	1, 248	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	6, 515	3, 416		0		192. 00
194. 00 07950 OTHER NONREI MBURSABLE	0	0	0	0		194. 00
194. 01 07951 PALN CLINIC 194. 02 07952 OCC HEALTH	0	0	0	0		194. 01
194. 02 07952 0CC HEALTH 194. 03 07953 FOUNDATI ON	0	0	0	0		194. 02 194. 03
194. 04 07954 PHYSI CI AN OFFI CES	0	0	0	0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	311	0	311	0		194. 05
194.06 07956 VACANT SPACE 200.00 Cross Foot Adjustments	0	0	0	0	0	194. 06 200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	2, 281, 468	283, 919	820, 759	693, 486	184, 913	1
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	30. 046199	0. 945728	11. 165270	20. 045265	0. 276747	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)	172, 739	18, 394	49, 418	54, 526	17, 024	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	2. 274917	0. 061270	0. 672262	1. 576078	0. 025479	205. 00
	·					

Cost	ARY TERIA TENANCE OF PERSONNEL ING ADMINISTRATION RAL SERVICES & SUPPLY MACY CAL RECORDS & LIBRARY AL SERVICE HYSICIAN ANESTHETISTS ING SCHOOL SERVICES-SALARY & FRINGES APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	(MEALS SERVED)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS) 13.00		Pri od:	Worksheet B-1 Date/Time Preps/22/2017 9: 3* MEDI CAL RECORDS & LI BRARY (GROSS REVENUE) 16.00	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00
1. 00 O0100 CAP RE	REVICE COST CENTERS REL COSTS-BLDG & FIXT REL COSTS-BLDG & FIXT REL COSTS-MYBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT DRY & LINEN SERVICE EKEEPING ARY TERIA TENANCE OF PERSONNEL ING ADMINISTRATION RAL SERVICES & SUPPLY MACY CAL RECORDS & LIBRARY AL SERVICE HYSICIAN ANESTHETISTS ING SCHOOL SERVICES-SALARY & FRINGES APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	PERSONNEL (MEALS SERVED) 12.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON (DI RECT NRSI NG HRS) 13. 00 175, 096 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REQUI S.) 14. 00 3, 002, 807 28, 852 0 0 0 0 0	(COSTED REQUIS.) 15.00	MEDI CAL RECORDS & LI BRARY (GROSS REVENUE) 16.00	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
1. 00 00100 CAP RE 2. 00 00200 CAP RE 4. 00 00400 EMPLOY 5. 00 00500 ADMI NI 7. 00 00700 OPERAT 8. 00 00800 LAUNDR 9. 00 00900 HOUSEK 11. 00 01100 DI ETAR 11. 00 01100 DI ETAR 11. 00 01100 MAINTI 12. 00 01200 MAINTI 13. 00 01300 NURSI 14. 00 01400 CENTRA 15. 00 01500 PHARMA 16. 00 01600 MEDI CA 17. 00 01700 SOCI AL 19. 00 01900 NONPHY 20. 00 02000 NURSI 11. 00 01900 NONPHY 22. 00 02200 I&R SE 23. 00 02200 I&R SE 23. 00 02200 J&R SE 23. 00 02200 J&R SE 23. 00 02300 PARAME INPATI ENT RC 30. 00 03000 ADULTS 43. 00 04300 NURSER ANCI LLARY SE 50. 00 05200 DELI VE 53. 00 05400 RADI OL 54. 01 05401 CAT 55. 00 06500 RESPI R 66. 00 06600 LABORA 62. 30 06250 BLOOD 65. 00 06500 RESPI R 66. 00 06600 LABORA 62. 30 06250 BLOOD 65. 00 06700 OCCUPA 68. 00 06600 RESPI R 69. 00 06900 ELECTR 71. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07699 LI TIOT 90. 00 09000 CLI NI C 90. 00 09000 CLI NI C 90. 00 09000 CLI NI C 91. 00 09100 EMERGE 92. 00 09200 OBSERV 0THER REI MBL 09500 AMBULAS 9500 AMBULAS	REL COSTS-BLDG & FIXT REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT DRY & LINEN SERVICE EKEEPING ARY TERIA TENANCE OF PERSONNEL ING ADMINISTRATION RAL SERVICES & SUPPLY MACY CAL RECORDS & LIBRARY AL SERVICE HYSICIAN ANESTHETISTS ING SCHOOL SERVICES-OTHER PRGM COSTS APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	12.00 0 0 0 0 0 0 0 0 0	HRS) 13.00 175,096 0 0 0 0 0 0 0 0	3, 002, 807 28, 852 0 0 0	2, 801, 455	REVENUE) 16. 00 189, 983, 516 0 0	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
1. 00 00100 CAP RE 2. 00 00200 CAP RE 4. 00 00400 EMPLOY 5. 00 00500 ADMI NI 7. 00 00700 OPERAT 8. 00 00800 LAUNDR 9. 00 00900 HOUSEK 11. 00 01100 DI ETAR 11. 00 01100 DI ETAR 11. 00 01100 MAINTI 12. 00 01200 MAINTI 13. 00 01300 NURSI 14. 00 01400 CENTRA 15. 00 01500 PHARMA 16. 00 01600 MEDI CA 17. 00 01700 SOCI AL 19. 00 01900 NONPHY 20. 00 02000 NURSI 11. 00 01900 NONPHY 22. 00 02200 I&R SE 23. 00 02200 I&R SE 23. 00 02200 J&R SE 23. 00 02200 J&R SE 23. 00 02300 PARAME INPATI ENT RC 30. 00 03000 ADULTS 43. 00 04300 NURSER ANCI LLARY SE 50. 00 05200 DELI VE 53. 00 05400 RADI OL 54. 01 05401 CAT 55. 00 06500 RESPI R 66. 00 06600 LABORA 62. 30 06250 BLOOD 65. 00 06500 RESPI R 66. 00 06600 LABORA 62. 30 06250 BLOOD 65. 00 06700 OCCUPA 68. 00 06600 RESPI R 69. 00 06900 ELECTR 71. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07699 LI TIOT 90. 00 09000 CLI NI C 90. 00 09000 CLI NI C 90. 00 09000 CLI NI C 91. 00 09100 EMERGE 92. 00 09200 OBSERV 0THER REI MBL 09500 AMBULAS 9500 AMBULAS	REL COSTS-BLDG & FIXT REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT DRY & LINEN SERVICE EKEEPING ARY TERIA TENANCE OF PERSONNEL ING ADMINISTRATION RAL SERVICES & SUPPLY MACY CAL RECORDS & LIBRARY AL SERVICE HYSICIAN ANESTHETISTS ING SCHOOL SERVICES-OTHER PRGM COSTS APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	000000000000000000000000000000000000000	13. 00 175, 096 0 0 0 0 0 0	3, 002, 807 28, 852 0 0 0 0	2, 801, 455	16. 00 189, 983, 516 0 0	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
1. 00 00100 CAP RE 2. 00 00200 CAP RE 4. 00 00400 EMPLOY 5. 00 00500 ADMI NI 7. 00 00700 OPERAT 8. 00 00800 LAUNDR 9. 00 00900 HOUSEK 11. 00 01100 DI ETAR 11. 00 01100 DI ETAR 11. 00 01100 MAINTI 12. 00 01200 MAINTI 13. 00 01300 NURSI 14. 00 01400 CENTRA 15. 00 01500 PHARMA 16. 00 01600 MEDI CA 17. 00 01700 SOCI AL 19. 00 01900 NONPHY 20. 00 02000 NURSI 11. 00 01900 NONPHY 22. 00 02200 I&R SE 23. 00 02200 I&R SE 23. 00 02200 J&R SE 23. 00 02200 J&R SE 23. 00 02300 PARAME INPATI ENT RC 30. 00 03000 ADULTS 43. 00 04300 NURSER ANCI LLARY SE 50. 00 05200 DELI VE 53. 00 05400 RADI OL 54. 01 05401 CAT 55. 00 06500 RESPI R 66. 00 06600 LABORA 62. 30 06250 BLOOD 65. 00 06500 RESPI R 66. 00 06600 LABORA 62. 30 06250 BLOOD 65. 00 06700 OCCUPA 68. 00 06600 RESPI R 69. 00 06900 ELECTR 71. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07699 LI TIOT 90. 00 09000 CLI NI C 90. 00 09000 CLI NI C 90. 00 09000 CLI NI C 91. 00 09100 EMERGE 92. 00 09200 OBSERV 0THER REI MBL 09500 AMBULAS 9500 AMBULAS	REL COSTS-BLDG & FIXT REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT DRY & LINEN SERVICE EKEEPING ARY TERIA TENANCE OF PERSONNEL ING ADMINISTRATION RAL SERVICES & SUPPLY MACY CAL RECORDS & LIBRARY AL SERVICE HYSICIAN ANESTHETISTS ING SCHOOL SERVICES-OTHER PRGM COSTS APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	000000000000000000000000000000000000000	175, 096 0 0 0 0 0 0 0 0	3, 002, 807 28, 852 0 0 0 0 0	2, 801, 455	189, 983, 516 0 0	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 00200 CAP RE	REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL ATION OF PLANT DRY & LINEN SERVICE EKEEPING ARY TERIA TENANCE OF PERSONNEL ING ADMINISTRATION RAL SERVICES & SUPPLY MACY CAL RECORDS & LIBRARY AL SERVICE HYSICIAN ANESTHETISTS ING SCHOOL SERVICES-SALARY & FRINGES APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	0	0 0 0 0 0 0 0	28, 852 0 0 0 0 0 0		0	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
10. 00	ARY TERIA TENANCE OF PERSONNEL ING ADMINISTRATION RAL SERVICES & SUPPLY MACY CAL RECORDS & LIBRARY AL SERVICE HYSICIAN ANESTHETISTS ING SCHOOL SERVICES-SALARY & FRINGES APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	0	0 0 0 0 0 0 0	28, 852 0 0 0 0 0 0		0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
16. 00	CAL RECORDS & LIBRARY AL SERVICE HYSICIAN ANESTHETISTS ING SCHOOL SERVICES-SALARY & FRINGES APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	0	0 0 0 0 0 0 0 0	0 0 0 0 0		0	16. 00 17. 00
19. 00 01900 NONPHY 20. 00 02000 NURSI N 21. 00 02100 I &R SE 22. 00 02200 J &R SE 23. 00 02300 PARAME INPATI ENT RC 30. 00 03000 ADULTS 43. 00 04300 NURSER ANCI LLARY SE 50. 00 05200 DELI VE 53. 00 05500 DELI VE 53. 00 05500 DELI VE 54. 00 05400 RADI OL 54. 01 05401 CAT SC 60. 00 06600 LABORA 62. 30 06250 BLODD 65. 00 06600 PHYSI C 65. 00 06600 RESPI R 66. 00 06600 RESPI R 66. 00 06600 SPECH 69. 00 06900 ELECTR 71. 00 07100 MEDI CA 72. 00 07200 I MPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07698 HYPERB 76. 99 07699 LITHOT 0000 0000 CLI NI C 91. 00 09100 EMERGE 92. 00 09200 OBSERV 07500 AMBULA 09500 AMBULA 18. 00 SUBTOT NONREI MBURSA	HYSICIAN ANESTHETISTS ING SCHOOL SERVICES-SALARY & FRINGES APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	0	0 0 0 0 0 0	0 0 0 0	0 0 0	0	1
21. 00	SERVICES-SALARY & FRINGES APPRV SERVICES-OTHER PRGM COSTS APPRV MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	0	70. 843	0 0 0 	o	U,	1
23. 00 02300 PARAME NPATI ENT RC 30. 00 03000 ADULTS 80. 00 04300 NURSER 80. 00 05000 OPERAT 52. 00 05200 DELI VE 53. 00 05400 RADI OL 54. 01 05401 CAT SC 60. 00 06000 LABORA 62. 30 06500 RESPI R 66. 00 06600 PHYSI C 67. 00 06700 OCCUPA 68. 00 06600 PHYSI C 67. 00 06700 OCCUPA 68. 00 06600 SPECH 67. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07699 LITHOR 57. 00 09000 CLI NI C 91. 00 09100 EMERGE 92. 00 09200 OBSERV 07500 AMBULA 57. 00 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500	MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS TS & PEDIATRICS ERY	0	70.843	 0		0	21. 00
30. 00 03000 ADULTS 43. 00 04300 NURSER ANCI LLARY SE 52. 00 05200 DELI VE 53. 00 05300 ANESTH 54. 00 05400 RADI OL 54. 01 05401 CAT SC 60. 00 06600 LABORA 65. 00 06500 RESPI R 66. 00 06600 PHYSI C 67. 00 06700 OCCUPA 68. 00 06600 PHYSI C 67. 00 06700 OCCUPA 68. 00 06600 SPECH 69. 00 07100 MEDI CA 71. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07698 HYPERB 76. 99 07699 LITHOT 90. 00 09100 EMERGE 92. 00 09200 OBSERV 95. 00 09500 AMBULA 118. 00 SUBTOT NONREI MBURSA	TS & PEDIATRICS ERY	1	70 843		0	0	1 22. 0
43. 00 04300 NURSER ANCI LLARY SE 50. 00 05000 OPERAT 52. 00 05200 DELI VE 53. 00 05300 ANESTH 54. 00 05400 RADI OL 54. 01 05401 CAT SC 60. 00 06000 LABORA 62. 30 06250 BLODO 65. 00 06500 RESPI R 66. 00 06600 PHYSI C 67. 00 06700 OCCUPA 68. 00 06600 PHYSI C 69. 00 06900 ELECTR 71. 00 07100 MEDI C 72. 00 07200 IMPL 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07698 HYPERB 76. 99 07699 LI THOT 90. 00 09000 CLI NI C 91. 00 09100 EMERGE 92. 00 09200 OBSERV 95. 00 SUBTOT NONREI MBURSA	ERY	1		241, 958	1, 798	10, 933, 944	30.00
50. 00 05000 0PERAT 52. 00 05200 DELI VE 53. 00 05400 RADI VE 54. 00 05400 RADI VE 54. 00 05400 RADI VE 54. 00 06400 LABORA 62. 30 06500 RESPI R 66. 00 06600 PHYSI C 67. 00 06700 0CCUPA 68. 00 06600 SPEECH 69. 00 06700 CELECTR 71. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07698 HYPERS 76. 99 07699 LI THOT 0UTPATI ENT 5 09000 CLI NI C 091. 00 09100 EMERGE 92. 00 09200 0BSERV 07500 AMBUS AM			3, 636	241, 938	1, 746	532, 235	
53. 00 05300 ANESTH 54. 00 05400 RADI OL 54. 01 05401 CAT SC 60. 00 06000 LABORD 62. 30 06250 BLOOD 65. 00 06500 RESPI R 66. 00 06600 PHYSI C 67. 00 06700 OCCUPA 68. 00 06800 SPEECH 69. 00 06900 ELETTH 71. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07698 HYPERB 76. 99 07699 LITHOT 90. 00 09100 EMERGE 92. 00 09200 OBSERV 95. 00 09500 AMBULA 118. 00 SUBTOT NONREI MBURSA	SERVICE COST CENTERS ATING ROOM	0	37, 810	735, 647	77, 705	24, 874, 159	50.0
54. 00	VERY ROOM & LABOR ROOM THESIOLOGY	0	14, 426 0	0	0	2, 136, 715 3, 583, 766	1
60. 00 06000 LABORA 62. 30 06250 BLOOD 65. 00 06500 RESPI R 66. 00 06600 PHYSI C 67. 00 06700 OCCUPA 68. 00 06800 SPEECH 69. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07699 LI THOT 00179ATI ENT 90. 00 09100 CLI NI C 91. 00 09100 CLI NI C 92. 00 09200 OBSERV 07400 OTHOR 95. 00 09500 AMBUS A 95. 00 SPECI AL PUAR 118. 00 SUBTOT NONREI MBURSA	OLOGY-DI AGNOSTI C	0	0	67, 731	342	50, 927, 256	54.0
65. 00 06500 RESPIR 66. 00 06600 PHYSIC 67. 00 06600 OCCUPA 68. 00 06800 SPECTR 71. 00 07100 MEDICA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDIA 76. 98 07698 HYPERB 76. 99 07699 LITHOT 0017PATIENT 90. 00 09100 CLINIC 91. 00 09100 SMERGE 92. 00 09200 OBSERV 07400 OTHER REI MBL 95. 00 09500 AMBURS 118. 00 SUBTOT NONREI MBURS	RATORY	0	0	0	0	0 18, 527, 660	60.0
66. 00 06600 PHYSI C 67. 00 06700 OCCUPA 68. 00 06800 SPEECH 69. 00 06900 ELECTR 71. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07698 HYPERB 76. 99 07699 LI THOT 90. 00 09100 EMERGE 92. 00 09200 OBSERV 0THER REI MBL 95. 00 SUBTOT NONREI MBURSA	D CLOTTING FOR HEMOPHILIACS IRATORY THERAPY	0	0	0 47, 202	0	0 6, 399, 348	1
68. 00 06800 SPEECH 69. 00 06900 ELECTR 71. 00 07100 MEDI CA 72. 00 07200 IMPL. 73. 00 07300 DRUGS 76. 97 07697 CARDI A 76. 98 07698 HYPERB 76. 99 07699 LITHOT 0UTPATI ENT 90. 00 09900 CLI NI C 91. 00 09100 EMERGE 92. 00 09200 OBSERV 0THER REI MBU 95. 00 09500 AMBULA SPECI AL PURE 118. 00 SUBTOT NONREI MBURSA	I CAL THERAPY	0	0	21, 485	309	2, 833, 191 1, 210, 803	66.0
71. 00 07100 MEDI CA 72. 00 07200 I MPL. 73. 00 07300 DRUGS 76. 97 CARDI A 76. 98 07699 LI THOT 0UTPATI ENT 5 90. 00 09100 EMERGE 92. 00 09200 0BSERV 0THER REI MBL 95. 00 SPECI AL PURE 118. 00 SUBTOT NONREI MBURSA 18. 00 07200 MBURSA 18. 00 SUBTOT NONREI MBURSA 18. 00 07200 MBURSA 18. 00 SUBTOT NONREI MBURSA 18. 00 MEDI CA CARDI C	CH PATHOLOGY	o	o	o	o	649, 182	68. 0
73. 00	TROCARDIOLOGY CAL SUPPLIES CHARGED TO PATIENT	0	0	0 1, 419, 892	0	684, 043 8, 355, 848	
76. 97 07697 CARDI A 76. 98 07698 HYPERB 76. 99 07699 LI THOT OUTPATI ENT S 90. 00 09000 CLI NI C 91. 00 09100 EMERGE 92. 00 09200 OBSERV OTHER REI MBL OPSOO AMBULA SPECI AL PURF 118. 00 SUBTOT NONREI MBURSA	. DEV. CHARGED TO PATIENTS S CHARGED TO PATIENTS	0	o	0 77, 598	0 2, 714, 121	2, 763, 023 16, 421, 728	
76. 99	IAC REHABILITATION	o	o	0	0	0	76. 9
90. 00 09000 CLI NI C 91. 00 09100 EMERGE 92. 00 09200 OBSERV OTHER REI MBULA SPECI AL PURE 118. 00 SUBTOT NONREI MBURSA	RBARI C OXYGEN THERAPY OTRI PSY	0	30 0	361 0	0	2, 813, 131 0	1
91. 00 09100 EMERGE 92. 00 09200 0BSERV 0THER REI MBL 95. 00 09500 AMBURS SPECI AL PURE 118. 00 SUBTOT NONREI MBURSA	SERVICE COST CENTERS		-1		-		
95. 00 OTHER REI MBL 95. 00 O9500 AMBULA SPECI AL PURE 118. 00 SUBTOT NONREI MBURSA		0	48, 351	3, 596 191, 231	0 153	174, 595 27, 519, 170	1
95. 00 09500 AMBULA SPECIAL PURE 118. 00 SUBTOT NONREI MBURSA	RVATION BEDS (NON-DISTINCT PART IBURSABLE COST CENTERS						92.0
118. 00 SUBTOT NONREI MBURSA	LANCE SERVICES	0	0	128, 656	6, 283	8, 643, 719	95. 0
	OTALS (SUM OF LINES 1-117)	0	175, 096	2, 964, 209	2, 800, 711	189, 983, 516	118. 0
190. 00 19000 GFFI,	SABLE COST CENTERS , FLOWER, COFFEE SHOP & CANTEEN	0	0	26, 303	0	0	190. 0
	ICIANS' PRIVATE OFFICES	0	o	975 0	0		192. 0 194. 0
194. 01 07951 PAIN C	CLINIC	O	o	0	o	0	194. 0
194. 02 07952 OCC HE 194. 03 07953 FOUNDA		0	0	0	0 744		194. 0 194. 0
194. 04 07954 PHYSI C	ICIAN OFFICES	0	0	0	0	0	194. 0
194. 06 07956 VACANT		0	0	11, 320 0	0		194. 0 194. 0
	s Foot Adjustments						200. 0 201. 0
		0	1, 042, 382	177, 250	296, 834	75, 971	
203.00 Unit c	tive Cost Centers to be allocated (per Wkst. B,	0. 000000	5. 953203 173, 392	0. 059028 23, 740	0. 105957 101, 584	0. 000400 10, 443	
205.00 Unit c	tive Cost Centers to be allocated (per Wkst. B, I) cost multiplier (Wkst. B, Part I) to be allocated (per Wkst. B,	0		0. 007906	0. 036261	0. 000055	205. 0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

