modi en inidiro	ar of stome			u 0 0 00 2002
This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can resul	t in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments (4)	2 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 05-31-2019
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provi der CCN: 15-0146	Peri od: From 01/01/2018 To 12/31/2018	
			10 12/31/2010	5/28/2019 10: 28 am
PART I - COST	REPORT STATUS			
Provi der	<ol> <li>[ X ] Electronically filed cost report</li> </ol>		Date: 5/28/20	19 Time: 10:28 am
use only	2. [ ] Manually submitted cost report			
	3. [ 0 ] If this is an amended report enter the number 4. [ F ] Medicare Utilization. Enter "F" for full or "I		esubmitted this co	ost report
Contractor use only	5. [ 1 ] Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [ N ] Initial Report for (3) Settled with Audit 9. [ N ] Final Report for (4) Reopened (5) Amended	11.0 or this Provider CCN 12.		

## PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL 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 HOSPITAL OF NOBLE CTY, INC (15-0146) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 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.

[ X ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) JEANNE WICKENS
Officer or Administrator of Provider(s)

CFO/SVP
Title

(Dated when report is electronically signed.)
Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-45, 360	4, 326	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	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
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	-45, 360		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.

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0146 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 401 SAWYER ROAD 1.00 P0 Box: 728 1.00 Zip Code: 46755-0728 County 2.00 City: KENDALLVILLE State: IN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Туре Number Number Certi fi ed 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 HOSPITAL OF 150146 99915 05/30/2000 N 3.00 NOBLE CTY, INC Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 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 Separately Certified ASC 13.00 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 Hospital-Based (CMHC) I 17.00 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19. 00 19.00 Other From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 2 21.00 1.00 3.00 2.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate 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 N Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be 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 in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22.03 rural as a result 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 ves or "N" for no 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 3 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no In-State In-State Out-of Out-of Medi cai d Other Medi cai d Medi cai d State Medi cai d State HMO days paid days el i gi bl e Medi cai d Medi cai d days el i gi bl e unpai d paid days unpai d days 1.00 2.00 3.00 4.00 5.00 6.00 644 24.00 If this provider is an IPPS hospital, enter the 120 267 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.

HOULINE AND	ial Systems COMMUNITY HO HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC		Peri od:			neet S-2	2552-1
					From 01/0	01/2018 31/2018	Part I Date/T		pared:
		In-State	In-State	Out-of	Out-of	Medi ca	aid (	Other	
		Medicaid paid days		State Medicaid	State Medi cai d	HMO da	<i>-</i>	edi cai d days	
			unpai d	paid days	el i gi bl e			,	
		1.00	2. 00	3. 00	unpai d 4. 00	5. 00	,	6. 00	-
25.00   f thi	s provider is an IRF, enter the in-state		0 0		4.00		0	6.00	25. 00
	id paid days in column 1, the in-state								
	id eligible unpaid days in column 2, -state Medicaid days in column 3, out-of-state								
	id eligible unpaid days in column 4, Medicaid								
	id and eligible but unpaid days in column 5.		<u> </u>		1				
						<u> 00</u>		f Geogr 00	
	your standard geographic classification (not w		s at the beg	inning of t		2			26. 00
	eporting period. Enter "1" for urban or "2" fo your standard geographic classification (not w		at the one	l of the cos	.+	2	10/01	1/2016	27.00
	ing period. Enter in column 1, "1" for urban o				, (	2	10/01	172010	27.00
enter	the effective date of the geographic reclassif	ication in	column 2.						
	s is a sole community hospital (SCH), enter th in the cost reporting period.	e number of	f periods SC	H status ir	1	C			35.00
Begi ni							End	i ng:	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number							2.	00	24.04
	applicable beginning and ending dates of SCH s lods in excess of one and enter subsequent dat		script line	36 for numb	er				36. 0
37.00   If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status									37. 0
is in effect in the cost reporting period.  37 01 Is this bosnital a former MDH that is eligible for the MDH transitional payment in									07.0
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see									37. 0
instructions)									
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 06/22 greater than 1, subscript this line for the number of periods in excess of one and						/2018	12/31	1/2018	38.00
	subsequent dates.	i perrous i	III excess of	one and					
						/N		/N	
39.00 Does t	his facility qualify for the inpatient hospita	l pavment a	adiustment f	for low volu		00 Y		00 Y	39.00
hospi t	als in accordance with 42 CFR §412.101(b)(2)(i	), (ii), oı	r (iii)? Ent	er in colum					
	for yes or "N" for no. Does the facility meet ance with $42 \text{ CFR } 412.101(b)(2)(i), (ii), or (iii)$								
	for no. (see instructions)	ii): Liitei	TH COLUMN 2	. I TOT ye	:5				
40.00 Is thi	s hospital subject to the HAC program reduction	n adjustmer	nt? Enter "Y	" for yes o	or l	V		N	40.00
	r no in column 1, for discharges prior to Octo column 2, for discharges on or after October 1			es or "N" f	for				
	cordinir 2, Tor di scharges on or arter october i	. (366 1113	ti ucti ons)			V	XVIII	XIX	
lin i i						1.00	2.00	3.00	
						1.00	, , 2. 00		
Prospe	ctive Payment System (PPS)-Capital	nt for dis	oronorti onat	e share in	accordance			N	45.00
Prospe 45.00 Does t	ctive Payment System (PPS)-Capital his facility qualify and receive Capital payme 2 CFR Section §412.320? (see instructions)	nt for disp	oroporti onat	e share in	accordance		N	N	45. 0
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1. 00

N

2.00

3.00

60. 00

60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0146 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

COMMUNITY HOSPITAL OF NOBLE CTY. INC In Lieu of Form CMS-2552-10	J
	J

HOSPITAL AND HOSP	ITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA Provider Co	CN: 15-0146	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pro 5/28/2019 10:	epared:
					1 00	-
Long Term (	Care Hospital PPS				1.00	
31.00 Is this a I	ong term care hospital (LTCH)? Enter "Y" TCH co-located within another hospital for and "N" for no.			ng period? Enter	N N	80. 0 81. 0
6.00 Did this fa	new hospital under 42 CFR Section §413.40(f acility establish a new Other subprovider (	(excluded unit) under			N	85. 0 86. 0
7.00 Is this hos	(1)(ii)? Enter "Y" for yes and "N" for no. spital an extended neoplastic disease care (B)(vi)? Enter "Y" for yes or "N" for no.		under section	า	N	87. (
1000(u)(1)	2)(11)1 211(31 1 1 31 4 32 31 11 131 1131			V	XI X	
				1. 00	2.00	
	d XIX Services Facility have title V and/or XIX inpatient	hospital services? E	nter "Y" for	N	Υ	90.
	for no in the applicable column. spital reimbursed for title V and/or XIX th	nrough the cost repor	t either in	N	N	91.
full or in	part? Enter "Y" for yes or "N" for no in t (IX NF patients occupying title XVIII SNF b	the applicable column			N	92.
i nstructi o	ns) Enter "Y" for yes or "N" for no in the Facility operate an ICF/IID facility for pu	applicable column.		N		
"Y" for yes	N	93.				
4.00 Does title applicable	N	N	94.			
5.00 If line 94 6.00 Does title	0. 00 N	95. 96.				
applicable column.  27.00 If line 96 is "Y", enter the reduction percentage in the applicable column.  28.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post  Y						97.
stepdown a	Y	98.				
column 1 for title V, and in column 2 for title XIX.  18.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.  19.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for						98.
bed costs	V or XIX follow Medicare (title XVIII) for on Wkst. D-1, Pt. IV, line 89? Enter "Y" fo			Y	Y	98.
B. 03 Does title	/, and in column 2 for title XIX. V or XIX follow Medicare (title XVIII) for 101% of inpatient services cost? Enter "Y"				N	98.
3.04 Does title	/, and in column 2 for title XIX. V or XIX follow Medicare (title XVIII) for services cost? Enter "Y" for yes or "N" fo			N	N	98.
3.05 Does title	2 for title XIX. V or XIX follow Medicare (title XVIII) and c. I, col. 4? Enter "Y" for yes or "N" for				Y	98.
8.06 Does title Pts. I thro	or title XIX. V or XIX follow Medicare (title XVIII) who ough IV? Enter "Y" for yes or "N" for no ir or title XIX.			Y	Y	98.
Rural Provi						10-
06.00 If this fac	nospital qualify as a CAH? cility qualifies as a CAH, has it elected 1	the all-inclusive met	hod of payme	nt N		105. 106.
07.00 If this fac training po yes, the G	ent services? (see instructions) cility qualifies as a CAH, is it eligible for a community of the community	n column 1. (see inst	ructions) If			107.
08.00 Is this a i	If yes complete Wkst. D-2, Pt. II. Fural hospital qualifying for an exception n §412.113(c). Enter "Y" for yes or "N" for		dul e? See 4.	2 N		108.
12 33321 01		Physi cal 1.00	Occupation 2.00	Speech 3.00	Respiratory 4.00	
therapy se	spital qualifies as a CAH or a cost provide vices provided by outside supplier? Enter "N" for no for each therapy.	er, are N	2.00	3.00	4.00	109.
, , ,	- 17					
Demonstrati	ospital participate in the Rural Community on) for the current cost reporting period? orksheet E, Part A, lines 200 through 218,	Enter "Y" for yes or	"N" for no.	If yes,	1.00 N	110.

133.00

134.00

140. 00

15H032

133.00 of this is a Medicare certified other transplant center, enter the certification date

134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1

140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1,

chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)

in column 1 and termination date, if applicable, in column 2.

and termination date, if applicable, in column 2.

All Providers

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0146 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: To 12/31/2018 5/28/2019 10:28 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 08101 141 00 SERVI CES 142.00 Street: 10501 CORPORATE DRIVE PO Box: 5600 142.00 46845-1700 143.00 City: FORT WAYNE State: ΙN Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157. 00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161.00 161. 10 CORF N 161. 10 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. CBSA FTE/Campus State Zip Code Name County 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00|If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99 169. 00 transition factor. (see instructions) Endi ng Begi nni ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 10/01/2017 09/30/2018 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 0171.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in Ν section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSE	EMENT QUESTIONNAIRE		Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/28/2019 10:3	pared:
			Y/N	Date	
			1. 00	2. 00	
C	VEC F-+ N 6-	II NO F+-		la a	

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0		Peri od: From 01/01/2018 To 12/31/2018		epared:
		· · · · ·	<u>'</u>	Y/N	Date	
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	esponses. Ente	r all dates in t	the	-
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)			
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	Drogram? If	1.00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provic officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
	Toratronom por (see Thetraetrone)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports		1		00.40= 4===	
4.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A	03/27/2018	4. 00
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is the	he provider is	N		6. 00
	the legal operator of the program?					
7.00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7.00
<ul><li>8. 00</li><li>9. 00</li></ul>	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		· ·	N N		9.00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	is.		N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than ${\sf I}$	& R in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.				\/ (N	
					Y/N 1. 00	
	Bad Debts				1.00	
12.00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruc	tions.		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	oolicy change	during this co	, ,	N	13.00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.00
15. 00	Did total beds available change from the prior cost reporti				N N	15. 00
		Y/N	rt A Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	05/01/2019	Y	05/01/2019	17. 00
18. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed  but are not included on the PS&R Percet used to file this	N		Y		18. 00
19. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems COMMUNITY HOSPITAL	OF NOBLE CTY.	LNC	In Lie	u of Form CMS	-2552-10	
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0146 F	Peri od:	Worksheet S-		
				From 01/01/2018 o 12/31/2018	Part II Date/Time Pr	anarad:	
			'	0 12/31/2010	5/28/2019 10		
		Desci	ription	Y/N	Y/N		
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	IV	20.00	
	,,	Y/N	Date	Y/N	Date		
		1. 00	2.00	3. 00	4. 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 (EXC	EPT CHILDRENS	HOSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, se					22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprai	sals made durin	ig the cost		23. 00	
24. 00	Were new leases and/or amendments to existing leases enter	ed into durina	this cost reno	rting period?		24. 00	
21.00	If yes, see instructions	ca mito adming	, till 3 cost repe	n tring perrou.		21.00	
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period? I	f yes, see		25. 00	
24 00	instructions.	ho cost mans-t	ing ported 15	V05 505		24 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	ne cost report	ing perroa? IT	yes, see		26. 00	
27. 00	Has the provider's capitalization policy changed during th	e cost reporti	ng period? If y	es, submit		27. 00	
	copy.	<u> </u>					
00.00	Interest Expense						
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	enterea into au	iring the cost r	eporting		28. 00	
29. 00	Did the provider have a funded depreciation account and/or	erve Fund)		29. 00			
	treated as a funded depreciation account? If yes, see instructions						
30. 00	00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see						
21 00	instructions.	couppes of now	. dob+2 l.f. voo			21 00	
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance or new	debt? IT yes,	see		31. 00	
	Purchased Services						
32. 00	Have changes or new agreements occurred in patient care se		ed through cont	ractual		32. 00	
	arrangements with suppliers of services? If yes, see instr						
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	pried pertaini	ng to competiti	ve blading? IT		33. 00	
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facility under an a	rrangement wit	h provi der-base	ed physicians?		34.00	
	If yes, see instructions.						
35. 00	If line 34 is yes, were there new agreements or amended ex		ents with the pr	ovi der-based		35. 00	
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
	Were home office costs claimed on the cost report?					36.00	
37.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	nome office?			37. 00	
38. 00	If line 36 is yes , was the fiscal year end of the home of	fice different	from that of			38. 00	
55	the provider? If yes, enter in column 2 the fiscal year en					-3.00	
39. 00	If line 36 is yes, did the provider render services to oth	er chain compo	nents? If yes,			39. 00	
40.00	see instructions.	homo office?	If you can			40.00	
40.00	If line 36 is yes, did the provider render services to the instructions.	: nome office?	ii yes, see			40. 00	
	The tradition of						
	T	1	. 00	2.	00		
41 00	Cost Report Preparer Contact Information	EDLC		NI CKECON		41.00	
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	
	respectively.						
42.00	Enter the employer/company name of the cost report	PARKVI EW HEAL	TH SYSTEM, INC.			42. 00	
	preparer.	0.00707.		EDI O 111 211 222	3.510.0 E 55		
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	2603738406		ERI C. NI CKESON@F	PARKVI EW. COM	43. 00	
	proport proparor in continuis rand 2, respectivery.	1		I		II	

Heal th	Financial Systems	COMMUNITY HOSPITAL	OF NOBLE CTY,	INC	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTIONNAIRE	Provi der C		Period: From 01/01/2018		
					Го 12/31/2018	Date/Time Pre 5/28/2019 10:	pared: 28 am
			3.	00			
	Cost Report Preparer Contact Information	on					
41.00	Enter the first name, last name and the	e title/position	DIRECTOR REIME	BURSEMENT			41. 00
	held by the cost report preparer in col respectively.	umns 1, 2, and 3,					
42.00	Enter the employer/company name of the	cost report					42.00
	preparer.	·					
43.00	Enter the telephone number and email ad	ddress of the cost					43.00
	report preparer in columns 1 and 2, res	specti vel y.					

 Heal th Financial
 Systems
 COMMUNITY HOST

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provi der CCN: 15-0146

Peri od: Worksheet S-3
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2010 10: 28 am

						'		5/28/2019 10:	28 am
	·							I/P Days / O/P	
								Visits / Trips	
	Component	Worksheet A	No.	of Be	eds	Bed Days	CAH Hours	Title V	
		Line Number				Avai I abl e			
		1. 00		2.00		3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00			31	11, 315	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days)(see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2. 00
3.00	HMO IPF Subprovider								3. 00
4.00	HMO IRF Subprovider								4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							0	
6.00	Hospital Adults & Peds. Swing Bed NF							0	
7.00	Total Adults and Peds. (exclude observation				31	11, 315	0.00	0	7. 00
	beds) (see instructions)								
8.00	INTENSIVE CARE UNIT	31. 00			0	0			
9.00	CORONARY CARE UNIT	32. 00			0	0	0.00		9. 00
10. 00	BURN INTENSIVE CARE UNIT	33. 00			0	0	0. 00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00			0	0	0. 00	0	11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)								12. 00
13. 00	NURSERY	43. 00						0	
14. 00	Total (see instructions)				31	11, 315	0. 00	0	
15. 00	CAH visits							0	
16. 00	SUBPROVI DER - I PF	40. 00			0	0		0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00			0	0		0	17. 00
18. 00	SUBPROVI DER								18. 00
19. 00	SKILLED NURSING FACILITY	44. 00			0	0		0	
20. 00	NURSING FACILITY	45. 00			0	0		0	20. 00
21. 00	OTHER LONG TERM CARE	46. 00			0	0			21. 00
22. 00	HOME HEALTH AGENCY	101. 00						0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	115. 00							23. 00
24. 00	HOSPI CE	116. 00			0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00	CMHC - CMHC	99. 00						0	
25. 10	CMHC - CORF	99. 10						0	
26. 00	RURAL HEALTH CLINIC	88. 00						0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	26. 25
27. 00	Total (sum of lines 14-26)				31				27. 00
28. 00	,							0	
29. 00	Ambul ance Tri ps								29. 00
	Employee discount days (see instruction)								30. 00
31.00	Employee discount days - IRF								31. 00
32. 00	Labor & delivery days (see instructions)				0	0			32. 00
32. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days								33. 00
33. 01	LTCH site neutral days and discharges								33. 01

Health Financial Systems COMMUNITY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0146

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 10: 28 am

						5/28/2019 10:	28 am
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 085	88	4, 691			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)	1, 053	873				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0	_			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	0.005	0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	2, 085	88	4, 691			7. 00
9 00	beds) (see instructions)		0	_			0 00
8. 00 9. 00	INTENSIVE CARE UNIT	0	0	0			8. 00 9. 00
10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0				11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	J	U	0			12.00
13. 00	NURSERY		27	413			13. 00
14. 00	Total (see instructions)	2, 085	115			207.00	
15. 00	CAH visits	2,000	0			207.00	15. 00
16. 00	SUBPROVI DER - I PF	0	0			0.00	
17. 00	SUBPROVI DER - I RF	0	0				•
18. 00	SUBPROVI DER	Ĭ	ŭ	Ĭ	0.00	0.00	18. 00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
20.00	NURSING FACILITY		0	0	0.00	0.00	20. 00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21. 00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE	0	0	0	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			174			24. 10
25. 00	CMHC - CMHC	0	0	0			25. 00
25. 10	CMHC - CORF	0	0	0	0.00		
26. 00	RURAL HEALTH CLINIC	0	0	0			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				0.00	207. 00	
28. 00	Observation Bed Days		247	1, 380			28. 00
29. 00	Ambul ance Tri ps	1, 598					29. 00
30. 00	Employee discount days (see instruction)			44			30. 00
31. 00	Employee discount days - IRF	_		0			31.00
32. 00	Labor & delivery days (see instructions)	0	50	78			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33. 00 33. 01
33.01	LTCH site neutral days and discharges	ų ų		I	l	I	33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0146

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/28/2019 10:28 am Full Time Di scharges Equi val ents Title V Title XVIII Title XIX Total All Component Nonpai d Workers Pati ents 12.00 13.00 14.00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 771 31 1, 865 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) 274 2 00 366 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 NURSERY 13.00 13.00 14.00 Total (see instructions) 0.00 0 771 31 1,865 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 0.00 16.00 16.00 0 0 0 17.00 SUBPROVIDER - IRF 0 0.00 0 0 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0.00 19.00 20 00 NURSING FACILITY 0 00 20 00 21.00 OTHER LONG TERM CARE 0.00 0 21.00 22.00 HOME HEALTH AGENCY 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 0.00 23.00 HOSPI CE 24.00 0.00 24 00 HOSPICE (non-distinct part) 24. 10 24. 10 25. 00 CMHC - CMHC 0.00 25.00 25. 10 CMHC - CORF 0.00 25. 10 RURAL HEALTH CLINIC 26.00 0.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 27.00 Observation Bed Days 28.00 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 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | From 2004 | Part | Part

						o 12/31/2018	Date/lime Pre 5/28/2019 10:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2.00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							4
1.00	Total salaries (see	200. 00	14, 518, 377	4, 022, 561	18, 540, 938	563, 497. 00	32. 90	1.00
2.00	instructions) Non-physician anesthetist Part		0	0	C	0.00	0. 00	2. 00
3.00	A  Non-physician anesthetist Part		0	О		0.00	0. 00	3.00
4. 00	B Physician-Part A -		48, 000	0	48, 000	407.00	117. 94	4.00
4. 01	Administrative Physicians - Part A - Teaching		0	0		0.00	0.00	4. 01
5. 00	Physician and Non Physician-Part B		0	0	C	0.00	0.00	5. 00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	C	0.00	0.00	6.00
7.00	Interns & residents (in an	21. 00	0	0	C	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	C	0.00	0.00	7. 01
8. 00	programs) Home office and/or related organization personnel		4, 022, 473	0	4, 022, 473	115, 832. 00	34. 73	8. 00
9.00	SNF	44. 00	0	0		0.00		
10. 00	Excluded area salaries (see instructions)		2, 064, 354	6, 616	2, 070, 970	78, 149. 00	26. 50	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		1, 103, 627	0	1, 103, 627	16, 388. 00	67. 34	11.00
12. 00	Care Contract Labor: Top Level		0	0		0.00	0. 00	12.00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		0	0	C	0.00	0. 00	13.00
14. 00	Home office and/or related organization salaries and		0	0	C	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		4, 022, 473	О	4, 022, 473			14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	(	0. 00 0. 00		14. 02 15. 00
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0. 00	16. 00
	WAGE-RELATED COSTS							1
17. 00	Wage-related costs (core) (see instructions)		4, 737, 156	0	4, 737, 156			17. 00
18. 00	Wage-related costs (other) (see instructions)		0	0	C			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		803, 807 0	0				19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	(			21. 00
22. 00	B Physician Part A -		0	0	(			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	(			22. 01
23. 00	Physician Part B		0	Ō	d			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	-				24. 00 25. 00
25. 50	approved program) Home office wage-related		2, 210, 386	_				25. 50
25. 51	(core) Related organization		2, 210, 300					25. 51
	wage-related (core)		-					
25. 52	Home office: Physician Part A - Administrative -		0	0	(			25. 52
25. 53	wage-related (core)   Home office & Contract   Physicians Part A - Teaching -   wage-related (core)		0	0	C			25. 53
0	OVERHEAD COSTS - DIRECT SALARIE		0.153.5		I	-		1
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00						26. 00 27. 00
								-

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018

							5/28/2019 10:	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0. 00	0. 00	28. 00
	contract (see inst.)							
	Maintenance & Repairs	6. 00	0	0	0	0. 00		
	Operation of Plant	7. 00	324, 627	34, 376	359, 003	12, 963. 00	27. 69	30.00
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00	0. 00	31.00
32. 00	Housekeepi ng	9. 00	288, 056	30, 503	318, 559	22, 748. 00	14. 00	32.00
33. 00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	384, 315	-136, 734	247, 581	14, 176. 00	17. 46	34.00
35. 00	Dietary under contract (see		0	0	0	0.00	0.00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	171, 946	171, 946	11, 807. 00	14. 56	36.00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	382, 725	40, 528	423, 253	10, 191. 00	41. 53	38. 00
39. 00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40. 00	Pharmacy	15. 00	577, 320	61, 134	638, 454	11, 864. 00	53. 81	40.00
41. 00	Medical Records & Medical	16. 00	0	0	0	0.00	0. 00	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0.00	42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Total overhead cost (see

instructions)

7.00

36.31

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0146 Worksheet S-3 Peri od: From 01/01/2018 To 12/31/2018 Part III Date/Time Prepared: 5/28/2019 10:28 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) (from Salaries in 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 10, 495, 904 4, 022, 561 14, 518, 465 447, 665. 00 32. 43 1.00 instructions) 2.00 2, 064, 354 6, 616 2, 070, 970 78, 149. 00 26. 50 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 8, 431, 550 4, 015, 945 12, 447, 495 369, 516. 00 33.69 3.00 minus line 2) 4.00 Subtotal other wages & related 5, 126, 100 5, 126, 100 132, 220. 00 38.77 4.00 costs (see inst.) Subtotal wage-related costs 5.00 6, 947, 542 Ω 6, 947, 542 0.00 55.81 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 20, 505, 192 4, 015, 945 24, 521, 137 501, 736. 00 48 87

4, 787, 101

3, 081, 722

7, 868, 823

216, 731. 00

| Period: | Worksheet S-3 | From 01/01/2018 | Part IV | To | 12/31/2018 | Date/Time Prepared: COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

	To 12/31/2018	Date/Time Prep 5/28/2019 10:	pared: 28 am
		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	254, 737	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 250, 147	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, 287	6. 00
7.00	Employee Managed Care Program Administration Fees	35, 838	7. 00
	HEALTH AND INSURANCE COST	•	
8.00	Health Insurance (Purchased or Self Funded)	0	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)	2, 797, 934	8. 02
8.03	Health Insurance (Purchased)	0	
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)	28, 542	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, 679	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	15, 595	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	989, 815	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	63, 622	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	37, 767	
24.00	Total Wage Related cost (Sum of lines 1 -23)	5, 540, 963	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC		In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0146	Peri od:	Worksheet S-3

Form 01/01/2018 Part V
To 12/31/2018 Date/Time Prepared: 5/28/2019 10: 28 am Cost Center Description Contract Labor Benefit Cost 1. 00 2.00 PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component Identification: 5, 540, 963 5, 540, 963 1.00 Total facility's contract labor and benefit cost 1, 103, 627 2.00 1, 103, 627 2.00 Hospi tal Subprovider - IPF 3.00 0 3.00 Subprovi der - IRF Subprovi der - (Other) Swing Beds - SNF 4.00 0 4.00 5.00 0 0 0 0 0 5.00 6.00 0 6.00 Swing Beds - NF 7.00 0 7. 00 Hospi tal -Based SNF 8.00 0 8.00 9.00 Hospi tal -Based NF 9.00 Hospi tal -Based OLTC Hospi tal -Based HHA 10.00 10.00 0 0 0 0 0 0 0 0 0 11.00 11.00 12.00 Separately Certified ASC 0 12.00 13.00 Hospi tal -Based Hospi ce 0 13.00 Hospital -Based Health Clinic RHC 14.00 14.00 0 15.00 Hospital-Based Health Clinic FQHC 15.00 0 16.00 Hospi tal -Based-CMHC 0 16.00 16. 10 Hospi tal -Based-CMHC 10 16. 10 0

17.00 0

0 18.00

17.00 Renal Dialysis

18.00 Other

Heal th	Financial Systems COMMUNITY HOSPITAL OF N	NOBLE CTY,	I NC	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO		Peri od:	Worksheet S-10	0
				From 01/01/2018 To 12/31/2018	Date/Time Prep 5/28/2019 10:	
					1. 00	
	Uncompensated and indigent care cost computation			->		
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by li	ne 202 column	1 8)	0. 198369	1. 00
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid				1, 686, 768	2.00
2.00	Did you receive DSH or supplemental payments from Medicaid?				1, 686, 768 Y	3.00
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal naumant	s from Modics	u 42	Y	4.00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fi			ii u ?	,	5.00
6. 00	Medicaid charges	on wearcar	u		17, 419, 174	6.00
7. 00	Medicaid cost (line 1 times line 6)				3, 455, 424	7.00
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of lir	nes 2 and 5: if	1, 768, 656	
0.00	<pre>&lt; zero then enter zero)</pre>	(TITIE 7 IIITI	us sum or iii	ies z ana s, i i	1, 700, 030	0.00
	Children's Health Insurance Program (CHIP) (see instructions for	or each lin	e)			
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 mi	nus line 9: i	f < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see ins	tructions f	or each line)			
13.00	Net revenue from state or local indigent care program (Not inc				2, 525, 837	13. 00
14.00	Charges for patients covered under state or local indigent care	e program (	Not included	in lines 6 or	18, 700, 083	14. 00
	10)					
15. 00	State or local indigent care program cost (line 1 times line 1				3, 709, 517	
16. 00	Difference between net revenue and costs for state or local in	digent care	program (lir	ne 15 minus line	1, 183, 680	16. 00
	13; if < zero then enter zero)	5				
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/Local Indig	jent care program	ns (see	
17. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to form</pre>	ındi na shar	ity cara		0	17. 00
18.00	Government grants, appropriations or transfers for support of				0	18.00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and Local			(cum of lines	2, 952, 336	
19.00	8, 12 and 16)	That gent	care programs	s (suii oi iiiles	2, 752, 550	19.00
	10, 12 und 10)		Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire fa	cility	2, 982, 22	20 1, 007, 400	3, 989, 620	20.00
	(see instructions)	_				
21. 00	Cost of patients approved for charity care and uninsured disco	unts (see	591, 58	1, 007, 400	1, 598, 980	21. 00
	instructions)					
22. 00	Payments received from patients for amounts previously written	off as	6, 00	00 10, 553	16, 553	22. 00
23 00	charity care (line 21 minus line 22)		585 58	996 847	1 582 427	22.00
23 OO	ILOST OF CHAFLEY CARE (LINE 21 MINUS LINE 22)		לא לאל	KUI 996 8/1/1	1 587 477	1 ノく ()()