Peri od: Worksheet B-1 From 01/01/2016 To 12/31/2016 Date/Ti me Prepared:

5/22/2017 9:39 am INTERNS & RESIDENTS Cost Center Description SOCIAL SERVICE NONPHYSI CI AN NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER Y & FRINGES **ANESTHETISTS** PRGM COSTS (ASSI GNED (ASSI GNFD (TIME SPENT) **APPRV APPRV** TIME) TIME) (ASSI GNED (ASSI GNED TIME) TIME) 17.00 19. 00 20.00 21.00 22. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10 00 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 02000 NURSING SCHOOL 20.00 0 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 30.00 04300 NURSERY 0 0 0 0 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 50.00 0 o 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 0 0 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 000000000000 54.00 0 0 0 0 0 0 0 0 0 0 54.00 54.01 05401 CAT SCAN 0 0 0 54.01 06000 LABORATORY 0 60.00 0 0 60.00 0 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 0 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 Ω 0 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07697 CARDIAC REHABILITATION 0 0 0 76. 97 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76 98 0 0 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09100 EMERGENCY 0 O 91.00 C 0 Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 0 95.00 95.00 0 0 0 0 SUBTOTALS (SUM OF LINES 1-117) 0 0 0 0 0 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190 00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 194. 00 07950 OTHER NONREI MBURSABLE 0 0 0 0 194.00 0 0 194. 01 07951 PAIN CLINIC 0 194. 01 0 0 194, 02 194. 02 07952 OCC HEALTH 0 0 194. 03 07953 FOUNDATI ON 0 0 0 194. 03 194. 04 07954 PHYSICIAN OFFICES 0 0 194. 04 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 0 194. 05 0 194.06 07956 VACANT SPACE 0 0 0 194, 06 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 0 202.00 Cost to be allocated (per Wkst. B, 202.00 0 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 0 204. 00 Part II)

Health Financial Systems C	OMMUNITY HOSPT. O	F NOBLE CTY, I	NC.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2016	Worksheet B-1	
				Γο 12/31/2016	Date/Time Pre 5/22/2017 9:3	
				INTERNS &	RESI DENTS	
Cost Center Description	SOCI AL SERVI CE		NURSI NG SCHOOL	SERVI CES-SALAR		
		ANESTHETI STS		Y & FRINGES	PRGM COSTS	
	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
		TIME)	TIME)	(ASSI GNED	(ASSI GNED	
				TIME)	TIME)	
	17. 00	19. 00	20.00	21.00	22. 00	
205.00 Unit cost multiplier (Wkst. B, Part II)	0. 000000	0. 000000	0.00000	0. 000000	0. 000000	205. 00

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17. 00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING SCHOOL 20.00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 53.00 00000000000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 54 00 54.01 05401 CAT SCAN 54.01 06000 LABORATORY 60.00 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 65.00 06500 RESPIRATORY THERAPY 65 00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 07697 CARDIAC REHABILITATION 76.97 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 76. 99 07699 LI THOTRI PSY 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190.00 00000 192.00 194.00 07950 OTHER NONREIMBURSABLE 194. 00 194. 01 07951 PAIN CLINIC 194. 01 194. 02 07952 OCC HEALTH 194. 02 194. 03 07953 FOUNDATION 194. 03 194. 04 07954 PHYSICIAN OFFICES 194.04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194.05 194.06 07956 VACANT SPACE 0 194.06 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203. 00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 205.00 H)

Health Financial Systems C	OMMUNITY HOSPT. O	F NOBLE CTY, IN	NC.	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
				From 01/01/2016	Part I	
				Γο 12/31/2016	Date/Time Pre 5/22/2017 9:3	pared: 9 am
		Title	XVIII	Hospi tal	PPS	, alli
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS	6, 449, 693		6, 449, 693		6, 449, 693	1
43. 00 04300 NURSERY	243, 916		243, 916	6 0	243, 916	43. 00
ANCILLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATING ROOM	4, 851, 798		4, 851, 798		4, 851, 798	
52.00 05200 DELIVERY ROOM & LABOR ROOM	995, 120	l .	995, 120		995, 120	1
53. 00 05300 ANESTHESI OLOGY	29, 123		29, 123		34, 362	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 147, 980		4, 147, 980		4, 147, 980	
54. 01 05401 CAT SCAN	0		(٦ ١	0	54. 01
60. 00 06000 LABORATORY	3, 524, 468		3, 524, 468		3, 524, 468	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	_	(٦ ١	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	1, 157, 008		., ,		1, 157, 008	
66. 00 06600 PHYSI CAL THERAPY	1, 260, 682		1, 200, 001		1, 260, 682	
67. 00 06700 OCCUPATI ONAL THERAPY	684, 719		684, 719		684, 719	
68. 00 06800 SPEECH PATHOLOGY	363, 321		363, 32		363, 321	
69. 00 06900 ELECTROCARDI OLOGY	15, 644		15, 644		15, 644	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 342, 118		1, 342, 118		1, 342, 118	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	836, 305	l .	836, 305		836, 305	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 420, 684		4, 420, 684		4, 420, 684	
76. 97 07697 CARDIAC REHABILITATION	0		(٦ ١	0	1 , 0. , ,
76. 98 07698 HYPERBARI C OXYGEN THERAPY	933, 972	l .	933, 972		933, 972	1
76. 99 07699 LI THOTRI PSY	0		(0	0	76. 99
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLI NI C	79, 237		79, 237		79, 237	
91. 00 09100 EMERGENCY	3, 559, 278	l .	3, 559, 278		3, 559, 278	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1, 400, 720		1, 400, 720	الــــــــــــــــــــــــــــــــــــ	1, 400, 720	92.00
OTHER REIMBURSABLE COST CENTERS	2 2/7 205		2 2/7 22	- -	2 2/7 225	05.00
95. 00 09500 AMBULANCE SERVICES	3, 367, 905		3, 367, 905		3, 367, 905	
200.00 Subtotal (see instructions)	39, 663, 691	l .	,,		39, 668, 930	
201.00 Less Observation Beds	1, 400, 720	l .	1, 400, 720		1, 400, 720	
202.00 Total (see instructions)	38, 262, 971	0	38, 262, 97	5, 239	38, 268, 210	1202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0146 Peri od: Worksheet C From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/22/2017 9:39 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 9, 083, 010 9, 083, 010 30.00 30.00 43.00 04300 NURSERY 532, 235 532, 235 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 541, 303 18, 332, 856 24, 874, 159 0.195054 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 2, 136, 715 0.465724 0.000000 52.00 2.136.715 52 00 53.00 05300 ANESTHESI OLOGY 861, 101 2, 722, 665 3, 583, 766 0.008126 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 773, 116 46, 154, 140 50, 927, 256 0.081449 0.000000 54.00 05401 CAT SCAN 0.000000 0.000000 54.01 54.01 14, 885, 275 0. 190227 06000 LABORATORY 3, 642, 385 18, 527, 660 0.000000 60.00 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 65.00 06500 RESPIRATORY THERAPY 1, 581, 829 4, 817, 519 6, 399, 348 0.180801 0.000000 65.00 277, 989 2, 555, 202 0. 444969 66.00 06600 PHYSI CAL THERAPY 2, 833, 191 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 36, 334 1, 174, 469 1, 210, 803 0.565508 0.000000 67.00 06800 SPEECH PATHOLOGY 27,036 622, 146 649, 182 0.559660 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 579, 412 104, 631 684, 043 0.022870 0.000000 69.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 2, 266, 819 6,089,029 8, 355, 848 71 00 0.160620 0.000000 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 054, 553 708, 470 2, 763, 023 0. 302678 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 754, 808 10, 666, 920 0. 269197 0.000000 73.00 16, 421, 728 73.00 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 76.97 07698 HYPERBARI C OXYGEN THERAPY 2, 808, 291 76. 98 4,840 2, 813, 131 0. 332004 0.000000 76.98 76.99 07699 LI THOTRI PSY 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 1 900 172, 695 174 595 0 453833 0.000000 90 00 09100 EMERGENCY 91.00 3, 273, 604 24, 245, 566 27, 519, 170 0.129338 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 850, 934 1, 850, 934 0.756764 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 8, 643, 719 8, 643, 719 0.389636 200.00 Subtotal (see instructions) 43, 428, 989 146, 554, 527 189, 983, 516 200.00 201.00 Less Observation Beds 201. 00 202 00 Total (see instructions) 43 428 989 146, 554, 527 189 983 516 202 00

Peri od: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am

		T: 11 \0.0111		3/22/2017 9.39 dill
	Inno 1 11 1	Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30. 0
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 195054			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 465724			52. 0
53. 00 05300 ANESTHESI OLOGY	0. 009588			53. 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 081449			54. 0
54. 01 05401 CAT SCAN	0. 000000			54. 0
60. 00 06000 LABORATORY	0. 190227			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 180801			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 444969			66. 0
67. 00 06700 OCCUPATI ONAL THERAPY	0. 565508			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 559660			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 022870			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 160620			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 302678			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 269197			73. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 9
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 332004			76. 9
76. 99 07699 LI THOTRI PSY	0. 000000			76. 9
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 453833			90.00
91. 00 09100 EMERGENCY	0. 129338			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 756764			92. 0
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES	0. 389636			95. 0
200.00 Subtotal (see instructions)				200. 0
201.00 Less Observation Beds				201. 0
202.00 Total (see instructions)				202. 0
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1			1202.0

		MUNITY HOSPT. O	F NOBLE CTY, II	NC.	In Lie	u of Form CMS-	2552-10
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2016 To 12/31/2016		pared:
							9 am
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2.00	2.00	4.00	Г 00	
LND	ATIENT ROUTINE SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
	00 ADULTS & PEDIATRICS	6, 449, 693	1	. 440.40	2	(440 (02	30.00
	OO NURSERY	243, 916		6, 449, 69 243, 91			
	ILLARY SERVICE COST CENTERS	243, 910	1	243, 91	0	243, 910	43.00
	OO OPERATING ROOM	4, 851, 798	,	4, 851, 79	8 0	4, 851, 798	50.00
	00 DELIVERY ROOM & LABOR ROOM	995, 120		995, 12		4, 851, 798 995, 120	
	OO ANESTHESI OLOGY	29, 123		29, 12			
	00 RADI OLOGY-DI AGNOSTI C	4, 147, 980		4, 147, 98	· ·	· ·	
	01 CAT SCAN	4, 147, 900		4, 147, 90	0	4, 147, 960	1
	00 LABORATORY	3, 524, 468	()	3, 524, 46	0	3, 524, 468	
	50 BLOOD CLOTTING FOR HEMOPHILIACS	3, 324, 400		3, 324, 40	0	3, 324, 406	62. 30
	00 RESPIRATORY THERAPY	1, 157, 008		1, 157, 00	8 0	_	
	00 PHYSI CAL THERAPY	1, 157, 006		1, 157, 00		1, 157, 008	
	00 OCCUPATIONAL THERAPY	684, 719	•	684, 71		684, 719	
	00 SPEECH PATHOLOGY	363, 321		363, 32		363, 321	
	00 ELECTROCARDI OLOGY	15, 644		15, 64		15, 644	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 342, 118		1, 342, 11		1, 342, 118	
	00 IMPL. DEV. CHARGED TO PATIENTS	836, 305		836, 30		836, 305	
	OO DRUGS CHARGED TO PATIENTS	4, 420, 684		4, 420, 68			
	97 CARDI AC REHABI LI TATI ON	1, 420, 004	1	4, 420, 00	0 0	0	1
	98 HYPERBARI C OXYGEN THERAPY	933, 972	1	933, 97	-	-	
	99 LI THOTRI PSY	755, 772			0 0	733, 772	
	PATIENT SERVICE COST CENTERS		1		0	0	70. 77
	OO CLINIC	79, 237		79, 23	7 0	79, 237	90.00
	OO EMERGENCY	3, 559, 278		3, 559, 27			
	OO OBSERVATION BEDS (NON-DISTINCT PART	1, 400, 720		1, 400, 72		1, 400, 720	•
	ER REIMBURSABLE COST CENTERS	1, 100, 720	1	1, 100, 72	~	1, 100, 720	1 /2. 50
	OO AMBULANCE SERVICES	3, 367, 905		3, 367, 90	5 0	3, 367, 905	95.00
200.00	Subtotal (see instructions)	39, 663, 691					
201. 00	Less Observation Beds	1, 400, 720		1, 400, 72		1, 400, 720	
202. 00	Total (see instructions)	38, 262, 971					
1		1			., ., .,	=	

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0146 Peri od: Worksheet C From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/22/2017 9:39 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 9, 083, 010 9, 083, 010 30.00 30.00 43.00 04300 NURSERY 532, 235 532, 235 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 541, 303 18, 332, 856 24, 874, 159 0.195054 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 2, 136, 715 0.465724 0.000000 52.00 2.136.715 52 00 53.00 05300 ANESTHESI OLOGY 861, 101 2, 722, 665 3, 583, 766 0.008126 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 773, 116 46, 154, 140 50, 927, 256 0.081449 0.000000 54.00 05401 CAT SCAN 0.000000 0.000000 54.01 54.01 14, 885, 275 0. 190227 06000 LABORATORY 3, 642, 385 18, 527, 660 0.000000 60.00 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 65.00 06500 RESPIRATORY THERAPY 1, 581, 829 4, 817, 519 6, 399, 348 0.180801 0.000000 65.00 277, 989 2, 555, 202 0. 444969 66.00 06600 PHYSI CAL THERAPY 2, 833, 191 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 36, 334 1, 174, 469 1, 210, 803 0.565508 0.000000 67.00 06800 SPEECH PATHOLOGY 27,036 622, 146 649, 182 0.559660 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 579, 412 104, 631 684, 043 0.022870 0.000000 69.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 2, 266, 819 6,089,029 8, 355, 848 71 00 0.160620 0.000000 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 054, 553 708, 470 2, 763, 023 0. 302678 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 754, 808 10, 666, 920 0. 269197 0.000000 73.00 16, 421, 728 73.00 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 76.97 07698 HYPERBARI C OXYGEN THERAPY 2, 808, 291 76. 98 4,840 2, 813, 131 0. 332004 0.000000 76.98 76.99 07699 LI THOTRI PSY 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 1 900 172, 695 174 595 0 453833 0.000000 90 00 09100 EMERGENCY 91.00 3, 273, 604 24, 245, 566 27, 519, 170 0.129338 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 850, 934 1, 850, 934 0.756764 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 8, 643, 719 8, 643, 719 0.389636 200.00 Subtotal (see instructions) 43, 428, 989 146, 554, 527 189, 983, 516 200.00 201.00 Less Observation Beds 201. 00 202 00 Total (see instructions) 43 428 989 146, 554, 527 189 983 516 202 00

			To 12/31/2016	Date/Time Prepared: 5/22/2017 9:39 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 195054			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 465724			52.00
53. 00 05300 ANESTHESI OLOGY	0. 009588			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 081449			54.00
54. 01 05401 CAT SCAN	0. 000000			54. 01
60. 00 06000 LABORATORY	0. 190227			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 180801			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 444969			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 565508			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 559660			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 022870			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 160620			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 302678			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 269197			73.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 332004			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 453833			90.00
91. 00 09100 EMERGENCY	0. 129338			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 756764			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 389636			95. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems COMMUNITY HOSPT.
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0146

				'	12/01/2010	5/22/2017 9: 3	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
				Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
	1	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS	,		,			
50. 00	05000 OPERATING ROOM	4, 851, 798	544, 017		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	995, 120	79, 940		0	0	
53.00	05300 ANESTHESI OLOGY	29, 123	1, 620		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 147, 980	406, 878	3, 741, 102	0	0	54. 00
54. 01	05401 CAT SCAN	0	0	0	0	0	54. 01
60.00	06000 LABORATORY	3, 524, 468	190, 796	3, 333, 672	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	1, 157, 008	103, 281		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 260, 682	83, 035		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	684, 719	37, 344		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	363, 321	19, 303		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	15, 644	1, 474		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 342, 118	76, 176		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	836, 305	43, 071		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 420, 684	311, 750	4, 108, 934	0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	933, 972	55, 712	878, 260	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	79, 237	4, 112		0	0	
91. 00	09100 EMERGENCY	3, 559, 278	257, 271		0	0	, , , , , ,
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 400, 720	113, 692	1, 287, 028	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	3, 367, 905	202, 555		0		95. 00
200.00		32, 970, 082	2, 532, 027		0		200. 00
201.00	l l	1, 400, 720	113, 692		0		201. 00
202.00	Total (line 200 minus line 201)	31, 569, 362	2, 418, 335	29, 151, 027	0	0	202. 00

Health Financial Systems COMMUNITY HOSPT.
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-0146