Cost Center Description   Salaries   Other   Total (col. 1   Reclassificati ons (See A-6)   Total (col. 2)   Reclassified ons (See A-6)   Total (col. 3   Loo	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
Cost Center Description   Salaries   Other   Total (col. 1   Reclassificati ons (See A-6)   Trial Balance (col. 3 + col. 4)	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
Cost Center Description	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
+ col . 2   ons (See A-6)   Tri al Balance (col . 3 +- col . 4)	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
Col. 4    Col.	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1.00   2.00   3.00   4.00   5.00   5.00   6ENERAL SERVICE COST CENTERS   2,478,281   2,478,281   -832,760   1,645,521   2.00   00200   CAP REL COSTS-BLDG & FIXT   2,478,281   2,478,281   -832,760   1,645,521   2.00   00200   CAP REL COSTS-MVBLE EQUIP   0   0   1,001,150   1,001,150   3.00   00300   OTHER CAP REL COSTS   0   0   0   0   0   0   0   0   0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
CANON   CAP REL COSTS - BLDG & FIXT   CAP REL COSTS   CA	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00       00100 CAP REL COSTS-BLDG & FIXT       2, 478, 281       2, 478, 281       -832, 760       1, 645, 521         2. 00       00200 CAP REL COSTS-MVBLE EQUI P       0       0       0       1, 001, 150       1, 001, 150         3. 00       00300 OTHER CAP REL COSTS       0       0       0       0       0       0         4. 00       00400 EMPLOYEE BENEFI TS DEPARTMENT       2, 199, 946       4, 718, 876       6, 918, 822       -2, 199, 946       4, 718, 876         5. 00       00500 ADMINISTRATI VE & GENERAL       630, 112       20, 172, 521       20, 802, 633       1, 001, 646       21, 804, 279         6. 00       00600 MAI NTENANCE & REPAIRS       0       0       0       0       0       0       0         7. 00       00700 OPERATI ON OF PLANT       324, 627       1, 288, 872       1, 613, 499       40, 821       1, 654, 320         8. 00       00800 LAUNDRY & LI NEN SERVI CE       0       0       0       162, 897       162, 897         9. 00       00900 HOUSEKEEPI NG       288, 056       341, 742       629, 798       -132, 394       497, 404         10. 00       01000 DI ETARY       384, 315       250, 554       634, 869       -264, 364       370, 505	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00     00200 CAP REL COSTS-MVBLE EQUI P     0     0     1, 001, 150     1, 001, 150       3. 00     00300 OTHER CAP REL COSTS     0     0     0     0     0       4. 00     00400 EMPLOYEE BENEFI TS DEPARTMENT     2, 199, 946     4, 718, 876     6, 918, 822     -2, 199, 946     4, 718, 876       5. 00     00500 ADMI NI STRATI VE & GENERAL     630, 112     20, 172, 521     20, 802, 633     1, 001, 646     21, 804, 279       6. 00     00600 MAI NTENANCE & REPAIRS     0     0     0     0     0     0       7. 00     00700 OPERATI ON OF PLANT     324, 627     1, 288, 872     1, 613, 499     40, 821     1, 654, 320       8. 00     00800 LAUNDRY & LI NEN SERVI CE     0     0     0     162, 897     162, 897       9. 00     00900 HOUSEKEEPI NG     288, 056     341, 742     629, 798     -132, 394     497, 404       10. 00     01000 DI ETARY     384, 315     250, 554     634, 869     -264, 364     370, 505	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3.00   00300   OTHER CAP REL COSTS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
5. 00       00500       ADMI NI STRATI VE & GENERAL       630, 112       20, 172, 521       20, 802, 633       1, 001, 646       21, 804, 279         6. 00       00600       MAI NTENANCE & REPAI RS       0       0       0       0       0         7. 00       00700       OPERATI ON OF PLANT       324, 627       1, 288, 872       1, 613, 499       40, 821       1, 654, 320         8. 00       00800       LAUNDRY & LI NEN SERVI CE       0       0       0       162, 897       162, 897         9. 00       00900       HOUSEKEEPI NG       288, 056       341, 742       629, 798       -132, 394       497, 404         10. 00       01000       DI ETARY       384, 315       250, 554       634, 869       -264, 364       370, 505	5. 00 6. 00 7. 00 8. 00
6. 00	6. 00 7. 00 8. 00
7. 00     00700     OPERATI ON OF PLANT     324, 627     1, 288, 872     1, 613, 499     40, 821     1, 654, 320       8. 00     00800     LAUNDRY & LI NEN SERVI CE     0     0     0     162, 897     162, 897       9. 00     00900     HOUSEKEEPI NG     288, 056     341, 742     629, 798     -132, 394     497, 404       10. 00     01000     DI ETARY     384, 315     250, 554     634, 869     -264, 364     370, 505	7. 00 8. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE   0   0   0   162, 897   162, 897   9. 00   00900   HOUSEKEEPI NG   288, 056   341, 742   629, 798   -132, 394   497, 404   10. 00   01000   DI ETARY   384, 315   250, 554   634, 869   -264, 364   370, 505	8. 00
9. 00   00900   HOUSEKEEPI NG   288, 056   341, 742   629, 798   -132, 394   497, 404   10. 00   01000   DI ETARY   384, 315   250, 554   634, 869   -264, 364   370, 505	
10. 00 01000 DI ETARY 384, 315 250, 554 634, 869 -264, 364 370, 505	9.00
11. 00   01100   CAFETERIA   0   0   297. 515   297. 515	10. 00
	11. 00
12. 00   01200   MAI NTENANCE OF PERSONNEL 0 0 0 0	12.00
13. 00   01300   NURSI NG ADMI NI STRATI ON 382, 725 15, 980 398, 705 40, 528 439, 233	13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY   0   0   0   0   15. 00   01500   PHARMACY   577, 320   104, 266   681, 586   61, 134   742, 720	14. 00 15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY   0   0   0   0	16. 00
17. 00   01700  SOCI AL SERVI CE   0   0   0   0	17. 00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 0 0	18. 00
19.00   01900   NONPHYSICIAN ANESTHETISTS   0 0 0 0 0	19. 00
20. 00   02000   NURSI NG SCHOOL	20.00
21. 00   02100   1 &R SERVI CES-SALARY & FRINGES APPRVD   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00 22. 00
23. 00   02300   PARAMED ED PRGM-(SPECIFY)	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 2, 244, 406 1, 177, 950 3, 422, 356 -347, 038 3, 075, 318	30. 00
31.00   03100   INTENSIVE CARE UNIT   0 0 0 0	31. 00
32. 00   03200   CORONARY CARE UNI T	32. 00
33.00   03300   BURN INTENSIVE CARE UNIT   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 00 34. 00
40. 00   04000   SUBPROVI DER - I PF   0   0   0   0	40.00
41.00   04100   SUBPROVI DER - I RF   0 0 0 0 0	41. 00
43. 00   04300   NURSERY   0   0   126, 428   126, 428	43.00
44.00   04400   SKILLED NURSING FACILITY   0   0   0   0   0	44. 00
45. 00   04500   NURSI NG FACILITY	45. 00
46. 00   04600   OTHER LONG TERM CARE   0   0   0   0   0   0   0   0   0	46. 00
50. 00   05000   OPERATING ROOM   887, 529   721, 900   1, 609, 429   101, 243   1, 710, 672	50. 00
51.00   05100   RECOVERY ROOM   0 0 0 0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   0   526, 976   526, 976	52. 00
53. 00   05300   ANESTHESI OLOGY   0   1, 076, 837   1, 076, 837   0   1, 076, 837	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   1, 395, 817   860, 844   2, 256, 661   83, 336   2, 339, 997   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0	54. 00 55. 00
56. 00   05600   RADI 01 SOTOPE   0 0 0 0 0	56. 00
57. 00   05700  CT SCAN	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON 0 0 0 0	59. 00
60. 00   06000   LABORATORY   0   2, 557, 848   2, 557, 848   0   2, 557, 848	60.00
60. 01   06001   BLOOD LABORATORY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60. 01 61. 00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0	62. 00
	63.00
	64. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0	64. 00 65. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0	64. 00 65. 00 66. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0	64. 00 65. 00 66. 00 67. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0	64. 00 65. 00 66. 00 67. 00 68. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0	64. 00 65. 00 66. 00 67. 00 68. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00
63. 00   06300   06300   06300   06300   06400   06400   06400   06400   06400   06400   06400   06400   06400   06400   06500	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
63. 00   06300   06300   06300   06300   06300   06400   06400   06400   06400   06400   065. 00	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
63. 00	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98
63. 00	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
63. 00	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 74. 00 75. 00 76. 98 77. 00
63. 00	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 89. 00
63. 00	64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 90. 00
63. 00	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00 88. 00 89. 00

Health Financial Systems COMMU	JNITY HOSPITAL C	F NOBLE CTY,	I NC	In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		eri od:	Worksheet A	
				rom 01/01/2018 o 12/31/2018		narod:
			'	0 12/31/2010	5/28/2019 10:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
·			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVICES	1, 820, 018	325, 005	2, 145, 023	-4, 253	2, 140, 770	1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	
98.00   09850 OTHER REIMBURSABLE COST CENTERS 99.00   09900 CMHC	0	0			0	98. 00 99. 00
99. 10   09910  CMRC 99. 10   09910  CORF	0	0			0	99. 00
100.00 10000 1&R SERVICES-NOT APPRVD PRGM	0	0			0	
101.00 10100 HOME HEALTH AGENCY	0	0				101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>			) O	0	1101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	O	0	C	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON		0	ď	0		106.00
107. 00 10700 LIVER ACQUISITION	l ol	0	ď	0		107. 00
108.00 10800 LUNG ACQUISITION	o	0	d	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	o	o		0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	o	0	C	0	0	110.00
111.00 11100 ISLET ACQUISITION	o	0	C	0	0	111. 00
113.00 11300 I NTEREST EXPENSE		0	C	0	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	C	0	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	C	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	14, 274, 041	41, 154, 650	55, 428, 691	160	55, 428, 851	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	26, 004	35, 620	61, 624			190. 00
191. 00 19100 RESEARCH	0	0	50.000	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	34, 017	16, 206	50, 223	1, 320		192. 00
193. 00 19300 NONPALD WORKERS	0	0		0		193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0		194. 00
194. 01 07951 PAIN CLINIC	0	0		0		194. 01
194. 02 07952 0CC HEALTH 194. 03 07953  FOUNDATI ON	-260	0	-260	0		194. 02 194. 03
194. 04 07954 PHYSI CLAN OFFI CES	-200	0	-200	-28		194. 03
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	184, 575	295, 870	480, 445	-3, 504	-	
194.06 07956  VACANT SPACE	104, 3/3	290, 0/U	400, 445	3, 504		194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	14, 518, 377	41, 502, 346	56, 020, 723	_	-	
200.00   TOTAL (SOM OF LINES THE CHI DUGIT 177)	14,510,577	71, 302, 340	30, 020, 720	,	30, 020, 723	1200.00

Health FinancialSystemsCOMMUNITY HOSPITRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0146

| Period: | Worksheet A | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/28/2019 10: 28 am

In Lieu of Form CMS-2552-10

				5/28/2019 1	
	Cost Center Description	Adjustments	Net Expenses	0,20,2017	0.20 a
	·	(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-1, 284, 588	360, 933		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	1, 001, 150		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 196, 864	2, 522, 012		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-7, 118, 225	14, 686, 054		5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0		6. 00
7. 00	00700 OPERATION OF PLANT	-2, 264	1, 652, 056		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	162, 897		8. 00
9.00	00900 HOUSEKEEPI NG	0	497, 404		9. 00
10. 00	01000 DI ETARY	-162	370, 343		10. 00
11. 00	01100  CAFETERI A	-222, 707	74, 808		11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0		12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-4, 233	435, 000		13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	0		14. 00
	01500 PHARMACY	-742, 720	0		15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0		16. 00
	01700 SOCI AL SERVI CE	0	0		17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		18. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	0		19. 00
20. 00	02000 NURSI NG SCHOOL	0	0		20. 00
	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDI ATRI CS	51, 884	3, 127, 202		30. 00
	03100 INTENSIVE CARE UNIT	0	0		31. 00
32. 00	03200 CORONARY CARE UNIT	0	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0		40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0		41. 00
43. 00	04300 NURSERY	0	126, 428		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44. 00
45. 00	04500 NURSING FACILITY	0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0		46. 00
	ANCILLARY SERVICE COST CENTERS		4 740 (70		
50.00	05000 OPERATING ROOM	0	1, 710, 672		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	526, 976		52. 00
53.00	05300 ANESTHESI OLOGY	-1, 059, 412	17, 425		53.00
54.00	05400   RADI OLOGY - DI AGNOSTI C	-72, 859	2, 267, 138		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0		56.00
57. 00	05700 CT SCAN	0	0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0 557 040		59. 00
60.00	06000 LABORATORY	0	2, 557, 848		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400 I NTRAVENOUS THERAPY	0 005	400.004		64.00
65. 00	06500 RESPIRATORY THERAPY	-2, 825	690, 996		65. 00
66.00	06600 PHYSI CAL THERAPY	-132, 346	845, 312		66.00
67. 00	06700 OCCUPATIONAL THERAPY	0	364, 130		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	255, 929		68. 00
69. 00	06900 ELECTROCARDI OLOGY		0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	750 724		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	750, 736		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	40.445	478, 714		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-42, 165	2, 470, 268		73.00
74.00	07400 RENAL DI ALYSI S	0	0		74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	(E1 00)		75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	651, 006		76. 98
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0		77. 00
00.00	OUTPATIENT SERVICE COST CENTERS				00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	1 , 0	U E/ 014		89.00
90.00	09000 CLINIC	-456	56, 914		90.00
91.00	09100 EMERGENCY	-3, 969	1, 793, 819		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	OTHER REIMBURSABLE COST CENTERS				
04 00	09400 HOME PROGRAM DIALYSIS	0	0		94. 00

Health FinancialSystemsCOMMUNITY HOSPITRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0146

			5/28/2019 1	
Cost Center Description	Adjustments	Net Expenses		
		or Allocation		
	6.00	7. 00		
95. 00 09500 AMBULANCE SERVI CES	-41, 006	2, 099, 764		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10   09910   CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 I SLET ACQUISITION	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE	0	0		113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-12, 874, 917	42, 553, 934		118. 00
NONREI MBURSABLE COST CENTERS	,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-35, 912	27, 764		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	51, 543		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 00
194. 01 07951 PAIN CLINIC	0	0		194. 01
194. 02 07952 OCC HEALTH	0	0		194. 02
194. 03 07953 FOUNDATI ON	0	-288		194. 03
194. 04 07954 PHYSI CI AN OFFI CES	0	0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	-128, 462	348, 479		194. 05
194. 06 07956 VACANT SPACE	0	0		194. 06
200.00   TOTAL (SUM OF LINES 118 through 199)	-13, 039, 291	42, 981, 432		200. 00

| Peri od: | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/28/2019 10: 28 am

					10 12/31/2010	<u>5/28/2019 10:28 am</u>
		Increases				
	Cost Center	Li ne #	Salary	Other		
	2.00	3. 00	4. 00	5. 00		
1. 00	B - REHAB THERAPY  OCCUPATIONAL THERAPY	67.00	312, 704	51, 426		1.00
2. 00	SPEECH PATHOLOGY	68. 00	219, 784	36, 145		2.00
2.00	0		532, 488	87, 571		2.00
	C - I NSURANCE		002, 100	07,071		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	26, 633		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	14, 306		2. 00
	0		0	40, 939		
	D - EQUIP LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	60, 280		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	76, 799		2.00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	o	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	o	Ö		10.00
11. 00		0.00	o	Ö		11. 00
12.00		0.00	О	0		12. 00
13.00		0.00	О	0		13. 00
14.00		0.00	0	0		14. 00
	0			137, 079		
	F - CLINIC DIETICIAN					
1.00	CLINIC	<u> </u>	<u>5, 4</u> 84	0		1.00
	0		5, 484	0		
1 00	G - EMPLOYEE SALARY BENEFITS	F 00	1 057 (40	0		1 00
1.00	ADMI NI STRATI VE & GENERAL	5. 00	1, 057, 642	0		1.00
2.00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	34, 376	0		2.00
3. 00 4. 00	DI ETARY	10. 00	30, 503 40, 696	0		3. 00 4. 00
5. 00	NURSING ADMINISTRATION	13. 00	40, 528	0		5. 00
6. 00	PHARMACY	15. 00	61, 134	0		6. 00
7. 00	ADULTS & PEDIATRICS	30.00	311, 389	0		7. 00
8. 00	OPERATING ROOM	50.00	119, 451	Ö		8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	147, 807	Ö		9. 00
10.00	RESPI RATORY THERAPY	65. 00	58, 628	Ö		10.00
11. 00	PHYSI CAL THERAPY	66.00	132, 874	O		11.00
12.00	HYPERBARIC OXYGEN THERAPY	76. 98	12, 742	О		12.00
13.00	CLINIC	90.00	3, 621	0		13.00
14.00	EMERGENCY	91.00	142, 227	0		14. 00
16.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	2, 754	0		16. 00
	CANTEEN					
17. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	3, 602	0		17. 00
	0		2, 199, 974	0		
1. 00	H - CAFETERI A CAFETERI A	11 00	171 044	125, 569		1.00
1.00	0	<u>11.</u> 00	17 <u>1, 9</u> 46 171, 946	125, 569		1.00
	I - DEPRECIATION		171, 740	123, 307		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	O	903, 085		1. 00
2.00	OPERATION OF PLANT	7. 00	o	9, 628		2. 00
	0	+		912, 713		
	J - HOME OFFICE SALARIES					
1.00	ADMI NI STRATI VE & GENERAL	5.00	4, 022, 273	0		1. 00
	0		4, 022, 273	0		
4 66	K - LAUNDRY	0.05	اء ا	4.6.007		
1. 00	LAUNDRY & LINEN SERVICE			162, 897		1.00
	0   M - IMPLANTS		0	162, 897		
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	478, 714		1.00
1.00	PATI ENTS	72.00		470, 714		1.00
	0			478, 714		
	N - OB		<u> </u>	,,,,,		
1.00	NURSERY	43.00	107, 624	18, 804		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	448, 596	78, 380		2.00
			556, 220	97, 184		
	P - OTHER		<u> </u>			
1.00		0.00	0	0		1. 00
	0		0			
	Q - PERSONAL PROP TAX					
1.00	CAP REL COSTS-MVBLE EQUIP		•	6, 960		1. 00
	0		0	6, 960		

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

RECLASSIFICATIONS Provider CCN: 15-0146 Period: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 10: 28 am

						5/28/2019 10:	28 am
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	R - SALARY TO OTHER FOR FOUND	DATI ON					
1.00	FOUNDATI ON	194. 03	288	0			1.00
	TOTALS		288	0			
500.00	Grand Total: Increases		7, 488, 673	2, 049, 626			500.00

RECLASSIFICATIONS Provider CCN: 15-0146 Perior

Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Ti me Prepared:

5/28/2019 10: 28 am Decreases Cost Center Li ne # Sal ary 0ther Wkst. A-7 Ref. 6.00 7.00 8.00 9.00 10.00 B - REHAB THERAPY 1.00 1.00 PHYSI CAL THERAPY 66.00 532, 488 87, 571 0 0 2.00 2.00 0.00 532, 488 87, 571 - INSURANCE 1.00 ADMINISTRATIVE & GENERAL 5. 00 40, 939 12 1.00 2.00 0.00 2.00 0 12 ō 40, 939 D - EQUIP LEASE ADMINISTRATIVE & GENERAL 1.00 5.00 15, 057 10 1.00 2 00 OPERATION OF PLANT 7.00 0 3, 183 10 2 00 10.00 3.00 DI ETARY 0 2,061 0 3.00 4.00 ADULTS & PEDIATRICS 30.00 o 5, 023 0 4.00 5.00 OPERATING ROOM 50.00 0 18, 208 0 5.00 RADI OLOGY-DI AGNOSTI C 0 0 6 00 54 00 64 471 6 00 0 7.00 RESPIRATORY THERAPY 65.00 0 2,746 7.00 8.00 PHYSICAL THERAPY 66.00 o 4, 416 0 8.00 HYPERBARIC OXYGEN THERAPY 0 9.00 76.98 0 6, 203 9.00 Ol 0 4, 970 91.00 **IFMERGENCY** 10.00 10.00 11.00 AMBULANCE SERVICES 95.00 0 4, 253 0 11.00 GIFT, FLOWER, COFFEE SHOP & 190.00 702 12.00 12.00 CANTEEN PHYSICIANS' PRIVATE OFFICES 192.00 13.00 0 2.282 0 13.00 14.00 COMMUNITY & VOLUNTEER 194.05 3,504 0 14.00 SERVI CES 137, 079 F - CLINIC DIETICIAN 1.00 DI ETARY 10.00 <u>5, 4</u>84 0 1.00 5, 484 G - EMPLOYEE SALARY BENEFITS EMPLOYEE BENEFITS DEPARTMENT 1 00 4 00 2, 199, 946 0 0 1.00 2.00 IFOUNDATI ON 194.03 28 0 0 2.00 3.00 0.00 0 0 0 3.00 4.00 0.00 0 0 0 4.00 0 5.00 0 0 00 0 5 00 0 6.00 0.00 0 0 6.00 7.00 0.00 0 7.00 0 8.00 0.00 0 0 8.00 0 9.00 0.00 9.00 0 10.00 0.00 0 10.00 11.00 0.00 o 0 11.00 0 0 12.00 12.00 0.00 0 13.00 0.00 0 13.00 14.00 0.00 0 0 14.00 16.00 0.00 0 16.00 17.00 0.00 0 17.00 2, 199, 974 H - CAFETERIA 1.00 10.00 171, 946 125, 569 1.00 DI ETARY 0 171, 946 125, 569 - DEPRECIATION 1.00 CAP REL COSTS-BLDG & FIXT 1. 00 912, 713 9 1.00 2.00 0.00 0 2.00 0 912, 713 J - HOME OFFICE SALARIES 1.00 ADMINISTRATIVE & GENERAL 5.00 4, 022, 273 0 1.00 4, 022, 273 - LAUNDRY HOUSEKEEPI NG 1.00 9.00 0 0 162, 897 0 1.00 162, 897 M - IMPLANTS 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 478, 714 0 1.00 PATI ENTS Ō 478, 714 N - OB 1.00 ADULTS & PEDIATRICS 30.00 556, 220 97, 184 0 1.00 2.00 0.00 0 2.00 556, 220 97, 184 **OTHER** 1.00 0.00 1.00

Heal th	Financial Systems	COMM	IUNITY HOSPITAL	OF NOBLE CTY,	INC	In Lie	eu of Form CMS-	-2552-10
RECLASS	IFICATIONS			Provi der (	CCN: 15-0146	Peri od: From 01/01/2018	Worksheet A-	6
							Date/Time Pro 5/28/2019 10:	epared: : 28 am
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref			
	6. 00	7. 00	8. 00	9. 00	10.00			
	Q - PERSONAL PROP TAX							
1.00	CAP REL_COSTS-BLDG_&_FIXT	1.00	0	<u>6, 9</u> 60	1	3		1. 00
	0		0	6, 960				
	R - SALARY TO OTHER FOR FOUND	DATI ON						
1.00	FOUNDATI ON	194. 03	0	288		0		1. 00
	TOTALS		0	288				
500.00	Grand Total: Decreases		3, 466, 112	6, 072, 187				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 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 755, 392 0 2.00 Land Improvements 0 2.00 ő 3.00 3, 845, 756 56, 100 56, 100 29, 985 3 00 Buildings and Fixtures 0 4.00 Building Improvements 63, 781 C 0 4.00 5.00 Fixed Equipment 405, 024 0 5.00 13, 291, 626 0 6.00 Movable Equipment 985, 919 985, 919 408, 898 6.00 0 7.00 3, 149, 130 60, 043 HIT designated Assets 60, 043 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 21, 510, 709 1, 102, 062 1, 102, 062 438, 883 8.00 9.00 Reconciling Items 2, 879, 370 -1, 127, 626 0 -1, 127, 626 9.00 2, 229, 688 Total (line 8 minus line 9) 18, 631, 339 2, 229, 688 438, 882 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, 392 186, 011 2.00 3, 871, 871 3.00 Buildings and Fixtures 551, 924 3.00 1, 000 4.00 Building Improvements 63, 781 4.00 5.00 Fi xed Equipment 405, 024 27, 526 5.00 Movable Equipment 13, 868, 647 6.00 7, 719, 118 6.00 7.00 HIT designated Assets 3, 209, 173 7.00

22, 173, 888

1, 751, 743

20, 422, 145

8, 485, 579

8, 485, 579

			Т	o 12/31/2018	Date/Time Pre 5/28/2019 10:	pared: 28 am_
		SU	IMMARY OF CAPIT	AL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see instructions)	
	9. 00	10.00	11. 00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	2, 478, 281	0	0	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2. 00
3.00 Total (sum of lines 1-2)	2, 478, 281	0	0	0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	2, 478, 281				1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00 Total (sum of lines 1-2)	0	2, 478, 281				3. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0146	Peri od:	Worksheet A-7
			From 01/01/2018	
				D 1 /T' D 1

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Prep 5/28/2019 10:2	pared: 28 am
	COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 - col.	instructions)		
			2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FLXT	5, 096, 069		-,,		0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	17, 077, 829	·			0	2. 00
3.00 Total (sum of lines 1-2)	22, 173, 898				0	3. 00
	ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY OF CAPITAL		
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
DART III DECONOLILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C  1.00 CAP REL COSTS-BLDG & FIXT				200,000	(0.200	1 00
1.00   CAP REL COSTS-BLDG & FLXT 2.00   CAP REL COSTS-MVBLE EQUIP	0	0		280, 980 903, 085	60, 280 76, 799	1. 00 2. 00
3.00 Total (sum of lines 1-2)	0	0		1, 184, 065		
3.00   Total (Suil Of Titles 1-2)	U	<u> </u>	IUMMARY OF CAPI		137, 079	3.00
Cost Center Description	Interest	Insurance (see	,		Total (2) (sum	
		instructions)	instructions)			
				d Costs (see	through 14)	
	11.00	12.00	13.00	instructions)	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	13.00	
1. 00 CAP REL COSTS-BLDG & FLXT	0	26, 633	-6, 960		360, 933	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP		14, 306			1, 001, 150	2. 00
	()	14, 300		/  (//	1, 001, 1301	1 2.00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0146 Peri od: Worksheet A-8 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4. 00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other В -1, 681 PHARMACY 15.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 O 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -81 ADMINISTRATIVE & GENERAL 7.00 5.00 7.00 Α stations excluded) (chapter 21) 8.00 Tel evi si on and radio servi ce -1, 973 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 Provider-based physician -1 063 381 10.00 10.00 A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 -4, 846, 308 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests -66, 009 CAFETERI A 11.00 14.00 Α Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines 20.00 0.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review OUTILIZATION REVIEW-SNF 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 27.00 2.00 27.00 COSTS-MVBLE EQUIP 28.00 ONONPHYSICIAN ANESTHETISTS 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00

OADULTS & PEDIATRICS

OSPEECH PATHOLOGY

30.00

68.00

0.00

30.99

31.00

32.00

instructions)

30.99

31.00

32.00

therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see

pathology costs in excess of limitation (chapter 14)

A-8-3

Adjustment for speech

CAH HIT Adjustment for

Depreciation and Interest

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0146 Peri od: Worksheet A-8 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 10: 28 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 2.00 3.00 4. 00 5.00 33.00 OTHER ADJUSTMENTS (SPECIFY) 33. 00 0.00 33.01 OTHER ADJUSTMENTS (SPECIFY) 0 0.00 33.01 (3)33.02 TELEPHONE Α -18 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.02 OTHER ADJUSTMENTS (SPECIFY) 33.03 33.03 0.00 PHÝSICIAN RECRUITMENT 33.04 -917 ADMINISTRATIVE & GENERAL 5.00 33.04 Α 33.05 PHARMACY SALES -737, 839 PHARMACY 15.00 33.05 В -2, 196, 846 EMPLOYEE BENEFITS DEPARTMENT 33.06 SELF INSURANCE 4.00 33.06 Α OTHER ADJUSTMENTS (SPECIFY) 33.07 0 00 33 07 33.08 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.08 (3)LOBBY DUES 33.09 Α -4, 380 ADMI NI STRATI VE & GENERAL 5.00 33.09 33 10 LLOUOR -162 ADMINISTRATIVE & GENERAL 5 00 0 33 10 Α OTHER ADJUSTMENTS (SPECIFY) 33.11 0.00 33.11 INTERUNIT SUBSIDY -129, 271 PHYSI CAL THERAPY Α 66.00 33.12 33, 13 OTHER ADJUSTMENTS (SPECIFY) 0.00 33. 13 INTERUNIT SUBSIDY -1, 284, 588 CAP REL COSTS-BLDG & FIXT 33 14 Δ 1.00 33 14 -70, 797 COMMUNITY & VOLUNTEER 33.15 INTERUNIT SUBSIDY 194.05 33.15 SERVI CES INTERUNIT SUBSIDY -13, 405 RADI OLOGY-DI AGNOSTI C 33. 16 54.00 33. 16 Α OTHER OPERATING REVENUE -18, 318 ADMI NI STRATI VE & GENERAL 33 17 5.00 ol 33 17 В OTHER OPERATING REVENUE 33. 18 В -291 OPERATION OF PLANT 7.00 33.18 OTHER OPERATING REVENUE -42, 165 DRUGS CHARGED TO PATIENTS 73.00 33. 19 33.19 В -162 DI ETARY 33. 20 OTHER OPERATING REVENUE В 10.00 33. 20 OTHER OPERATING REVENUE 11.00 33. 21 В -156, 698 CAFETERI A 33. 21 33. 22 OTHER OPERATING REVENUE В -4, 233 NURSING ADMINISTRATION 13.00 33. 22 -3, 200 PHARMACY OTHER OPERATING REVENUE

-874 ADULTS & PEDIATRICS

-59, 454 RADI OLOGY-DI AGNOSTI C

-2, 825 RESPIRATORY THERAPY

-3, 075 PHYSI CAL THERAPY

-41,006 AMBULANCE SERVICES

-57.665 COMMUNITY & VOLUNTEER

52, 758 ADULTS & PEDIATRICS

124, 931 ADMINI STRATI VE & GENERAL

OADMINISTRATIVE & GENERAL

OPHYSICAL THERAPY

-2, 372, 990 ADMINI STRATI VE & GENERAL

CANTEEN

SERVI CES

-35, 912 GIFT, FLOWER, COFFEE SHOP &

-456 CLINIC

-13, 039, 291

15.00

30.00

54.00

65.00

66.00

90.00

95.00

190.00

194.05

30.00

5.00

66.00

5.00

5.00

33.23

33. 25

33. 26

33. 27

33, 28

33 29

33.30

33. 31

33.32

33.33

33.34

33 35

33. 36

50.00

0 33. 24

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В

В

В

В

В

В

В

В

В

Α

Α

Α

Α

Α

TOTAL (sum of lines 1 thru 49)

OTHER OPERATING REVENUE

HOSPITAL ASSESSMENT FEE

(Transfer to Worksheet A,

TELEMETRY CHARGES

LOBBYING EXPENSE

LOBBYING EXPENSE

ADMIN PHYS SALARIES

33. 23

33. 24

33. 25

33.26

33 27

33, 28

33. 29

33.30

33.31

33.32

33.33

33.34

33 35

33.36

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

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

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0146 Period: From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					5/28/2019 10:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	11, 591, 664	9, 300, 996	1. 00
2.00	5. 00	ADMINISTRATIVE & GENERAL	PPG SUBSIDY	0	6, 493, 981	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	642, 995	3. 00
4.00	0.00			0	0	4. 00
5.00	TOTALS (sum of lines 1-4).			11, 591, 664	16, 437, 972	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED 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.

6. 00	В	0. 00 PARKVI EW HEALTH 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10. 00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Heal th	Financial Syste	ems	CO	MMUNITY HOSPITAL OF	NOBLE CTY, INC		In Lieu	u of Form CM:	S-2552-1
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGAN	NIZATIONS AND HOME	Provider CCN: 15		Peri od:	Worksheet A	-8-1
OFFICE	COSTS						From 01/01/2018	İ	
							To 12/31/2018		
								5/28/2019 1	<u>0:28 am</u>
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRE	D AS A RESULT OF TR	ANSACTIONS WITH R	ELATED OF	RGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:							
1.00	2, 290, 668	0							1.00
2.00	-6, 493, 981	0							2.00

\* 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.

3.00

4.00

5.00

nas not	been posted to worksheet A,	cordinals i and/or 2, the amount arrowable should be indicated in cordinal 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	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
8. 00 9. 00		9. 00
10.00		10.00
10. 00 100. 00		100.00

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

0

- 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.