						5/22/2017 9: 3	9 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges				
		Capital and		Cost to Charge			
		Operating Cost		Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 851, 798		1			50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	995, 120					52. 00
53.00	05300 ANESTHESI OLOGY	29, 123	3, 583, 766	1			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 147, 980	50, 927, 256	0. 081449			54.00
54. 01	05401 CAT SCAN	0	0	0.000000			54. 01
60.00	06000 LABORATORY	3, 524, 468	18, 527, 660	0. 190227			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65.00	06500 RESPI RATORY THERAPY	1, 157, 008	6, 399, 348	0. 180801			65. 00
66.00	06600 PHYSI CAL THERAPY	1, 260, 682	2, 833, 191	0. 444969			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	684, 719	1, 210, 803	0. 565508			67. 00
68.00	06800 SPEECH PATHOLOGY	363, 321	649, 182	0. 559660			68. 00
69.00	06900 ELECTROCARDI OLOGY	15, 644	684, 043	0. 022870			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 342, 118	8, 355, 848	0. 160620			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	836, 305	2, 763, 023	0. 302678			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 420, 684	16, 421, 728	0. 269197			73. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0.000000			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	933, 972	2, 813, 131	0. 332004			76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.000000			76. 99
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	79, 237	174, 595	0. 453833			90.00
91.00	09100 EMERGENCY	3, 559, 278	27, 519, 170	0. 129338			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 400, 720	1, 850, 934	0. 756764			92. 00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	3, 367, 905	8, 643, 719	0. 389636			95. 00
200.00	Subtotal (sum of lines 50 thru 199)	32, 970, 082	180, 368, 271				200. 00
201.00	Less Observation Beds	1, 400, 720	0				201. 00
202.00	Total (line 200 minus line 201)	31, 569, 362	180, 368, 271				202. 00

Health Financial Systems COMM	IUNI TY HOSPT. OI	F NOBLE CTY, II	NC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2016 Fo 12/31/2016		nanad.
				To 12/31/2016	5/22/2017 9:3	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	523, 504	0	523, 504	6, 451	81. 15	30.00
43. 00 NURSERY	19, 153		19, 153	492	38. 93	43.00
200.00 Total (lines 30-199)	542, 657		542, 657	6, 943		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 089	169, 522	2			30. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	2, 089	169, 522	2			200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0146 Period: Worksheet D From 01/01/2016 Part II	
To 12/31/2016 Date/Time Prepa	rad:
5/22/2017 9:39	am
Title XVIII Hospital PPS	
Cost Center Description Capital Total Charges Ratio of Cost Inpatient Capital Costs	
Related Cost (from Wkst. C, to Charges Program (column 3 x	
(from Wkst. B, Part I, col. (col. 1 ÷ col. Charges column 4)	
Part II, col. 8) 2)	
26)	
1.00 2.00 3.00 4.00 5.00	
ANCILLARY SERVICE COST CENTERS	
	50. 00
	52.00
	53. 00
	54. 00
	54. 01
	50.00
	52. 30
	55.00
	66.00
	57. 00
	58. 00
	59. 00
	71. 00
	72. 00
	73. 00
	76. 97
	76. 98
	76. 99
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 4, 112 174, 595 0. 023552 0 0 0	90.00
	91. 00
	92.00
OTHER REIMBURSABLE COST CENTERS	
	95.00
200. 00 Total (Lines 50-199) 2, 329, 472 171, 724, 552 12, 493, 329 178, 002 20	00.00

Health Financial Systems COMM	IUNI TY HOSPT. OF	NOBLE C	TY, I	NC.	In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	S Provi	der C	CN: 15-0146	Period: From 01/01/2016	Worksheet D	
					To 12/31/2016		
				XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied H	leal th	All Other	Swi ng-Bed	Total Costs	
		Cos ⁻		Medi cal	Adjustment	(sum of cols.	
				Education Cos		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	0		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.	Inpatient	I npati 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, 451		0.00	2, 08	19 0		30.00
43. 00 04300 NURSERY	492		0.00		0 0		43.00
200.00 Total (lines 30-199)	6, 943			2, 08	0		200. 00

Health Financial Systems COMMUNITY HOSPT. OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Period: | Worksheet D | From 01/01/2016 | Part IV | To | 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0146 THROUGH COSTS

Title XVIII Hospital Cost Center Description Non Physician Nursing School Allied Health All Other Total C	ol 1
Cost Center Description Non Physician Nursing School Allied Health All Other Total C	ol 1
Anesthetist Medical (sum of c	col.
Cost Cost Education Cost through	
4)	
1.00 2.00 3.00 4.00 5.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 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 0LOGY-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 BL00D CLOTTING FOR HEMOPHILIACS 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 0CCUPATI 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 1 MPL. 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 0XYGEN THERAPY 0 0 0 0	0 76. 98
76. 99 07699 LI THOTRI PSY 0 0 0 0	0 76. 99
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 0 0 0	0 90.00
91. 00 09100 EMERGENCY 0 0 0 0	0 91.00
92. 00 09200 0BSERVATI 0N BEDS (NON-DI STI NCT PART 0 0 0 0 0	0 92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES	95. 00
200.00 Total (lines 50-199) 0 0 0 0	0 200. 00

Health Financial Systems	COMMUNITY HOSPT. OF N	IOBLE CTY, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	Γ ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0146	Peri od:	Worksheet D

From 01/01/2016 Part IV
To 12/31/2016 Date/Time Prepared: THROUGH COSTS 5/22/2017 9:39 am Title XVIII Hospi tal PPS Total Charges Ratio of Cost I npati ent Cost Center Description Total Outpati ent to Charges Outpati ent (from Wkst. C, Ratio of Cost Program Cost (sum of Part I, col. (col. 5 ÷ col to Charges Charges 7) col. 2, 3 and 8) $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 24, 874, 159 0.000000 0.000000 2, 357, 371 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 2, 136, 715 0.000000 0.000000 52.00 05300 ANESTHESI OLOGY 3, 583, 766 0.000000 0.000000 245, 098 53.00 000000000000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 50, 927, 256 0.000000 0.000000 2, 027, 282 54.00 05401 CAT SCAN 0.000000 54.01 0.000000 54.01 Ω 60.00 06000 LABORATORY 18, 527, 660 0.000000 0.000000 1,000,455 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 6, 399, 348 06500 RESPIRATORY THERAPY 0.000000 0.000000 648, 641 65 00 65 00 06600 PHYSI CAL THERAPY 0.000000 66.00 2, 833, 191 0.000000 160, 631 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 210, 803 0.000000 0.000000 14, 569 67.00 06800 SPEECH PATHOLOGY 649, 182 0.000000 0.000000 68.00 19, 439 68.00 06900 ELECTROCARDI OLOGY 327, 632 684, 043 0.000000 0.000000 69 00 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 8, 355, 848 0.000000 0.000000 515, 501 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 763, 023 0.000000 0.000000 1, 244, 912 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 289, 765 73 00 16, 421, 728 0.000000 0.000000 73 00 07697 CARDIAC REHABILITATION 76.97 0.000000 0.000000 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 2, 813, 131 0.000000 0.000000 0 76. 98 07699 LI THOTRI PSY 76.99 0.000000 0.000000 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 174, 595 0.000000 0.000000 0 90.00 91.00 09100 EMERGENCY 0 27, 519, 170 0.000000 0.000000 1, 642, 033 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 1, 850, 934 0.000000 0.000000 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50-199) 171, 724, 552 12, 493, 329 200. 00

| Peri od: | Worksheet D | From 01/01/2016 | Part IV | To 12/31/2016 | Date/Time Prepared: | Part IV | Par THROUGH COSTS

					10 12/31/2010	5/22/2017 9: 3	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col.	9		
		x col. 10)		x col. 12)			
		11. 00	12. 00	13. 00			
	ANCILLARY SERVICE COST CENTERS	1		T			
	05000 OPERATING ROOM	0	2, 596, 494		0		50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
	05300 ANESTHESI OLOGY	0	409, 668		0		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	11, 305, 080		0		54. 00
	05401 CAT SCAN	0	0		0		54. 01
	06000 LABORATORY	0	206, 817		0		60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62. 30
	06500 RESPI RATORY THERAPY	0	1, 631, 429		0		65. 00
	06600 PHYSI CAL THERAPY	0	69, 723		0		66. 00
	06700 OCCUPATI ONAL THERAPY	0	0		0		67. 00
	06800 SPEECH PATHOLOGY	0	0		0		68. 00
	06900 ELECTROCARDI OLOGY	0	33, 156		0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	463, 373		0		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	87, 477		0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	3, 386, 094		0		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0		76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0		0		76. 98
	07699 LI THOTRI PSY	0	0		0		76. 99
	OUTPAȚIENT SERVICE COST CENTERS	,					_
	09000 CLI NI C	0	3, 096	l .	0		90.00
	09100 EMERGENCY	0	5, 360, 972		0		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	981, 514		0		92. 00
	OTHER REIMBURSABLE COST CENTERS	,					
	09500 AMBULANCE SERVICES						95. 00
200. 00	Total (lines 50-199)	0	26, 534, 893		0		200. 00

Health Financial Systems COM	MUNITY HOSPT. OF	NOBLE CTY, IN			u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	nared:
				10 12/31/2010	5/22/2017 9: 3	9 am
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge F			Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.405054	0.507.407			E0. 153	
50. 00 05000 OPERATING ROOM	0. 195054	2, 596, 494		0	506, 457	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 465724	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 008126	409, 668		0	3, 329	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 081449	11, 305, 080		0	920, 787	
54. 01 05401 CAT SCAN	0. 000000	0		0	0	54. 01
60. 00 06000 LABORATORY	0. 190227	206, 817		0	39, 342	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 180801	1, 631, 429		0 0	294, 964	
66. 00 06600 PHYSI CAL THERAPY	0. 444969	69, 723		0	31, 025	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 565508	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 559660	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 022870	33, 156		0	758	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 160620	463, 373		0 0	74, 427	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 302678	87, 477		0 0	26, 477	
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 269197	3, 386, 094		0 0	911, 526	
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 332004	0		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	T					
90. 00 09000 CLI NI C	0. 453833	3, 096		0	1, 405	
91. 00 09100 EMERGENCY	0. 129338	5, 360, 972		0	693, 377	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 756764	981, 514		0 0	742, 774	92. 00
OTHER REIMBURSABLE COST CENTERS	1 000000					
95. 00 09500 AMBULANCE SERVICES	0. 389636	0, 50, 000		0		95. 00
200.00 Subtotal (see instructions)		26, 534, 893	'	0	4, 246, 648	
201.00 Less PBP Clinic Lab. Services-Program			'			201. 00
Only Charges (Line 200 / Line 201)		24 E24 002			4 244 440	202 00
202.00 Net Charges (line 200 +/- line 201)	1	26, 534, 893		0 0	4, 246, 648	1202.00

| Peri od: | Worksheet D | From 01/01/2016 | Part V | To 12/31/2016 | Date/Time Prepared:

				To 12/31/2016	Date/Time Pre 5/22/2017 9:3	
		Title	XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0				52.00
53. 00 05300 ANESTHESI OLOGY	o	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	0				54. 00
54. 01 05401 CAT SCAN	ol	0				54. 01
60. 00 06000 LABORATORY	o	0				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0				62. 30
65. 00 06500 RESPIRATORY THERAPY	o	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	o	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	O	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Subtotal (see instructions)	0	0				200.00
201. 00 Subtotal (see First uctions) 201. 00 Less PBP Clinic Lab. Services-Program		U				200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	0	0				202. 00
202. 00	١	O ₁	I			1202.00

Health Financial Systems COMM	IUNI TY HOSPT. OI	F NOBL	LE CTY, IN	NC.		In Lie	eu of Form CMS	-2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Р	rovi der C		Peri od		Worksheet D	
						01/01/2016		
					To '	12/31/2016	Date/Time Pr 5/22/2017 9:	
			Ti tl	e XIX	Но	spi tal	PPS	07 diii
Cost Center Description	Capi tal	Swi	ing Bed	Reduced	Tota	l Patient	Per Diem (col	
· ·	Related Cost	Adj	ustment	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	523, 504		0	523, 50)4	6, 451	81. 1	5 30.00
43. 00 NURSERY	19, 153			19, 15	3	492	38. 9	3 43.00
200.00 Total (lines 30-199)	542, 657			542, 65	57	6, 943		200. 00
Cost Center Description	I npati ent	In	pati ent					
	Program days	Pi	rogram					
		Capi	tal Cost					
		(col.	5 x col.					
			6)					
	6. 00		7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 ADULTS & PEDIATRICS	116		9, 413					30. 00
43. 00 NURSERY	85		3, 309					43.00
200.00 Total (lines 30-199)	201		12, 722	1				200. 00

Health Financial Systems COMM	MUNITY HOSPT. O	F NOBLE CTY, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od: From 01/01/2016	Worksheet D Part II	
				To 12/31/2016		pared:
					5/22/2017 9: 3	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00		4.00		
ANOLLI ADV. CEDVILOE, COCT. CENTEDO	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	544.047	04.074.450	0.004.07	4 070 740	07.050	F0 00
50. 00 05000 OPERATING ROOM	544, 017					50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	79, 940				_	52. 00
53. 00 05300 ANESTHESI OLOGY	1, 620					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	406, 878					
54. 01 05401 CAT SCAN	100 700		0.00000		0	54. 01
60. 00 06000 LABORATORY	190, 796	18, 527, 660				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	100 001	0 000 040	0.00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY	103, 281					65. 00
66. 00 06600 PHYSI CAL THERAPY	83, 035		0. 02930			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	37, 344					67. 00
68. 00 06800 SPEECH PATHOLOGY	19, 303					68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 474					69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 176					71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	43, 071					72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	311, 750					73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	· · · · · · · · · · · · · · · · · · ·	0. 00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	55, 712		0. 01980		0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS		1	1			
90. 00 09000 CLI NI C	4, 112		•			90. 00
91. 00 09100 EMERGENCY	257, 271					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	113, 692	1, 850, 934	0. 06142	4 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	1	1	1	T		
95. 00 09500 AMBULANCE SERVICES					, ,	95. 00
200.00 Total (lines 50-199)	2, 329, 472	171, 724, 552	l	4, 327, 291	62, 646	200.00

Health Financial Systems COMM	UNI TY HOSPT. OF	NOBLE CTY, II	NC.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	S Provider C		Period: From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3,	
	4.00				minus col. 4)	
LABATI ENT. DOUTLAGE OFFICE OF COOT, OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0	0	
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 Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00 03000 ADULTS & PEDIATRICS	6, 451	0.00	11	6 0		30.00
43. 00 04300 NURSERY	492	0.00	1			43. 00
200.00 Total (lines 30-199)	6, 943		20			200. 00

| Peri od: | Worksheet D | From 01/01/2016 | Part IV | To 12/31/2016 | Date/Time Prepared: Health Financial Systems COMMUNITY HOSPT. OF NAPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 THROUGH COSTS

					10 12/31/2016	5/22/2017 9:3	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician Nu Anesthetist Cost	ursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
54. 01	05401 CAT SCAN	0	0	(0	0	54. 01
60.00	06000 LABORATORY	0	0	(0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
		0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
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						
90.00	09000 CLI NI C	0	0	(0	0	90.00
91. 00	09100 EMERGENCY	0	0		0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0	(0	0	200. 00

Health Financial Systems	COMMUNITY HOSPT. OF N	IOBLE CTY, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	Γ ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0146	Peri od:	Worksheet D

From 01/01/2016 Part IV
To 12/31/2016 Date/Time Prepared: THROUGH COSTS 5/22/2017 9:39 am Title XIX Hospi tal PPS Total Charges Ratio of Cost I npati ent Cost Center Description Total Outpati ent to Charges Outpati ent (from Wkst. C, Ratio of Cost Program Cost (sum of Part I, col. (col. 5 ÷ col to Charges Charges 7) col. 2, 3 and 8) $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 24, 874, 159 0.000000 0.000000 1, 273, 742 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 2, 136, 715 0.000000 0.000000 0 52.00 05300 ANESTHESI OLOGY 3, 583, 766 0.000000 0.000000 321, 270 53.00 000000000000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 50, 927, 256 0.000000 0.000000 546, 212 54.00 05401 CAT SCAN 0.000000 54.01 0.000000 54.01 Ω 60.00 06000 LABORATORY 18, 527, 660 0.000000 0.000000 475, 058 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 6, 399, 348 06500 RESPIRATORY THERAPY 0.000000 0.000000 179, 215 65 00 65 00 06600 PHYSI CAL THERAPY 0.000000 66.00 2, 833, 191 0.000000 13, 607 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 210, 803 0.000000 0.000000 2, 436 67.00 06800 SPEECH PATHOLOGY 649, 182 0.000000 0.000000 68.00 870 68.00 06900 ELECTROCARDI OLOGY 0.000000 684, 043 0.000000 36, 669 69 00 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 8, 355, 848 0.000000 0.000000 179, 472 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 763, 023 0.000000 0.000000 77, 231 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 794, 596 0.000000 73 00 16, 421, 728 0.000000 73 00 07697 CARDIAC REHABILITATION 76.97 0.000000 0.000000 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 2, 813, 131 0.000000 0.000000 0 76. 98 07699 LI THOTRI PSY 76.99 0.000000 0.000000 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 174, 595 0.000000 0.000000 0 90.00 91.00 09100 EMERGENCY 0 27, 519, 170 0.000000 0.000000 426, 913 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 1, 850, 934 0.000000 0.000000 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50-199) 171, 724, 552 4, 327, 291 200. 00

THROUGH COSTS

					5/22/2017 9:3	39 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE 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	C		0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
54. 01 05401 CAT SCAN	0	C		0		54. 01
60. 00 06000 LABORATORY	0	C		0		60. 00
62.30 O6250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0		62. 30
65. 00 06500 RESPI RATORY THERAPY	0	C		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 IMPL. 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 HYPERBARIC OXYGEN THERAPY	0	C		0		76. 98
76. 99 07699 LI THOTRI PSY	0	C		0		76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C		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						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	C)	0		200. 00

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2016 Part V 12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 195054 4, 042, 270 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.465724 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0.008126 0 465 583 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.081449 0 8, 285, 451 0 54.00 54.01 05401 CAT SCAN 0.000000 0 54.01 60.00 06000 LABORATORY 0.190227 2, 664, 886 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 0. 180801 376, 060 0 65.00 06600 PHYSI CAL THERAPY 0. 444969 66.00 605, 317 0 66.00 06700 OCCUPATIONAL THERAPY 0. 565508 451, 180 67 00 67 00 0 06800 SPEECH PATHOLOGY 68.00 0.559660 332, 301 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.022870 28, 356 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.160620 578, 568 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 67, 396 72 00 0.302678 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 269197 0 1, 548, 822 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0. 332004 0 0 0 0 76. 98 07699 LI THOTRI PSY 76. 99 0 76. 99 0.000000 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 0. 453833 0 0 90.00 09000 CLI NI C 09100 EMERGENCY 7, 872, 253 91.00 91.00 0.129338 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 756764 0 92.00 92.00 852, 825 Ω OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0. 389636 1, 611, 740 95.00 0 200.00 200.00 Subtotal (see instructions) 0 0 29, 783, 008 Less PBP Clinic Lab. Services-Program 201.00 C 201.00

29, 783, 008

0 202.00

Only Charges

Net Charges (line 200 +/- line 201)

202.00

					10 12/31/2016	5/22/2017 9:3	
			Ti tl	e XIX	Hospi tal	PPS	
		Cos	its				
Cost Center Descrip	oti on	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subj ect To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
110111 ABV 05BV 05 000T 05	NTERO.	6. 00	7. 00				
ANCILLARY SERVICE COST CE	INTERS	700 4/4					
50. 00 05000 OPERATI NG ROOM	ADD DOOM	788, 461	0				50.00
52. 00 05200 DELIVERY ROOM & LAB	SOR ROOM	0	Ü				52. 00
53. 00 05300 ANESTHESI OLOGY		3, 783	Ü				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI	C	674, 842	Ü				54.00
54. 01 05401 CAT SCAN		0	0	1			54. 01
60. 00 06000 LABORATORY		506, 933	0	1			60.00
62. 30 06250 BLOOD CLOTTING FOR		0	0	1			62. 30
65. 00 06500 RESPIRATORY THERAPY	'	67, 992	0	1			65. 00
66. 00 06600 PHYSI CAL THERAPY		269, 347	0	1			66. 00
67. 00 06700 OCCUPATI ONAL THERAP	PΥ	255, 146	0	1			67. 00
68.00 06800 SPEECH PATHOLOGY		185, 976	0	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY		649	0	1			69. 00
71.00 07100 MEDICAL SUPPLIES CH		92, 930	0	1			71. 00
72. 00 07200 I MPL. DEV. CHARGED		20, 399	0	1			72. 00
73.00 07300 DRUGS CHARGED TO PA	-	416, 938	0	1			73. 00
76. 97 07697 CARDI AC REHABI LI TAT		0	0	1			76. 97
76. 98 07698 HYPERBARI C OXYGEN T	HERAPY	0	0	1			76. 98
76. 99 07699 LI THOTRI PSY		0	0	1			76. 99
OUTPATIENT SERVICE COST (CENTERS	_1		T			4
90. 00 09000 CLI NI C		0	0	1			90.00
91. 00 09100 EMERGENCY		1, 018, 181	0	1			91. 00
92. 00 09200 OBSERVATI ON BEDS (N		645, 387	0	1			92. 00
OTHER REIMBURSABLE COST (LENTERS	407.000					05.00
95. 00 09500 AMBULANCE SERVICES		627, 992					95. 00
200.00 Subtotal (see instr		5, 574, 956	Ü	1			200. 00
201.00 Less PBP Clinic Lab	o. Services-Program	0					201. 00
Only Charges	100 . / Line 201	E E74 OF/	^	J			202.00
202.00 Net Charges (line 2	:00 +/- ITHE 201)	5, 574, 956	0	'			202. 00

Health Financial Systems	COMMUNITY HOSPT. OF N	OBLE CTY, INC.	In Lie	u of Form CMS-2552-1
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0146	Peri od: From 01/01/2016	Worksheet D-1
				Date/Time Prepared: 5/22/2017 9:39 am
		Title XVIII	Hospi tal	PPS

Dept 1 - ALL PROVIDES COMPONENTS			Title XVIII	Hospi tal	PPS	7 alli
Inpatient days (Including private room days and saing-bed days, excluding newborn) 6,615 1,00 Impatient days (Including private room days, excluding saing-bed and membern days) 6,631 2,00 Impatient days (Including private room days, excluding saing-bed and membern days) 6,631 2,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1		Cost Center Description			1 00	
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 999.80 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	57.00	27 minus line 36)	p	. 17 0.11.131 (11110	5, 117, 070	37.00
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
		,	•			
	41. 00	, , , , , , , , , , , , , , , , , , , ,	,		2, 088, 582	

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-0146	Peri od: From 01/01/2016 To 12/31/2016		
						5/22/2017 9:3	
	Cook Cooker Decorieties	T-4-1		e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Pe	r Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
42.00	NUDCEDY (+: +Lo V & VIV only)	1.00	2. 00	3. 00 0 0.	4. 00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		<u>U</u> U.	00		42. 00
43. 00	INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 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)			2, 321, 343	48. 00
	Total Program inpatient costs (sum of lines			ons)		4, 409, 925	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing	convices (fr	om Wket D ei	m of Darts L and	169, 522	50. 00
30. 00	[11]	attent routine	services (iii	JIII WKSt. D, SC	iii Oi Faits i ailu	109, 522	30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	178, 002	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				347, 524	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-ph	nysician anest	hetist, and	4, 062, 401	1
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54.00				
55. 00	Target amount per discharge						55. 00 56. 00
56. 00 57. 00	Target amount (line 54 x line 55)						
58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)						57. 00 58. 00
59. 00							59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61. 00						0.00	1
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54)	(60), or 1% c	of the target		
62. 00	Relief payment (see instructions)	ilisti ucti olis)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payments	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of th	ne cost renort	ing period (See	<u> </u>	64. 00
01.00	instructions)(title XVIII only)	· ·		•		Ĭ	01.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportir	ng period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
	CAH (see instructions)			6.11			
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	reporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20)	routino costs (lino 67 i lir	20 69)		0	69.00
U 7. UU	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					1 0	J 07.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37	')		70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00
	Medically necessary private room cost applications		(line 14 x l	ine 35)			73. 00
74. 00	Total Program general inpatient routine serv	•		*	5		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	worksneet B,	Part II, Column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77.00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der recor	ds)			78. 00 79. 00
30. 00	Total Program routine service costs for compa	arison to the c			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi		,				81. 00 82. 00
82.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				83.00
84. 00	Program inpatient ancillary services (see in	structions)	•				84. 00 85. 00
	Utilization review - physician compensation						

86.00

87.00 999. 80 88. 00 1, 400, 720 89. 00

1, 401

85.00

86.00

Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

Health Financial Systems COMM	IUNI TY HOSPT.	OF N	IOBLE CTY, IN	C.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der CC		Peri od: From 01/01/2016	Worksheet D-1	
					To 12/31/2016	Date/Time Prep 5/22/2017 9:39	pared: 9 am
			Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Ro	outine Cost	column 1 ÷	Total	Observation	
		(fr	rom line 21)	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	523, 50)4	6, 449, 693	0. 08116	7 1, 400, 720	113, 692	90.00
91.00 Nursing School cost		0	6, 449, 693	0.00000	0 1, 400, 720	0	91.00
92.00 Allied health cost		0	6, 449, 693	0.00000	0 1, 400, 720	0	92.00
93.00 All other Medical Education	[0	6, 449, 693	0. 00000	0 1, 400, 720	0	93. 00

Health Financial Systems	COMMUNITY HOSPT. OF N	OBLE CTY, INC.	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0146	Peri od: From 01/01/2016	Worksheet D-1	
				Date/Time Pre 5/22/2017 9:3	
		Title XIX	Hospi tal	PPS	
Cook Cooker December 1					

		Title XIX	Hospi tal	5/22/2017 9: 3 ^o PPS	9 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	I NPATI ENT DAYS			=-	4 00
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.	ped and newborn days)	ivate room da y s,	6, 451 6, 451 0	1. 00 2. 00 3. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period		r 31 of the cost	5, 050 0	4. 00 5. 00
6.00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	116	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period			0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar years).	ear, enter O on this lin	e)	0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra $$ Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 492	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			85	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00					19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	6, 449, 693 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 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
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions)	Tino 21 minus lino 24)		0 6, 449, 693	26. 00
	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28. 00 29. 00
30. 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	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	6, 449, 693	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			999. 80	38. 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			115, 977	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40. 00
	Total Program general inpatient routine service cost (line 39	•		115, 977	