3.00

4.00

5.00

642, 995

-4, 846, 308

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT COMMUNITY HOSPITAL OF NOBLE CTY, INC Provider CCN: 15-0146 

						0 12/31/2018	5/28/2019 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		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	53. 00	ANESTHESI OLOGY	1, 076, 791	1, 058, 791	18, 000	239, 400	151	1. 00
2.00	91. 00	EMERGENCY	30, 000	0	30, 000	211, 500	256	2. 00
3.00	0. 00		0	0	0	0	0	3. 00
4.00	0. 00		0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	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			1, 106, 791	1, 058, 791	48, 000		407	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14. 00	
1. 00		ANESTHESI OLOGY	17, 379		-	0	0	
2.00		EMERGENCY	26, 031	1, 302		0	0	
3.00	0. 00		0	0	0	0	0	0.00
4.00	0. 00		0	0	0	0	0	
5. 00	0. 00		0	0	0	0	0	0.00
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	
200.00			43, 410		0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	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	0			1, 059, 412		1. 00
2. 00		EMERGENCY	0			3, 969		2. 00
3. 00	0.00		0	0		0, 707		3. 00
4. 00	0.00		0	0	0	0		4. 00
5. 00	0.00		0	0	0	0		5. 00
6. 00	0.00		0	0	0	0		6. 00
7. 00	0.00		0	0	0	0		7. 00
8. 00	0.00		0	0	0	0		8. 00
9. 00	0.00		0			0		9. 00
10. 00	0.00		1			0		10.00
200.00	3.00		l ő	43, 410	4, 590	1, 063, 381		200.00
200.00		I	1	1 75,410	7, 370	1,000,001	I	200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 360, 933 360, 933 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1,001,150 1,001,150 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 522, 012 2, 522, 012 4.00 00500 ADMINISTRATIVE & GENERAL 79, 012 5 00 14, 686, 054 15, 549, 084 7.318 776, 700 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 1, 652, 056 30, 528 21,601 48, 833 1, 753, 018 7.00 00800 LAUNDRY & LINEN SERVICE 162, 897 2,626 8.00 8.00 165, 523 497, 404 00900 HOUSEKEEPI NG 3, 799 43, 332 9 00 544, 645 110 9 00 10.00 01000 DI ETARY 370, 343 7,820 8, 368 33, 677 420, 208 10.00 01100 CAFETERI A 11.00 74,808 5,059 23, 389 103, 256 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 607, 185 13.00 435,000 1.064 113, 548 57, 573 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 9, 770 9,770 14.00 01500 PHARMACY 15.00 0 2,881 73, 514 86, 845 163, 240 15.00 01600 MEDICAL RECORDS & LIBRARY 0 4, 401 4, 401 16,00 0 16,00 17 00 01700 SOCIAL SERVICE 0 0 0 Ω 17 00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 18.00 18.00 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 O 19.00 0 0 02000 NURSING SCHOOL 20.00 0 20.00 C 0 0 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 Λ 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 C 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 127, 202 45, 952 46, 751 271, 990 3, 491, 895 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 Ω 0 0 Ω 40.00 41 00 Ω  $\cap$ Λ 41 00 04300 NURSERY 43.00 126, 428 661 2, 935 14, 639 144, 663 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 0 44.00 04500 NURSING FACILITY 45.00 45.00 0 0 04600 OTHER LONG TERM CARE 46.00  $\cap$ 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 710, 672 34, 423 156, 395 136, 973 2, 038, 463 50.00 05100 RECOVERY ROOM 51 00 51 00 C 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 526, 976 4, 242 12, 415 61, 020 604, 653 52.00 53.00 05300 ANESTHESI OLOGY 17, 425 17, 425 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 267, 138 32, 271 397, 823 209, 970 2, 907, 202 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 05700 CT SCAN 0 0 0 57.00 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 58.00 0 05900 CARDIAC CATHETERIZATION 0 59 00 0 59 00 60.00 06000 LABORATORY 2, 557, 848 8, 879 0 0 2, 566, 727 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0 C 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 0 06400 I NTRAVENOUS THERAPY 64.00 64.00 06500 RESPIRATORY THERAPY 805, 821 690, 996 25.876 83.285 65.00 5.664 65 00 66.00 06600 PHYSI CAL THERAPY 845, 312 24, 483 11,098 116, 325 997, 218 66.00 06700 OCCUPATIONAL THERAPY 67.00 364, 130 0 42, 535 406, 665 67.00 06800 SPEECH PATHOLOGY 68.00 255, 929 0 29, 896 285, 825 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 750, 736 750, 736 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 478.714 0 72.00 0 0 478, 714 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 2, 470, 268 C 0 0 2, 470, 268 73.00 07400 RENAL DIALYSIS 0 0 74.00 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 651,006 877 76.98 4,510 18, 100 674, 493 76.98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 C 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 0 Ω 89 00 0 90.00 09000 CLI NI C 56, 914 5, 890 62, 804 90.00 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 91. 00 09100 EMERGENCY 1, 793, 819 19, 243 17, 394 179, 338 2,009,794 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 95.00 09500 AMBULANCE SERVICES 2, 099, 764 247, 566 95.00 Ω 101, 663 2 448 993 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 0 98.00 0 09900 CMHC 0 99 00 99 00 0 0 99. 10 09910 CORF 0 0 0 0 Λ 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 0 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 0 0 106. 00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 0 108 00 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 116. 00 11600 HOSPI CE 0 116, 00 SUBTOTALS (SUM\_OF\_LINES\_1 through 117) 997, 686 42, 553, 934 327, 288 42, 482, 689 118. 00 118.00 2, 487, 876 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 27, 764 3, 255 1, 992 3, 912 36, 923 190. 00 191. 00 19100 RESEARCH 0 191.00 51, 543 192.00 19200 PHYSICIANS' PRIVATE OFFICES 17, 283 1, 160 5, 117 75, 103 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194 00 0 C 0 0 0 194. 01 194. 01 07951 PAIN CLINIC 0 C 0 0 194. 02 07952 OCC HEALTH 0 0 0 0 194. 02 0 194. 03 07953 FOUNDATI ON -288 0 -288 194. 03 0 0 194. 04 07954 PHYSI CI AN OFFI CES 0 194. 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 348, 479 13, 107 312 25, 107 387, 005 194. 05 194.06 07956 VACANT SPACE C 0 194.06 Cross Foot Adjustments 200.00 0 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 42, 981, 432 360, 933 1, 001, 150 2, 522, 012 42, 981, 432 202. 00 Health Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/28/2019 10:28 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 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 15, 549, 084 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 993, 628 7.00 2, 746, 646 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 93.820 28, 694 288, 037 8.00 906, 685 00900 HOUSEKEEPI NG 9.00 308, 710 41, 505 11, 825 9 00 10.00 01000 DI ETARY 238, 178 85, 444 410 28, 945 10.00 11.00 01100 CAFETERI A 58, 527 55, 272 409 18,724 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 C 0 0 13.00 01300 NURSING ADMINISTRATION 344, 159 11, 622 3, 937 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 5,538 106, 747 8, 718 36, 162 14.00 01500 PHARMACY 31, 476 15.00 92.526 10, 663 15.00 01600 MEDICAL RECORDS & LIBRARY 48.084 16.00 2.495 0 16, 289 16.00 17.00 01700 SOCIAL SERVICE 0 C 0 0 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18 00 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 0 0 19.00 02000 NURSING SCHOOL 0 20 00 0 C 0 Λ 20 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 0 O 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 1, 979, 233 502, 059 100, 481 170, 079 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 03200 CORONARY CARE UNIT 32.00 0 C 0 0 Λ 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0 34.00 04000 SUBPROVIDER - IPF 0 0 0 ol 40.00 0 40.00 04100 SUBPROVIDER - IRF 41.00 0 C  $\cap$ 0 Λ 41.00 43.00 04300 NURSERY 81, 996 7, 217 290 2, 445 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 0 0 44.00 C 45 00 04500 NURSING FACILITY 0 Ω 0 0 45 00 0 04600 OTHER LONG TERM CARE 46.00 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 155, 421 0 376, 093 75, 729 127, 407 50.00 05100 RECOVERY ROOM 51.00 C 51.00 n 05200 DELIVERY ROOM & LABOR ROOM 342, 723 52.00 C 46, 345 291 15,700 52.00 05300 ANESTHESI OLOGY 53.00 9,877 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 1, 647, 831 Ω 352, 587 28 705 119, 444 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 C 0 55.00 C 05600 RADI OI SOTOPE 56.00 0 56.00 57.00 05700 CT SCAN 0 0 0 o 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 58 00 58 00 0 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 1, 454, 847 60.00 06000 LABORATORY 97,009 713 32,863 60.00 06001 BLOOD LABORATORY 60.01 60.01 0 C 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 0 0  $\cap$ 0 06500 RESPIRATORY THERAPY 65 00 456, 747 61.880 1, 758 20, 963 65 00 66.00 06600 PHYSI CAL THERAPY 565, 233 267, 491 90, 616 66.00 67.00 06700 OCCUPATIONAL THERAPY 230, 502 0 0 67.00 Ω 06800 SPEECH PATHOLOGY 0 68.00 162,008 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 425, 525 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 271.340 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 400, 173 C 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 75.00 0 07698 HYPERBARIC OXYGEN THERAPY 76.98 382, 309 Ω 49, 272 0 16, 692 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 C 0 0 0 89.00 09000 CLI NI C 90.00 35.598 0 0 0 90.00 91.00 09100 EMERGENCY 1, 139, 171 210, 248 55, 409 71, 225 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0 94.00 95. 00 09500 AMBULANCE SERVICES 1, 388, 114 0 0 n 95 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

| Peri od: | Worksheet B | From 01/01/2018 | Part I | Date/Time Prepared: |

				12/31/2010	5/28/2019 10:	
Cost Center Description	ADMI NI STRATI VE I	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6. 00	7. 00	8. 00	9. 00	
96. 00   09600   DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00  09900  CMHC	0	0	0	0	0	99. 00
99. 10  09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 266, 229	0	2, 379, 045	284, 738	782, 154	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	20, 928	0	35, 563	0	12, 048	
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	42, 569	0	188, 829	3, 299	63, 969	
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
194. 01 07951 PALN CLINIC	0	0	0	0		194. 01
194. 02 07952 OCC HEALTH	0	0	0	0		194. 02
194. 03 07953 FOUNDATI ON	0	0	0	0		194. 03
194. 04 07954 PHYSICIAN OFFICES	0	0	0	0	_	194. 04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	219, 358	0	143, 209	0	48, 514	
194.06 07956 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 through 201)	15, 549, 084	0	2, 746, 646	288, 037	906, 685	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 |

					To 12/31/2018	Date/Time Pre 5/28/2019 10:	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE C		CENTRAL	20 4111
				PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY	
		10.00	11. 00	12. 00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	773, 185					10.00
11. 00	01100 CAFETERI A	0	236, 188	3			11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	( 522	)	0 072 425		12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	6, 532		0 973, 435	166, 935	13. 00 14. 00
15. 00	01500 PHARMACY	0	7, 604			2, 355	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	o	0			0	16. 00
17. 00	01700 SOCIAL SERVICE	o	0		0 0	0	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0 0	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	2	0 0	0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0			0	21. 00
22. 00 23. 00	02200   1&R SERVICES-OTHER PRGM COSTS APPRVD   02300   PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		′1	0  0		23.00
30. 00	03000 ADULTS & PEDIATRICS	773, 185	40, 773	1	0 389, 505	14, 790	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	31. 00
32.00	03200 CORONARY CARE UNIT	0	0		0 0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	)	0 0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0		0 0	0	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	2, 359		0 22, 538	0	41. 00 43. 00
44. 00	04400 SKI LLED NURSING FACILITY	0	2, 309 0		0 22, 330	0	44. 00
45. 00	04500 NURSING FACILITY		0			0	45. 00
46. 00	04600 OTHER LONG TERM CARE	o	0		0 0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	20, 437	1	0 195, 233	23, 064	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	0	9, 834		0 93, 949	0	52.00
54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY - DI AGNOSTI C	0	31, 040			0 5, 179	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		31, 040			0, 177	55. 00
56. 00	05600 RADI OI SOTOPE	o	0			0	56. 00
57.00	05700 CT SCAN	o	0		0 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
		0	0	2	0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	)		0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0	61. 00 62. 00
63. 00	1		0			0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	l ől	0		o o	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	13, 317	·	0 0	4, 361	65.00
66. 00	06600 PHYSI CAL THERAPY	0	13, 235	5	0 0	1, 635	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	6, 771	1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	4, 760	)	0 0	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY	0	0			0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0 80, 623	70. 00 71. 00
71.00	1		0			00, 023	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	l ől	0		o o	6, 317	73. 00
74. 00	07400 RENAL DIALYSIS	o	0		0 0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	3, 785	1	0 36, 162	1, 831	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	)	0 0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS		^	N.		^	00 00
88. 00 89. 00	08800   RURAL HEALTH CLINIC   08900   FEDERALLY QUALIFIED HEALTH CENTER		0	S)		0	88. 00 89. 00
90.00	09000 CLINIC		942			146	90.00
91. 00	09100 EMERGENCY	o	24, 709	1	0 236, 048	14, 636	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
_	OTHER REIMBURSABLE COST CENTERS				_		
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	ין	0 0	0	94. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

973, 435

166, 935 202. 00

5/28/2019 10:28 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL PERSONNEL ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 12.00 13.00 14.00 95. 00 09500 AMBULANCE SERVICES 95. 00 9. 177 0 42, 633 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 00000 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 0 0 99. 00 99. 00 09900 CMHC 0 0 99. 10 09910 CORF 0 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 0 106.00 10600 HEART ACQUISITION 0 0 106. 00 00000 0 0 107.00 107.00 10700 LIVER ACQUISITION 0 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113. 00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 115.00 0 0 0 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 773, 185 228, 731 0 973, 435 164, 114 118. 00 118.00 NONREI MBURSABLE COST CENTERS 1, 690 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 710 0 0 191. 00 19100 RESEARCH 00000000 0 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 122 192. 00 1, 352 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 C 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 00 C 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 0 0 194. 02 0 194. 03 07953 FOUNDATION 0 0 194. 03 1, 692 194. 04 07954 PHYSICIAN OFFICES 0 194. 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 1,009 194.05 3, 703 194.06 07956 VACANT SPACE 0 0 194.06 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201. 00

773, 185

236, 188

202.00

TOTAL (sum lines 118 through 201)

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/28/2019 10:28 am OTHER GENERAL SERVI CE **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSI CI AN Cost Center Description (SPECIFY) RECORDS & **ANESTHETISTS** LI BRARY 19.00 15.00 16.00 17.00 18.00 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 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 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 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 307, 864 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 71, 269 16.00 01700 SOCIAL SERVICE 17 00 0 17 00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 C 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 O 19.00 19.00 0 0 02000 NURSING SCHOOL 20.00 0 20.00 0 02100 | &R SERVICES-SALARY & FRINGES APPRVD 0 21 00 Ω 21 00 0 0 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 C 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4.713 0 0 30.00 162 0 31.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 03200 CORONARY CARE UNIT 0 0 32.00 0 0 0 0 0 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 34.00 C 0 34.00 0 04000 SUBPROVIDER - IPF 40.00 0 0 0 40.00 04100 SUBPROVIDER - IRF 0 41.00 41.00 0 43.00 04300 NURSERY 194 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 C 0 44 00 04500 NURSING FACILITY 0 0 0 45.00 45.00 0 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 6, 923 50.00 05000 OPERATING ROOM 11, 754 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 821 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0 53.00 905 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 25 16, 620 0 0 0 0 0 0 0 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0 0 56.00 05600 RADI OI SOTOPE C 0 56.00 0 57.00 05700 CT SCAN C 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 0 06000 LABORATORY 0 60.00 8, 450 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 C 0 0 0 0 0 0 0 0 0 0 0 0 0 62.00 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 3,072 65.00 0 66 00 06600 PHYSI CAL THERAPY 86 1 083 0 0 66 00 06700 OCCUPATIONAL THERAPY 0 0 67.00 396 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 263 0 68.00 0 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 70 00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2,718 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 900 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 291, 863 7.318 0 0 73.00 07400 RENAL DIALYSIS 0 74 00 0 C 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 C 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.98 1,627 0 76.98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 0 89.00 0 0 90 00 09000 CLI NI C 0 67 0 90.00 91.00 09100 EMERGENCY 0 0 0 91.00 1, 174 11, 334 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146

			1	0 12/31/2018	5/28/2019 10: 28 am	
				OTHER GENERAL	97 297 29 17 191 29 diii	ĺ
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	(SPECLEY)	NONPHYSI CI AN	
·		RECORDS &		, ,	ANESTHETI STS	
		LI BRARY				
	15. 00	16. 00	17. 00	18. 00	19. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	1		0 94.00	
95. 00 09500 AMBULANCE SERVICES	1, 675	3, 865	0	0	0 95.00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0 97.00	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00	
99. 00 09900 CMHC	0	0	0	0	0 99.00	
99. 10   09910   CORF	0	0	0	0	0 99. 10	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101. 00	
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	_		0 105. 00	
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 106. 00	
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00	
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00	
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00	
111.00   11100   I SLET ACQUI SI TI ON	0	0	0	0	0 111.00	
113.00 11300 INTEREST EXPENSE					113. 00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0		0 115.00	
116. 00 11600 HOSPI CE	0	0	0		116. 00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	306, 739	71, 269	0	0	0 118. 00	
NONREI MBURSABLE COST CENTERS			1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			0 190.00	
191. 00 19100 RESEARCH	0	Ü	0	0	0 191.00	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	Ü		0	0 192.00	
193. 00 19300 NONPALD WORKERS	0	Ü		0	0 193. 00	
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	Ü		0	0 194. 00	
194. 01 07951 PALN CLINIC	0	Ü		0	0 194. 01	
194. 02 07952 OCC HEALTH	0	Ü		0	0 194. 02	
194. 03 07953 FOUNDATION	0	0	1	0	0 194. 03	
194. 04 07954 PHYSI CI AN OFFI CES	0	0	1	0	0 194. 04	
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	1, 125	0	1	0	0 194. 05	
194. 06 07956 VACANT SPACE	0	Ü	1 0	0	0 194. 06	
200.00 Cross Foot Adjustments					0 200. 00	
201.00 Negative Cost Centers	207.0(4	71 040		0	0 201.00	
202.00   TOTAL (sum lines 118 through 201)	307, 864	71, 269	0	0	0 202. 00	

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am INTERNS & RESIDENTS NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER PARAMED ED Subtotal Cost Center Description Y & FRINGES PRGM COSTS PRGM 24.00 20.00 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 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 16.00 01700 SOCIAL SERVICE 17.00 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18 00 18 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02000 NURSING SCHOOL 20.00 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD O 22 00 22 00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS n O 7, 466, 875 30 00 0 0 0 31.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 0 03200 CORONARY CARE UNIT 0 32.00 32.00 0 0 33.00 03300 BURN INTENSIVE CARE UNIT 00000 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT Ω 0 34 00 0 34 00 0 0 40.00 04000 SUBPROVI DER - I PF 0 0 40.00 04100 SUBPROVIDER - IRF 0 0 41.00 0 41.00 0 43.00 04300 NURSERY 0 0 261, 702 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 0 44 00 45.00 04500 NURSING FACILITY 0 C 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50 00 0 05000 OPERATING ROOM 0 0 0 4, 030, 524 50 00 05100 RECOVERY ROOM 0 0 51.00 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 0000000000 0 0 0 1, 114, 316 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0 28, 207 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C Ω 5, 108, 633 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 0 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 57.00 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 0 Ω 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 06000 LABORATORY 0 0 4, 160, 609 60.00 60.00 0 60.01 06001 BLOOD LABORATORY C 0 Ω 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 62.00 0 0 06300 BLOOD STORING, PROCESSING & TRANS 63.00 0 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 00000000 0 1, 367, 919 65.00 0 06600 PHYSI CAL THERAPY 0 1, 936, 597 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 644, 334 67.00 68.00 0 06800 SPEECH PATHOLOGY C 0 452, 856 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 259, 602 71.00 C 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 750, 954 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 4, 175, 939 73.00

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99, 557

3, 773, 748

09000 CLI NI C

09100 EMERGENCY

07400 RENAL DIALYSIS

07500 ASC (NON-DISTINCT PART)

08800 RURAL HEALTH CLINIC

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

07700 ALLOGENEIC STEM CELL ACQUISITION

08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

74 00

75.00

76.98

77.00

88.00

89.00

90.00

91 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 Provider CCN: 15-0146 | Peri od: | Worksheet B | From 01/01/2018 | Part I | Date/Time Prepared: |

				12/31/2010	5/28/2019 10:	
		INTERNS &	RESI DENTS			
Cost Center Description	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
		Y & FRINGES	PRGM COSTS	PRGM		
	20. 00	21. 00	22. 00	23. 00	24. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	1 , 00
95. 00  09500 AMBULANCE SERVICES	0	0	0	0	3, 894, 457	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10  09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	o	0	101.00
SPECIAL PURPOSE COST CENTERS						1
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	o	o	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	o	o	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	o	ol	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	o	ol	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	ol ol	ol	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	o	ol		111.00
113. 00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	ol	0	115. 00
116. 00 11600 HOSPI CE	0	_		ol		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	o	ol	41, 693, 000	
NONREI MBURSABLE COST CENTERS			<u> </u>	<u> </u>	11, 070, 000	1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	107, 862	190 00
191. 00 19100 RESEARCH	0	0		ő		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		Ö	375, 243	
193. 00 19300 NONPALD WORKERS	0	0		Ö		193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	ĺ		Ö		194. 00
194. 01 07951 PAIN CLINIC	0	0		0		194. 01
194. 02 07952  OCC   HEALTH	0	0		0		194. 02
194. 03 07953 FOUNDATI ON		0				194. 02
194. 04 07954 PHYSI CI AN OFFI CES		0		0		194. 03
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0		o o	803, 923	
194. 06 07956 VACANT SPACE				0		194. 05
				o O		200. 00
				o O		200.00
1 1 3				0		
202.00   TOTAL (sum lines 118 through 201)	1	0	이	υĮ	42, 981, 432	1202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Tim Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146

				10	12/31/2018	Date/lime Prepared: 5/28/2019 10:28 am
	Cost Center Description	Intern &	Total	<u> </u>	<u> </u>	
		Residents Cost				
		& Post Stepdown				
		Adjustments				
	JOSUS DE LA COLOR	25. 00	26. 00			
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	T				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL					5. 00
6. 00 7. 00	00600 MAI NTENANCE & REPAIRS 00700 OPERATION OF PLANT					6.00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00 12. 00	01100   CAFETERI A   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 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE					16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)					18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS					19. 00
20. 00	02000 NURSI NG SCHOOL					20. 00
21. 00 22. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD   02200   &R SERVICES-OTHER PRGM COSTS APPRVD					21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)					23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	1	0	7, 466, 875			30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0			31.00
33. 00	03300 BURN INTENSIVE CARE UNIT		o			33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	O	О			34. 00
40. 00	04000 SUBPROVI DER – I PF	0	0			40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0 261, 702			41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0			44. 00
45.00	04500 NURSING FACILITY	0	0			45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0			46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	4, 030, 524			50. 00
51. 00	05100 RECOVERY ROOM	O	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 114, 316			52. 00
53. 00 54. 00	05300  ANESTHESI OLOGY 05400  RADI OLOGY-DI AGNOSTI C	0	28, 207 5, 108, 633			53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0			55. 00
56. 00	05600 RADI OI SOTOPE	O	О			56. 00
57. 00		0	0			57. 00
	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION		0			58. 00 59. 00
60. 00	1 1	o	4, 160, 609			60. 00
60. 01	06001 BLOOD LABORATORY	0	O			60. 01
61.00	1		0			61.00
62. 00 63. 00	1 1		0			62. 00 63. 00
64. 00	1 1	o	Ö			64. 00
65. 00	1	0	1, 367, 919			65. 00
66. 00 67. 00		0	1, 936, 597			66. 00 67. 00
68. 00			644, 334 452, 856			68. 00
69. 00	1	o	0			69. 00
70. 00	1 1	0	0			70. 00
71. 00 72. 00		0	1, 259, 602 750, 954			71. 00 72. 00
72.00	l l		4, 175, 939			73. 00
74. 00	07400 RENAL DIALYSIS	0	0			74. 00
75. 00		0	0			75. 00
76. 98 77. 00	07698 HYPERBARI C OXYGEN THERAPY 07700 ALLOGENEI C STEM CELL ACQUISITION	0	1, 166, 171 0			76. 98 77. 00
, , , , , , , , , , , , , , , , , , , ,	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U			//.00
	08800 RURAL HEALTH CLINIC	0	0			88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	00 557			89. 00
90. 00 91. 00	1	0	99, 557 3, 773, 748			90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		5, 7, 5, 740			92. 00
	·	,	•			·

201. 00

202.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 000000 94.00 09500 AMBULANCE SERVICES 95.00 3, 894, 457 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 C 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 09900 CMHC 0 99.00 99.00 99. 10 09910 CORF 0 99.10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 105.00 106. 00 10600 HEART ACQUISITION 0 106. 00 00000 107. 00 10700 LIVER ACQUISITION 107. 00 0 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 110.00 0 111.00 11100 I SLET ACQUISITION 0 111.00 113. 00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 115 00 116. 00 11600 HOSPI CE 0 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 41, 693, 000 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 107, 862 0 190 00 191. 00 19100 RESEARCH 000000000000 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 375, 243 192. 00 193. 00 19300 NONPALD WORKERS 193. 00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194. 00 0 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 194. 02 194. 03 07953 FOUNDATION 1, 404 194. 03 194. 04 07954 PHYSICIAN OFFICES 194 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 803, 923 194. 05 194.06 07956 VACANT SPACE 194. 06 0 Cross Foot Adjustments 200.00 200.00 0

42, 981, 432

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

5. 00       00500   ADMI NI STRATI VE & GENERAL       2, 343, 335       79, 012       7, 318       2, 429, 665         6. 00       00600   MAI NTENANCE & REPAI RS       0       0       0       0         7. 00       00700   OPERATI ON OF PLANT       0       30, 528       21, 601       52, 129         8. 00       00800   LAUNDRY & LI NEN SERVI CE       0       2, 626       0       2, 626         9. 00       00900   HOUSEKEEPI NG       0       3, 799       110       3, 909         10. 00       01000   DI ETARY       0       7, 820       8, 368       16, 188         11. 00       01100   CAFETERI A       0       5, 059       0       5, 059         12. 00       01200   MAI NTENANCE OF PERSONNEL       0       0       0       0         13. 00       01300   NURSI NG ADMI NI STRATI ON       0       1, 064       113, 548       114, 612         14. 00       01400   CENTRAL SERVI CES & SUPPLY       0       9, 770       0       9, 770	1. 00 2. 00 0 4. 00 0 5. 00 0 6. 00 0 7. 00 0 8. 00 0 10. 00 0 11. 00 0 12. 00 0 13. 00 0 14. 00 0 15. 00 0 16. 00 0 17. 00 0 18. 00 0 17. 00 0 18. 00 0 19. 00 0 19. 00 0 19. 00
Assigned New Capital Related Costs  O 1.00 2.00 2A 4.00    GENERAL SERVICE COST CENTERS	2.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 10.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
Assigned New Capital Related Costs  O 1.00 2.00 2A 4.00    GENERAL SERVICE COST CENTERS	2.00 0 4.00 0 5.00 0 6.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
Capi tal   Rel ated Costs   O   1.00   2.00   2A   4.00	2.00 0 4.00 0 5.00 0 6.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
Related Costs   O	2.00 0 4.00 0 5.00 0 6.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
CENERAL SERVICE COST CENTERS   O	2.00 0 4.00 0 5.00 0 6.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
1. 00	2.00 0 4.00 0 5.00 0 6.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
2.00   00200   CAP REL COSTS-MVBLE EQUIP   4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   0   0   0   0   0   0   0   0   0	2.00 0 4.00 0 5.00 0 6.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0
5. 00       00500       ADMINISTRATIVE & GENERAL       2, 343, 335       79, 012       7, 318       2, 429, 665         6. 00       00600       MAINTENANCE & REPAIRS       0       0       0       0         7. 00       00700       OPERATI ON OF PLANT       0       30, 528       21, 601       52, 129         8. 00       00800       LAUNDRY & LI NEN SERVI CE       0       2, 626       0       2, 626         9. 00       00900       HOUSEKEEPI NG       0       3, 799       110       3, 909         10. 00       01000       DI ETARY       0       7, 820       8, 368       16, 188         11. 00       01100       CAFETERI A       0       5, 059       0       5, 059         12. 00       01200       MAI NTENANCE OF PERSONNEL       0       0       0       0         13. 00       01300       NURSI NG ADMINISTRATION       0       1, 064       113, 548       114, 612         14. 00       01400       CENTRAL SERVI CES & SUPPLY       0       9, 770       0       9, 770	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
6. 00	0 6.00 0 7.00 0 8.00 0 9.00 0 10.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
7. 00 00700 OPERATI ON OF PLANT 0 30, 528 21, 601 52, 129 8. 00 00800 LAUNDRY & LI NEN SERVI CE 0 2, 626 0 2, 626 9. 00 00900 HOUSEKEEPI NG 0 3, 799 110 3, 909 10. 00 01000 DI ETARY 0 7, 820 8, 368 16, 188 11. 00 01100 CAFETERI A 0 5, 059 0 5, 059 12. 00 01200 MAI NTENANCE OF PERSONNEL 0 0 0 0 0 0 13. 00 01300 NURSI NG ADMI NI STRATI ON 0 14. 00 01400 CENTRAL SERVI CES & SUPPLY 0 9, 770 0 9, 770	0 7.00 0 8.00 0 9.00 10.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 17.00 0 18.00 0 19.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE   0   2, 626   0   2, 626   9. 00   00900   HOUSEKEEPI NG   0   3, 799   110   3, 909   10. 00   10100   DI ETARY   0   7, 820   8, 368   16, 188   11. 00   01100   CAFETEI A   0   5, 059   0   5, 059   12. 00   01200   MAI NTENANCE OF PERSONNEL   0   0   0   0   0   0   0   0   0	0 8.00 0 9.00 10.00 0 11.00 0 12.00 13.00 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
10. 00     01000     DI ETARY     0     7,820     8,368     16,188       11. 00     01100     CAFETERI A     0     5,059     0     5,059       12. 00     01200     MAI NTENANCE OF PERSONNEL     0     0     0     0       13. 00     01300     NURSI NG ADMI NI STRATI ON     0     1,064     113,548     114,612       14. 00     01400     CENTRAL SERVI CES & SUPPLY     0     9,770     0     9,770	0 10.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
11. 00     01100 CAFETERIA     0     5, 059     0     5, 059       12. 00     01200 MAI NTENANCE OF PERSONNEL     0     0     0     0       13. 00     01300 NURSI NG ADMI NI STRATI ON     0     1, 064     113, 548     114, 612       14. 00     01400 CENTRAL SERVI CES & SUPPLY     0     9, 770     0     9, 770	0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
12. 00     01200     MAI NTENANCE OF PERSONNEL     0     0     0       13. 00     01300     NURSI NG ADMI NI STRATI ON     0     1,064     113,548     114,612       14. 00     01400     CENTRAL SERVI CES & SUPPLY     0     9,770     0     9,770	0 12.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
13. 00   01300   NURSI NG ADMI NI STRATI ON 0 1, 064 113, 548 114, 612 14. 00   01400   CENTRAL SERVI CES & SUPPLY 0 9, 770 0 9, 770	0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 9,770 0 9,770	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	15. 00 16. 00 17. 00 18. 00 19. 00
	16. 00 17. 00 18. 00 0 19. 00
	0 17.00 0 18.00 0 19.00
	0 18.00 0 19.00
19.00   01900   NONPHYSI CI AN ANESTHETI STS   0   0   0   0	20.00
	0 21.00
	0 22.00
	0 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   03000   ADULTS & PEDI ATRI CS   0   45,952   46,751   92,703	30.00
	0 31.00
	0 32.00
	0 33.00
34.00 O3400 SURGICAL INTENSIVE CARE UNIT O O O O	0 34.00
	0 40.00
	0 41.00
	0 43.00
	0 44.00
	0 45. 00 0 46. 00
ANCI LLARY SERVI CE COST CENTERS	1 40.00
	50.00
	0 51.00
	0 52.00
53. 00   05300   ANESTHESI OLOGY	0 53.00
54. 00   05400   RADI 0LOGY-DI AGNOSTI C   0   32, 271   397, 823   430, 094   55. 00   05500   RADI 0LOGY-THERAPEUTI C   0   0   0   0	0 54.00 0 55.00
56. 00   05600  RADI 0LOGT - I HERAPEUTI C	0 56.00
	0 57.00
	0 58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON 0 0 0	59.00
	0 60.00
	0 60. 01
61.00   O6100   PBP   CLI NI CAL LAB SERVI CES-PROM ONLY   O	61.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0   0	0 62.00
	0 63.00
	0 65.00
66.00   06600  PHYSI CAL THERAPY   0   24, 483   11, 098   35, 581	0 66.00
	0 67.00
68. 00   06800   SPEECH PATHOLOGY   0   0   0	0 68.00
	0 69.00
	0 70.00
	0 71.00
	0 72.00 0 73.00
	0 74.00
	0 75.00
	0 76. 98
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0	0 77.00
OUTPATIENT SERVICE COST CENTERS	
	0 88. 00
	0 89.00
	0 90.00 0 91.00
71. 00   07. 17. 243  17. 374  30, 037	71 71.00

194. 04 07954 PHYSICIAN OFFICES

194.06 07956 VACANT SPACE

200.00

201.00

202.00

194. 05 07955 COMMUNITY & VOLUNTEER SERVICES

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

0 194. 04

0 194. 05

0 194. 06

0 201. 00

0 202.00

200.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **BENEFITS** Assigned New Capi tal DEPARTMENT Related Costs 0 1.00 2.00 2A 4.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 00000 95.00 09500 AMBULANCE SERVICES 0 101, 663 101, 663 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97 00 Ω O 0 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 0 0 98.00 99. 00 09900 CMHC 0 0 0 99.00 0 0 0 99. 10 09910 CORF 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 C 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 105, 00 000000 0 0 106.00 10600 HEART ACQUISITION 0 0 0 106. 00 107.00 10700 LIVER ACQUISITION 0 0 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 109.00 109.00 10900 PANCREAS ACQUISITION 0 Ω 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 997, 686 2, 343, 335 327, 288 3, 668, 309 118.00 0 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 255 1, 992 5, 247 0 190. 00 191. 00 19100 RESEARCH 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1, 160 0 192. 00 17, 283 18, 443 193. 00 19300 NONPALD WORKERS 0 0 193. 00 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 00 0 194. 01 07951 PAIN CLINIC 0 0 194. 01 0 0 194. 02 07952 OCC HEALTH 0 0 0 194 02 C 194. 03 07953 FOUNDATI ON 0 194. 03 C 0 0

0

0

2.343.335

13, 107

360, 933

0

0

13, 419

3, 705, 418

0

0

312

1, 001, 150

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 10:28 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 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 2, 429, 665 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 207, 390 7.00 155, 261 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 14.660 0 2.167 19.453 8.00 00900 HOUSEKEEPI NG 56,080 9.00 48.238 0 3.134 799 9 00 10.00 01000 DI ETARY 37, 217 6, 452 28 1, 790 10.00 11.00 01100 CAFETERI A 9, 145 4, 173 28 1, 158 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12 00 0 C C 0 0 13.00 01300 NURSING ADMINISTRATION 53, 777 878 0 244 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 865 8,060 589 2, 237 14.00 01500 PHARMACY 15.00 2.377 14.458 660 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 390 3.631 1,008 16.00 17.00 01700 SOCIAL SERVICE 0 C 0 0 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 18 00 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 0 19.00 02000 NURSING SCHOOL 0 0 20 00 C 0 Ω 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 C 0 0 O 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 309, 282 37, 908 6, 783 10, 518 30.00 03100 INTENSIVE CARE UNIT 31.00 C 31.00 0 03200 CORONARY CARE UNIT 32.00 0 C 0 0 Λ 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0 34.00 04000 SUBPROVIDER - IPF o 0 0 0 40.00 0 40.00 04100 SUBPROVIDER - IRF 0 41.00 0 C 0 Λ 41.00 43.00 04300 NURSERY 12,813 0 545 20 151 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 0 44.00 0 0 45 00 04500 NURSING FACILITY 0 Ω 0 0 45 00 0 04600 OTHER LONG TERM CARE 46.00 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 180, 543 50.00 05000 OPERATING ROOM 0 28.398 7. 880 50.00 5.115 05100 RECOVERY ROOM 51.00 C Λ 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 53, 553 C 3, 499 20 971 52.00 05300 ANESTHESI OLOGY 53.00 1,543 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 257, 485 Ω 7, 388 54 00 26, 623 939 1. 05500 RADI OLOGY-THERAPEUTI C 55.00 C 0 55.00 C 0 05600 RADI OI SOTOPE 0 56.00 0 56.00 57.00 05700 CT SCAN 0 0 0 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 58 00 58 00 Ω 0 59.00 05900 CARDIAC CATHETERIZATION C 0 0 59.00 60.00 06000 LABORATORY 227, 330 7.325 48 2,033 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 0 C 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 C 0 06500 RESPIRATORY THERAPY 1, 297 65 00 71.370 Ω 4 672 119 65 00 66.00 06600 PHYSI CAL THERAPY 88, 322 20, 197 5,605 66.00 67.00 06700 OCCUPATIONAL THERAPY 36, 018 0 0 O 67.00 06800 SPEECH PATHOLOGY 0 68.00 25, 315 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 66, 491 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 42.399 0 0 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 218, 787 C 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0 0 75.00 0 0 07698 HYPERBARIC OXYGEN THERAPY 76.98 59, 738 Ω 3,720 0 1,032 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 C 0 0 0 89.00 09000 CLI NI C 90.00 5, 562 0 0 0 90.00 91.00 09100 EMERGENCY 178,003 15, 875 3, 742 4, 405 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0 94.00 95. 00 09500 AMBULANCE SERVICES 216, 902 0 0 95.00 n

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2018 Part II 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am ADMINISTRATIVE MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS** LINEN SERVICE **PLANT** 5.00 6.00 7.00 8.00 9.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96. 00 0 n 0000 0 97.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD C 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00 0 09900 CMHC 0 99.00 0 0 99.00 0 99. 10 09910 CORF 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY ol 0 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUISITION 0 105, 00 0 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 0 106. 00 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 108. 00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00

111.00 11100 | SLET ACQUISITION 0 0 111.00 0 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 116. 00 11600 HOSPI CE 0 116.00 0 0 SUBTOTALS (SUM OF LINES 1 through 117) 2, 385, 467 179, 634 19, 230 48, 377 118. 00 118.00 0 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 745 190. 00 3, 270 2, 685 0 191. 00 19100 RESEARCH 0 191.00 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 6,652 0 14, 258 223 3, 957 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193. 00 0 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 0 0 0 OI 0 194. 01 194. 01 07951 PAIN CLINIC 0 0 194. 02 07952 OCC HEALTH 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 0 0 194. 03 0 0 194. 04 07954 PHYSICIAN OFFICES 0 0 0 194. 04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 3, 001 194. 05 34, 276 10, 813 194. 06 07956 VACANT SPACE 0 0 194.06

2, 429, 665

0

0

0

19, 453

207, 390

200.00

0 201.00

56, 080 202. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC Provider CCN: 15-0146

					To 12/31/2018	Date/Time Pre 5/28/2019 10:	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O	F NURSING ADMINISTRATION	CENTRAL SERVICES &	
						SUPPLY	
	GENERAL SERVI CE COST CENTERS	10.00	11. 00	12. 00	13. 00	14. 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						5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	61, 675					9. 00 10. 00
11. 00	01100 CAFETERI A	01, 675	19, 563				11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL		17, 309		0		12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	o	541		0 170, 052		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	o	0		o o	21, 521	14. 00
15. 00	01500 PHARMACY	0	630		0 0	304	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	)	0 0	0	16. 00
17. 00	+ +	0	0	1	0 0	0	17. 00
18.00		0	0	1	0 0	0	18.00
19. 00	+ I	0	0			0	19.00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0			0	20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		0			0	22.00
23. 00	1 1		0			0	23. 00
20.00	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		1	<u> </u>		20.00
30.00	03000 ADULTS & PEDIATRICS	61, 675	3, 377		0 68, 044	1, 907	30.00
31.00	03100 INTENSIVE CARE UNIT	o	0	)	0 0	0	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0		0 0	0	32. 00
33. 00	1	0	0	)	0 0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	1	0 0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	1	0 0	0	40.00
41. 00		0	105		0 0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	195		0 3, 937	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	0			0	45. 00
46. 00	04600 OTHER LONG TERM CARE		0			0	46. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>			<u> </u>		10.00
50.00		0	1, 693		0 34, 106	2, 973	50.00
51.00	05100 RECOVERY ROOM	o	0	)	o o	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	815		0 16, 412	0	52. 00
53.00		0	0	)	0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 571		0 0	668	54.00
55. 00	+ +	0	0	1	0 0	0	55. 00
56.00	05600   RADI OI SOTOPE	0	0			0	56.00
57. 00 58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0			0	57. 00 58. 00
59. 00	1 1		0			0	59.00
60.00	I I		0		ol ol	0	60.00
60. 01		o	0	,	o o	0	60. 01
61.00							61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	O	0	)	0 0	0	62. 00
63. 00		0	0		0 0	0	63. 00
64. 00		0	0	1	0 0	0	64. 00
65. 00		0	1, 103		0 0	562	65.00
66.00	I I	0	1, 096	1		211	66.00
67. 00 68. 00		0	561 394		0	0	67. 00 68. 00
69. 00	1 1		0			0	69. 00
70. 00	I I	0	0		o n	0	70.00
71. 00	1 1	o	0	,	o o	10, 393	71. 00
72. 00	1 1		0		o o	0	72. 00
73.00	1	o	0		o  o	814	73. 00
74. 00		0	0		0 0	0	74. 00
75. 00		0	0		0 0	0	75. 00
76. 98		0	314	1	0 6, 317	236	76. 98
77. 00		0	0		0 0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		^	1		0	88. 00
89. 00	1 1		0			0	89.00
90.00	+ I		78		ol ol	19	90.00
91. 00	+ I	o o	2, 047	l .	0 41, 236	1, 887	91.00
92. 00	1 1						92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	1	0 0	0	94. 00

COMMUNITY HOSPITAL OF NOBLE CTY, INC

Provider CCN: 15-0146
From 01/01/2018
To 12/31/2018
DIETARY

CAFETERIA MAINTENANCE OF NURSING

In Lieu of Form CMS-2552-10
Worksheet B
Part II
Date/Time Prepared:
5/28/2019 10: 28 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Cost Center Description

Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
	10.00	44.00	10.00	10.00	SUPPLY	
or as learned MIRIT MASS OFFICE OFFI	10.00	11. 00	12.00	13.00	14.00	05.00
95. 00   09500   AMBULANCE   SERVI CES	0	3, 530	0	0	1, 183	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00   09900   CMHC	0	0	0	0	0	99. 00
99. 10   09910   CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	61, 675	18, 945	0	170, 052	21, 157	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	112	0	0	16	192. 00
193. 00 19300 NONPAI D WORKERS	0	0	0	0	0	193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 PAIN CLINIC	0	0	0	0	0	194. 01
194. 02 07952 OCC HEALTH	0	0	0	0	0	194. 02
194. 03 07953 FOUNDATI ON	0	140	0	0	0	194. 03
194. 04 07954 PHYSI CI AN OFFI CES	0	0	0	0	0	194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	0	307	0	0	130	194. 05
194. 06 07956 VACANT SPACE	0	0	0	0	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	O	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	61, 675	19, 563	0	170, 052	21, 521	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 10: 28 am

				72/31/2010	5/28/2019 10:	
				OTHER GENERAL SERVICE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	(SPECIFY)	NONPHYSI CI AN	
,		RECORDS &			ANESTHETI STS	
	45.00	LI BRARY	47.00	10.00	10.00	
GENERAL SERVICE COST CENTERS	15. 00	16. 00	17. 00	18. 00	19. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 OO200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMINISTRATIVE & GENERAL						5.00
6.00   00600   MAI NTENANCE & REPAI RS 7.00   00700   OPERATI ON OF PLANT						6. 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						11.00
12. 00 O1200 MAINTENANCE OF PERSONNEL 13. 00 O1300 NURSING ADMINISTRATION						12. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY	94, 824					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	9, 430	1			16. 00
17. 00 01700 SOCIAL SERVICE	0	0		0		17. 00
18.00   01850 OTHER GENERAL SERVICE (SPECIFY) 19.00   01900   NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00   02000   NURSI NG SCHOOL	o	0	Ö	Ö	Ü	20.00
21.00   02100   &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21. 00
22.00   02200   I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0		0		22. 00
23. 00   02300   PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23. 00
30.00 O3000 ADULTS & PEDIATRICS	50	626	0	0		30.00
31. 00 03100   NTENSIVE CARE UNIT	0	0	1	Ö		31. 00
32.00 03200 CORONARY CARE UNIT	0	0	0	0		32. 00
33. 00   03300   BURN INTENSIVE CARE UNIT	0	0		0		33. 00
34. 00   03400   SURGI CAL I NTENSI VE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF	0	0		0		34.00
41. 00   04100   SUBPROVI DER - 1 FF		0		0		40. 00 41. 00
43. 00   04300   NURSERY	o	26		Ō		43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0		44. 00
45. 00   04500   NURSI NG FACI LITY	0	0		0		45. 00
46. 00 O4600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0		46. 00
50. 00 05000 OPERATING ROOM	3, 620	919	O	0		50.00
51.00 05100 RECOVERY ROOM	0	0	0	0		51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	109		0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	120		0		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	8	2, 175 0	0	0		54. 00 55. 00
56. 00 05600 RADI OI SOTOPE	0	0	ő	0		56. 00
57.00 05700 CT SCAN	0	0	0	0		57. 00
58.00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	0		0		58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	1 122		0		59.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY		1, 122 0	0	0		60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		J		61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	0	0 408		0		64. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY	26	144	1	0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	53	1	Ō		67. 00
68.00 06800 SPEECH PATHOLOGY	0	35	0	0		68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	0	0		69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 361		0		70. 00 71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	119		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	89, 896	971		0		73. 00
74.00 07400 RENAL DIALYSIS	0	0		0		74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0		0		75. 00
76.98   07698 HYPERBARI C OXYGEN THERAPY 77.00   07700   ALLOGENEI C STEM CELL ACQUISITION	0	216 0		0		76. 98 77. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	<u> </u>	0		, , , , , , , , , , , , , , , , , , , ,
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89. 00
90. 00   09000   CLI NI C	0	9	0	0		90.00
91.00   09100   EMERGENCY 92.00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)	362	1, 504		O		91. 00 92. 00
.2. 33  37230 383ERVATTON DEBS (NON-DISTINCT TART)	<u> </u>		I .		İ.	, ,2,00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146

			'	0 12/31/2016	5/28/2019 10:	
				OTHER GENERAL		
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
	45.00	LI BRARY	17.00	10.00	10.00	
OTHER RELABILITION OF COST CENTERS	15. 00	16. 00	17. 00	18. 00	19. 00	
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S				ا		04.00
94. 00   09400   HOME PROGRAM DI ALYSIS 95. 00   09500   AMBULANCE SERVICES	0 516	0 513		0		94. 00 95. 00
	510	513				96.00
	0	0				
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
99. 00   09900   CMHC	0	0				99. 00
99. 10   09910   CORF	0	0				99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		0		100.00
101. 00 10100 HOME HEALTH AGENCY	U U	0	C	0		101. 00
SPECIAL PURPOSE COST CENTERS  105. 00 10500 KIDNEY ACQUISITION		0		ol		105. 00
106. 00 10600 HEART ACQUISITION		0				106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107. 00
107. 00 10700 ELIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION		0				1
109. 00 10900 PANCREAS ACQUISITION		0				108. 00 109. 00
		0				1
110. 00 11000   NTESTI NAL ACQUI SI TI ON	0	0				110.00
111. 00 11100   SLET ACQUI SI TI ON	U U	Ü		U		111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0				115. 00
116.00 11600 HOSPICE 118.00  SUBTOTALS (SUM OF LINES 1 through 117)	04 470	0 420	i d	0	0	116. 00 118. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	94, 478	9, 430		oj Oj	0	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	ol ol		190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0				191. 00
192. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0				192. 00
193. 00 19300 NONPALD WORKERS		0				193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS		0				194. 00
194. 01 07951 PALN CLINIC		0				194. 00
194. 02 07952  OCC HEALTH	0	0				194. 01
194. 03 07953 FOUNDATION		0				194. 02
194. 04 07954 PHYSI CI AN OFFI CES	0	0				194. 03
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	346	0				194. 05
194. 06 07956 VACANT SPACE	340	0				194. 06
200.00 Cross Foot Adjustments		U		i i	0	200. 00
201.00 Negative Cost Centers		0				201. 00
202.00 TOTAL (sum lines 118 through 201)	94, 824	9, 430		o		202.00
202. 00   TOTAL (Sum Titles 110 till bugil 201)	74, 024	7, 430		ا ا	0	1202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 10:28 am INTERNS & RESIDENTS NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER PARAMED ED Subtotal Cost Center Description Y & FRINGES PRGM COSTS PRGM 24.00 20.00 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 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 16.00 01700 SOCIAL SERVICE 17.00 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18 00 18 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02000 NURSING SCHOOL 20.00 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD C 22 00 22 00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 592 873 30 00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 03200 CORONARY CARE UNIT 32.00 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 34 00 40.00 04000 SUBPROVI DER - I PF 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 43.00 04300 NURSERY 21, 283 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44 00 45.00 04500 NURSING FACILITY 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 456, 065 50.00 05100 RECOVERY ROOM 51.00 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 92,036 52.00 05300 ANESTHESI OLOGY 53.00 1,663 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 728, 951 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 57.00 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 Ω 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 246, 737 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS O 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY Λ 64.00 65.00 06500 RESPIRATORY THERAPY 111, 071 65.00 06600 PHYSI CAL THERAPY 66.00 151, 182 66.00 06700 OCCUPATI ONAL THERAPY 67.00 36, 632 67.00 68.00 06800 SPEECH PATHOLOGY 25, 744 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 77, 245 71.00 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 42, 518 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 310, 468 73.00 07400 RENAL DIALYSIS 74 00 74 00 0 75.00 07500 ASC (NON-DISTINCT PART) 75.00  $\cap$ 07698 HYPERBARI C OXYGEN THERAPY 76, 960 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 5.668 90.00 09100 EMERGENCY 91 00 285, 698 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 194. 03 07953 FOUNDATI ON

194.06 07956 VACANT SPACE

200.00

201.00

202.00

194. 04 07954 PHYSICIAN OFFICES

194. 05 07955 COMMUNITY & VOLUNTEER SERVICES

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

140 194. 03

62, 292 194. 05

3, 705, 418 202. 00

0 194. 04

0 194. 06

0 200. 00

0 201.00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0146 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am INTERNS & RESIDENTS NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER PARAMED ED Cost Center Description Subtotal Y & FRINGES PRGM COSTS PRGM 23.00 20.00 24.00 21.00 22.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 95.00 09500 AMBULANCE SERVICES 324, 307 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 Ω 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 98. 00 0 09900 CMHC 99.00 99.00 0 99. 10 09910 CORF 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 106. 00 10600 HEART ACQUISITION 0 106.00 107. 00 10700 LI VER ACQUI SI TI ON 0 107.00 108.00 10800 LUNG ACQUISITION 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116.00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 3, 587, 101 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12, 224 190. 00 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 43, 661 192. 00 193. 00 19300 NONPALD WORKERS 0 193. 00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194. 00 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 0 194. 02

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In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

					0 12/31/2018	5/28/2019 10: 28 am
	Cost Center Description	Intern &	Total	-		
		Residents Cost				
		& Post				
		Stepdown				
		Adjustments 25.00	26. 00			
	GENERAL SERVICE COST CENTERS	23.00	20.00			
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					5. 00
6.00	00600 MAI NTENANCE & REPAI RS					6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	00900 HOUSEKEEPING					9. 00
10. 00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
12.00	01200 MAINTENANCE OF PERSONNEL					12. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE					16. 00 17. 00
17. 00 18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)					18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS					19. 00
20. 00	02000 NURSI NG SCHOOL					20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD					21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD					22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)					23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		500.070			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	592, 873			30.00
31.00	03200 CORONARY CARE UNIT		0			31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0			33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	o	0			34.00
40.00	04000 SUBPROVI DER - I PF	o	0			40. 00
41. 00	04100 SUBPROVI DER - I RF	O	0			41.00
43.00	04300 NURSERY	0	21, 283			43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0			44.00
45. 00 46. 00	04500 NURSING FACILITY	0	0			45. 00 46. 00
40.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	ı o	U			46.00
50. 00		O	456, 065			50. 00
51.00	05100 RECOVERY ROOM	O	0			51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	92, 036			52. 00
53.00	05300 ANESTHESI OLOGY	0	1, 663			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	728, 951			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			55. 00
56. 00 57. 00	05600		0			56. 00 57. 00
58. 00	1 1		0			58.00
59. 00		o	0			59. 00
60.00	06000 LABORATORY	o	246, 737			60. 00
60. 01	06001 BLOOD LABORATORY	0	0			60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_			61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0			63. 00 64. 00
65. 00	1		111, 071			65. 00
66. 00	06600 PHYSI CAL THERAPY		151, 182			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		36, 632			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	25, 744			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0			69. 00
70.00	1 1	0	77 245			70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		77, 245 42, 518			71. 00 72. 00
73. 00	1		310, 468			72.00
74. 00			0			74. 00
75. 00			0			75. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	76, 960			76. 98
77. 00		0	0			77. 00
00.05	OUTPATIENT SERVICE COST CENTERS					20
88. 00		0	0			88. 00
89. 00 90. 00	1		5, 668			89. 00 90. 00
91.00	09100 EMERGENCY		285, 698			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_55, 570			92.00
	· · · · · · · · · · · · · · · · · · ·	1				

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 000000 94.00 95.00 09500 AMBULANCE SERVICES 324, 307 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 C 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 09900 CMHC 99.00 99.00 0 99. 10 09910 CORF 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 105.00 106. 00 10600 HEART ACQUISITION 0 106. 00 00000 107. 00 10700 LIVER ACQUISITION 107. 00 0 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 110.00 0 111.00 11100 I SLET ACQUISITION 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 115. 00 0 0 116. 00 11600 HOSPI CE 0 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 3, 587, 101 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 12, 224 190 00 191. 00 19100 RESEARCH 191. 00 0 0 0 0 0 0 0 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 43, 661 192. 00 193. 00 19300 NONPALD WORKERS 193. 00 0 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194. 00 0 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 194. 02 194. 03 07953 FOUNDATION 140 194. 03 194. 04 07954 PHYSICIAN OFFICES 194 04 r 62, 292 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 194. 05

0

0

3, 705, 418

194. 06

200. 00

201. 00

202.00

194.06 07956 VACANT SPACE

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 10: 28 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 136, 058 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 927, 570 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 18, 540, 938 4.00 00500 ADMINISTRATIVE & GENERAL 6, 780 5 00 29 785 5, 710, 027 -15, 549, 084 27, 432, 636 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 11,508 20, 013 359, 003 1, 753, 018 7.00 0 00800 LAUNDRY & LINEN SERVICE 990 8.00 8.00 165, 523 00900 HOUSEKEEPI NG 9 00 318, 559 544.645 1 432 102 9 00 10.00 01000 DI ETARY 2,948 7, 753 247, 581 0 420, 208 10.00 01100 CAFETERI A 1, 907 o 11.00 171, 946 103, 256 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 607, 185 105, 203 13.00 401 423, 253 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 3,683 0 9,770 14.00 01500 PHARMACY 15.00 1,086 68, 111 638, 454 163, 240 15.00 01600 MEDICAL RECORDS & LIBRARY 0 1, 659 4, 401 16,00 C 16,00 17 00 01700 SOCIAL SERVICE 0 C 0 0 Ω 17 00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18.00 18.00 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 O 19.00 0 02000 NURSING SCHOOL 20.00 0 0 20.00 C 0 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 Λ 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 C 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17.322 43, 315 1, 999, 575 0 3, 491, 895 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 C 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 0 Ω 40.00 0 41 00 Ω  $\cap$ Λ 41 00 0 43.00 04300 NURSERY 249 2,719 107, 624 144, 663 43.00 04400 SKILLED NURSING FACILITY o 44.00 0 0 0 44.00 04500 NURSING FACILITY 45.00 0 45.00 0 0 04600 OTHER LONG TERM CARE 46.00  $\cap$ 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 12, 976 144, 901 1, 006, 980 2, 038, 463 50.00 o 05100 RECOVERY ROOM 51 00 51 00 C 0 05200 DELIVERY ROOM & LABOR ROOM 1, 599 52.00 11, 503 448, 596 0 604, 653 52.00 17, 425 53.00 05300 ANESTHESI OLOGY 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 368, 584 1, 543, 624 2, 907, 202 54.00 12, 165 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 05700 CT SCAN 0 0 0 57.00 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 58.00 0 05900 CARDIAC CATHETERIZATION O 59 00 0 0 59 00 60.00 06000 LABORATORY 3, 347 0 0 2, 566, 727 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 0 06500 RESPIRATORY THERAPY 805, 821 23 974 612, 283 65 00 2.135 65 00 66.00 06600 PHYSI CAL THERAPY 9, 229 10, 282 855, 178 997, 218 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 312, 704 0 406, 665 67.00 06800 SPEECH PATHOLOGY 68.00 0 219, 784 285, 825 68.00 06900 ELECTROCARDI OLOGY 0 69.00 C C 0 69 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71 00 0 750, 736 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 478, 714 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 2, 470, 268 73.00 07400 RENAL DIALYSIS 0 0 74.00 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 O 75.00 07698 HYPERBARIC OXYGEN THERAPY 1, 700 76.98 813 133,068 0 674, 493 76.98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER

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Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0146

CAPITAL RELATED COSTS	5/28/2019 10:28 am
Cost Center Description  BLDG & FIXT   MVBLE EQUIP   EMPLOYEE   BENEFITS   DEPARTMENT   (GROSS   SALARIES)	liation ADMINISTRATIVE & GENERAL (ACCUM. COST)
1.00 2.00 4.00 50	A 5.00
91. 00   09100   EMERGENCY	0 2,009,794 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS	72.00
94.00   09400  HOME PROGRAM DI ALYSIS   0   0   0	0 94.00
95. 00   09500   AMBULANCE SERVI CES 0 94, 191 1, 820, 018	0 2, 448, 993 95. 00
96. 00   09600  DURABLE MEDI CAL EQUI P-RENTED   0   0   0	0 96.00
97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0   0	0 0 97.00
98. 00   09850   OTHER REI MBURSABLE COST CENTERS 0 0 0	0 98.00
99. 00   09900   CMHC   0   0	0 99.00
99. 10   09910   CORF   0   0   0	0 99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 0 0 0	0 100.00
101.00 10100 HOME HEALTH AGENCY 0 0 0	0 0 101.00
SPECIAL PURPOSE COST CENTERS	
105.00 10500 KIDNEY ACQUISITION 0 0 0	0 0 105.00
106. 00 10600 HEART ACQUISITION 0 0 0	0 106.00
107. 00 10700 LIVER ACQUISITION 0 0 0	0 107.00
108.00 10800 LUNG ACQUISITION 0 0 0	0 108.00
109. 00 10900 PANCREAS ACQUISITION 0 0 0	0 109.00
110.00   11000   INTESTINAL ACQUISITION 0 0 0	0 110.00
111.00   11100   I SLET ACQUI SI TI ON 0 0 0	0 111.00
113. 00 11300 I NTEREST EXPENSE	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	114. 00
115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. ) 0 0 0	0 0 115.00
116. 00 11600 H0SPI CE 0 0 0 0	0 0 116.00
	549, 084 26, 933, 605 118. 00
NONREI MBURSABLE COST CENTERS   1,227   1,846   28,758	0 36, 923 190. 00
190. 00 19000 GFF, FLOWER, COFFEE SHOP & CANTEEN 1,227 1,640 26,756 191. 00 19100 RESEARCH 0 0 0	0 0 0 191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 6, 515 1, 075 37, 619	0 75, 103 192. 00
193. 00 19300 NONPALD WORKERS 0 0 0	0 75, 103 172. 00
194. 00 07950  OTHER NONREI MBURSABLE COST CENTERS 0 0 0	0 0 1194.00
194. 01 07951 PAIN CLINIC 0 0 0	0 0 174.00
194. 02 07952  OCC HEALTH 0 0 0	0 0 194. 02
194. 03 07953  FOUNDATION 0 0 0	288 0 194. 03
194. 04 07954 PHYSI CI AN OFFI CES 0 0 0	0 0 194.04
194. 05 07955 COMMUNI TY & VOLUNTEER SERVI CES 4, 941 289 184, 575	0 387, 005 194, 05
194. 06 07956 VACANT SPACE 0 0 0	0 194.06
200.00 Cross Foot Adjustments	200. 00
201.00 Negative Cost Centers	201. 00
202.00   Cost to be allocated (per Wkst. B, 360,933 1,001,150 2,522,012 Part I)	15, 549, 084 202. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 2.652788 1.079326 0.136024	0. 566810 203. 00
204.00 Cost to be allocated (per Wkst. B,	2, 429, 665 204. 00
Part II)	2, 727, 003 204. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.000000	0. 088568 205. 00
206.00 NAHE adjustment amount to be allocated	206. 00
(per Wkst. B-2)	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Ti me Prepared:

5/28/2019 10:28 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY **REPALRS** PLANT LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 6.00 9.00 10.00 8.00 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 00600 MAINTENANCE & REPAIRS 6.00 106, 273 6.00 00700 OPERATION OF PLANT 11, 508 7.00 7.00 94, 765 00800 LAUNDRY & LINEN SERVICE 8.00 990 990 260, 605 8.00 10, 699 9.00 00900 HOUSEKEEPI NG 1, 432 1, 432 92.343 9.00 01000 DI ETARY 2,948 2, 948 371 2, 948 27, 330 10.00 10.00 1, 907 1, 907 1, 907 01100 CAFETERI A 11.00 370 Λ 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 C 0 12.00 13.00 01300 NURSING ADMINISTRATION 401 401 401 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 3.683 3.683 7.888 3.683 14.00 01500 PHARMACY 15.00 1,086 1,086 0 1,086 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,659 1,659 0 1, 659 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 17.00 0 01850 OTHER GENERAL SERVICE (SPECIFY) 18 00 0 0 0 18 00 C 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 02000 NURSING SCHOOL 0 0 0 20.00 20.00 C 0 0 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 0 22 00 22 00 C 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 17 322 17, 322 90, 911 17, 322 27, 330 30 00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 03200 CORONARY CARE UNIT 0 ol 32.00 32.00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 0 0 Ω 0 34 00 40.00 04000 SUBPROVI DER - I PF 0 C 0 0 0 40.00 04100 SUBPROVIDER - IRF 0 0 0 41.00 C 41.00 43.00 04300 NURSERY 249 249 262 249 0 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 C 0 0 44 00 45.00 04500 NURSING FACILITY 0 C 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 12, 976 12, 976 50.00 05000 OPERATING ROOM 68.517 12, 976 0 05100 RECOVERY ROOM 0 51.00 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 599 1, 599 263 1, 599 52.00 05300 ANESTHESI OLOGY 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 12, 165 12, 165 25.971 12, 165 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C C 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 0 05700 CT SCAN 57.00 0 0 0 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 06000 LABORATORY 3, 347 60.00 3.347 645 3.347 0 60.00 60.01 06001 BLOOD LABORATORY C Ω 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS 63.00 0 C 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 2, 135 2, 135 1,591 2, 135 0 65.00 06600 PHYSI CAL THERAPY 9, 229 9, 229 9, 229 66.00 66.00 C 0 06700 OCCUPATI ONAL THERAPY 67.00 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 C 06900 ELECTROCARDI OLOGY 0 0 69.00 0 69.00 0 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 C 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 C 0 0 73.00 07400 RENAL DIALYSIS 74 00 0 0 0 74 00 C 0 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 75.00 07698 HYPERBARI C OXYGEN THERAPY 1,700 1, 700 0 1,700 0 76. 98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0 90.00 C 09100 EMERGENCY 50.132 91.00 91 00 7.254 7, 254 7.254 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (SQUARE FEET) (MEALS SERVED) **REPAIRS** PLANT (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 6.00 7.00 9. 00 10.00 8.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 95.00 09500 AMBULANCE SERVICES 00000 0 0 0 0 0 0 0 95.00 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 Ω 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98. 00 98.00 09900 CMHC 0 99.00 99.00 0 0 99. 10 09910 CORF 0 99. 10 Ω 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 0 0 106.00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 111.00 0 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115. 00 116.00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 93, 590 82,082 257, 620 79,660 27, 330 118. 00 NONREI MBURSABLE COST CENTERS 1, 227 1, 227 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 227 O 0 190, 00 191. 00 19100 RESEARCH 0 191. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 6,515 6, 515 2, 985 6, 515 0 192. 00 193. 00 19300 NONPALD WORKERS 0 193. 00 0 0 0 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194. 00 0 0 0 C 194. 01 07951 PAIN CLINIC 0 0 194. 01 0 C 0 194. 02 07952 OCC HEALTH 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 0 194. 03 0 0 0 o 0 194. 04 194. 04 07954 PHYSICIAN OFFICES 0 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 4,941 4, 941 0 4, 941 0 194. 05 0 194.06 194.06 07956 VACANT SPACE 200.00 Cross Foot Adjustments 200.00

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2, 746, 646

28. 983760

207, 390

2. 188466

288, 037

1.105263

0.074646

19, 453

906, 685

9. 818665

0.607301

56, 080

201. 00

206.00

207 00

773, 185 202. 00

61, 675 204. 00

28. 290706 203. 00

2. 256678 205. 00

201.00

202.00

203.00

204.00

205.00

206.00

207 00

Negative Cost Centers

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146 In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					To 12/31/2018	Date/Time Pre 5/28/2019 10:	
	Cost Center Description		MAINTENANCE OF		CENTRAL	PHARMACY	20 4111
		(MEALS SERVED)	PERSONNEL	ADMI NI STRATI ON		(COSTED REQUIS.)	
			(NUMBER HOUSED)	(DI RECT NURS.	SUPPLY (COSTED	REQUIS.)	
			1.000257	HRS. )	REQUIS.)		
	JOSUS DE LOS CONTROLOS DE LA C	11.00	12. 00	13. 00	14.00	15. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1		1			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						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A	368, 506					11.00
12.00	01200 MAINTENANCE OF PERSONNEL	10 101	(	150.00	,		12.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	10, 191	(	0 158, 984 0 (			13. 00 14. 00
15. 00	01500 PHARMACY	11, 864	(			2, 521, 639	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	(		0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	(	0	0	0	17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	(		0	0	18.00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	(			0	19. 00 20. 00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD	0	(			0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	(		0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	(	) (	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(2 (15		N (2 (1)	225 520	1 22/	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	63, 615 0		0 63, 615	225, 529	1, 326 0	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	(			0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	(		0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	(	0	0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	(		0	0	40.00
41. 00 43. 00	04100  SUBPROVI DER - I RF 04300  NURSERY	3, 681	(	3, 68		0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	(	0, 00		Ö	44. 00
45.00	04500 NURSING FACILITY	0	(		0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	(	) (	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	31, 886		31, 886	351, 699	96, 273	50.00
51.00	05100 RECOVERY ROOM	0	(	0 31,000	0	70, 273	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 344	(	15, 344	1 0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	(	0	0	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	48, 430	(		78, 980	204	54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	(			0	55. 00 56. 00
57. 00	05700 CT SCAN	0	(			0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	(	0 (	0	0	59. 00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	0	(		0	0	60.00
60. 01 61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	i o	(			U	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(		0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	(	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	20, 778 20, 650	(		66, 499 24, 935	0 701	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	10, 565	(		) 24, 733	0	67.00
68. 00	06800 SPEECH PATHOLOGY	7, 426	(		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(		0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(		1, 229, 450	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	(		96, 322	2, 390, 579	73.00
74. 00	07400 RENAL DIALYSIS	0	(		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	(	0	0	0	75. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	5, 906	(	5, 906	· ·	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	(	0 (	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	O	(		) 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o o	(		o o	0	89. 00
90. 00	09000 CLI NI C	1, 469	(		2, 233	0	90.00
91.00	09100 EMERGENCY	38, 552	(	38, 552	223, 182	9, 620	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 1		1			92. 00