COMPUT	Financial Systems COMM ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0146	Peri od:	Worksheet D-1	
					From 01/01/2016 To 12/31/2016	Date/Time Prep 5/22/2017 9:39	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	243, 916	492				42.00
	Intensive Care Type Inpatient Hospital Units						
3. 00	INTENSIVE CARE UNIT						43.0
1.00	CORONARY CARE UNIT						44.0
5. 00 5. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 0 46. 0
	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description						1710
						1. 00	
	Program inpatient ancillary service cost (Wk					748, 868	
9. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	ons)		906, 985	49.0
0. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	12, 722	50.0
	[111)		•				
. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	62, 646	51. C
2. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				75, 368	52.0
3. 00	Total Program inpatient operating cost exclusion		lated, non-phy	sician anest	hetist, and	831, 617	
	medical education costs (line 49 minus line					, ,	
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0 0. 00	
5. 00 5. 00							
7. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	56. C
8. 00							
9. 00							
0. 00	market basket Lesser of lines 53/54 or 55 from prior year	rost renort un	dated by the m	narket hasket		0. 00	60.0
1. 00	If line 53/54 is less than the lower of line:					0.00	61.0
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% o	f the target ´		
2 00	amount (line 56), otherwise enter zero (see	nstructions)					/
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (see instru	ctions)			0	
3.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstru	Ctrons)			0	03.0
4. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost report	ing period (See	0	64.0
	instructions)(title XVIII only)		04 0 11				,
5. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reportin	g period (See	0	65.0
6. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line 6	55)(title XVI	II only). For	0	66.0
	CAH (see instructions)	`	·	, ,	3,		
7. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost r	eporting period	0	67.0
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 0
0. 00	(line 13 x line 20)		0.00	3031 . 35	or tring porrod		00.0
9. 00	Total title V or XIX swing-bed NF inpatient					0	69. 0
0 00	PART III - SKILLED NURSING FACILITY, OTHER NU				`		70 0
0. 00 1. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of	,)		70. 0 71. 0
2. 00	Program routine service cost (line 9 x line		THE 70 : TIME	2)			72.0
3. 00	Medically necessary private room cost application		(line 14 x li	ne 35)			73.0
4. 00	Total Program general inpatient routine serv						74.0
5. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	vorksheet B,	rart II, column		75.0
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 0
7. 00	Program capital -related costs (line 9 x line						77.0
3. 00	Inpatient routine service cost (line 74 minus						78. C
9. 00	Aggregate charges to beneficiaries for excess			*.			79. (
0.00	Total Program routine service costs for compa		ost limitation	n (line 78 mi	nus line 79)		80.0
1. 00 2. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. C
	Reasonable inpatient routine service costs (•				83.0
	Program inpatient ancillary services (see in						84.0

85. 00

86.00

87.00 999. 80 88. 00 1, 400, 720 89. 00

1, 401

85.00

86.00

84.00 Program inpatient ancillary services (see instructions)

Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

Health Financial Systems COMM	IUNI TY HOSPT. OI	NOBLE CTY, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 Fo 12/31/2016	Date/Time Prep 5/22/2017 9:39	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	523, 504	6, 449, 693	0. 08116	1, 400, 720	113, 692	90.00
91.00 Nursing School cost	0	6, 449, 693	0.000000	1, 400, 720	0	91.00
92.00 Allied health cost	0	6, 449, 693	0.000000	1, 400, 720	0	92.00
93.00 All other Medical Education	0	6, 449, 693	0. 000000	1, 400, 720	0	93. 00

Health Financial Systems COMMUNI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	NITY HOSPT. OF NOBLE CTY, IN Provider C		Peri od:	eu of Form CMS-: Worksheet D-3	
THEATTENT ANGIELANT SERVICE COST AFFORTIONWENT	Frovider C		From 01/01/2016		
			To 12/31/2016	Date/Time Pre 5/22/2017 9:3	epared: 19 am
	Ti tl e	xVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		,			
30. 00 03000 ADULTS & PEDI ATRI CS			3, 294, 815		30.0
43. 00 04300 NURSERY					43. C
ANCILLARY SERVICE COST CENTERS		,			
50.00 05000 OPERATING ROOM		0. 19505		459, 815	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 46572			
53. 00 05300 ANESTHESI OLOGY		0. 00958			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08144			
54. 01 05401 CAT SCAN		0.00000		1	
60. 00 06000 LABORATORY		0. 19022			
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	1
55. 00 06500 RESPIRATORY THERAPY		0. 18080		117, 275	
66. 00 06600 PHYSI CAL THERAPY		0. 44496		71, 476	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 56550			
68. 00 06800 SPEECH PATHOLOGY		0. 55966			
59. 00 06900 ELECTROCARDI OLOGY		0. 02287			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 16062			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 30267			
73.00 07300 DRUGS CHARGED TO PATLENTS		0. 26919		616, 398	
76. 97 07697 CARDIAC REHABILITATION		0.00000		0	
76.98 07698 HYPERBARIC OXYGEN THERAPY		0. 33200	04	0	76.
76. 99 07699 LI THOTRI PSY		0.00000	00	0	76. 9
OUTPATIENT SERVICE COST CENTERS					
00. 00 09000 CLI NI C		0. 45383		_	1
91. 00 09100 EMERGENCY		0. 12933		212, 377	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 75676	0	0	92. (
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95. (
200.00 Total (sum of lines 50-94 and 96-98)		I	12, 493, 329	2, 321, 343	1200

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

95. 00 2, 321, 343 200. 00 201. 00 202. 00

12, 493, 329

12, 493, 329

200.00

201. 00 202. 00

	Financial Systems COMMUNITY HOSPT. OF				u of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0146	Peri od: From 01/01/2016	Worksheet D-3	
				To 12/31/2016	Date/Time Pre 5/22/2017 9:3	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS			1, 799, 405		30.00
43. 00	043000 NURSERY			315, 990		43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS		1	310, 990		43.00
50. 00	05000 OPERATING ROOM		0. 1950!	1, 273, 742	248, 448	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 46572		240, 440	1
53.00	05300 ANESTHESI OLOGY		0. 00958		3. 080	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 08144		44, 488	
54. 01	05401 CAT SCAN		0. 00000		0	1
60.00	06000 LABORATORY		0. 19022	475, 058	90, 369	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000	00	0	62. 30
65.00	06500 RESPI RATORY THERAPY		0. 18080	179, 215	32, 402	65.00
66.00	06600 PHYSI CAL THERAPY		0. 44496	13, 607	6, 055	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 56550			
68. 00	06800 SPEECH PATHOLOGY		0. 55966			68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 02287	· ·	839	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 16062		28, 827	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3026			
	07300 DRUGS CHARGED TO PATIENTS		0. 26919		213, 903	
	07697 CARDI AC REHABI LI TATI ON		0.00000		0	
	07698 HYPERBARI C OXYGEN THERAPY		0. 33200		0	1
76. 99	07699 LI THOTRI PSY		0.00000	00 0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS		0.4500	20		00.00
	09000 CLINIC		0. 45383		0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 12933 0. 75676		55, 216 0	
72. UU	OTHED DELMBURGARIE COST CENTERS		0.75070	J 4 U	1 0	72.00

4, 327, 291

4, 327, 291

95.00

748, 868 200. 00 201. 00 202. 00

OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

200.00

201.00 202.00 Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

	Financial systems community hospi. Or noble Cit, Inc.			u or Form CWS-2	2332-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0		Period: From 01/01/2016	Worksheet E Part A	
			To 12/31/2016	Date/Time Pre	
	Title XVIII		Hospi tal	5/22/2017 9: 3 PPS	9 am
	THE AVIII		Before GEO	On/After GEO	
			Recl ass	Recl ass	
			1. 00	1. 01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to Octobe	- 1	2, 534, 553	0	
1.01	(see instructions)		2, 554, 555	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after Octo	ober 1	0	1, 036, 752	1. 02
	(see instructions)				
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occur	ri ng	0	0	1. 03
1. 04	prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occur	ci na	0	0	1. 04
1.04	on or after October 1 (see instructions)	riig			1.04
2.00	Outlier payments for discharges. (see instructions)		11, 419	4, 115	2. 00
2.01	Outlier reconciliation amount		0	0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see		27. 17	0	3. 00 4. 00
4.00	linstructions)		27.17		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost repor	ti ng	0.00		5. 00
	period ending on or before 12/31/1996. (see instructions)				
6. 00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR		0.00		7. 00
7.00	§412. 105(f) (1) (i v) (B) (1)		0.00		/
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR		0.00		7. 01
	$\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July 1, 2011 then see				
0.00	instructions.	_	0.00		0.00
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b),	3	0.00		8. 00
	413.79(c) (2) (i v), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5	503 of	0.00		8. 01
	the ACA. If the cost report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed		0.00		8. 02
9. 00	teaching hospital under section 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,0)	2)	0.00		9. 00
7.00	(see instructions)	2)	0.00		7.00
10.00			0.00	•	10.00
	records				
11.00	1 1 9		0.00		11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		0.00		12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after	r	0.00		14. 00
11.00	September 30, 1997, otherwise enter zero.		0.00		11.00
15. 00	Sum of lines 12 through 14 divided by 3.		0.00		15. 00
16. 00			0.00		16. 00
	Adjustment for residents displaced by program or hospital closure		0.00		17. 00
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).		0. 00 0. 000000		18. 00 19. 00
20. 00	Prior year resident to bed ratio (see instructions)		0. 000000		20.00
21. 00	· · · · · · · · · · · · · · · · · · ·		0. 000000		21.00
22. 00	IME payment adjustment (see instructions)		0	0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)		0	0	22. 01
00.00	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	40	0.00		00.00
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under Sec. 412.105 (f)(1)(iv)(C).	42	0.00		23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)		0. 00		24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or	line	0.00		25. 00
	24 (see instructions)				
26. 00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions)		0.000000	0	27. 00
28. 00	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)		0	0	
29. 00	Total IME payment (sum of lines 22 and 28)		0	ő	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	0	
	Di sproporti onate Share Adjustment				
30. 00			5. 11		30. 00
31. 00	instructions) Percentage of Medicaid patient days (see instructions)		23. 27		31.00
31.00	Sum of lines 30 and 31		28. 38		32.00
33. 00	Allowable disproportionate share percentage (see instructions)		12. 00		33. 00
34.00	Di sproporti onate share adjustment (see instructions)		76, 037	31, 103	34.00

	Financial Systems COMMUNITY HOSPT. OF ATION OF REIMBURSEMENT SETTLEMENT	NOBLE CTY, INC. Provider CCN: 15-0146	In Lie	worksheet E	2552-10
CALCUL	ATTON OF RELIMBORSEMENT SETTEEMENT	Frovider Con. 15-0140	From 01/01/2016 To 12/31/2016	Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/22/2017 9: 3° PPS	9 am
		THE C AVITT	Prior to 10/1		
			1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6 406 145 534	5, 977, 483, 147	35. 00
35. 01	Factor 3 (see instructions)		0. 000034471		
35. 02					35. 02
35. 03	(see instructions) .03 Pro rata share of the hospital uncompensated care payment amount (see instructions) .03 165,318				35. 03
	Total uncompensated care (sum of columns 1 and 2 on line 35.0	03)	221, 741		36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46) 0		40. 00
	652, 682, 683, 684 and 685 (see instructions)		Before GEO	On/After GEO	
			Recl ass	Recl ass	
41 00	Table ECDD Madiana disabagga analysisa MC DDC- (F2 (O2 ((02 (04 == (05 (===	1.00	1. 01	41.00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, (instructions)	000, 004 an 085. (See	0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-DRGs 652, 682, 683, 684	0	0	41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)	•			43. 00
44. 00	00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 0.000000 days)				44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions		0.00	0.00	45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 47 Subtotal (see instructions)	1.01)	2, 843, 750	1, 071, 970	46. 00 47. 00
48. 00	8.00 Hospital specific payments (to be completed by SCH and MDH, small rural hospitals 0				48. 00
	only. (see instructions)			Amount	
				1 00	
	-	`		1. 00	10.00
49. 00 50. 00	Total payment for inpatient operating costs (see instructions			3, 915, 720	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.	nd Pt. II, as applicable) III, see instructions)			49. 00 50. 00 51. 00
50. 00 51. 00 52. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii	nd Pt. II, as applicable) III, see instructions)		3, 915, 720 288, 023 0 0	50. 00 51. 00 52. 00
50. 00 51. 00 52. 00 53. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment	nd Pt. II, as applicable) III, see instructions)		3, 915, 720 288, 023 0	50. 00 51. 00 52. 00 53. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions).		3, 915, 720 288, 023 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions).		3, 915, 720 288, 023 0 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see into	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions). 69) ructions)		3, 915, 720 288, 023 0 0 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions). 69) ructions) II, column 9, lines 30 t		3, 915, 720 288, 023 0 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00
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50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cost of physicians' services in a teaching hospital (see introducine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions). 69) ructions) II, column 9, lines 30 t IV, col. 11 line 200)		3, 915, 720 288, 023 0 0 0 0 0 0 0 0 0 0 0 4, 203, 743	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cost of physicians' services in a teaching hospital (see interesting to the cost of physicians' services in a teaching hospital (see interesting to the cost of physicians' services in a teaching hospital (see interesting to the cost of physicians' services in a teaching hospital (see interesting to the cost of physicians' services in a teaching hospital (see interesting to the cost of physicians' services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see interesting to the cost of physicians') services in a teaching hospital (see inte	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions). 69) ructions) II, column 9, lines 30 t IV, col. 11 line 200)		3, 915, 720 288, 023 0 0 0 0 0 0 0 0 0 0 4, 203, 743	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions). 69) ructions) II, column 9, lines 30 t IV, col. 11 line 200)		3, 915, 720 288, 023 0 0 0 0 0 0 0 0 0 0 0 4, 203, 743	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 57. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
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50. 00 51. 00 52. 00 53. 00 54. 00 54. 00 55. 00 56. 00 57. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 67. 00 68. 00 70. 00 70. 50 70. 88 70. 89 70. 90	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. In Ancillary service other pass through costs (from Wkst. D, Pt. In III) amounts on lines 49 through 58) Primary payer payments Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions)	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions). 69) ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction	hrough 35). ee instructions)	3, 915, 720 288, 023 0 0 0 0 0 0 0 0 4, 203, 743 543, 279 0 54, 319 35, 307 54, 319 3, 695, 771 0 0	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 66. 00 67. 00 68. 00 67. 00 69. 00 70. 50 70. 50 70. 50 70. 89 70. 90
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 59. 00 60. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 67. 00 68. 00 70. 50 70. 50 70. 90 70. 91	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) (Tredits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions). 69) ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction	hrough 35). ee instructions)	3, 915, 720 288, 023 0 0 0 0 0 0 0 0 4, 203, 743 543, 279 0 54, 319 35, 307 54, 319 35, 307 54, 319 35, 307 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 88 70. 90 70. 90 70. 91
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 89 70. 91 70. 92	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVRP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions). 69) ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction	hrough 35). ee instructions)	3, 915, 720 288, 023 0 0 0 0 0 0 0 0 4, 203, 743 543, 279 0 54, 319 35, 307 54, 319 35, 307 54, 319 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 89 70. 91 70. 92
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 89 70. 91 70. 92 70. 93	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) (Tredits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions). 69) ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction	hrough 35). ee instructions)	3, 915, 720 288, 023 0 0 0 0 0 0 0 0 4, 203, 743 543, 279 0 54, 319 35, 307 54, 319 35, 307 54, 319 35, 307 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 88 70. 89 70. 90 70. 92 70. 93

	nancial Systems COMMUNITY HOSPT. OF N ION OF REIMBURSEMENT SETTLEMENT	Provi der CC	CN: 15-0146	Peri od: From 01/01/2016 To 12/31/2016		pared:
		Title	XVIII	Hospi tal	PPS	
			FFY	' (yyyy)	Amount	
				0	1. 00	
	ow volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		2016	355, 683	70. 96
	ne corresponding federal year for the period prior to 10/1)					
	ow volume adjustment for federal fiscal year (yyyy) (Enter in			2017	125, 851	70. 97
	ne corresponding federal year for the period ending on or aft	ter 10/1)				
	ow Volume Payment-3				0	
	AC adjustment amount (see instructions)				0	70. 99
	mount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			4, 201, 120	
	equestration adjustment (see instructions)				84, 022	
	nterim payments				4, 058, 103	
	entative settlement (for contractor use only)	>			0	
	alance due provider (Program) (line 71 minus lines 71.01, 72,				58, 995	
	rotested amounts (nonallowable cost report items) in accordar	nce with			157, 587	75.00
	MS Pub. 15-2, chapter 1, §115.2					
	BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	perating outlier amount from Wkst. E, Pt. A, line 2 (see inst	tructions)			0	,
	apital outlier from Wkst. L, Pt. I, line 2				0	,
	perating outlier reconciliation adjustment amount (see instru				0	,
	apital outlier reconciliation adjustment amount (see instruct				0	93.00
	ne rate used to calculate the time value of money (see instru	uctions)				94.00
	me value of money for operating expenses (see instructions)				0	, , , , ,
96. 00 Ti	me value of money for capital related expenses (see instruct	tions)			01	96.00

	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	1. 0073368200	1. 0078353980	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	1. 0000	0. 9981	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	ol	0	104. 00

Prior to 10/1 On/After 10/1

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2016 Part A Exhibit 4
To 12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0146

					'	0 12/31/2016	5/22/2017 9:3	
				_	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		0.00	1.00
	payments	00		J	· ·		3	
1. 01	DRG amounts other than outlier payments for discharges	1. 01	2, 534, 553	0	2, 534, 553		2, 534, 553	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 036, 752	0		1, 036, 752	1, 036, 752	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O	0		O	0	1. 04
2. 00	Outlier payments for	2. 00	15, 534	0	11, 419	4, 115	15, 534	2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	О	0	0	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
F 00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0.000000	0. 000000	0.000000	0. 000000		5. 00
5. 00	A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 000000	0.000000		5.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adju	istment for the	Add-on for Se	ction 422 of t	he MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01		0	0		0	8. 01
8.01	for managed care (see instructions)	20.01	J	O	O	J	O	8.01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34.00	107, 140	0	76, 037	31, 103	107, 140	11. 00
11. 01	Uncompensated care payments	36. 00	221, 741	0	165, 318	56, 423	221, 741	11. 01
	Additional payment for high per	centage of ESF		di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	3, 915, 720 0	0 0	2, 787, 327 0	1, 128, 393 0	3, 915, 720 0	13. 00 14. 00
45.05	small rural hospitals only.) (see instructions)	40.00	0.045.75		0 707 5	4 400 0	0.045.5	45.0-
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	3, 915, 720	0	2, 787, 327	1, 128, 393	3, 915, 720	15.00
16. 00	Payment for inpatient program capital	50. 00	288, 023	0	203, 391	84, 632	288, 023	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from	68. 00	0	0	0	0	0	17. 01 17. 02
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	0	0	0	0	0	18. 00
	adjustment amount (see instructions)							

near th	Tribuncial Systems	COMIN	ONT TI TIOSI I. OI	NODEL CIT, III	v C.	TIT LIC	u or rorm cws .	2002 10
LOW VO	DLUME CALCULATION EXHIBIT 4			Provider CO	F		Date/Time Pre 5/22/2017 9:3	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
19.00	SUBTOTAL			0	2, 990, 718	1, 213, 025	4, 203, 743	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	284, 642	0	200, 860	83, 782	284, 642	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	3, 381	0	2, 53°	850	3, 381	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	O	0	(0	0	21. 01
22. 00	1 7	5. 00	0. 0000	0.0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	(0	0	23. 00
24. 00		10.00	0. 0000	0.0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	288, 023	0	203, 391	84, 632	288, 023	26. 00
	payments (see Thisti de trons)	W/S E, Part A	(Amounts to F					
		line	Part A)					
		0	1.00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	-			0. 118929	0. 103750		27. 00
28. 00		70. 96			355, 683		355, 683	
20.00	(transfer amount to Wkst. E, Pt. A, line)	70.70			000,000		000,000	20.00
29. 00		70. 97				125, 851	125, 851	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 15-0146

Peri od:

From 01/01/2016

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 5/22/2017 9:39 am 12/31/2016 Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 2, 534, 553 2, 726, 153 2, 726, 153 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 1, 036, 752 1, 115, 126 1, 115, 126 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 15, 534 12, 282 4, 426 16, 708 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 2.01 Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 33.00 0.1200 0.1200 0.1200 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 107, 140 73, 686 33.454 107, 140 11.00 instructions) 56, 423 11.01 Uncompensated care payments 36.00 221, 741 165, 318 221, 741 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see O 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 3, 915, 720 2, 706, 291 1, 209, 429 3, 915, 720 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 3, 915, 720 2, 706, 291 1, 209, 429 3, 915, 720 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 288, 023 210, 151 77,872 288, 023 16.00 Special add-on payments for new technologies 17.00 54.00 17.00 Net organ acquisition cost 17.01 17.01 17.02 Credits received from manufacturers for 68.00 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 18.00 amount (see instructions) SUBTOTAL 19 00 2, 916, 442 1 287 301 4, 203, 743 19. 00

Heal th	Financial Systems COMM	UNITY HOSPT. OF	NOBLE CTY, IN	IC.	In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/22/2017 9:3	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
		0	Wkst. L) 1.00	2.00	3. 00	4.00	
20.00	Carital DDC athan than authing	1, 00				4.00	20.00
20.00	Capital DRG other than outlier		284, 642	207, 62	0 77, 022	284, 642	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0.50	0	0	1 -0.0.
21. 00	Capital DRG outlier payments	2.00	3, 381	2, 53	1 850		
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	288, 023	210, 15	1 77, 872	288, 023	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt.				
			A)				
		0	1. 00	2.00	3. 00	4. 00	
27. 00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	355, 683	355, 68	3	355, 683	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	125, 851		125, 851	125, 851	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	25, 710	17, 89	3 7, 817	25, 710	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	-1, 895		0 -1, 895	-1, 895	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	-1, 073		0 -1, 073	0	
	instructions)						
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	COMMUNITY HOSPT. OF NOBL	LE CTY, INC.	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pı	rovider CCN: 15-0146	Peri od: From 01/01/2016	Worksheet E Part B
				Date/Time Prepared