5,778

236, 188

0.640934

0.053087

19, 563

0.000000

0.000000

194. 05 07955 COMMUNITY & VOLUNTEER SERVICES

Cross Foot Adjustments

Negative Cost Centers

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

194.06 07956 VACANT SPACE

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

11)

MCRI F32 - 15. 5. 166. 1

200.00

202.00

203.00

204.00

205.00

206.00

207.00

15, 380

166, 935

0.065578

0.008454

21, 521

0

973, 435

6. 122849

170, 052

1.069617

9, 213 194. 05

307, 864 202. 00

0. 122089 203. 00

0. 037604 205. 00

94, 824 204. 00

0 194.06

200. 00

201.00

206. 00

207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 Provider CCN: 15-0146 Peri od: From 01/01/2018 To 12/31/2018 Worksheet B-1 Date/Time Prepared: 5/28/2019 10:28 am OTHER GENERAL

Cost Center Description  MEDICAL RECORDS & LIBRARY (GROSS CHARGES)  16.00  MEDICAL SCRVICE (SPECIFY) (SPECIFY) (TIME SPENT) (ASSIGNED TIME)	NURSI NG SCHOOL  (ASSI GNED TI ME)	
GENERAL SERVICE COST CENTERS		
1.00   00100   CAP REL COSTS-BLDG & FIXT		1.00
2.00   00200   CAP REL COSTS-MVBLE EQUIP   4.00   00400   EMPLOYEE BENEFITS DEPARTMENT		2. 00 4. 00
5. 00   00500   admi ni strati ve & general		5. 00
6.00 00600 MAI NTENANCE & REPAI RS		6. 00
7.00   00700   OPERATION OF PLANT		7. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE		8. 00
9. 00   00900  HOUSEKEEPI NG 10. 00   01000  DI ETARY		9. 00 10. 00
11. 00   01100   CAFETERI A		11. 00
12.00 01200 MAI NTENANCE OF PERSONNEL		12. 00
13.00   01300   NURSI NG   ADMI NI STRATI ON		13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY		14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY 210, 178, 764		15. 00 16. 00
17. 00   01700   SOCI AL SERVI CE   0   0		17. 00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 0		18. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0		19. 00
20. 00   02000   NURSI NG SCHOOL	0	20.00
21. 00   02100   1 &R SERVI CES-SALARY & FRI NGES APPRVD   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		21. 00 22. 00
23. 00   02300   PARAMED ED PRGM-(SPECIFY)		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 03000 ADULTS & PEDIATRICS 13, 901, 432 0 0 0	0	30.00
31. 00   03100   I NTENSI VE CARE UNI T	0	31. 00
32.00   03200   CORONARY CARE UNIT   0 0 0 0 0 0 0 33.00   03300   BURN INTENSIVE CARE UNIT 0 0 0 0 0	0	32. 00 33. 00
34. 00   03400   SURGI CAL   INTENSI VE CARE UNI T	ő	34. 00
40. 00   04000   SUBPROVI DER - 1 PF   0   0   0	0	40.00
41. 00   04100   SUBPROVI DER - I RF   0   0   0	0	41.00
43. 00   04300   NURSERY   572, 569   0   0   0   44 00   04400   SKILLED NURSING FACILITY   0   0   0   0   0	0	43.00
44.00   04400   SKI LLED NURSI NG FACI LI TY	0	44. 00 45. 00
46. 00   04600   OTHER LONG TERM CARE   0   0   0	0	46. 00
ANCILLARY SERVICE COST CENTERS		
50. 00   05000   0PERATI NG ROOM   20, 422, 768   0   0   0   51. 00   05100   RECOVERY ROOM   0   0   0   0	0	50. 00 51. 00
51. 00   05100   RECOVERT ROOM   0   0   0   0   0   0   0   0   0	0	51.00
53. 00   05300   ANESTHESI OLOGY   2, 668, 743   0   0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   48, 971, 409   0   0   0	0	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0	0	55. 00
56. 00   05600   RADI 01 SOTOPE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	56. 00 57. 00
58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   0   0   0   0	0	59.00
60. 00   06000   LABORATORY   24, 927, 639   0   0	0	60.00
60. 01   06001   BLOOD LABORATORY	0	60. 01 61. 00
62. 00   06200  WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0	0	62. 00
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0	0	63.00
64. 00   06400   NTRAVENOUS THERAPY   0   0   0   0	0	64. 00
65. 00   06500   RESPI RATORY THERAPY   9, 060, 822   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   3, 193, 223   0   0   0	0	65. 00
66. 00   06600  PHYSI CAL THERAPY 3, 193, 223 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	66. 00 67. 00
68. 00   06800  SPEECH PATHOLOGY 775, 266 0 0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY   0   0   0	0	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY	0	70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   8,019,116   0   0   0   72.00   07200   MPL. DEV. CHARGED TO PATIENTS   2,655,303   0   0   0   0   0   0   0   0   0	0	71. 00 72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   21, 587, 779   0   0	ő	73. 00
74.00 07400 RENAL DIALYSIS 0 0 0 0	0	74. 00
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0	0	75. 00
76. 98   07698   HYPERBARI C OXYGEN THERAPY	0	76. 98
77. 00 OT700 ALLOGENEIC STEM CELL ACQUISITION O O O O OUTPATIENT SERVICE COST CENTERS	0	77. 00
88. 00   08800   RURAL HEALTH CLINIC   0   0   0   0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0	0	89. 00
90. 00  09000  CLI NI C   197, 326  0  0  0	0	90. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 Provider CCN: 15-0146 

				T	o 12/31/2018	Date/Time Pre 5/28/2019 10:	pared:
				OTHER GENERAL		3/20/2019 10.	20 alli
				SERVI CE			
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	NURSING SCHOOL	
	·	RECORDS &		(TIME SPENT)	ANESTHETI STS		
		LI BRARY	(TIME SPENT)		(ASSI GNED	(ASSI GNED	
		(GROSS			TIME)	TIME)	
		CHARGES)	17.00	10.00	10.00	20.00	
01 00 00100	EMEDOENOV	16.00	17.00	18.00	19. 00	20.00	01.00
	EMERGENCY	33, 433, 173	0	0	0	0	
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92. 00
	HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
	AMBULANCE SERVICES	11, 400, 459				<b>l</b>	1
	DURABLE MEDICAL EQUIP-RENTED	11, 400, 437		_		l	1
	DURABLE MEDICAL EQUIP-SOLD	0					
	OTHER REIMBURSABLE COST CENTERS	0					
99. 00 09900		Ö				1	
99. 10 09910		0	l o			l o	
	I&R SERVICES-NOT APPRVD PRGM	0	l o	o	0	0	100.00
	HOME HEALTH AGENCY	0	l c	o	0	0	101.00
SPECI	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0	0	0			105. 00
	HEART ACQUISITION	0	0				106. 00
	LIVER ACQUISITION	0	0			•	107. 00
	LUNG ACQUISITION	0	0				108. 00
	PANCREAS ACQUISITION	0	0			•	109. 00
	INTESTINAL ACQUISITION	0	0	0	_	•	110.00
	I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
	I NTEREST EXPENSE						113.00
	UTILIZATION REVIEW-SNF	0	0	0	0	_	114. 00 115. 00
116. 00 11600	AMBULATORY SURGICAL CENTER (D. P.)	0		_	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	210, 178, 764					118.00
	IMBURSABLE COST CENTERS	210, 176, 764		<u> </u>	0	0	1110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100		0					191. 00
	PHYSICIANS' PRIVATE OFFICES	0				1	192. 00
	NONPALD WORKERS	0	O				193. 00
	OTHER NONREIMBURSABLE COST CENTERS	0	l c	o	0	0	194. 00
194. 01 07951	PAIN CLINIC	0	0	0	0	0	194. 01
194. 02 07952	OCC HEALTH	0	0	0	0	0	194. 02
194. 03 07953	FOUNDATI ON	0	0	0	0	0	194. 03
	PHYSICIAN OFFICES	0	0	0	0	<b>l</b>	194. 04
	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194. 05
	VACANT SPACE	0	0	0	0	0	194. 06
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers		_	_	_	_	201. 00
202. 00	Cost to be allocated (per Wkst. B,	71, 269	C	0	0	0	202. 00
202 00	Part I)	0.000000	0.000000	0.000000	0.000000	0 000000	202 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000339		0.000000	0.000000		
204. 00	Cost to be allocated (per Wkst. B, Part II)	9, 430	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1	U	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000045	0. 000000	0. 000000	0. 000000	0. 000000	205 00
203.00		0.000045	3. 000000	3.000000	3. 000000	0.00000	200.00
206. 00	NAHE adjustment amount to be allocated					0	206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,					0. 000000	207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Ti me Prepared:

5/28/2019 10:28 am INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Y & FRINGES PRGM COSTS PRGM (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) 21.00 23.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 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 00600 MAINTENANCE & REPAIRS 6.00 6 00 00700 OPERATION OF PLANT 7.00 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 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 01700 SOCIAL SERVICE 17.00 17.00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 0 21 00 22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 0 0 0 03100 INTENSIVE CARE UNIT 0 31.00 0000000 0 31.00 03200 CORONARY CARE UNIT 0 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT C 34.00 04000 SUBPROVI DER - I PF 0 40.00 40.00 0 41.00 04100 SUBPROVIDER - IRF 0 41.00 04300 NURSERY 0 43 00 0 43 00 0 44.00 04400 SKILLED NURSING FACILITY 0 44.00 04500 NURSING FACILITY 0 0 45.00 C 45.00 04600 OTHER LONG TERM CARE 0 0 46.00 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 000000000000 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 05600 RADI OI SOTOPE 56,00 0 56,00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 58.00 59 00 05900 CARDIAC CATHETERIZATION 0 59 00 Ω 0 60.00 06000 LABORATORY 0 60.00 06001 BLOOD LABORATORY 0 0 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 000000000000000 Ω 0 62 00 62 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 66 00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS С 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 Ω 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 76. 98 0 76. 98 0 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 89.00 0 0 90.00 09000 CLI NI C 90.00 91. 00 09100 EMERGENCY 0 0 0 91.00 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 

				T	o 12/31/2018	Date/Time Prepared: 5/28/2019 10: 28 am
		INTERNS &	RESI DENTS			3/20/2019 10. 20 dill
Cost Center D	escri pti on	SERVI CES-SALAR				
		Y & FRINGES	PRGM COSTS	PRGM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED		
		TI ME)	TIME)	TI ME)		
92. 00   09200   0BSERVATI ON B	EDS (NON-DISTINCT PART)	21.00	22. 00	23. 00		92.00
OTHER REIMBURSABLE						92.00
94. 00 09400 HOME PROGRAM		O	0	0		94. 00
95. 00 09500 AMBULANCE SER			0			95. 00
96. 00 09600 DURABLE MEDIC		l ol	0			96. 00
97. 00 09700 DURABLE MEDIC		o	0	0		97. 00
98. 00 09850 OTHER REIMBUR	SABLE COST CENTERS	o	0	0		98. 00
99. 00 09900 CMHC		o	0	0		99. 00
99. 10 09910 CORF		o	0	0		99. 10
100.00 10000 I &R SERVICES-		O	0	0		100. 00
101.00 10100 HOME HEALTH A	GENCY	0	0	0		101. 00
SPECIAL PURPOSE COS						
105.00 10500 KIDNEY ACQUIS		0	0			105. 00
106.00 10600 HEART ACQUISI		0	0			106. 00
107. 00 10700 LIVER ACQUISI		0	0	_		107. 00
108. 00 10800 LUNG ACQUISIT		0	0	_		108. 00
109. 00 10900 PANCREAS ACQU		0	0			109. 00
110. 00 11000   INTESTINAL AC		0	0	_		110.00
111. 00 11100   SLET ACQUI SI 113. 00 11300   NTEREST EXPE		U U	0	0		111.00
114. 00 11400 UTI LI ZATI ON R						113. 00 114. 00
115. 00 11500 AMBULATORY SU			0	0		115. 00
116. 00 11600 HOSPI CE	NOTONE CENTER (B.T.)		J	Ö		116.00
	M OF LINES 1 through 117)	o	0			118. 00
NONREI MBURSABLE COS	T CENTERS	·	-		l.	
190.00 19000 GIFT, FLOWER,	COFFEE SHOP & CANTEEN	0	0	0		190. 00
191. 00 19100 RESEARCH		0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' P		0	0			192. 00
193. 00 19300 NONPALD WORKE		0	0			193. 00
194. 00 07950 OTHER NONREI M	BURSABLE COST CENTERS	0	0	· ·		194. 00
194. 01 07951 PAIN CLINIC		0	0	_		194. 01
194. 02 07952 OCC HEALTH		0	0	_		194. 02
194. 03 07953 FOUNDATION	LOFO	0	0	· ·		194. 03
194. 04 07954 PHYSI CI AN OFF 194. 05 07955 COMMUNI TY & V		0	0	0		194. 04 194. 05
194. 05 07955 COMMUNITY & V	ULUNIEER SERVICES	0	0	0		194. 05
200.00 Cross Foot Ad	iustmonts	١	U	U		200. 00
201.00 Negative Cost						201. 00
1 1 3	located (per Wkst. B,	0	0	0		202. 00
Part I)	rocated (per witst. B,	Ĭ	0			202.00
203.00 Unit cost mul	tiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000		203. 00
204.00 Cost to be al	located (per Wkst. B,	0	0	0		204. 00
Part II)						
	tiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000		205. 00
11)				_		001.00
	nt amount to be allocated			0		206. 00
(per Wkst. B- 207.00 NAHE unit cos	2) t multiplier (Wkst. D,			0. 000000		207. 00
Parts III and				0.00000		207.00
i i i i i i i i i i i i i i i i i i i	• • /	ı		ı	l	ı

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 Worksheet C Part I Date/Time Prepared: 5/28/2019 10: 28 am PPS Provider CCN: 15-0146 Peri od: From 01/01/2018 To 12/31/2018 Title XVIII Hospi tal Costs Total Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE

oost senter bescription	(from Wkst. B, Part I, col.	Adj .	Total costs	Di sal I owance	10141 00313	
	26)					
INDATIONT DOUTING CERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	7, 466, 875		7, 466, 875	0	7, 466, 875	30.00
31. 00   03100   NTENSI VE CARE UNI T	0		0	o	0	31.00
32.00 03200 CORONARY CARE UNIT	0		0	0	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0		0	0	0	34.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	0		0	0	0	40. 00 41. 00
43. 00   04300   NURSERY	261, 702		261, 702	Ö	261, 702	43. 00
44.00 04400 SKILLED NURSING FACILITY	0		0	0	0	44. 00
45.00 04500 NURSING FACILITY	0		0	0	0	45. 00
46. 00 04600 OTHER LONG TERM CARE	0		0	0	0	46. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   0PERATI NG ROOM	4, 030, 524		4, 030, 524	0	4, 030, 524	50.00
51. 00   05100   RECOVERY ROOM	4, 030, 324		4, 030, 324		4, 030, 324	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 114, 316		1, 114, 316	0	1, 114, 316	52.00
53. 00 05300 ANESTHESI OLOGY	28, 207		28, 207		28, 828	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	5, 108, 633		5, 108, 633	0	5, 108, 633	
55. 00   05500   RADI OLOGY-THERAPEUTI C 56. 00   05600   RADI OI SOTOPE	0		0	0	0	55. 00 56. 00
57. 00   05700 CT SCAN	0		0	0	0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			Ö	Ö	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60. 00   06000   LABORATORY	4, 160, 609		4, 160, 609	0	4, 160, 609	60. 00
60. 01 06001 BLOOD LABORATORY	0		0	0	0	60. 01
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		Ö	Ö	Ö	64. 00
65. 00 06500 RESPIRATORY THERAPY	1, 367, 919	0	.,,		1, 367, 919	65. 00
66. 00   06600   PHYSI CAL THERAPY	1, 936, 597	0	1, 936, 597		1, 936, 597	66. 00
67. 00   06700 OCCUPATI ONAL THERAPY 68. 00   06800 SPEECH PATHOLOGY	644, 334	0	644, 334		644, 334	1
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	452, 856 0	Ü	452, 856	0	452, 856 0	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	Ö	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 259, 602		1, 259, 602	0	1, 259, 602	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	750, 954		750, 954		750, 954	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 175, 939		4, 175, 939	0	4, 175, 939	73.00
74. 00   07400   RENAL DIALYSIS 75. 00   07500   ASC (NON-DISTINCT PART)	0		0	0	0	74. 00 75. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 166, 171		1, 166, 171	0	1, 166, 171	•
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC	00.557		99, 557	0	0 557	89.00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	99, 557 3, 773, 748		3, 773, 748		99, 557 3, 777, 717	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 697, 303		1, 697, 303		1, 697, 303	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0		0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	3, 894, 457		3, 894, 457	0	3, 894, 457	95. 00
96. 00   09600   DURABLE   MEDI CAL   EQUI P-RENTED 97. 00   09700   DURABLE   MEDI CAL   EQUI P-SOLD	0		0	0	0	96. 00 97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98. 00
99. 00   09900   CMHC	0		0		Ö	99. 00
99. 10   09910   CORF	0		0		0	1
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0		0			100.00
101.00 10100 HOME HEALTH AGENCY	0		] 0		0	101. 00
SPECIAL PURPOSE COST CENTERS  105. 00 10500 KI DNEY ACQUI SI TI ON	0		1 0		n	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0		0			106.00
107.00 10700 LIVER ACQUISITION	0		0			107. 00
108.00 10800 LUNG ACQUISITION	0		0			108. 00
109. 00 10900 PANCREAS ACQUISITION	0		0			109.00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0				l	110. 00 111. 00
113.00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0		0			115. 00
116. 00 11600 H0SPI CE	0		0		0	116. 00

MCRI F32 - 15. 5. 166. 1

Health Financial Systems COMMU			UNITY HOSPITAL OF NOBLE CTY, INC			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 15-0146		Period: From 01/01/2018 To 12/31/2018			
							5/28/2019 10:	<u>28 am</u>	
				Titl∈	e XVIII	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)						
			1. 00	2. 00	3. 00	4. 00	5. 00		
200.00	Subtotal (see instructions)		43, 390, 303	C	43, 390, 30	3 4, 590	43, 394, 893	200.00	
201.00	Less Observation Beds		1, 697, 303		1, 697, 30	3	1, 697, 303	201.00	
202. 00	Total (see instructions)	1	41, 693, 000	C	41, 693, 00	0 4, 590	41, 697, 590	202. 00	

Provider CCN: 15-0146

Peri od:

From 01/01/2018

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 9, 122, 742 9, 122, 742 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 C 03200 CORONARY CARE UNIT 0 32.00 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34 00 40.00 04000 SUBPROVIDER - IPF 0 40.00 41.00 04100 SUBPROVIDER - IRF O 41.00 04300 NURSERY 43.00 43.00 572, 569 572, 569 04400 SKILLED NURSING FACILITY 44.00 C 44 00 45.00 04500 NURSING FACILITY 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 05000 OPERATING ROOM 5, 990, 111 14, 432, 657 20, 422, 768 0.197354 50.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 422, 723 2, 422, 723 0.459944 0.000000 52.00 05300 ANESTHESI OLOGY 657, 606 2.011.137 0.010569 53.00 2, 668, 743 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 082, 167 43, 889, 242 48, 971, 409 0.104319 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 0.000000 55.00 0 05600 RADI OI SOTOPE 0.000000 56.00 0 0.000000 56.00 0 0 0.000000 57.00 05700 CT SCAN C 0 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0.000000 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 24, 927, 639 06000 LABORATORY 5. 383. 467 19, 544, 172 0 000000 60 00 60 00 0 166907 60.01 06001 BLOOD LABORATORY C 0.000000 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0.000000 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0.000000 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 0 0 0.000000 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 2, 679, 040 6, 381, 782 9,060,822 0.150971 0.000000 65.00 66 00 06600 PHYSI CAL THERAPY 250 643 2, 942, 580 3 193 223 0 606471 0 000000 66 00 06700 OCCUPATIONAL THERAPY 67.00 49, 418 1, 119, 301 1, 168, 719 0.551316 0.000000 67.00 06800 SPEECH PATHOLOGY 19, 260 756, 006 775, 266 0.584130 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70 00 0.000000 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 320, 301 5, 698, 815 8, 019, 116 0.157075 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 766, 768 2, 655, 303 0. 282813 0.000000 72.00 888, 535 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 322, 851 16, 264, 928 21, 587, 779 0.193440 0.000000 73.00 07400 RENAL DIALYSIS 0.000000 74 00 0.000000 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 76.98 07698 HYPERBARIC OXYGEN THERAPY 18,864 4, 781, 431 4, 800, 295 0.242937 0.000000 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0.000000 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 C 88.00 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 197, 326 09000 CLINIC 0.504531 90.00 1.157 196, 169 0.000000 90.00 91.00 09100 EMERGENCY 4.482.047 28, 951, 126 33, 433, 173 0.112874 0.000000 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 4, 778, 690 4, 778, 690 0.355182 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 0.000000 94.00 94.00 95.00 09500 AMBULANCE SERVICES 0 11, 400, 459 11, 400, 459 0.341605 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED C 0.000000 0.000000 96.00 0 09700 DURABLE MEDICAL FOULP-SOLD 0.000000 0.000000 97.00 97.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0.000000 0.000000 98.00 09900 CMHC 0 0 99.00 99.00 0 99. 10 09910 CORF 0 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 C 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 105.00 0 106. 00 10600 HEART ACQUISITION 0 C 106, 00 107. 00 10700 LIVER ACQUISITION 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 116. 00 11600 HOSPI CE 116. 00 200.00 Subtotal (see instructions) 46, 141, 734 164, 037, 030 210, 178, 764 200. 00

Health Financial Systems	COMMUNITY HOSPITAL C	F NOBLE CTY,	I NC	In Lie	eu of Form CMS-2552-1	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN:		Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. (	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8.00	9. 00	10.00	
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	46, 141, 734	164, 037, 030	210, 178, 76	4		202. 00

COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146 | In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 10: 28 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

			Title XVIII	Hospi tal	5/28/2019 10: 28 an	<u>m</u>
	Cost Center Description	PPS Inpatient	THE AVIII	поэрт саг	113	
	p	Ratio				
	T	11.00				
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				20	00
30. 00 31. 00	03000 ADULTS & PEDIATRICS				30.	
31.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T				31.	
33. 00	03300 BURN INTENSIVE CARE UNIT				33.	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT				34.	
40. 00	04000 SUBPROVI DER - I PF				40.	
41.00	04100 SUBPROVI DER - I RF				41.	00
43.00	04300 NURSERY				43.	00
44.00	04400 SKILLED NURSING FACILITY				44.	00
45.00	04500 NURSING FACILITY				45.	00
46. 00	04600 OTHER LONG TERM CARE				46.	00
F0 00	ANCILLARY SERVICE COST CENTERS	0.407054				00
50.00	05000 OPERATING ROOM	0. 197354			50.	
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0. 000000 0. 459944			51. ( 52. (	
53. 00	05300 ANESTHESI OLOGY	0. 439944			53.	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 104319			54.	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.	
56.00	05600 RADI 0I SOTOPE	0. 000000			56.	
57.00	05700 CT SCAN	0. 000000			57.	00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.	00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.	00
60.00	06000 LABORATORY	0. 166907			60.	
60. 01	06001 BLOOD LABORATORY	0. 000000			60.	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0. 000000 0. 150971			64.	
66. 00	06600 PHYSI CAL THERAPY	0. 606471			66.	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 551316			67.	
68. 00	06800 SPEECH PATHOLOGY	0. 584130			68.	
69.00		0. 000000			69.	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 157075			71.	00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 282813			72.	00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 193440			73.	00
74. 00	07400 RENAL DIALYSIS	0. 000000			74.	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000			75.	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 242937			76.	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77.	00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC				88.	00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.	
90. 00	09000 CLINIC	0. 504531			90.	
91. 00	09100 EMERGENCY	0. 112993			91.	
92.00		0. 355182			92.	
	OTHER REIMBURSABLE COST CENTERS	'				
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			94.	00
95.00	09500 AMBULANCE SERVICES	0. 341605			95.	00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.	
97. 00	l i	0. 000000			97.	
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98.	
	09900 CMHC				99.	
	09910 CORF				99.	
	10000    &R SERVICES-NOT APPRVD PRGM   10100  HOME HEALTH AGENCY				100. 101.	
101.00	SPECIAL PURPOSE COST CENTERS				101.	00
105 00	10500 KI DNEY ACQUI SI TI ON				105.	00
	10600 HEART ACQUISITION				106.	
	10700 LIVER ACQUISITION				107.	
	10800 LUNG ACQUISITION				108.	
	10900 PANCREAS ACQUISITION				109.	
	11000 INTESTINAL ACQUISITION				110.	
	11100 ISLET ACQUISITION				111.	
	11300 INTEREST EXPENSE				113.	
	11400 UTILIZATION REVIEW-SNF				114.	
	11500 AMBULATORY SURGICAL CENTER (D. P.)				115.	
	11600 H0SPI CE				116.	
200.00					200.	
201.00					201.	
202.00		1			202.	

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0146 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Hospi tal Title XIX PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. B, Adj Di sal I owance Part I, col 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 7, 466, 875 7, 466, 875 7, 466, 875 03100 INTENSIVE CARE UNIT 31.00 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 Λ 34 00 04000 SUBPROVIDER - IPF 40.00 0 0 0 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 C 0 04300 NURSERY 43.00 261, 702 43.00 261, 702 261, 702 44.00 04400 SKILLED NURSING FACILITY 0 C 0 44.00 45.00 04500 NURSING FACILITY 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 030, 524 4, 030, 524 0 4, 030, 524 50.00 05100 RECOVERY ROOM 51.00 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM ol 52 00 1 114 316 1 114 316 1 114 316 52 00 53.00 05300 ANESTHESI OLOGY 28, 207 28, 207 621 28, 828 53.00 05400 RADI OLOGY-DI AGNOSTI C 5, 108, 633 5, 108, 633 5, 108, 633 54.00 54.00 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 0 05600 RADI OI SOTOPE O 56 00 0 0 56 00 57.00 05700 CT SCAN 0 0 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0 0 58.00 59 00 05900 CARDIAC CATHETERIZATION 0 O 59 00 0 60.00 06000 LABORATORY 4, 160, 609 4, 160, 609 4, 160, 609 60.00 06001 BLOOD LABORATORY 0 60.01 Ω 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62 00 62 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 1, 367, 919 1, 367, 919 1, 367, 919 65.00 06600 PHYSI CAL THERAPY 1, 936, 597 1, 936, 597 1, 936, 597 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 644, 334 644, 334 644, 334 67.00 06800 SPEECH PATHOLOGY 68.00 452, 856 452, 856 452, 856 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 0 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 259, 602 1, 259, 602 1, 259, 602 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 750, 954 750, 954 0 750, 954 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 4, 175, 939 4, 175, 939 4, 175, 939 73.00 07400 RENAL DIALYSIS 74.00  $\cap$ Λ 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 76. 98 07698 HYPERBARIC OXYGEN THERAPY 1, 166, 171 1, 166, 171 76. 98 1, 166, 171 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 0 99, 557 99, 557 99, 557 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 3, 773, 748 3, 773, 748 3, 969 3, 777, 717 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 697, 303 1, 697, 303 1, 697, 303 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 3, 894, 457 95.00 95.00 09500 AMBULANCE SERVICES 3, 894, 457 3, 894, 457 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 0 0 Λ 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 09900 CMHC 0 99.00 0 99.00 0 09910 CORF 0 99. 10 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 Ol 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 0 105. 00 10500 KIDNEY ACQUISITION O 0 105, 00 106.00 10600 HEART ACQUISITION 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00

0 1111.00

0

0

113.00

114.00

0 115.00

0 116.00

116.00 11600 HOSPI CE

111.00 11100 I SLET ACQUISITION

114.00 11400 UTILIZATION REVIEW-SNF

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

113.00 11300 INTEREST EXPENSE

Health Fina	ancial Systems	COMMUNITY HOS	PITAL (	OF NOBLE CTY,	INC	In Lie	u of Form CMS-	2552-10
COMPUTATI O	MPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-			Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre	narodi
						10 12/31/2016	5/28/2019 10:	28 am
				Ti tl	e XIX	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total	Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wk	st. B,	Adj .		Di sal I owance		
		Part I,	col.					
		26)						
		1.0	0	2.00	3. 00	4. 00	5. 00	
200.00	Subtotal (see instructions)	43, 3	90, 303	0	43, 390, 30	4, 590	43, 394, 893	200. 00
201.00	Less Observation Beds	1, 6	97, 303		1, 697, 30	3	1, 697, 303	201.00
202. 00	Total (see instructions)	41, 6	93, 000	0	41, 693, 00	4, 590	41, 697, 590	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0146

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 10: 28 am

Cost Center Description			Titl	e XIX	Hospi tal	5/28/2019 10: PPS	28 am_
1994   1997   1998			Charges				
NUMATIENT ROUTINE SERVICE COST CENTERS	Cost Center Description	Inpatient	Outpatient				
INVALLED   ROUTHS SERVINCE COST CENTERS   9,122,742   3,100   30				1 601. 77		Rati o	
30.00   30.000   ADMITTS A PPIDIATRICS   9,122,742   9,122,742   32,000   30.000   30.000   32.0000   32.000   32.000   32.000   32.000   32.000   32.000   32.0000   32.000   32.000   32.000   32.000   32.0000   32.0000   32.0000   32.0000   32.0000   32.00000   32.0000   32.0000   32.0000   32.0000   32.0000   32.0000   32.0000   32.0000   32.0000	INDATIENT DOUTING CEDVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
31.00   30300   INTENSIVE CARE UNIT   0   0   31.00   32.00   33.00		9, 122, 742		9, 122, 742			30.00
33 00   03000 BURN INTENSIVE CARE UNIT		1		77 1227 7 12			1
34.00 0 30400 SURGICAL INTERSIVE CARE UNIT 0 0 0 0 4.0. 0 0 4.1. 0		O					•
49.00   GROON SURFROYING FE - IPF   0   0   41.00   41		0		(			•
41.00   04100 SUBPROVIPER - 1 INF							•
44.00   0440		o					
45.00   0.40		572, 569		572, 569			
46.00   04.0		0					
MICHILLARY SERVICE COST CENTERS   5,990, 111		0					1
51.00   05.0	ANCILLARY SERVICE COST CENTERS	-					
52.00   05.0		1	_				1
0.00000   0.00000   0.0000000   0.0000000   0.0000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.00000			0				
55.00   05500   RADIOLOGY-THERAPEUTIC   0   0   0   0   0   0   0   0   0			2, 011, 137				1
56. 00   05600   RADIOISTORE   0   0   0   0   0   0   0   0   0							
57.00   05700   CT SCAM   0   0   0   0   0   0   0   0   0		0	0	(			
58.00   08500   MAGNETI C RESINANCE I INGLING (MRI)   0   0   0   0   0   0   0   0   0		0	0				
60 00   06000   LABORATORY   5, 383, 467   19, 544, 1772   24, 927, 639   0, 166907   0, 000000   0, 010   0   0   0   0   0   0   0   0   0		l o	0				
		O	0	(			
61.00   06-100   PBP CLI NI CAL LAB SERVI (CES-PROM ONLY   0   0   0   0   0   0   0   0   0		5, 383, 467	19, 544, 172	24, 927, 639			•
Color   Colo			0				•
64.00		l o	0				
65.00   06500   RESPIRATORY THERAPY   2,679,040   6,381,782   9,060,822   0.150971   0.000000   65.00   66.00   06600   097091 CALT HERAPY   250,643   2,942,580   1,198,719   0.551316   0.000000   66.00   068.00   06800   05800   SPEECH PATHOLOGY   19,260   756,006   775,266   0.0000000   0.0000000   0.0000000   0.0000000   0.		О	0	(			
66.00   06600   PHYSI CAL THERAPY   250, 643   2,942   580   3, 193, 223   0.006471   0.000000   67.00   67.00   67.00   06700   0.000000   67.00   67.00   0.000000   67.00   68.00   0.000000   67.00   68.00   0.000000   67.00   68.00   0.000000   67.00   68.00   0.000000   67.00   68.00   0.000000   67.00   0.000000   77.00   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.000000		0	0	()			•
67: 00   06700   06700   0620PATIONAL THERAPY   49, 418   1,119, 301   1,168, 719   0.551316   0.000000   67: 00   68: 00   0.00000   0.000000   0.000000   68: 00   0.0000000   0.00000000							•
88. 00   06800   SPEECH PATHOLOGY   19, 260   756, 006   775, 266   0.584130   0.000000   68, 00							
70.00							
17.0		0	0	(			•
172.00   07200   IMPL   DEV. CHARGED TO PATIENTS   1,766,768   888,535   2,655,303   0.282813   0.000000   72.00   73.00   75.00   7		2 320 301	5 698 815	8 019 116			1
74. 00   07400   RENAL DITALYSIS   0   0   0   0   0   0   0   0   0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS						1
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0		5, 322, 851	16, 264, 928	21, 587, 779			1
77. 08   07598   IMPERBARII C OXYGEN THERAPY   18, 864   4, 781, 431   4, 800, 295   0. 242937   0. 000000   76, 98   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   0. 000000   0. 000000   77. 00   000000   0. 0000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000		0	0	(			
77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0   0   0   0		18. 864	4. 781. 431	4, 800, 295			
88. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   0   0		0	0	., 222, 21			
89 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   1,05   169, 169   197, 326   0.504531   0.000000   90.00   9				1			
90. 00   09000   CLINIC   1,157   196, 169   197, 326   0.504531   0.000000   90. 00   91. 00   09100   CMERGENCY   4,482,047   28,951,126   33,433,173   0.112874   0.000000   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   4,778,690   4,778,690   0.355182   0.000000   92. 00   OTHER REI MBURSABLE COST CENTERS   0   0   0.000000   0.000000   0.000000   93. 00   09500   AMBULANCE SERVI CES   0   11,400,459   11,400,459   0.341605   0.000000   96. 00   96. 00   09500   AMBULANCE SERVI CES   0   11,400,459   11,400,459   0.341605   0.000000   96. 00   97. 00   09700   DURABLE MEDI CAL EQUI P-ROTED   0   0   0   0.000000   0.000000   96. 00   98. 00   09500   OURABLE MEDI CAL EQUI P-SOLD   0   0   0   0.000000   0.000000   97. 00   99. 00   09900   CMHC   0   0   0   0   0   0.000000   0.000000   99. 00   99. 00   09900   CMHC   0   0   0   0   0   0   0.000000   0.000000   99. 00   99. 10   09910   CORF   0   0   0   0   0   0   0   101. 00   10000   LARS SERVI CES-NOT APPRVD PRGM   0   0   0   0   0   0   0   105. 00   10500   KI DIEY ACQUI SITI ON   0   0   0   0   0   0   0   0   105. 00   10500   KI DIEY ACQUI SITI ON   0   0   0   0   0   0   0   0   0   106. 00   10900   PANCREAS ACQUI SITI ON   0   0   0   0   0   0   0   0   0   110. 00   11000   INTESTINAL ACQUI SITI ON   0   0   0   0   0   0   0   0   0			0				
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   4,778,690   4,778,690   0.355182   0.000000   92.00   94. 00   09400   HOME PROGRAM DIALYSIS   0   0   0   0.000000   0.000000   94.00   95. 00   09500   AMBULANCE SERVICES   0   11,400,459   11,400,459   0.341605   0.000000   95.00   96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0   0   0.000000   0.000000   96.00   97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0   0   0.000000   0.000000   97.00   98. 00   09800   OTHER REI MBURSABLE COST CENTERS   0   0   0   0.000000   0.000000   98.00   99. 10   09900   CMHC   0   0   0   0   0.000000   0.000000   99.00   99. 10   09900   CMHC   0   0   0   0   0   0.000000   0.000000   99.00   99. 10   100.00   LASS ERVICES-NOT APPRVD PRGM   0   0   0   0   0.0000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			196, 169	197, 326			
OTHER REIMBURSABLE COST CENTERS							
94. 00   09400   HOME PROGRAM DI ALYSIS   0   0   0   0   0   0   0   0   0		0	4, 778, 690	4, 778, 690	0. 355182	0.000000	92.00
95. 00		ol	0		0. 000000	0.000000	94.00
97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0   0   0   0   0   0   0   0		Ö	11, 400, 459	11, 400, 459		0. 000000	•
98. 00		0	0	(			ł
99. 00		0	0	(			1
100. 00   10000   1 &R SERVI CES-NOT APPRVD PRGM   0   0   0   100. 00   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   101. 00   101. 00   SPECI AL PURPOSE COST CENTERS		0	0		0.000000	0.00000	•
101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   0   0   0   101. 00	99. 10 09910 CORF	O	0				•
SPECIAL PURPOSE COST CENTERS   105. 00   10500   KI DNEY ACQUI SI TI ON   0   0   0   0   105. 00   106. 00   106. 00   106. 00   106. 00   106. 00   107. 00   107. 00   107. 00   107. 00   107. 00   107. 00   107. 00   107. 00   108. 00   108. 00   108. 00   109.			0	(			
105. 00		0	0		)		101.00
106. 00   10600   HEART ACQUI SI TI ON		О	0	(			105. 00
108. 00   10800   LUNG ACQUISITION   0 0 0 0 109. 00   1	106.00 10600 HEART ACQUISITION		0	(			
109. 00   10900   PANCREAS ACQUI SI TI ON		0	0	9			
110. 00   11000   INTESTINAL ACQUISITION			0				
111. 00   11100   1   SLET ACQUI SI TI ON   0   0   0   111. 00   113. 00   11300   I NTEREST EXPENSE   114. 00   11400   UTI LI ZATI ON REVI EW-SNF   115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. )   0   0   0   0   115. 00   116. 00   116. 00   116. 00   116. 00   116. 00   0   0   0   0   0   0   0   0   0			0				
114. 00   11400   UTI LI ZATI ON REVI EW-SNF   114. 00   11500   AMBULATORY SURGI CAL CENTER (D. P.)   0   0   0   115. 00   116. 00   116. 00   116. 00   116. 00   116. 00   0   0   0   0   0   0   0   0   0		0	0	(			
115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. ) 0 0 0 115. 00 116. 00   116. 00							
116. 00 11600 HOSPI CE 0 0 0 116. 00		n	n	(			
200. 00    Subtotal (see instructions)   46, 141, 734  164, 037, 030  210, 178, 764    200. 00	116. 00 11600 HOSPI CE	0	0				116. 00
	200.00   Subtotal (see instructions)	46, 141, 734	164, 037, 030	210, 178, 764	H I		200. 00

Health Financial Systems	COMMUNITY HOSPITAL	OF NOBLE CTY,	I NC	In Lie	eu of Form CMS-2552-1	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-014		Period: From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. (	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7.00	8. 00	9. 00	10.00	
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	46, 141, 734	164, 037, 030	210, 178, 76	4		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 10: 28 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0146

		Title XIX	Hospi tal	5/28/2019 10: 28 am PPS
Cost Center Description	PPS Inpatient	THE XIX	1103pi tai	113
	Ratio			
INDATIENT DOUTINE CEDVICE COCT CENTERS	11. 00			
30. 00 O3000 ADULTS & PEDIATRICS				30.00
31. 00   03100   NTENSI VE CARE UNI T				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34. 00   03400   SURGI CAL INTENSIVE CARE UNIT				34.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF				40. 00 41. 00
43. 00   04300   NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
45.00 04500 NURSING FACILITY				45. 00
46. 00 O4600 OTHER LONG TERM CARE				46. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   0PERATI NG ROOM	0. 197354			E0.00
51. 00   05100   RECOVERY ROOM	0. 000000			50. 00 51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 459944			52.00
53. 00 05300 ANESTHESI OLOGY	0. 010802			53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 104319			54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C 56. 00   05600   RADI OI SOTOPE	0. 000000 0. 000000			55. 00 56. 00
57. 00   05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00   06000   LABORATORY	0. 166907			60.00
60. 01   06001   BLOOD LABORATORY 61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000 0. 000000			60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 150971			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 606471			66.00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0. 551316 0. 584130			67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 157075			71. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS	0. 282813			72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	0. 193440 0. 000000			73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 242937			76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS	0.000000			00.00
88.00   08800   RURAL HEALTH CLINIC 89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0. 000000 0. 000000			88. 00 89. 00
90. 00   09000   CLINI C	0. 504531			90.00
91. 00   09100   EMERGENCY	0. 112993			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 355182			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			0.4.00
94. 00   09400   HOME PROGRAM DI ALYSIS 95. 00   09500   AMBULANCE SERVICES	0. 000000 0. 341605			94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
99. 00   09900   CMHC				99.00
99. 10   09910   CORF 100. 00   10000   L&R   SERVI CES-NOT   APPRVD   PRGM				99. 10 100. 00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				101100
105.00 10500 KIDNEY ACQUISITION				105. 00
106. 00 10600 HEART ACQUI SI TI ON				106. 00
107. 00 10700 LI VER ACQUI SI TI ON				107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION				108. 00 109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON				110.00
111. 00 11100   SLET ACQUI SI TI ON				111.00
113.00 11300 INTEREST EXPENSE				113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
115. 00 11500  AMBULATORY SURGI CAL CENTER (D. P. ) 116. 00 11600  HOSPI CE				115. 00 116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Heal th Financial Systems COMMUNITY HOSPIT CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Peri od: | Worksheet C | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | From 12/31/2018 | Date/Time Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepared: | From 12/31/2018 | Prepa Provi der CCN: 15-0146

				11	) 12/31/2018	5/28/2019 10:	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
				Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
		1.00	2. 00	col . 2) 3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
	05000 OPERATING ROOM	4, 030, 524	456, 065	3, 574, 459	0	0	50.00
	05100 RECOVERY ROOM	0	C	ή	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 114, 316			0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY	28, 207		1	0	0	53.00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	5, 108, 633	728, 951	4, 379, 682	0	0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE				0	0	56.00
57. 00	05700 CT SCAN	Ö		ol ö	Ö	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	c	o	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	d c	0	0	0	59. 00
60.00	06000 LABORATORY	4, 160, 609	246, 737	3, 913, 872	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	62. 00 63. 00
64. 00	06400 INTRAVENOUS THERAPY	0			0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	1, 367, 919	111, 071	1, 256, 848	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 936, 597			0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	644, 334	36, 632	607, 702	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	452, 856	25, 744	427, 112	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	77.045	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 259, 602			0	0	71. 00 72. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	750, 954 4, 175, 939		1	0	0	72.00
	07400 RENAL DIALYSIS	4, 173, 737	310, 400	0 0 0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	d	o o	0	0	75. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 166, 171	76, 960	1, 089, 211	0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0	0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS				ما	0	00.00
	08800   RURAL HEALTH CLINIC   08900   FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	88. 00 89. 00
	09000 CLINIC	99, 557	5, 668	93, 889	0	0	90.00
	09100 EMERGENCY	3, 773, 748		1	o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 697, 303			0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0	004.00	0	0	0	94.00
	09500  AMBULANCE SERVI CES   09600  DURABLE MEDI CAL EQUI P-RENTED	3, 894, 457	324, 307	3, 570, 150	0	0	95. 00 96. 00
	09700 DURABLE MEDICAL EQUIP-RENTED	0			0	0	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0			0	0	98. 00
99. 00	09900 CMHC	0	d	0	0	0	99. 00
99. 10	09910 CORF	0	C	0	0	0	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	C	0	0		100. 00
101. 00	10100 HOME HEALTH AGENCY	0	C	0	0	0	101. 00
105.00	SPECIAL PURPOSE COST CENTERS				٥	0	105 00
	10500   KIDNEY ACQUISITION   10600   HEART ACQUISITION				0		105. 00 106. 00
	10700 LI VER ACQUI SI TI ON	0			0		107. 00
	10800 LUNG ACQUISITION	Ö	l c	o o	Ö		108. 00
	10900 PANCREAS ACQUISITION	0	c	0	0		109. 00
	11000 INTESTINAL ACQUISITION	0	C	0	0		110. 00
	11100   SLET ACQUI SI TI ON	0	C	0	0	0	111.00
	11300 I NTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00 115. 00
	11500  AMBULATORY SURGI CAL CENTER (D. P. )  11600  HOSPI CE				O O		116. 00
200.00		35, 661, 726	3, 107, 711	32, 554, 015	o O		200. 00
201.00		1, 697, 303			ő		201. 00
202.00		33, 964, 423			O		202. 00
				,	·		

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: 15-0146

REDUCTIONS FOR MEDICALD ONLY

Peri od: From 01/01/2018 To 12/31/2018

| In Lieu of Form CMS-2552-10 | Worksheet C | Part II | B1/2018 | Date/Time Prepared: 5/28/2019 10: 28 am | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS | DBS |

		Ti tl	e XIX	Hospi tal	PPS	20 a
Cost Center Description	Cost Net of	Total Charges				
, , , , , , , , , , , , , , , , , , ,	Capital and		Cost to Charge			
	Operating Cost					
	Reduction	8)	/ col. 7)			
	6.00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS			<u>'</u>			
50. 00 05000 OPERATI NG ROOM	4, 030, 524	20, 422, 768	0. 197354			50.00
51.00 05100 RECOVERY ROOM			0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 114, 316	2, 422, 723				52.00
53. 00 05300 ANESTHESI OLOGY	28, 207	2, 668, 743				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 108, 633	48, 971, 409	1			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	,,	0.000000			55. 00
56. 00   05600   RADI OI SOTOPE		Č	0. 000000			56.00
57. 00 05700 CT SCAN		Č	0. 000000			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		Č	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 000000			59.00
60. 00   06000   LABORATORY	4, 160, 609	24, 927, 639				60.00
60. 01   06001   BLOOD LABORATORY	4, 100, 007	24, 727, 037	0.000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0.000000			61.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS						1
	0		0.000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0.000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY	1 0/7 010	0.000.000	0.000000			64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 367, 919	9, 060, 822				65. 00
66. 00   06600   PHYSI CAL THERAPY	1, 936, 597	3, 193, 223				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	644, 334	1, 168, 719				67. 00
68. 00   06800   SPEECH PATHOLOGY	452, 856	775, 266				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	C	0.000000			69. 00
70. 00  07000 ELECTROENCEPHALOGRAPHY	0	C	0.000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 259, 602	8, 019, 116	0. 157075			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	750, 954	2, 655, 303	0. 282813			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 175, 939	21, 587, 779	0. 193440			73. 00
74.00 07400 RENAL DIALYSIS	o	C	0.000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	o	C	0.000000			75. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 166, 171	4, 800, 295	0. 242937			76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	C	0.000000			77. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		<u>'</u>			1
88. 00 08800 RURAL HEALTH CLINIC	0	C	0.000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	C	0. 000000			89. 00
90. 00 09000 CLI NI C	99, 557	197, 326				90.00
91. 00   09100   EMERGENCY	3, 773, 748	33, 433, 173				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 697, 303	4, 778, 690				92.00
OTHER REIMBURSABLE COST CENTERS	1,077,000	177707070	0.000.02			1 /2:00
94. 00 09400 HOME PROGRAM DI ALYSI S	O	C	0.000000			94. 00
95. 00 09500 AMBULANCE SERVI CES	3, 894, 457	11, 400, 459				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	11, 100, 10,	0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	l o	Č	0. 000000			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0. 000000			98. 00
99. 00   09900   CMHC			0.000000			99.00
99. 10   09910   CORF			0.000000			99. 10
						100.00
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0		0.000000			1
101. 00 10100 HOME HEALTH AGENCY	0	C	0.000000			101. 00
SPECIAL PURPOSE COST CENTERS			0.000000			105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	C	0.000000			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	C	0. 000000			106. 00
107.00 10700 LIVER ACQUISITION	0	C				107. 00
108.00 10800 LUNG ACQUISITION	0	C				108. 00
109.00 10900 PANCREAS ACQUISITION	0	C	0.000000			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	C	0.000000			110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	C	0.000000			111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	C	0.000000			115. 00
116. 00 11600 HOSPI CE	o	C	0. 000000			116. 00
200.00 Subtotal (sum of lines 50 thru 199)	35, 661, 726	200, 483, 453	В			200.00
201.00 Less Observation Beds	1, 697, 303	C				201.00
202.00 Total (line 200 minus line 201)	33, 964, 423	200, 483, 453	B			202.00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ROUTINE	SERVICE CAPITAL COSTS	Provider CCN: 15-0146	Peri od:	Worksheet D

Heal th Financia	ol Systems (	COMMUNITY HOSPITAL (	OF NOBLE CTY,	INC	In Lie	eu of Form CMS-2	2552-10
APPORTI ONMENT (	OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2018		
				-	Γο 12/31/2018		
						5/28/2019 10:	28 am_
				XVIII	Hospi tal	PPS	
Cos	st Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
		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	
I NPATI EN	T ROUTINE SERVICE COST CENTERS			•			
30. 00 ADULTS &		592, 873	0	592, 873	6, 071	97. 66	30.00
	/E CARE UNIT	0			0	0.00	
•	CARE UNIT	Ö		1	0	0.00	
•	ENSIVE CARE UNIT	ام				0.00	
	INTENSIVE CARE UNIT			)		0.00	
	DER - IPF	0	0			0.00	
	DER - IPF	0	0			0.00	
	DER - IRF	21 202	Ü	21 201	112		
43. 00 NURSERY	AUIDOLNO FAOLLITY	21, 283		21, 28	413		
	NURSING FACILITY	O		(	0	0.00	
45. 00 NURSI NG		0			0	0.00	
	ines 30 through 199)	614, 156		614, 156	6, 484		200. 00
Cos	st Center Description	I npati ent	Inpati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6. 00	7.00				
I NPATI EN	T ROUTINE SERVICE COST CENTERS						
30.00 ADULTS &	PEDI ATRI CS	2, 085	203, 621				30.00
31.00 INTENSIV	/E CARE UNIT	ol	0	)			31.00
32. 00 CORONARY	CARE UNIT	l ol	0	)			32. 00
	ENSIVE CARE UNIT	o	0	,			33. 00
•	INTENSIVE CARE UNIT	Ö	0				34. 00
•	DER - I PF		0				40.00
	DER - IRF	الم	0				41. 00
43. 00 NURSERY	DER - TRI	0	0				43. 00
	NUDCING FACILITY		0				
	NURSING FACILITY		0				44.00
45. 00 NURSI NG		0 005	0	1			45. 00
200.00 lotal (1	ines 30 through 199)	2, 085	203, 621	1			200. 00

Heal th	Financial Systems COMM	UNITY HOSPITAL	OF NOBLE CTY,	INC	In Lie	eu of Form CMS-:	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0146	Peri od:	Worksheet D	
					From 01/01/2018	Part II	
					To 12/31/2018	Date/Time Pre 5/28/2019 10:	pared:
						5/28/2019 10:	28 am_
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	456, 065	20, 422, 768	0. 02233	1, 441, 843	32, 198	50.00
51.00	05100 RECOVERY ROOM	0	0	0. 00000	00	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	92, 036	2, 422, 723	0. 03798	7, 846	298	52.00
53. 00	05300 ANESTHESI OLOGY	1, 663	2, 668, 743			88	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	728, 951	48, 971, 409	1		30, 578	
55. 00	05500 RADI OLOGY-THERAPEUTI C	720, 701	10, 77 1, 107	0. 00000		0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	ı		0	56.00
57. 00	05700 CT SCAN	0	0	1		0	57. 00
58. 00			0	1		0	58. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0			0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	044 707	_			1	59. 00
60.00	06000 LABORATORY	246, 737	24, 927, 639			20, 505	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1 0.0000		0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0. 00000	0 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	111, 071	9, 060, 822	0. 01225	1, 151, 921	14, 120	65. 00
66.00	06600 PHYSI CAL THERAPY	151, 182	3, 193, 223	0. 04734	114, 894	5, 440	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	36, 632	1, 168, 719	0. 03134	11, 128	349	67. 00
68.00	06800 SPEECH PATHOLOGY	25, 744	775, 266	0. 03320	9, 966	331	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0. 00000	00	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	00	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	77, 245	8, 019, 116			4, 778	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	42, 518	2, 655, 303	1			
73. 00	07300 DRUGS CHARGED TO PATIENTS	310, 468	21, 587, 779	1	•	26, 858	
74. 00	07400 RENAL DI ALYSI S	0.07.00	0	i		0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	i		o o	75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	76, 960	4, 800, 295			Ö	76. 98
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	70, 700	4, 000, 273	1		0	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	U	U	0.00000	0	0	77.00
00 00	08800 RURAL HEALTH CLINIC		0	0.0000	0	0	00.00
88. 00 89. 00		0	0			0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER			0.0000		ľ	89. 00
90.00	09000 CLI NI C	5, 668	197, 326	1		0	90.00
91. 00	09100 EMERGENCY	285, 698	33, 433, 173				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	134, 766	4, 778, 690	0. 02820	01 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0.00000	00	0	94. 00
95.00	09500 AMBULANCE SERVI CES			1			95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.00000	0 0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 00000	0 0	0	98. 00
200.00	Total (lines 50 through 199)	2, 783, 404	189, 082, 994		11, 859, 594	162, 339	200.00
				•	•	-	•

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2018 Part III Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Title XVIII Hospi tal PPS Nursing School Nursing School Allied Health Allied Health All Other Cost Center Description Post-Stepdown Post-Stepdown Medi cal Cost Adjustments Adjustments Education Cost 1.00 2. 00 1A 2A 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 0 0 0 0 0 0 0 0 31.00 03100 INTENSIVE CARE UNIT 000000000 0 0 0 31.00 03200 CORONARY CARE UNIT 32.00 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 34.00 04000 SUBPROVIDER - IPF 0 40.00 0 40.00 0 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 43.00 04300 NURSERY 0 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 45.00 04500 NURSING FACILITY 0 45.00 200.00 Total (lines 30 through 199) 200.00 Cost Center Description Swi ng-Bed Total Costs Total Patient Per Diem (col Inpati ent (sum of cols. Days Program Days Adi ustment 5 ÷ col. 6) Amount (see 1 through 3, <u>instructions)</u> minus col 4) 4.00 5.00 6.00 7.00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 6, 071 0. 00 2, 085 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 0.00 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0.00 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0.00 0 34.00 04000 SUBPROVI DER - I PF 0 40.00 0 0.00 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 0.00 0 41.00 04300 NURSERY 0 43.00 413 0.00 0 43.00 OI 44.00 04400 SKILLED NURSING FACILITY 0 0.00 0 44.00 04500 NURSING FACILITY 45.00 C 0 0.00 0 45.00 Total (lines 30 through 199) 2, 085 200. 00 200.00 6, 484 Cost Center Description I npati ent Program Pass-Through Cost (col. 7 x col. 8) 9. 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0000000000 31.00 03200 CORONARY CARE UNIT 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 04300 NURSERY 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 04500 NURSING FACILITY 45.00 45.00 200. 00 Total (lines 30 through 199) 200.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 10: 28 am 
 Heal th Financial
 Systems
 COMMUNITY
 HOSPITAL OF

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 COMMUNITY HOSPITAL OF NOBLE CTY, INC RY SERVICE OTHER PASS | Provider CCN: 15-0146 THROUGH COSTS

			T: +1 a	xVIII	Hooni tal	PPS	20 4111
	0 1 0 1 0 1 1	N DI : :			Hospi tal		
	Cost Center Description			Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments	0.00	Adjustments	0.00	
	ANOLLI ADV. CEDVI OF COCT. CENTERS	1.00	2A	2.00	3A	3. 00	
F0 00	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	ļ			0	
51. 00	05100 RECOVERY ROOM	0	0	1	0	0	51. 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
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	(	0	0	56. 00
57. 00	05700 CT SCAN	0	0	(	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0	0	59. 00
60.00	06000 LABORATORY	0	0	(	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	(	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	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
69.00	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o c		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o c		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	o c		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90. 00	09000 CLI NI C		i o		0	0	90.00
91. 00	09100 EMERGENCY				0	Ö	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1				Ö	92.00
72.00	OTHER REIMBURSABLE COST CENTERS			`	21		72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	(	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES			`			95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED				0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD					0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS					0	•
200.00	1						200.00
200.00	1.00a. (11103 00 till odgir 177)	1	1	1	-1	۰	1-50. 00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 | Peri od: | Worksheet D | From 01/01/2018 | Part IV | To | 12/31/2018 | Date/Time | Prepared: THROUGH COSTS

						10	12/31/2016	5/28/2019 10:	
				Title	: XVIII		Hospi tal	PPS	
	Cost Center Description	All Other	Tota	Cost	Total	Т		Ratio of Cost	
	'	Medi cal	(sum c	f cols.	Outpatient		from Wkst. C,	to Charges	
		Education Cost		3, and	Cost (sum of	f Ì Ì	Part I, col.	(col. 5 ÷ col.	
				4)	col s. 2, 3,		8)	7)	
					and 4)		,	,	
		4. 00	5.	.00	6. 00		7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATI NG ROOM	0		0		0	20, 422, 768	0.000000	50. 00
51.00	05100 RECOVERY ROOM	0		0		0	0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0		0	2, 422, 723	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0		0		0	2, 668, 743	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0		0	48, 971, 409	0.000000	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0		0	0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0		0		0	0	0.000000	56. 00
57.00	05700 CT SCAN	0		0		0	0	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0		0	0	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0		0	0	0. 000000	59. 00
60.00	06000 LABORATORY	0		0		0	24, 927, 639	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0		0		0	0	0.000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						_		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		0	0	0. 000000	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0		0	0	0. 000000	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		0		0	0	0. 000000	64. 00
65. 00	06500 RESPIRATORY THERAPY	0		0		0	9, 060, 822	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		0		0	3, 193, 223	0. 000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		0		0	1, 168, 719	l	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		0		0	775, 266	l	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0		0	773, 200	0.000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0		0	0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	8, 019, 116	0.000000	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0	2, 655, 303	0.00000	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0		0	21, 587, 779	l e	73.00
74.00	07400 RENAL DIALYSIS	0		0		0	21, 367, 779	0.00000	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0		0	0	0.000000	75. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		0		0	4, 800, 295	l	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	1	0	4, 800, 293	l	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	U				U	U	0.000000	77.00
88. 00	08800 RURAL HEALTH CLINIC	0		0		0	0	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	1	0	0	0.000000	89. 00
90.00	09000 CLINIC	0		0		0	197, 326	0.000000	90.00
91. 00	09100 EMERGENCY	0		0		0	33, 433, 173	l	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	4, 778, 690		91.00
92.00	OTHER REIMBURSABLE COST CENTERS	U		U		U	4, 778, 690	0.000000	92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0		0		o	0	0.000000	94. 00
94. 00 95. 00	09500 AMBULANCE SERVICES	U		U		U	U	0.00000	95. 00
				^			0	0 000000	
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED			0		0	0	0.000000	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD			0	1	0	0	0.000000	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS			0	1	0	100 000 004	0.000000	
200. 00	Total (lines 50 through 199)	0	l	0	T .	0	189, 082, 994	l	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2018 THROUGH COSTS Part IV 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am Title XVIII Hospi tal PPS Outpati ent Inpati ent Outpati ent Cost Center Description Inpatient Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col . 12) 13.00 7) x col. 10) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 3, 419, 983 50.00 1, 441, 843 0 0 05100 RECOVERY ROOM 51.00 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 52.00 7,846 0 05300 ANESTHESI OLOGY 0.000000 141, 593 0 323, 261 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0.000000 2, 054, 302 10, 155, 097 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 0 o 57.00 05700 CT SCAN 0.000000 57.00 Ω 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.000000 C 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 59.00 06000 LABORATORY 60.00 0.000000 2, 071, 591 0 2, 335, 499 0 60.00 06001 BLOOD LABORATORY 0.000000 O 60 01 60 01 0 |06100| PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63 00 0 0 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 0.000000 1, 151, 921 1, 810, 293 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 114, 894 45,084 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67 00 11, 128 Ω 67 00 O 06800 SPEECH PATHOLOGY 0 68.00 0.000000 9, 966 0 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 496, 043 554, 323 71 00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 738, 036 142, 275 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1, 867, 465 0 5, 679, 502 0 73.00 73.00 07400 RENAL DIALYSIS 0.000000 0 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75 00 0.000000 Ω 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 0 0 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0.000000 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 0.000000 88.00 08800 RURAL HEALTH CLINIC 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89.00 0 90.00 09000 CLI NI C 0.000000 0 90.00 09100 EMERGENCY 0 0.000000 5, 715, 174 91.00 91.00 1, 752, 966 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 1, 192, 282 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97.00

0.000000

11, 859, 594

0

31, 372, 773

98.00 0

0 200.00

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

200.00

71.00

72.00

73.00

89.00

91.00

92.00

94.00

95.00

96.00 Ω

97.00

200.00

201 00

40, 237

Ω 74.00 75.00

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Λ 90.00

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0 98.00

4, 722, 711 202. 00

645, 095

423, 477

4, 722, 711

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Health Financial Systems COMMUNITY HOSPITAL 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 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed 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. 197354 3, 419, 983 674, 947 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0 459944 52 00 0 05300 ANESTHESI OLOGY 0 0 53.00 0.010569 323, 261 3, 417 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.104319 10, 155, 097 0 1, 059, 370 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 C 55 00 0 05600 RADI OI SOTOPE 0 56.00 0.000000 C 0 56.00 57.00 05700 CT SCAN 0.000000 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.000000 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 59 00 59 00 0 60.00 06000 LABORATORY 0.166907 2, 335, 499 389, 811 60.00 06001 BLOOD LABORATORY 0.000000 0 60.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0.000000 62 00 Ω 0 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 C 0 0 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0.150971 1, 810, 293 0 273, 302 65.00 0 06600 PHYSI CAL THERAPY 66.00 0.606471 45, 084 27, 342 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.551316 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 0.584130 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 69.00 0 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.157075 554, 323 0 87,070

0. 282813

0.193440

0.000000

0.000000

0. 242937

0.000000

0. 000000

0.000000

0.504531

0.112874

0. 355182

0.000000

0.341605

0.000000

0.000000

0.000000

142, 275

0

0

5, 679, 502

5, 715, 174

1, 192, 282

31, 372, 773

31, 372, 773

71.00

72.00

73.00

74.00

75.00

76. 98

77.00

88.00

89.00

90.00

91.00

92.00

94.00

95.00

96.00

97.00

98.00

200.00

201.00

202.00

07200 IMPL. DEV. CHARGED TO PATIENTS

07700 ALLOGENEIC STEM CELL ACQUISITION

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

07300 DRUGS CHARGED TO PATIENTS

07698 HYPERBARIC OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

09850 OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

09700 DURABLE MEDICAL EQUIP-SOLD

09400 HOME PROGRAM DIALYSIS

09500 AMBULANCE SERVICES

Only Charges

07500 ASC (NON-DISTINCT PART)

08800 RURAL HEALTH CLINIC

07400 RENAL DIALYSIS

09000 CLI NI C

09100 EMERGENCY

Provider CCN: 15-0146

0

Peri od:

202.00

Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 59 00 60.00 06000 LABORATORY 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76. 98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 0 90.00 09000 CLI NI C 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 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 00000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 200.00 Subtotal (see instructions) 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201 00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems	COMMUNITY HOSPITAL	OF NOBLE CTY,	I NC	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERV	ICE CAPITAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2018 Fo 12/31/2018	Part I Date/Time Pre	narod:
				10 12/31/2010	5/28/2019 10:	28 am
		Ti tl	e XIX	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 .			
	<u>26)</u> 1. 00	2.00	2) 3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CE		2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	592, 873	0	592, 873	6, 071	97. 66	30.00
31. 00 INTENSIVE CARE UNIT	0,2,0,3	Ĭ	372, 073	0, 0, 1	0.00	
32. 00 CORONARY CARE UNIT	0			0	0.00	
33. 00 BURN INTENSIVE CARE UNIT	0			o o	0.00	1
34.00 SURGICAL INTENSIVE CARE UNIT	0			0	0.00	1
40. 00 SUBPROVI DER - I PF	0	0	(	0	0.00	40. 00
41. 00 SUBPROVI DER - I RF	0	0	(	0	0.00	41.00
43. 00 NURSERY	21, 283		21, 283	413	51. 53	
44.00 SKILLED NURSING FACILITY	0		(	0	0.00	
45.00 NURSING FACILITY	0		(	0	0.00	
200.00 Total (lines 30 through 199)	614, 156		614, 156	6, 484		200. 00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost (col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CE			I .			
30.00 ADULTS & PEDIATRICS	88	8, 594				30. 00
31.00 INTENSIVE CARE UNIT	0	0				31. 00
32. 00 CORONARY CARE UNIT	0	0				32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	l .			34. 00
40. 00 SUBPROVI DER - I PF	0	0	l .			40.00
41. 00 SUBPROVI DER - I RF	0	"				41.00
43.00 NURSERY 44.00 SKILLED NURSING FACILITY	27	1, 391				43. 00 44. 00
44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30 through 199)	115	9, 985				200. 00
200.00 10 tal (111163 30 till bugli 199)	113	1 7, 700	I			1200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2018 Part II 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am Title XIX Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent Related Cost (from Wkst. C. to Charges (column 3 x Program (from Wkst. B, column 4) Part I. col. (col. 1 + col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 6, 989 50.00 05000 OPERATING ROOM 456, 065 0.022331 312, 980 50.00 20, 422, 768 05100 RECOVERY ROOM 51.00 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 92, 036 0.037989 0 52.00 2, 422, 723 0 52.00 05300 ANESTHESI OLOGY 2, 668, 743 0.000623 62, 350 39 53.00 1,663 53.00 48, 971, 409 05400 RADI OLOGY-DI AGNOSTI C 728, 951 0.014885 81, 079 1, 207 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0.000000 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 0.000000 0 0 56.00 57.00 05700 CT SCAN 0 0.000000 0 57.00 Ω 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0.000000 0 0 59.00 60.00 06000 LABORATORY 246, 737 24, 927, 639 0.009898 91, 078 901 60.00 06001 BLOOD LABORATORY 0.000000 60 01 60 01 0 0 0 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0.000000 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63 00 0 0 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 Λ 64.00 06500 RESPIRATORY THERAPY 111, 071 9,060,822 0.012258 40, 811 500 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 151, 182 3, 193, 223 0.047345 125 66.00 2,636 06700 OCCUPATIONAL THERAPY 36, 632 0.031344 67 00 1, 168, 719 0 67 00 06800 SPEECH PATHOLOGY 68.00 25, 744 775, 266 0.033207 1, 595 53 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 0 70.00 8, 019, 116 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 77, 245 0.009633 426 71 00 44, 180 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 42, 518 2, 655, 303 0.016012 0 72.00 07300 DRUGS CHARGED TO PATIENTS 21, 587, 779 0.014382 139, 218 2,002 73.00 73.00 310, 468 07400 RENAL DIALYSIS 0.000000 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 75 00 0 0 75.00 76.98 07698 HYPERBARI C OXYGEN THERAPY 76, 960 4, 800, 295 0.016032 0 0 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88 00 0.000000 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 89.00 0 90.00 09000 CLI NI C 5,668 197, 326 0.028724 O 90.00 09100 EMERGENCY 91.00 285, 698 33, 433, 173 0.008545 388 91.00 45, 377 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 134, 766 4, 778, 690 0.028201 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 0 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 0 200.00 Total (lines 50 through 199) 2, 783, 404 189, 082, 994 821, 304 12, 630 200. 00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2018 Part III Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Title XIX Hospi tal PPS Nursing School Nursing School Allied Health Allied Health All Other Cost Center Description Post-Stepdown Post-Stepdown Medi cal Cost Adjustments Education Cost Adjustments 1.00 2. 00 1A 2A 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 0 0 0 0 0 0 0 0 31.00 03100 INTENSIVE CARE UNIT 000000000 0 0 0 31.00 03200 CORONARY CARE UNIT 32.00 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 34.00 04000 SUBPROVIDER - IPF 0 40.00 0 40.00 0 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 43.00 04300 NURSERY 0 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 45.00 04500 NURSING FACILITY 0 45.00 200.00 Total (lines 30 through 199) 200.00 Cost Center Description Swi ng-Bed Total Costs Total Patient Per Diem (col Inpati ent (sum of cols. Days Program Days Adi ustment 5 ÷ col. 6) Amount (see 1 through 3, <u>instructions)</u> minus col 4) 4.00 5.00 6.00 7.00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 6, 071 0. 00 88 03100 INTENSIVE CARE UNIT 31.00 0 0 0.00 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0.00 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0.00 0 34.00 04000 SUBPROVI DER - I PF 0 40.00 0 0.00 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 0.00 0 41.00 04300 NURSERY 0 43.00 413 0.00 27 43.00 OI 44.00 04400 SKILLED NURSING FACILITY 0 0.00 0 44.00 04500 NURSING FACILITY 45.00 C 0 0.00 0 45.00 Total (lines 30 through 199) 115 200. 00 200.00 6, 484 Cost Center Description I npati ent Program Pass-Through Cost (col. 7 x col. 8) 9. 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0000000000 31.00 32.00 03200 CORONARY CARE UNIT 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 04300 NURSERY 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 04500 NURSING FACILITY 45.00 45.00 200. 00

200.00

Total (lines 30 through 199)

 
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 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provi der CCN: 15-0146 THROUGH COSTS

								5/28/2019 10:	28 am_
				Ti tl	e XIX		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nurs	si na School	Nursi na Scho	ol Al	lied Health	Allied Health	
		Anesthetist		st-Stepdown			ost-Stepdown		
		Cost		djustments			Adjustments		
		1.00	1	2A	2.00	'	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00		2/1	2.00		JA	3.00	
FO 00	05000 OPERATING ROOM			0			O	0	FO 00
50.00				-	1	0	- 1	0	50.00
51. 00	05100 RECOVERY ROOM		기	0	1	0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM		)	0	1	O	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	(C	)	0	)	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C		0		0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	C		0	)	0	0	0	55.00
56.00	05600 RADI OI SOTOPE		ol	0	)	o	o	0	56.00
57. 00	05700 CT SCAN			0	,	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)			0		Ô	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON			0		0	0	0	59. 00
	i i			0		0	0	0	
60.00	06000 LABORATORY			0	'	0	U		60.00
60. 01	06001 BLOOD LABORATORY		4	0	1	O	U	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0	)	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C		0	1	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	C		0		0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	C		0	)	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY		ol	0	)	0	o	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY		ol	0	)	o	o	0	67.00
68. 00	06800 SPEECH PATHOLOGY		ol	0	)	0	o	0	68.00
69. 00	06900 ELECTROCARDI OLOGY			0	,	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY			0		0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		ĺ	0		0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS			0		0	0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		(	0		0	0	0	73. 00
	I I			0		0	0	-	
74.00	07400 RENAL DIALYSIS			0	'	0	U	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)		1	0	'	0	0	0	75. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY		וי	0	1	0	0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION			0		0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS								
88. 00	08800 RURAL HEALTH CLINIC	(C		0	)	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C		0	)	0	0	0	89. 00
90.00	09000 CLI NI C	C		0	)	0	0	0	90.00
91.00	09100 EMERGENCY	C		0	)	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		ol			0		0	92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>							
94.00	09400 HOME PROGRAM DI ALYSI S	(	ol l	0	1	0	0	0	94.00
95. 00	09500 AMBULANCE SERVICES		1	ŭ			Ŭ,	Ü	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		ا	0		0	Λ	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		íl .	0	J	0	0	0	97. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		(	0	J	0	0	0	98. 00
	1 1		(	0	]	0	0	-	200. 00
200.00	Total (lines 50 through 199)	1	4	Ü	1	ΟĮ	υĮ	0	200. UU

 
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 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provi der CCN: 15-0146 THROUGH COSTS

					To 12/31/2018	Date/Time Pre 5/28/2019 10:	
			Ti tl	e XIX	Hospi tal	PPS	20 4111
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCI LLARY SERVI CE COST CENTERS			ı			
50. 00	05000 OPERATING ROOM	0	0		20, 422, 768	l e	1
51. 00	05100 RECOVERY ROOM	0	0		0	0.000000	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	•	2, 422, 723	•	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	1	2, 668, 743	0.000000	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 48, 971, 409	0.000000	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0.000000	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0	0.000000	56. 00
57. 00	05700 CT SCAN	0	0		0	0.000000	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0.000000	59.00
60.00	06000 LABORATORY	0	0		24, 927, 639		60.00
60. 01	06001 BLOOD LABORATORY	0	0	1	0	0.000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0.000000	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0 000	0.000000	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		9, 060, 822	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		3, 193, 223	0.000000	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	1, 168, 719	l e	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY	0	0		775, 266	l	68. 00
70.00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	0	0	1	0 0	0. 000000 0. 000000	69.00
70.00		0	0	1	8, 019, 116	0.00000	70. 00 71. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	2, 655, 303	0.00000	•
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	2, 655, 303	l e	1
74. 00	07400 RENAL DIALYSIS	0	0		0 21, 367, 779	0.000000	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	0			0.000000	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	•	4, 800, 295	l e	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 4, 600, 273	0.000000	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		'	5  0	0.000000	77.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	0		0 0		1
90.00	09000 CLINIC	Ö	0		197, 326	l	90.00
91. 00	09100 EMERGENCY	0	0		33, 433, 173	0. 000000	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		4, 778, 690	l	ı
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			1,770,070	0.00000	72.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0.000000	94.00
95. 00	09500 AMBULANCE SERVICES		_				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	o	0		0	0. 000000	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	ol	0		0	l	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	ol	0		0	0. 000000	98. 00
200.00		o	0		189, 082, 994		200.00
	, , ,					•	

In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2018 THROUGH COSTS Part IV 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 am Title XIX Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col.  $(col. 6 \div col$ Costs (col. x col. 12) 13.00 7) x col. 10) 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 312, 980 173, 348 50.00 0 0 05100 RECOVERY ROOM 51.00 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0.000000 62, 350 13, 827 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 54.00 81,079 54.00 543, 546 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 o 57.00 05700 CT SCAN 0.000000 0 57.00 Ω 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.000000 C 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 59.00 06000 LABORATORY 60.00 0.000000 91,078 0 283, 030 0 60.00 06001 BLOOD LABORATORY 0 0.000000 60 01 60 01 0 |06100| PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63 00 0 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 0.000000 40, 811 55, 218 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 72, 344 0 66.00 2,636 06700 OCCUPATIONAL THERAPY 0.000000 0 67 00 49, 831 67 00 0 06800 SPEECH PATHOLOGY 0 68.00 0.000000 1, 595 62, 152 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 31, 553 71 00 71 00 44, 180 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 245, 374 0 73.00 73.00 139, 218 07400 RENAL DIALYSIS 0.000000 0 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75 00 0.000000 Ω 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 0 0 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0.000000 0 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 0.000000 88.00 08800 RURAL HEALTH CLINIC 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89.00 0 90.00 09000 CLI NI C 0.000000 0 0 90.00 09100 EMERGENCY 0 659, 565 91.00 91.00 0.000000 0 45, 377 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 53, 116 0 92.00 OTHER REIMBURSABLE COST CENTERS

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0 200.00

94.00

95.00

96.00

200.00

09400 HOME PROGRAM DIALYSIS

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

Health Financial Systems COMMUNITY HOSPITAL 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 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed 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. 197354 173, 348 34, 211 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 459944 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.010569 13, 827 146 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 104319 543, 546 0 56, 702 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 55.00 C 0 0 05600 RADI OI SOTOPE 56.00 0.000000 C 0 56.00 57.00 05700 CT SCAN 0.000000 C 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.000000 0 0 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 00 59 00 0 60.00 06000 LABORATORY 0.166907 283, 030 47, 240 60.00 06001 BLOOD LABORATORY 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0.000000 C 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 C 0 0 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0.150971 0 55, 218 8.336 65.00 0 06600 PHYSI CAL THERAPY 66.00 0.606471 72.344 43.875 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.551316 49, 831 27, 473 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.584130 62, 152 36, 305 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 69.00 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.157075 0 4, 956 71.00 71.00 31, 553 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0. 282813 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0.193440 245, 374 0 73.00 47, 465 73.00 0 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 0 0 o 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0. 242937 C 0 76. 98 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 77.00  $\Gamma$ 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 O 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0.000000 0 90.00 09000 CLI NI C 0.504531 0 0 Λ 90.00 91.00 09100 EMERGENCY 0.112874 659, 565 0 0 74, 448 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 355182 53, 116 0 18, 866 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES 0.341605 255, 932 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 96.00 0 0 C 0 0 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0.000000 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 0 98.00 0 0 200.00 Subtotal (see instructions) 2, 242, 904 487, 451 200.00

0

0

2, 242, 904

201 00

487, 451 202. 00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

201 00

202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/28/2019 10:28 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 59 00 60.00 06000 LABORATORY 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76. 98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 0 90.00 09000 CLI NI C 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 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 00000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 200.00 Subtotal (see instructions) 0 200.00

0

201.00

202.00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0146	Peri od: From 01/01/2018	Worksheet D-1	
			To 12/31/2018	Date/Time Prepared: 5/28/2019 10:28 am	
		Title XVIII	Hospi tal	PPS	

		Title XVIII	Hospi tal	5/28/2019 10: PPS	28 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-ber vate room days (excluding swing-bed and observation bed days)	ped and newborn days)	vate room days,	6, 071 6, 071 0	1. 00 2. 00 3. 00
4. 00 5. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private rooms and the seminary of the seminary o		31 of the cost	4, 691 0	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roomers) reporting period (if calendar year, enter 0 on this line)	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	swing-bed and	2, 085	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	3	,	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 ye	ear, enter O on this line	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 o	lays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	17. 00		
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0. 00	18. 00		
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	19. 00		
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne 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 December 5 x line 17)		ng period (line	7, 466, 875 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ line 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 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) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		7, 466, 875	26. 00 27. 00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		,	0.00	35. 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	7, 466, 875	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 229. 93	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		2, 564, 404	39. 00
40.00	Medically necessary private room cost applicable to the Progra	,		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IIne 40)	l	2, 564, 404	41.00

		UNITY HOSPITAL O				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0146	Peri od:	Worksheet D-1	
					From 01/01/2018 To 12/31/2018		pared: 28 am
			_	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total npatient 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	
42. 00	NURSERY (title V & XIX only)	0	C	0.	00 0	0	42. 00
	Intensive Care Type Inpatient Hospital Units	-			0.0		4
	INTENSIVE CARE UNIT	0	C		00 0	0	1
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	(	1	00 0	1	
	SURGICAL INTENSIVE CARE UNIT	0	(	•		0	
	OTHER SPECIAL CARE (SPECIFY)		C	1 0.	00	0	47.00
+7.00	Cost Center Description						47.00
	oost conten bosch per on					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1, 951, 257	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	ee instructio	ons)		4, 515, 661	49. 00
	PASS THROUGH COST ADJUSTMENTS						
	Pass through costs applicable to Program inpull!)		`	·			
	Pass through costs applicable to Program inplied IV)	,	services (fr	om Wkst. D,	sum of Parts II	162, 339	
52. 00 53. 00	00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4,149,701						
	medical education costs (line 49 minus line !	52)					-
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
	Target amount per discharge						55. 00
	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient operati	ing cost and tar	get amount (I	ine 56 minus	line 53)	Ö	1
	Bonus payment (see instructions)	9	9 (.			o o	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	ndi ng 1996, เ	updated and c	ompounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upd	ated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than	n expected costs				0	61. 00
	amount (line 56), otherwise enter zero (see	instructions)					
	Relief payment (see instructions)		±:>			0	
	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	•	ĺ	and manage	ing ported (Coo	0	
	medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	3		·	3 1	0	
	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing			•		0	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing					0	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU				`		1 70 00
	Skilled nursing facility/other nursing facil				)		70.00
	Adjusted general inpatient routine service of		ne /U ÷ line	2)			71.00
	Program routine service cost (line 9 x line )		(lino 14 v !:	no 25)			72. 00 73. 00
	Medically necessary private room cost applications Total Program general inpatient routine services.						74.00
	Capital-related cost allocated to inpatient				Dort II column		
75.00							75.00

		1.00	2.00	3.00	4.00	5.00	
42. 00	NURSERY (title V & XIX only)	0	(	0.00	0	0	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00	INTENSIVE CARE UNIT	0	(		0		
44. 00	CORONARY CARE UNIT	0	(				1
45. 00	BURN INTENSIVE CARE UNIT	0	(		0		
46. 00	SURGICAL INTENSIVE CARE UNIT	0	(	0.00	0	0	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wks	+ D 2 col 2	lino 200)			1. 00 1, 951, 257	48. 00
49. 00	Total Program inpatient costs (sum of lines 4			nns)		4, 515, 661	
47.00	PASS THROUGH COST ADJUSTMENTS	ri tili ougii 40) (	3cc mstructro	J113)		4, 515, 661	77.00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst D sum o	of Parts L and	203, 621	50.00
00.00			00. 1. 000 ( 0.		or ranto rana		00.00
51.00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, sur	m of Parts II	162, 339	51.00
	and IV)						
52.00	Total Program excludable cost (sum of lines 5					365, 960	1
53. 00	Total Program inpatient operating cost exclud		lated, non-phy	ysician anesthe	tist, and	4, 149, 701	53. 00
	medical education costs (line 49 minus line 5	52)				1	
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F4 00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operati	ng cost and ta	roet amount (	ine 56 minus li	ne 53)	0	
58. 00	Bonus payment (see instructions)	ng cost and ta	inger amount (i	1110 00 1111 1103 11	110 00)	Ö	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	ortina period	endi na 1996. u	updated and comp	oounded by the	0.00	
	market basket	3	3				
60.00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the r	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lines	55, 59 or 60	enter the less	ser of 50% of th	ne amount by	0	61. 00
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see i	nstructions)				_	
62.00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cost	s through Doco	mbor 21 of the	cost roporting	a ported (Soc	0	64. 00
04.00	instructions) (title XVIII only)	.s till ough bece	iliber 31 OF the	e cost reportini	g perrou (see	l	04.00
65. 00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the d	cost reporting p	period (See	0	65. 00
00.00	instructions)(title XVIII only)		0. 0. 0	soot roper tring p	301.0 <b>u</b> (000	l	00.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVIII	only). For	0	66. 00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routine	costs through	December 31 o	of the cost repo	orting period	0	67. 00
(0.00	(line 12 x line 19)	t6t D		46	L:		(0.00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs arter b	ecember 31 or	the cost repor	ting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r	coutine costs (	line 67 ± line	- 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU						07.00
70. 00	Skilled nursing facility/other nursing facili						70.00
71. 00	Adjusted general inpatient routine service co						71.00
72.00	Program routine service cost (line 9 x line 7	71)					72. 00
73.00	Medically necessary private room cost applica	able to Program	ı(line 14 x li	ne 35)			73. 00
74. 00	Total Program general inpatient routine servi						74. 00
75. 00	Capital-related cost allocated to inpatient r	outine service	costs (from V	Vorksheet B, Pai	rt II, column		75. 00
7/ 00	26, line 45)	. 2)					74 00
76.00	Per diem capital related costs (line 75 ÷ lin	,					76. 00 77. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						78.00
79. 00	Aggregate charges to beneficiaries for excess		rovi der record	46)			79.00
80. 00	Total Program routine service costs for compa				s line 79)	1	80.00
81. 00	Inpatient routine service cost per diem limit			. (			81.00
82. 00	Inpatient routine service cost limitation (li		)				82. 00
83. 00	Reasonable inpatient routine service costs (s						83. 00
84.00	Program inpatient ancillary services (see ins	structions)					84. 00
85. 00	Utilization review - physician compensation (						85. 00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86. 00
07 -	PART IV - COMPUTATION OF OBSERVATION BED PASS						
87. 00	Total observation bed days (see instructions)		1: 0)			1, 380	
88. 00 89. 00	Adjusted general inpatient routine cost per of	•				1, 229. 93	1
07.00	Observation bed cost (line 87 x line 88) (see	: instructions)			ا	1, 697, 303	09.00

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF NOBLE CTY,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	592, 873	7, 466, 875	0. 07940	0 1, 697, 303	134, 766	90.00
91.00 Nursing School cost	0	7, 466, 875	0.00000	0 1, 697, 303	0	91.00
92.00 Allied health cost	0	7, 466, 875	0.00000	0 1, 697, 303	0	92.00
93.00 All other Medical Education	0	7, 466, 875	0. 00000	1, 697, 303	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF NOBLE CTY, INC	In Li€	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0	From 01/01/2018	Worksheet D-1 Date/Time Pre 5/28/2019 10:			
	Title XIX	Hospi tal	PPS			

		Title XIX	Hospi tal	5/28/2019 10: PPS	28 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days).	ped and newborn days)	vate room days,	6, 071 6, 071 0	1. 00 2. 00 3. 00
4. 00 5. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period		31 of the cost	4, 691 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 roor reporting period	31 of the cost	0	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	0 . 0		88	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct	tions)	,	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, et	nter O on this line)	,	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	3 .	,	0	12.00
13. 00 14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	13. 00 14. 00
15. 00 16. 00	Total nursery days (title V or XIX only)  Nursery days (title V or XIX only)	413 27			
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	0.00	17. 00		
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	0.00			
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	20. 00		
21. 00 22. 00	reporting period Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		na period (line	7, 466, 875 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	·		0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	$7  ext{ x line 19}$ Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	(line 21 minus line 24)		7 444 075	26.00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		25000)	7, 466, 875	
28. 00 29. 00	Private room charges (excluding swing-bed private room charges (excluding swing-bed charges)	a and observation bed cha	arges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	÷ line 28)		0. 000000	31. 00
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)	1! 22\/ !	h!>	0.00	33.00
34. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line		tions)	0.00	
35. 00 36. 00	Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	7, 466, 875	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	·			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 229. 93	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		108, 234	
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 108, 234	40.00
41.00	Trotal Trogram general impatrent routine service cost (IIIIe 39	11116 40)	l	100, 234	41.00

llool +h	Financial Systems COMMI	INITY HOSDITAL	OF NODLE (	otv.	LNC	In Lie	ou of Form CMC	2552 10
	Financial Systems COMMU ATION OF INPATIENT OPERATING COST	JNITY HOSPITAL			N: 15-0146	Peri od:	eu of Form CMS-: Worksheet D-1	
COMI OT	ATTOM OF THE ATTEM OF ENATING GOST		110010	ici o	514. 15 0140	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
				Ti +1	e XIX	Hospi tal	5/28/2019 10: PPS	28 am
	Cost Center Description	Total	Total		Average Per		Program Cost	
		Inpatient Cost					(col. 3 x col. 4)	
		1. 00	2.00		3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	261, 702		413	633.	56 27	17, 109	42. 00
42.00	Intensive Care Type Inpatient Hospital Units				0.4	20 0	0	12.00
43.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0		0	0. ( 0. (		_	
	BURN INTENSIVE CARE UNIT	0		0	0.1			
	SURGICAL INTENSIVE CARE UNIT	0		0	0.			1
	OTHER SPECIAL CARE (SPECIFY)			Ū	0.1	50		47. 00
	Cost Center Description	!				_		
							1. 00	
	Program inpatient ancillary service cost (Wks						133, 791	1
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(	see instr	ucti o	ns)		259, 134	49. 00
50.00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa	ationt routino	sorvi cos	(from	Wkst D su	of Parts L and	9, 985	50.00
51. 00	Pass through costs applicable to Program inpo   Pass through costs applicable to Program inpo			,				51.00
31.00	and IV)	atrent unerrai	y service.	3 (11	om wkst. b, .	Juli Of Tarts II	12,030	31.00
52.00	Total Program excludable cost (sum of lines!	50 and 51)					22, 615	
53. 00	medical education costs (line 49 minus line 52)						236, 519	53. 00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						1	54.00
	Target amount per discharge							55. 00
	Target amount (line 54 x line 55)						0.00	1
	Difference between adjusted inpatient operati	nd cost and ta	ırdet amoui	nt (I	ine 56 minus	line 53)	l ő	1
58. 00	Bonus payment (see instructions)		9	(.			0	1
59. 00	Lesser of lines 53/54 or 55 from the cost reparket basket	porting period	endi ng 199	96, u	pdated and co	ompounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report. ur	dated by	the m	arket basket		0.00	60.00
	If line 53/54 is less than the lower of lines					the amount by	0	1
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see i	n expected cost						
62.00	Relief payment (see instructions)	,					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ıcti ons)				0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 o	f the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of	the c	ost reportino	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus li	ine 6	5)(title XVI	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December	31 o	f the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after [	ecember 3	1 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient :					3 1	0	
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU							]
	Skilled nursing facility/other nursing facili							70. 00
	Adjusted general inpatient routine service co		ine 70 ÷ 1	line	2)			71. 00
72. 00		,			05)			72.00
	Medically necessary private room cost applica				ne 35)			73.00
	Total Program general inpatient routine servi	•			orkshoot P	Part II column		74.00
75. 00	Capital-related cost allocated to inpatient	outine Service	: COSIS (TI	i Oiii W	orksneet B, I	art II, COTUMN		75. 00

42.00	NURSERY (title V & XIX only)	261, 702	413	633. 66	27	17, 109	42. 00
	Intensive Care Type Inpatient Hospital Units	6					
43.00	INTENSIVE CARE UNIT	O	0	0.00	0	0	43.00
44. 00	CORONARY CARE UNIT	o	o	0. 00	ol	0	44. 00
45. 00	BURN INTENSIVE CARE UNIT	o	ő	0. 00	ő	0	45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT		0	0.00	o	0	46.00
		٩	٩	0.00	٩	٥	
47.00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description				_	4 00	
	T=		>			1. 00	
48. 00	Program inpatient ancillary service cost (W					133, 791	•
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see i	nstructi on	s)		259, 134	49. 00
	PASS THROUGH COST ADJUSTMENTS						i
50.00	Pass through costs applicable to Program in	patient routine servi	ces (from	Wkst. D, sum of Par	ts I and	9, 985	50.00
	111)						ł
51.00	Pass through costs applicable to Program in	oatient ancillary ser	vices (fro	m Wkst. D, sum of P	arts II	12, 630	51.00
	and IV)						ł
52.00	Total Program excludable cost (sum of lines	50 and 51)				22, 615	52.00
53.00	Total Program inpatient operating cost exclu	uding capital related	. non-phys	ician anesthetist.	and	236, 519	53.00
	medical education costs (line 49 minus line		,				
	TARGET AMOUNT AND LIMIT COMPUTATION	,					l
54. 00	Program di scharges					0	54.00
55. 00	Target amount per discharge				ŀ	0.00	
56. 00						0.00	56.00
	Target amount (line 54 x line 55)			F/! I! F0		0	•
57. 00	Difference between adjusted inpatient opera	ting cost and target	amount (II	ne 56 minus iine 53	)		57. 00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period endin	g 1996, up	dated and compounde	d by the	0. 00	59. 00
	market basket						
60. 00	Lesser of lines 53/54 or 55 from prior year					0. 00	•
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that		nes 54 x 6	0), or 1% of the ta	rget		1
	amount (line 56), otherwise enter zero (see	instructions)					
62.00	Relief payment (see instructions)					0	62. 00
63.00	Allowable Inpatient cost plus incentive payr	ment (see instruction	s)			0	63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cos	sts through December	31 of the	cost reporting peri	od (See	0	64. 00
	instructions)(title XVIII only)						1
65.00	Medicare swing-bed SNF inpatient routine cos	sts after December 31	of the co	st reporting period	(See	0	65. 00
	instructions)(title XVIII only)						1
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64 pl	us line 65	)(title XVIII only)	. For	0	66. 00
	CAH (see instructions)						1
67.00	Title V or XIX swing-bed NF inpatient routing	ne costs through Dece	mber 31 of	the cost reporting	peri od	0	67. 00
	(line 12 x line 19)						1
68. 00	Title V or XIX swing-bed NF inpatient routing	ne costs after Decemb	er 31 of t	he cost reporting p	eri od	0	68. 00
	(line 13 x line 20)						ł
69.00	Total title V or XIX swing-bed NF inpatient	routine costs (line	67 + line	68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	JURSING FACILITY, AND	ICF/IID 0	NLY			
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID routine	servi ce co	st (line 37)			70. 00
71.00	Adjusted general inpatient routine service of	cost per diem (line 7	0 ÷ line 2	)			71. 00
72. 00	Program routine service cost (line 9 x line			,	İ		72. 00
73. 00	Medically necessary private room cost applic		e 14 x lin	e 35)	İ		73. 00
74. 00	Total Program general inpatient routine serv			0 00)			74. 00
75. 00	Capital -related cost allocated to inpatient			rkshoot R Dart II	column		75. 00
73.00	ļ ·	Toutine service cost	3 (11011 110	rksheet b, rait ii,	COLUMN		75.00
74 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	no 2)				ŀ	76. 00
76. 00	1	*			ŀ	ŀ	
77. 00	Program capital -related costs (line 9 x line	•					77. 00
78. 00	Inpatient routine service cost (line 74 minu	-					78. 00
79. 00	Aggregate charges to beneficiaries for exces	, .		•			79. 00
80. 00	Total Program routine service costs for comp		imitation	(line 78 minus line	: 79)		80. 00
81. 00	Inpatient routine service cost per diem limi						81. 00
82. 00	Inpatient routine service cost limitation (	,					82.00
83. 00	Reasonable inpatient routine service costs	` ,					83. 00
84.00	Program inpatient ancillary services (see in	nstructions)					84. 00
85.00	Utilization review - physician compensation	(see instructions)					85. 00
86.00	Total Program inpatient operating costs (sur	m of lines 83 through	85)				86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS						
87.00	Total observation bed days (see instructions					1, 380	87. 00
88. 00	Adjusted general inpatient routine cost per		2)			1, 229. 93	1
89. 00	, , , , , , , , , , , , , , , , , , , ,	•	•			1, 697, 303	
					'		