PART 8 - INDICAL MID CRIENTED AND CRIENTED				To 12/31/2016	Date/Time Pre 5/22/2017 9:3	
Name			Title XVIII	Hospi tal		, uiii
Name					1 00	
		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
3.547,071 3.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.	1. 00				0	1.00
Dutilier payment (see Instructions) 10,123 4,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00 10,00			ti ons)		4, 246, 648	•
Interest the fixed plant specific payment to cost ratio (see Instructions) 0.864 5.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	3.00	PPS payments			3, 547, 017	3. 00
Line 2 times line 5						1
			ctions)			1
Transitional corridor payment (see instructions) 0 8.00		1			1	
Ancil lary service other pass through costs from Wisst. D. Pt. IV, col. 13, line 200						1
10.00 Organ acquisitions 0.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00			IV col 12 line 200			
11,00			TV, COL. 13, TITLE 200		-	1
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Reasonable Reasonable charges Reasonable						1
20.00 Ancil lary service charges 0 12.00 13.00 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.01 10.						1 00
13.00 organ acquisition charges (from West. D-4, Pt. III, col. 4, line 69)		Reasonabl e charges				
14.00 Total reasonable charges (sum of lines 12 and 13) 14.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00					0	
Customary charges			ine 69)			ł
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 17.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.0	14. 00				0	14. 00
16.00 Amounts that would have been realized from patients iable for payment for services on a chargebasis na dauch payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	15 00				0	1 1 00
had such payment been made in accordance with 42 CFR \$413.13(e)					-	
17.00	10.00			iii a Cilai yebasi s	U	16.00
18.00 Total customary charges (see instructions) 0 18.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.	17. 00				0. 000000	17. 00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00						1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19. 00		ly if line 18 exceeds li	ne 11) (see	0	19. 00
instructions						
21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 0 21.00	20. 00		ly if line 11 exceeds li	ne 18) (see	0	20. 00
22.00 Interns and residents (see instructions) 0.22.00 0.23.00 Cot of physicians' services in a teaching hospital (see instructions) 0.23.00 0.24.00 Total prospective payment (sum of lines 3, 4, 8 and 9) 0.25.00 Total prospective payment (sum of lines 3, 4, 8 and 9) 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00 0.25.00	21 00		o instructions)		0	21 00
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26. 00 Deductible and Coinsurance relating to amount on line 24 (for CAH, see instructions) 793,745 26.00 26.00 27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 2,763,395 27.00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 2,763,395 30.00 29.00 30. 00 Subtotal (sum of lines 27 through 29) 2,763,395 30.00 30.00 2,763,395 30.00 30.00 31. 00 Primary payer payments 725 31.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33						
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38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2,823,331 40.00 40.01 Interim payments 2,786,930 41.00 42.00 Tentative settlement (for contractors use only) 2,786,930 41.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 71 me Value of Money (see instructions) 0 93.00			ructions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 0.00 9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00						
Pi oneer ACO demonstration payment adjustment (see instructions) 39. 50 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 82. 00 FECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 20. 823, 331 40. 00 40. 01 Sequestration adjustment (see instructions) 10. Interim payments 11. 00 Interim payments 12. 786, 930 41. 00 42. 00 43. 00 Balance due provider/program (see instructions) 12. 786, 930 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 00 10. BE COMPLETED BY CONTRACTOR 10. Original outlier amount (see instructions) 10. Outlier reconciliation adjustment amount (see instructions) 10. Outlier reconciliation adjustment amount (see instructions) 11. 00 Outlier reconciliation adjustment amount (see instructions) 12. 00 Outlier reconciliation adjustment amount (see instructions) 13. 00 Outlier reconciliation adjustment amount (see instructions) 14. 00 Outlier reconciliation adjustment amount (see instructions) 15. 0 Outlier reconciliation adjustment amount (see instructions) 16. 0 Outlier reconciliation adjustment amount (see instructions) 17. 0 Outlier reconciliation adjustment amount (see instructions) 18. 0 Outlier reconciliation adjustment amount (see instructions) 19. 00 Outlier reconciliation adjustment amount (see instructions) 29. 00 Outlier reconciliation adjustment amount (see instructions) 29. 00 Outlier reconciliation adjustment amount (see instructions) 29. 00 Outlier reconciliation adjustment amount (see instructions)						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 2, 823, 331 40. 00 40. 01 Interim payments 56, 467 40. 01 41. 00 Interim payments 2, 786, 930 41. 00 42. 00 43. 00 Balance due provider/program (see instructions) -20, 066 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 Fig. 10 15. 2 10 10 10 10 10 10 10			s)			
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99		1 3 3 1		tions)	_	
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 2, 786, 930 41.00 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\frac{\text{5115.2}}{\text{100}}}{\text{100}} \frac{\text{5115.2}}{\text{100}} \frac{\text{5115.2}}{\text{100}} \frac{\text{000}}{\text{100}} \frac{\text{000}}{\text{000}} \frac{\text{000}}{\tex		•	`	ĺ	0	
41.00 Interim payments 2,786,930 41.00 42.00 42.00 43.00 Balance due provider/program (see instructions) -20,066 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 15 15 15 2 10 15 15 15 15 15 15 15	40.00	Subtotal (see instructions)			2, 823, 331	40. 00
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{115.2}{5115.2}\$ 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Og 93.00	40. 01	Sequestration adjustment (see instructions)			56, 467	40. 01
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{5}{115.2}\$ TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 To BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)						•
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5}15.2\$ TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 1 The rate used to calculate the Time Value of Money 1 Time Value of Money (see instructions) 2 44.00 \$\frac{1}{5}15.2\$ TO BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 1 0 90.00 91.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00						•
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 pl.00 1 The rate used to calculate the Time Value of Money 0 color 93.00 1 Time Value of Money (see instructions) 0 pl.00			' II ONG D. I. 45 O			•
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 90.00 92.00 93.00 Outlier reconciliation adjustment amount (see instructions) 90.00 91.00 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	44.00	, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub. 15-2,	cnapter 1,	0	44.00
90. 00Original outlier amount (see instructions)090. 0091. 00Outlier reconciliation adjustment amount (see instructions)091. 0092. 00The rate used to calculate the Time Value of Money0. 0092. 0093. 00Time Value of Money (see instructions)093. 00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00 Time Value of Money (see instructions)	90. 00				0	90.00
92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		, ,			0	
		The rate used to calculate the Time Value of Money			0.00	l
94.00 Total (sum of lines 91 and 93) 0 94.00						1
	94. 00	Total (sum of lines 91 and 93)			0	94. 00

2, 766, 864

NPR Date (Mo/Day/Yr)

2 00

7.00

8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0146 Peri od: Worksheet E-1 From 01/01/2016 Part I 12/31/2016 Date/Time Prepared: 5/22/2017 9:39 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 4, 058, 103 2, 786, 930 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 3.53 0 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 4, 058, 103 2, 786, 930 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 58, 995 0 6.01 6 02 SETTLEMENT TO PROGRAM 20,066 6.02

4, 117, 098

0

Contractor

Number

1 00

7.00

8.00 Name of Contractor

Total Medicare program liability (see instructions)

Heal th	Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of					
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0146 From 01/01/2016 To 12/31/2016				pared: 9 am	
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			1, 789		
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1, 071	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		5, 050	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			189, 983, 516	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20		2, 505, 089	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00	
9.00	Sequestration adjustment amount (see instructions)			0	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10. 00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00	
	Other Adjustment (specify)			0	31. 00	
32 00	Ralance due provider (line 8 (or line 10) minus line 30 and L	ine 31) (see instruction	18)	O	32 00	

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

0 30.00 0 31.00 0 32.00

0 59.00

0 60.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column Provider CCN: 15-0146

Peri od: Worksheet G From 01/01/2016 12/31/2016 Date/Time Prepared:

only) 5/22/2017 9:39 am Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1, 745 1.00 1.00 Cash on hand in banks 0 0 0 0 0 2.00 Temporary investments 0 2.00 0 3.00 Notes receivable 0 0 3.00 23, 119, 021 0 4 00 4 00 Accounts receivable 0 0 5.00 Other receivable 1, 014, 203 0 0 5.00 6.00 Allowances for uncollectible notes and accounts receivable -15, 618, 666 6.00 0 7.00 Inventory 351, 037 0 0 7.00 0 8.00 Prepaid expenses 22, 320 0 8.00 0 9.00 Other current assets 0 9.00 10 00 Due from other funds 0 0 0 10 00 8, 889, 660 Total current assets (sum of lines 1-10) 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 0 0 0 12.00 Land improvements 755, 392 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 οl Accumulated depreciation 14.00 -370.2010 14.00 15.00 Bui I di ngs 3, 651, 286 0 0 15.00 -1, 318, 614 0 16.00 Accumulated depreciation 16.00 57, 402 0 17.00 Leasehold improvements 17.00 0 0 18 00 Accumulated depreciation -17, 303 0 18 00 Fi xed equipment 143, 565 19.00 19.00 0 0 20.00 Accumulated depreciation -40, 648 0 20.00 0 21.00 Automobiles and trucks 190, 035 0 21.00 22.00 Accumulated depreciation -89, 841 0 22.00 23.00 Major movable equipment 12, 659, 145 0 0 23.00 Accumulated depreciation -10, 200, 829 0 24.00 0 24.00 0 25.00 Mi nor equi pment depreci able 1, 103, 058 Λ 25, 00 26.00 Accumulated depreciation -355, 456 0 0 26.00 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 Accumulated depreciation Ω 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 6, 166, 991 0 30.00 OTHER ASSETS 31 00 Investments 5 000 0 0 31 00 0 0 32.00 Deposits on Leases 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 927.878 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 932, 878 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 15, 989, 529 0 0 0 36.00 CURRENT LIABILITIES 37 00 1 238 117 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 795, 085 0 38.00 0 Payroll taxes payable 0 39.00 39.00 0 40.00 Notes and Loans payable (short term) 151, 229 0 40.00 0 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments 0 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 0 0 44.00 -428, 123 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 0 45.00 1, 756, 308 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 46.00 0 0 47.00 Notes payable 0 0 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 400, 104 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 400, 104 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 51.00 2, 156, 412 0 0 0 51.00 CAPITAL ACCOUNTS General fund balance 52.00 13, 833, 117 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 0 57.00

13, 833, 117

15, 989, 529

0

0

replacement, and expansion

Total fund balances (sum of lines 52 thru 58)

Total liabilities and fund balances (sum of lines 51 and

58.00

59.00

60.00

15.00

16.00

17.00

18.00

19.00

COMMUNITY HOSPT. OF NOBLE CTY, INC. STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0146 Peri od: Worksheet G-1 From 01/01/2016 Date/Time Prepared: 5/22/2017 9:39 am 12/31/2016 General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 13, 833, 117 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 15, 586, 710 2.00 3.00 Total (sum of line 1 and line 2) 29, 419, 827 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 00000 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 29, 419, 827 Subtotal (line 3 plus line 10) 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 ASSET TRANSFERS 15, 586, 710 13.00 14.00 0 14.00 0 0 15.00 0 15.00 0 16.00 0 16.00 17.00 17.00 15, 586, 710 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 13, 833, 117 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 ASSET TRANSFERS 13.00 13.00

0

0

0 0

14.00

15.00 16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems COMMUNICATION OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0146

			То	12/31/2016	Date/Time Prep 5/22/2017 9:39	
	Cost Center Description	Inpatient		Outpati ent	Total	7 alli
		1.00		2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	8, 470, 1	10		8, 470, 110	1.00
2.00	SUBPROVI DER - I PF				., ,	2. 00
3.00	SUBPROVI DER - I RF					3. 00
4.00	SUBPROVI DER					4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6, 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	8, 470, 1	10		8, 470, 110	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 INTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of lines		0		0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8, 470, 1	10		8, 470, 110	17.00
18.00	Ancillary services	35, 445, 7	44	143, 889, 989	179, 335, 733	18.00
19.00	Outpatient services		0	0	0	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES		0	8, 669, 052	8, 669, 052	23.00
24.00	CMHC					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.	43, 915, 8	54	152, 559, 041	196, 474, 895	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			47, 554, 139		29. 00
30.00	PROVISION FOR BAD DEBT	7, 979, 5				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)			7, 979, 518		36. 00
37. 00	DEDUCT (SPECI FY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41. 00	T + 1 + 1 + 1 (C + 1 + 27 + 42)		O			41.00
42. 00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	er		55, 533, 657		43. 00
	to Wkst. G-3, line 4)	I	- 1			

Heal th	Financial Systems COMMUNITY HOSPT. OF N	OBLE CTY. INC.	In Lie	u of Form CMS-2	2552-10	
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0146	Peri od:	Worksheet G-3		
			From 01/01/2016 To 12/31/2016	Date/Time Prep 5/22/2017 9:39		
				1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			196, 474, 895	1.00	
2.00	Less contractual allowances and discounts on patients' account	ts		126, 886, 783	2. 00	
3.00	Net patient revenues (line 1 minus line 2)			69, 588, 112	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	13)		55, 533, 657	4. 00	
5.00	Net income from service to patients (line 3 minus line 4)			14, 054, 455	5. 00	
	OTHER I NCOME				6, 00	
6.00	6.00 Contributions, donations, bequests, etc					
7.00	7.00 Income from investments					
8.00	8.00 Revenues from telephone and other miscellaneous communication services					
9.00	Revenue from television and radio service			0	9. 00	
10.00	Purchase di scounts			0	10.00	
11.00	Rebates and refunds of expenses			0	11.00	
12.00	Parking Lot receipts			0	12.00	
13.00	Revenue from Laundry and Linen service			0	13.00	
14.00	Revenue from meals sold to employees and guests			128, 320	14.00	
15.00	Revenue from rental of living quarters			0	15. 00	
16.00	Revenue from sale of medical and surgical supplies to other the	nan patients		0	16. 00	
17.00	Revenue from sale of drugs to other than patients	·		0	17.00	
18.00	Revenue from sale of medical records and abstracts			0	18.00	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
21.00	Rental of vending machines			0	21.00	
22.00	Rental of hospital space			0	22. 00	
23. 00	Governmental appropriations			0	23. 00	
24. 00	OTHER (SPECIFY)			0	24. 00	
24. 01	GAIN/LOSS ON SALES OF CAPITAL ASSETS			-5, 903		
24. 02	EMS SUBSIDY			256, 202		
	OTHER DEVENUE			1 155 110		

1, 155, 110

1, 532, 255

15, 586, 710

0

0 28.00

15, 586, 710 29. 00

24. 03

25. 00 26. 00 27. 00

24. 03 OTHER REVENUE

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

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

Health Financial Systems COMMUNITY HOSPT. OF NOBLE CTY, INC. In Lieu of Form CMS-2					2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0146	Peri od: From 01/01/2016 To 12/31/2016		
		Title XVIII	Hospi tal	PPS	7 diii
			•		
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			284, 642	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			3, 381	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3. 00 4. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions) Number of interns & residents (see instructions)			14. 12 0. 00	3. 00 4. 00
4. 00 5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education percentage (see instructions) [Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0.00	6.00
0.00	1. 01) (see instructions)				0.00
7. 00				0.00	7. 00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see instructions)			0.00	8. 00
9.00				0.00	9. 00
10.00				0.00	
11. 00				0	
12. 00	0 Total prospective capital payments (see instructions) 288,				12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions)			Ö	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			Ö	3.00
4. 00	Applicable exception percentage (see instructions)			0.00	4. 00
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see in	structions)		0.00	6. 00
7 00				i _	l

8.00

9.00

0 10.00

11.00

0 16.00 0 17.00

0

0 12.00

0 13.00

0 14.00

0 15.00

Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)

10.00 | Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

11.00 | Carryover of accumulated capital minimum payment level over capital payment (from prior year

Capital minimum payment level (line 5 plus line 7)

(if line 12 is negative, enter the amount on this line)

16.00 | Current year operating and capital costs (see instructions)

17.00 | Current year exception offset amount (see instructions)

Worksheet L, Part III, line 14)

Current year capital payments (from Part I, line 12, as applicable)

15.00 Current year allowable operating and capital payment (see instructions)

7.00

9.00

12.00

13.00

14.00