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF NOBLE CTY,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 Fo 12/31/2018	Date/Time Prep 5/28/2019 10:3	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	592, 873	7, 466, 875	0. 07940	1, 697, 303	134, 766	90.00
91.00 Nursing School cost	0	7, 466, 875	0.00000	1, 697, 303	0	91.00
92.00 Allied health cost	0	7, 466, 875	0.00000	1, 697, 303	0	92.00
93.00 All other Medical Education	0	7, 466, 875	0.00000	1, 697, 303	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, IN	NC In Lie	u of Form CMS-2552-10

	ncial Systems COMMUNITY HOSPITAL OF	NOBLE CTY,	INC	In Li€	u of Form CMS-	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2018 To 12/31/2018		narod:
				10 12/31/2010	5/28/2019 10:	
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS			1	l	
1	ADULTS & PEDIATRICS			3, 330, 396	l	30.00
1	O I NTENSI VE CARE UNI T			0		31.00
1	CORONARY CARE UNIT			0		32.00
1	D BURN INTENSIVE CARE UNIT D SURGICAL INTENSIVE CARE UNIT			0		33. 00 34. 00
1	SUBPROVIDER - IPF			0		40.00
	SUBPROVIDER - I RF					41. 00
1	NURSERY					43. 00
	LLARY SERVICE COST CENTERS		1	_	l	43.00
	O OPERATING ROOM		0. 19735	4 1, 441, 843	284, 553	50.00
-	RECOVERY ROOM		0.00000		0	1
	DELIVERY ROOM & LABOR ROOM		0. 45994		3, 609	1
	ANESTHESI OLOGY		0. 01080			1
54.00 05400	RADI OLOGY-DI AGNOSTI C		0. 10431		214, 303	1
	RADI OLOGY-THERAPEUTI C		0.00000		0	55. 00
56. 00 05600	RADI OI SOTOPE		0.00000	0 0	0	56. 00
57. 00 05700	O CT SCAN		0.00000	0 0	0	57. 00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)		0.00000	0 0	0	58. 00
59.00 05900	CARDIAC CATHETERIZATION		0.00000	0 0	0	59. 00
	LABORATORY		0. 16690	7 2, 071, 591	345, 763	60. 00
60. 01 06001	1 BLOOD LABORATORY		0.00000	0	0	60. 01
1	PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61. 00
1	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	62. 00
1	D BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63. 00
1	O I NTRAVENOUS THERAPY		0.00000		0	64. 00
	RESPI RATORY THERAPY		0. 15097		173, 907	65. 00
	PHYSI CAL THERAPY		0. 60647		69, 680	1
1	OCCUPATIONAL THERAPY		0. 55131			1
	D SPEECH PATHOLOGY D ELECTROCARDI OLOGY		0. 58413		1	68. 00 69. 00
1	D ELECTROCARDI OLOGI D ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
1	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 15707		ľ	1
1	IMPL. DEV. CHARGED TO PATIENTS		0. 13707			1
	DRUGS CHARGED TO PATIENTS		0. 19344		361, 242	1
	RENAL DIALYSIS		0. 00000		0	1
1	ASC (NON-DISTINCT PART)		0. 00000		Ö	75. 00
-	B HYPERBARI C OXYGEN THERAPY		0. 24293		1	1
	ALLOGENEIC STEM CELL ACQUISITION		0.00000	0 0	0	77. 00
	ATIENT SERVICE COST CENTERS		•	<u> </u>		1
	RURAL HEALTH CLINIC		0.00000	0	0	88. 00
89. 00 08900	FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0	0	89. 00
90.00 09000	CLI NI C		0. 50453		0	90. 00
	D EMERGENCY		0. 11299	3 1, 752, 966	198, 073	91. 00
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 35518	2 0	0	92. 00
	R REIMBURSABLE COST CENTERS					
	HOME PROGRAM DIALYSIS		0.00000	0	0	
1	AMBULANCE SERVICES					95. 00
1	D DURABLE MEDI CAL EQUI P-RENTED		0.00000		0	
1	D DURABLE MEDI CAL EQUI P-SOLD		0.00000		0	
	O OTHER REIMBURSABLE COST CENTERS		0.00000		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(line (1)		11, 859, 594	1, 951, 257	1
201. 00 202. 00	Less PBP Clinic Laboratory Services-Program only charges	5 (TINE 61)		11 050 504		201. 00 202. 00
202.00	Net charges (line 200 minus line 201)		I	11, 859, 594	I	12U2. UU

Health Financial Systems COMMUNITY HOSPITAL OF	NOBLE CTY,	INC	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0146	Peri od:	Worksheet D-3	
			From 01/01/2018		
			To 12/31/2018		pared:
	<b></b>			5/28/2019 10:	28 am
	liti	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		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					1
30. 00   03000   ADULTS & PEDI ATRI CS			197, 257		30. 00
31. 00  03100 INTENSIVE CARE UNIT			0		31.00
32. 00  03200 CORONARY CARE UNIT			0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00   03400   SURGI CAL INTENSIVE CARE UNIT			0		34.00
40. 00   04000   SUBPROVI DER - 1 PF			0		40.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
43. 00   04300 NURSERY			45, 984		43.00
ANCI LLARY SERVI CE COST CENTERS			107.50		1
50. 00 05000 OPERATI NG ROOM		0. 19735	312, 980	61, 768	50.00
51. 00   05100   RECOVERY   ROOM		0.00000		0	1
52. 00 O5200 DELIVERY ROOM & LABOR ROOM		0. 45994		l o	
53. 00   05300   ANESTHESI OLOGY		0. 01080			1
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 10431			1
		1			1
		0.00000		0	1
56. 00   05600   RADI 0I SOTOPE		0.00000		0	
57. 00   05700   CT   SCAN		0.00000		0	
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0.00000		0	1
60. 00   06000   LABORATORY		0. 16690	91, 078	15, 202	60. 00
60. 01   06001   BLOOD LABORATORY		0.00000	00	0	60. 01
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000	00	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	00	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	00	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	00	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 15097		6, 161	1
66. 00 06600 PHYSI CAL THERAPY		0. 60647			1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 55131		0	1
68. 00   06800   SPEECH   PATHOLOGY		0. 58413			1
69. 00   06900   ELECTROCARDI OLOGY		0.00000		0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 15707		•	
		1			
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS		0. 28281		0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 19344			1
74. 00   07400   RENAL DI ALYSI S		0.00000		0	1
75. 00 O7500 ASC (NON-DISTINCT PART)		0.00000		0	1
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 24293		-	1
77.00 O7700 ALLOGENEIC STEM CELL ACQUISITION		0.00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					1
88.00   08800   RURAL HEALTH CLINIC		0.00000			1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	00	0	
90. 00   09000   CLI NI C		0. 50453	31 0	0	1
91. 00   09100   EMERGENCY		0. 11299		5, 127	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 35518	32 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DIALYSIS		0.00000	0 0	0	94.00
95. 00  09500  AMBULANCE SERVI CES					95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000	00 0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	1
200.00 Total (sum of lines 50 through 94 and 96 through 98)			821, 304		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			821, 304		202. 00
1 1 1 1 1 3 1 3 1 1 1 1 1 1 1 1 1 1 1 1		1		1	

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0146	Peri od: From 01/01/2018 To 12/31/2018		
		Title XVIII	Hospi tal	PPS	
			MDH	Non MDH	
	DADT A LABATIENT HOCKITAL CERVICES LINDER LDDS		1. 00	1. 01	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments		0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurri (see instructions)	ng prior to October 1	783, 794	1	
1. 02	DRG amounts other than outlier payments for discharges occurri (see instructions)	ng on or after October	913, 966	0	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for prior to October 1 (see instructions)	or discharges occurring	0	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for on or after October 1 (see instructions)	or discharges occurring	0	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		3, 381 0	0	2. 00 2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)	0	0	2. 02
3.00	Managed Care Simulated Payments		0	0	3. 00
4. 00	Bed days available divided by number of days in the cost report instructions)	rting period (see	26. 74		4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	t recent cost reporting	0.00		5. 00
6. 00	period ending on or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet the the conformal programs in accordance with 43 CEP 413.70(4).		n 0.00		6. 00
7. 00	to the cap for new programs in accordance with 42 CFR 413.79( $\epsilon$ MMA Section 422 reduction amount to the IME cap as specified $\epsilon$ §412.105(f)(1)(iv)(B)(1)		0.00		7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1,		0.00		7. 01
8. 00	instructions. Adjustment (increase or decrease) to the FTE count for allopat programs for affiliated programs in accordance with 42 CFR 413		0.00		8. 00
8. 01	413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 The amount of increase if the hospital was awarded FTE cap sloace. If the cost report straddles July 1, 2011, see instruction	ots under § 5503 of the	0.00		8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slotteaching hospital under § 5506 of ACA. (see instructions)		0.00		8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line (see instructions)	es (8, 8,01 and 8,02)	0.00		9. 00
10. 00	FTE count for allopathic and osteopathic programs in the currenceords	ent year from your	0.00		10. 00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)		0. 00 0. 00		11. 00 12. 00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that yea	ar ended on or after	0. 00 0. 00		13. 00 14. 00
15. 00	September 30, 1997, otherwise enter zero. Sum of Lines 12 through 14 divided by 3.		0.00		15. 00
	Adjustment for residents in initial years of the program		0.00		16. 00
17.00	Adjustment for residents displaced by program or hospital clos	sure	0.00		17. 00
	Adjusted rolling average FTE count		0.00		18. 00
	Current year resident to bed ratio (line 18 divided by line 4)	١.	0. 000000		19. 00
	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21. 00
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)		0	0	•
22.01	Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA	0		22.01
23. 00	Number of additional allopathic and osteopathic IME FTE reside CFR 412.105 (f)(1)(i $\vee$ )(C).		0.00		23. 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the I	ower of line 23 or line	0. 00 0. 00		24. 00 25. 00
	24 (see instructions)				
26.00	Resident to bed ratio (divide line 25 by line 4)		0. 000000		26. 00
27. 00	IME payments adjustment factor. (see instructions)		0. 000000		27. 00
28. 00	IME add-on adjustment amount (see instructions)		0	0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	)	0	0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)		0	0	•
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0° Disproportionate Share Adjustment	1)	0	0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A painstructions)	atient days (see	2. 33		30. 00
31.00	Percentage of Medicaid patient days (see instructions)		19. 86		31. 00
32.00	Sum of lines 30 and 31		22. 19		32. 00
	Allowable disproportionate share percentage (see instructions)	)	7. 52		33.00
34. 00	Disproportionate share adjustment (see instructions)		31, 918	33, 918	34.00

	N.T. 05 NOD 5 OTV			5.5	
Health Financial Systems COMMUNITY HOSP CALCULATION OF REIMBURSEMENT SETTLEMENT	PITAL OF NOBLE CTY, Provider C	TNC CN: 15-0146	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
	T' 11	V0 (1 1 1		5/28/2019 10:	28 am
	II ti e	MDH Prior to	Hospital Non MDH	PPS On/After 10/1	
		10/1	Non Mon	OII/AI LEI TO/T	
		1.00	1. 01	2.00	
Uncompensated Care Adjustment					
<ul> <li>35.00 Total uncompensated care amount (see instructions)</li> <li>35.01 Factor 3 (see instructions)</li> <li>35.02 Hospital uncompensated care payment (If line 34 is zer this line) (see instructions)</li> </ul>	ro, enter zero on	6, 766, 695, 16 0. 00005732 387, 89	24	8, 272, 872, 447 0. 000083315 689, 254	35. 01
Pro rata share of the hospital uncompensated care paym instructions)	ment amount (see	290, 12	23	173, 730	35. 03
35.04 Pro rata share of the hospital uncompensated care paym 36.00 Total uncompensated care (sum of columns 1 and 2 on li		107, 33 463, 85		173, 730	35. 04 36. 00
Additional payment for high percentage of ESRD benefic					30.00
40.00 Total Medicare discharges on Worksheet S-3, Part I exc for MS-DRGs 652, 682, 683, 684 and 685 (see instruction	cluding discharges		0		40. 00
	······	'	MDH	Non MDH	
			1. 00	1. 01	
11.00 Total ESRD Medicare discharges excluding MS-DRGs 652, instructions)		·	0	_	
41. 01 Total ESRD Medicare covered and paid discharges excludan 685. (see instructions)	ding MS-DRGs 652, 6	682, 683, 684	0	0	41. 01
42.00 Divide line 41 by line 40 (if less than 10%, you do no 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs instructions)			0.00		42. 00 43. 00
44.00 Ratio of average length of stay to one week (line 43 cdays)	divided by line 41 c	divided by 7	0. 000000		44. 00
45.00 Average weekly cost for dialysis treatments (see instr 46.00 Total additional payment (line 45 times line 44 times			0.00	0.00	45. 00 46. 00
47.00 Subtotal (see instructions)	,		2, 014, 124	2, 020, 829	47. 00
48.00 Hospital specific payments (to be completed by SCH and only. (see instructions)	d MDH, small rural h	nospi tal s	2, 642, 723	2, 020, 829	48. 00
			<u> </u>	Amount 1.00	
49.00 Total payment for inpatient operating costs (see instr	ructions)			4, 506, 402	49. 00
50.00 Payment for inpatient program capital (from Wkst. L, F	Pt. I and Pt. II, as			282, 204	50.00
51.00 Exception payment for inpatient program capital (Wkst.				0	51. 00
52.00 Direct graduate medical education payment (from Wkst.	E-4, line 49 see in	nstructions).		0	52.00
53.00 Nursing and Allied Health Managed Care payment				0	53.00
54.00   Special add-on payments for new technologies 54.01   Islet isolation add-on payment				0	54. 00 54. 01
55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,	line 69)				55. 00
56.00 Cost of physicians' services in a teaching hospital (s				Ö	56.00
57.00 Routine service other pass through costs (from Wkst. D		, lines 30 th	rough 35).	0	57.00
58.00 Ancillary service other pass through costs from Wkst.	D, Pt. IV, col. 11	line 200)	,	0	58. 00
59.00 Total (sum of amounts on lines 49 through 58)				4, 788, 606	59. 00
60.00 Primary payer payments				0	60.00
61.00 Total amount payable for program beneficiaries (line 5	59 minus line 60)			4, 788, 606	•
62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries				547, 372 2, 069	1
64.00 Allowable bad debts (see instructions)				50, 025	
65.00 Adjusted reimbursable bad debts (see instructions)				32, 516	1
66.00 Allowable bad debts for dual eligible beneficiaries (s	see instructions)			17, 819	
67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)	,			4, 271, 681	67. 00
68.00 Credits received from manufacturers for replaced device	ces for applicable t	to MS-DRGs (se	e instructions)	l 0	68 00

Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)

Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)

OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

0

68.00

69.00

70.00

70.50 Ω

70.00

70.50

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY	, INC		In Lieu	of Form	CMS-2552-10
AN AUGUST OF BELLEDINGS HENT OF THE FUELT			0.011 45 0444	n			

	Financial Systems COMMUNITY HOSPITAL OF	NOBLE CIY,	TNC	In Lie	u or form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co		Peri od:	Worksheet E	
				From 01/01/2018	Part A	
				To 12/31/2018	Date/Time Prep	
					5/28/2019 10: 2	28 am_
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		2018	436, 117	70. 96
	the corresponding federal year for the period prior to 10/1)				,	
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O	1	2019	193, 846	70. 97
70. 77	the corresponding federal year for the period ending on or af		<b>1</b>	2017	173, 040	70. 77
70.00		10/1)			0	70. 98
70. 98	Low Volume Payment-3				-	
70. 99	HAC adjustment amount (see instructions)	(0 0 70)			0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			4, 914, 592	
71. 01	Sequestration adjustment (see instructions)				98, 292	
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
72.00	Interim payments				4, 861, 660	72.00
73.00	Tentative settlement (for contractor use only)				0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.0)	2. 72. and			-45, 360	74.00
	73)				,	
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			65, 874	75. 00
70.00	CMS Pub. 15-2, chapter 1, §115.2	noc wi th			00,071	70.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
00 00		of 2 02	I		0	00.00
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum (	01 2.03			١	90. 00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instr	ucti ons)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93.00
94.00	The rate used to calculate the time value of money (see instru	uctions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)				ol	95.00
	Time value of money for capital related expenses (see instructions)				0	96.00
		,	<b>1</b>	5 1 1 10/1	On /Aftor 10/1	
				Prior to 10/11		
				Prior to 10/1		
	HSP Ronus Payment Amount			1.00	2.00	
100.00	HSP Bonus Payment Amount			1. 00	2. 00	100.00
100.00	HSP bonus amount (see instructions)				2. 00	100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1. 00	2. 00	
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			1. 00 246, 717 1. 0025970859	2. 00 224, 732 1. 0073999417	101. 00
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)	s)		1. 00	2. 00 224, 732 1. 0073999417	
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment	s)		1. 00 246, 717 1. 0025970859 641	2. 00 224, 732 1. 0073999417 1, 663	101. 00 102. 00
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)	s)		1. 00 246, 717 1. 0025970859	2. 00 224, 732 1. 0073999417 1, 663 0. 9990	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment			1. 00 246, 717 1. 0025970859 641	2. 00 224, 732 1. 0073999417 1, 663 0. 9990	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	)	stment	1. 00 246, 717 1. 0025970859 641 0. 9994	2. 00 224, 732 1. 0073999417 1, 663 0. 9990	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	) ration) Adju		1. 00 246, 717 1. 0025970859 641 0. 9994	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) RRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	) ration) Adju		1. 00 246, 717 1. 0025970859 641 0. 9994	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrations) Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	) ration) Adju		1. 00 246, 717 1. 0025970859 641 0. 9994	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration	) ration) Adju riod under t		1. 00 246, 717 1. 0025970859 641 0. 9994	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iine	) ration) Adju riod under t		1. 00 246, 717 1. 0025970859 641 0. 9994	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	) ration) Adju riod under t		1. 00 246, 717 1. 0025970859 641 0. 9994	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	) ration) Adju riod under t e 49)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	) ration) Adju riod under t e 49)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	) ration) Adju riod under t e 49)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	) ration) Adju riod under t e 49)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	) ration) Adju riod under t e 49) first year	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	) ration) Adju riod under t e 49) first year	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	) ration) Adju riod under t e 49) first year	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	) ration) Adju riod under t e 49) first year	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00 224, 732 1. 0073999417 1, 663 0. 9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration by the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	) ration) Adju riod under t e 49) first year ructions)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00  224, 732  1. 0073999417	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	) ration) Adju riod under t e 49) first year ructions)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2.00 224,732 1.0073999417 1,663 0.9990 -225	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (N/A in Project Pro	) ration) Adju riod under t e 49) first year ructions)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00  224, 732  1. 0073999417	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration because of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use	) ration) Adju riod under t e 49) first year ructions)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00  224, 732  1. 0073999417	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration because of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	) ration) Adju riod under t e 49) first year ructions)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00  224, 732  1. 0073999417	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration become and the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	nation) Adjuriod under te 49)  first year  ructions) line 59)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00  224, 732  1. 0073999417	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration by this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 204)	nation) Adjuriod under te 49)  first year  ructions) line 59)	the 21st	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00  224, 732  1. 0073999417	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line in tow-volume adjustment (see instructions)	ration) Adjuriod under te 49)  first year  ructions) line 59)	of the currer	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00  224, 732  1. 0073999417	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 212. 00 213. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration to this the first year of the current 5-year demonstration percentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line in 100 to 100	ration) Adjuriod under te 49)  first year  ructions) line 59)	of the currer	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00  224, 732  1. 0073999417	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line in tow-volume adjustment (see instructions)	ration) Adjuriod under te 49)  first year  ructions) line 59)	of the currer	1. 00 246, 717 1. 0025970859 641 0. 9994 -148	2. 00  224, 732  1. 0073999417	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 212. 00 213. 00

Health Financial Systems	COMMUNITY HOSPITAL OF NOBLE CTY, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0146	Peri od: From 01/01/2018	Worksheet E Part B

To 12/31/2018 | Part B | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 10:28 am

			10 12/01/2010	5/28/2019 10:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0	
2.00	Medical and other services reimbursed under OPPS (see instruct	tions)		4, 722, 711	2.00
3.00	OPPS payments			4, 160, 440	
4.00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)	ations)		0 0 4	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction 2 times line 5	etrons)		0. 864 4, 080, 422	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0.00	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V col 13 line 200		0	9. 00
10. 00	Organ acquisitions	v, cor. 13, 11116 200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p	3	9	0	
16. 00	Amounts that would have been realized from patients liable for		a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(6	e)			47.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)	wifling 10 avacada lin	. 11) (000	0	
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	y II IThe 18 exceeds ITh	e II) (See	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	v if line 11 exceeds line	e 18) (see	0	20. 00
20.00	instructions)	y IT TIME IT EXCEEDS ITM	(300	O	20.00
21. 00	Lesser of cost or charges (see instructions)			0	21. 00
22. 00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	•		4, 160, 440	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•		879, 650	
26. 00	Deductibles and Coinsurance amounts relating to amount on line			0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	3, 280, 790	27. 00
20.00	instructions)	50)		0	20.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 3, 280, 790	29. 00 30. 00
31. 00	Primary payer payments			3, 280, 790 285	•
32. 00	Subtotal (line 30 minus line 31)			3, 280, 505	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CFS)		3, 200, 303	32.00
33. 00				0	33. 00
34.00	Allowable bad debts (see instructions)			156, 402	34. 00
35.00	Adjusted reimbursable bad debts (see instructions)			101, 661	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		132, 185	36. 00
37. 00	Subtotal (see instructions)			3, 382, 166	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	_		0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		_	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruct	ions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			2 202 144	39. 99
40. 00 40. 01	Sequestration adjustment (see instructions)			3, 382, 166 67, 643	1
40. 01	Demonstration payment adjustment amount after sequestration			07, 043	
41. 00	Interim payments			3, 310, 197	
42. 00	Tentative settlement (for contractors use only)			0, 010, 177	
43. 00	Balance due provider/program (see instructions)			4, 326	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2. c	hapter 1,	0	
	§115. 2		'		
	TO BE COMPLETED BY CONTRACTOR				
90.00	, ,			0	
91.00				0	91. 00
92.00				0.00	
93.00	,			0	
74. UU	Total (sum of lines 91 and 93)		ı	Ü	94. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0146 Peri od: Worksheet E-1 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 10:28 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, 861, 660 3, 310, 197 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 3.02 0 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 3.53 0 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) 3, 310, 197 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4, 861, 660 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 5.01 TENTATIVE TO PROVIDER 0 0 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

0

Contractor

Number

1 00

45, 360

4, 816, 300

0

0

0

0

4, 326

3, 314, 523

NPR Date (Mo/Day/Yr)

2 00

5.52

5.99

6.00

6.01

6.02

7.00

8.00

5.52

5.99

6.00

6.01

6 02

7.00

5.50-5.98)

8.00 Name of Contractor

the cost report. (1) SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

Subtotal (sum of lines 5.01-5.49 minus sum of lines

Total Medicare program liability (see instructions)

Determined net settlement amount (balance due) based on

111-4-	Figure in Community Hochital (	OF MODIFICATIVILING	1 1:-	£ F CMC	2552 40
	Financial Systems COMMUNITY HOSPITAL (			u of Form CMS-	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0146 Period: Worksheet					
			From 01/01/2018 To 12/31/2018		parad.
			To 12/31/2018	5/28/2019 10:	
		Title XVIII	Hospi tal	PPS	20 am
			110001 tui		
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	ON			1
1.00	Total hospital discharges as defined in AARA §4102 from Wks	t. S-3, Pt. I col. 15 line	: 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of		Wkst. S-2. Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00		n (see instructions)			10.00
	LNDATI FOR THOSE TALL CEDVICES INDED THE LDDG & CALL	. (222 :::21: 2011 0110)			1

30. 00 31. 00

32.00

inpatient Hospital Services Under the ipps & CAH

30.00 Initial/interim HIT payment adjustment (see instructions)

31.00 Other Adjustment (specify)

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

Health Financial Systems COMMUNITY HOSPIT BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-0146

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Time Prepared:

onl y)			'	0 12/31/2016	5/28/2019 10:	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1, 645		-	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		-	0	2. 00 3. 00
4. 00	Accounts receivable	24, 075, 623	1	0	0	4. 00
5. 00	Other recei vabl e	-2, 059, 472		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-15, 186, 101	0	0	0	6. 00
7.00	Inventory	597, 051		0	0	7. 00
8.00	Prepai d expenses	32, 531		0	0	
9. 00 10. 00	Other current assets Due from other funds	0		0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	7, 461, 277			0	11.00
00	FIXED ASSETS	77 1017277		<u> </u>		1 00
12.00	Land	0	) C	0	0	12. 00
13. 00	Land improvements	755, 392	1		0	13. 00
14. 00	Accumulated depreciation	-476, 166	•	0	0	14. 00
15. 00 16. 00	Buildings Accumulated depreciation	3, 871, 871	1	0	0	15. 00 16. 00
17. 00	Leasehold improvements	-1, 665, 835 63, 781	1	-	0	17.00
18. 00	Accumulated depreciation	-28, 259	1	-	0	18. 00
19. 00	Fi xed equipment	143, 565	•	0	0	19. 00
20.00	Accumulated depreciation	-59, 046	o C	0	0	20. 00
21. 00	Automobiles and trucks	409, 433	1	0	0	21. 00
22. 00	Accumulated depreciation	-169, 346	1	0	0	22. 00
23. 00 24. 00	Major movable equipment Accumulated depreciation	12, 604, 871 -9, 795, 541	0	0	0	23. 00
25. 00	Mi nor equi pment depreci abl e	1, 115, 802		0	0	25.00
26. 00	Accumulated depreciation	-638, 628		-	0	26.00
27. 00	HIT designated Assets	0	o	0	0	27. 00
28. 00	Accumulated depreciation	0	) C	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	-	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	6, 131, 894	· C	0	0	30. 00
31. 00	OTHER ASSETS Investments	5, 001	1 0	0	0	31.00
32. 00	Deposits on Leases	3,001			0	32.00
33. 00	Due from owners/officers	Ö		-	0	33. 00
34.00	Other assets	2, 350, 599	o c	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	2, 355, 600	1		0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	15, 948, 771	C	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	1 520 000	) C	O	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 530, 090 774, 232	1	0	0	38.00
39. 00	Payrol I taxes payable	0		o	0	39.00
40.00	Notes and Loans payable (short term)	106, 230	o	0	0	40. 00
41. 00	Deferred income	0	) C	0	0	41. 00
42. 00	Accel erated payments	0	)			42. 00
43. 00	Due to other funds	0		0	0	1
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	2, 410, 552			0	
43.00	LONG TERM LIABILITIES	2,410,332	.]	9	0	45.00
46.00	Mortgage payable	0	) C	0	0	46. 00
47. 00	Notes payable	0	0	0	0	47. 00
48. 00	Unsecured Loans	0	0	-	0	
49. 00	Other long term liabilities	150, 352			0	49. 00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49)	150, 352			0	50. 00 51. 00
51.00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	2, 560, 904	·[ C	U	0	51.00
52. 00	General fund balance	13, 387, 867	,			52. 00
53. 00	Specific purpose fund	,,	C			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0	_	56. 00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	13, 387, 867	, c	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	15, 948, 771		o	0	
	59)		1			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					10 12/31/2010	5/28/2019 10:	
		General	Fund	Speci al I	Purpose Fund	Endowment Fund	
_		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		13, 248, 954				1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11, 442, 672				2. 00
3.00	Total (sum of line 1 and line 2)		24, 691, 626		-	)	3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7. 00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0	_		0	0	9. 00
10. 00	Total additions (sum of line 4-9)		0		(	)	10. 00
11. 00	Subtotal (line 3 plus line 10)		24, 691, 626		(	P	11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0	0	12. 00
13. 00	ASSET TRANSFERS	11, 946, 754			0	0	13. 00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		11, 946, 754		(	P	18. 00
19. 00	Fund balance at end of period per balance		12, 744, 872		(		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		LIIdowillerit Turid	Trant	T UTIU			
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00			O				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	ASSET TRANSFERS		0				13.00
14.00			0				14.00
15. 00			0				15.00
16.00			0				16.00
17. 00	T + 1 + 1 + 1 + 1 ( C + 10 + 17)		O				17. 00
18.00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)	1 1	I	I	T		l

 
 Heal th
 Financial
 Systems
 COMMUNI

 STATEMENT
 OF
 PATIENT REVENUES
 AND
 OPERATING
 EXPENSES
 Provider CCN: 15-0146

			10	J 12/31/2016	5/28/2019 10: 2	
	Cost Center Description		I npati ent	Outpati ent	Total	20 4
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		8, 396, 884		8, 396, 884	1.00
2.00	SUBPROVI DER - I PF		0		0	2.00
3.00	SUBPROVI DER - I RF		0		0	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		0		0	7. 00
8.00	NURSING FACILITY		0		0	8. 00
9.00	OTHER LONG TERM CARE		0 204 204		0	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)		8, 396, 884		8, 396, 884	10. 00
11. 00	Intensive Care Type Inpatient Hospital Services		0		0	11. 00
12. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT		0		0	12.00
13. 00	BURN INTENSIVE CARE UNIT		0		0	13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT		0		0	
15. 00	OTHER SPECIAL CARE (SPECIFY)		O		O	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	Lines	0		0	16. 00
	11-15)		ū		ŭ.	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		8, 396, 884		8, 396, 884	17.00
18.00	Ancillary services		38, 107, 107	o	38, 107, 107	18.00
19.00	Outpati ent servi ces		0	156, 236, 983	156, 236, 983	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			0	0	22.00
23. 00	AMBULANCE SERVICES		0	11, 488, 673	11, 488, 673	23.00
24. 00	CMHC			0	0	24. 00
24. 10	CORF		0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		0	0	0	25. 00
26. 00	HOSPI CE		0	0	0	26. 00
27. 00	OTHER (SPECIFY)	4- 1///4	47 502 001	1/7 705 /5/	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1)	to WKST.	46, 503, 991	167, 725, 656	214, 229, 647	28. 00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			56, 020, 723		29. 00
30.00	PROVISION FOR BAD DEBT		7, 591, 891	00, 020, 720		30.00
31. 00	HOME OFFICE INTEREST EXPENSE		642, 995			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)			8, 234, 886		36.00
37. 00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38.00
39. 00			0			39. 00
40. 00			0			40. 00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)	\(\( \dagger_{} \)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfer		64, 255, 609		43. 00
	to Wkst. G-3, line 4)			l		

Health Financial Systems	COMMUNITY HOSPITAL OF NO	OBLE CTY, INC	In Lieu	of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	P	Provider CCN: 15-0146	Peri od:	Worksheet G-3

Heal th	Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC. In Lieu of Form CMS-2552-					
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0146	Peri od:	Worksheet G-3		
			From 01/01/2018 To 12/31/2018	Date/Time Pre	narod:	
			10 12/31/2016	5/28/2019 10:		
		-		0,20,201, 101	LO GIII	
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ie 28)		214, 229, 647	1. 00	
2.00	Less contractual allowances and discounts on patients' accoun	its		140, 104, 215	2. 00	
3.00	Net patient revenues (line 1 minus line 2)			74, 125, 432	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		64, 255, 609	4. 00	
5.00	Net income from service to patients (line 3 minus line 4)			9, 869, 823	5. 00	
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6. 00	
7.00	Income from investments			1, 681	7. 00	
8. 00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00	
9. 00	Revenue from television and radio service			0	9. 00	
	Purchase di scounts			0	10.00	
	Rebates and refunds of expenses			0	11. 00	
	Parking lot receipts			0	12. 00	
	Revenue from Laundry and Linen service			0	13. 00	
	Revenue from meals sold to employees and guests			156, 698		
	Revenue from rental of living quarters			0	15. 00	
	Revenue from sale of medical and surgical supplies to other t	han patients		0	16. 00	
	Revenue from sale of drugs to other than patients			0	17. 00	
	Revenue from sale of medical records and abstracts			0	18. 00	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00	
	Rental of vending machines			0	21. 00	
	Rental of hospital space			0	22. 00	
	Governmental appropriations			0	23. 00	
	GAIN/LOSS ON SALE OF CAPITAL ASSETS			-2, 414		
	EMS SUBSI DY			278, 628		
	OTHER REVENUE			1, 138, 256		
	Total other income (sum of lines 6-24)			1, 572, 849	•	
	Total (line 5 plus line 25)			11, 442, 672		
	OTHER EXPENSES (SPECIFY)			0	27. 00	
	Total other expenses (sum of line 27 and subscripts)			0	28. 00	
29.00	Net income (or loss) for the period (line 26 minus line 28)			11, 442, 672	29.00	

Heal th	Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu					2552-10
CALCULATION OF CAPITAL PAYMENT         Provider CCN: 15-0146         Period: From 01/01/2018           To         12/31/2018						
	Title XVIII Hospital					
					1. 00	
	PART I - FULLY PROSPECTIVE METHOD			<u> </u>	1.00	
	CAPITAL FEDERAL AMOUNT					1
1.00	Capital DRG other than outlier				281, 838	1.00
1.01	Model 4 BPCI Capital DRG other than outlier				0	1. 01
2.00	Capital DRG outlier payments				366	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments				0	2. 01
3.00	Total inpatient days divided by number of days in	the cost reporti	ng period (see inst	ructions)	13. 19	
4.00	Number of interns & residents (see instructions)				0. 00	
5.00	Indirect medical education percentage (see instruc				0.00	
6. 00	Indirect medical education adjustment (multiply li	ine 5 by the sum	of lines 1 and 1.01	, columns 1 and	0	6. 00
7. 00	1.01)(see instructions)  Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line					7. 00
7.00	30) (see instructions)					7.00
8.00	00 Percentage of Medicaid patient days to total days (see instructions)					8. 00
9.00	0 Sum of lines 7 and 8					9. 00
	Allowable disproportionate share percentage (see i				0.00	
11. 00						1
12. 00	00   Total prospective capital payments (see instructions)					12. 00
					1. 00	
	PART II - PAYMENT UNDER REASONABLE COST					
1.00	Program inpatient routine capital cost (see instructions)				0	
2.00						2.00
3.00						3. 00
4.00						4.00
5. 00	Total inpatient program capital cost (line 3 x lin	ne 4)			0	5. 00
					1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
1.00						1. 00
2.00	Program inpatient capital costs for extraordinary		see instructions)		0	2. 00
3.00						3. 00 4. 00
4.00	Applicable exception percentage (see instructions)					