This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0146 Worksheet S Period: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 6/23/2020 3:46 pm Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR 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 01/01/2019 and ending 12/31/2019 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.

(Si gned) 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	133, 360	-21, 450	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
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	o		0		0	12.00
200.00	Total	0	133, 360	-21, 450	0	0	200.00

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

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 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 401 SAWYER ROAD P0 Box: 728 1.00 1.00 Zi p Code: 46755-0728 County 2.00 City: KENDALLVILLE State: IN 2.00 Component Name Provi der CCN CBSA Date Payment System (P, T, 0, or N)
V | XVIII | XIX Туре Certi fi ed Number Number 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 Ν 3.00 NOBLE CTY, INC Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 17. 10 Hospital -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) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 3.00 2.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ 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 N 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 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 N 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 yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 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 0ther Medi cai d Medi cai d State State HMO days Medi cai d pai d days Medi cai d eligible Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 3.00 4.00 5.00 2.00 6.00 24.00 If this provider is an IPPS hospital, enter the 169 339 448 0 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.

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	CN: 15-0146	Period: From 01/0		Part I	eet S-2	
						Date/T 6/23/2	020 3:4	epare 16 pm
	In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medica HMO da	ys Med	ther di cai d days	
	1.00	days 2.00	3.00	unpai d 4. 00	5. 00) /	5. 00	-
OO If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0			0		0		25
					<u>Rural S</u> 00	Date of 2.		1
00 Enter your standard geographic classification (not w		at the be	gi nni ng of		2			26
cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassification.	age) status or "2" for i	rural. If a	d of the co pplicable,	st	2			27
00 If this is a sole community hospital (SCH), enter th			CH status i	n	0			35
effect in the cost reporting period.				Begi n	ni ng:	Endi	ng:	
00 Enter applicable beginning and ending dates of SCH s	tatue Cub	ecript line	36 for num	1.		2.	00	36
of periods in excess of one and enter subsequent dat	es.	•						
OD If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	er the numbe	er of perio	ds MDH stat	us	1			37
O1 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)								37
OD If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.	es of MDH s of periods i	tatus. If I n excess o	ine 37 is f one and	01/01	/2019	12/31	/2019	38
					/N 00	Y/ 2.		
Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), on the mileage ii)? Enter	(iii)? En e requireme in column	ter in colu nts in 2 "Y" for y	ume mn es	()	′	39
00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for				N 1		40
					1. 00	XVIII 2.00		+
Prospective Payment System (PPS)-Capital Oo Does this facility qualify and receive Capital payme	nt for dis	roporti ona	to share in	accordance	e N	l N	N	45
with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks	eption for	extraordi n	ary circums	tances	N N	N	N	46
Pt. III. 00 Is this a new hospital under 42 CFR §412.300(b) PPS 10 Is the facility electing full federal capital paymen					N N	N N	N N	47
Teaching Hospitals ON Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for	impacted by	/ CR 11642						56
00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	period duri or yes or "N oth of this Y", comple	ng which r N" for no i cost repor te Workshee	n column 1. ting period	If column ? Enter "`	Y"			57
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I 00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	nbursement 1 complete V	for physici Vkst. D-5.		es as	N			58
00 Are costs claimed on line 100 of Worksheet A? If ye	es, complete	e Wkst. D-2	NAHE 413.8 Y/N		Neet Ae #	Pass-T Qualifi Crite	cation erion	59
00 Are you claiming remains and all the little to	CNAUEN	to f	1.00	2.	00	3.		1,0
Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent	8.85? (see Dlumn 1. Ii		N					60

|--|

	Financial Systems COMMUNITY HOS TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			CN: 15-0146 Pe	eri od:	u of Form CMS-2 Worksheet S-2	
					om 01/01/2019	Part I Date/Time Pre 6/23/2020 3:4	pare
		Y/N	IME	Direct GME	IME	Direct GME	о рі
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Did your hospital receive FTE slots under ACA	N			0.00		61
	section 5503? Enter "Y" for yes or "N" for no in						
1. 01	column 1. (see instructions) Enter the average number of unweighted primary care						61
1.01	FTEs from the hospital's 3 most recent cost reports						01
	ending and submitted before March 23, 2010. (see						
	instructions)						
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
1. 03	Enter the base line FTE count for primary care						61
	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see instructions)						
1. 04	Enter the number of unweighted primary care/or						61
	surgery allopathic and/or osteopathic FTEs in the						
	current cost reporting period. (see instructions).						
1. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61
	primary care and/or general surgery FTE counts (line						
	61.04 minus line 61.03). (see instructions)						
1. 06	Enter the amount of ACA §5503 award that is being						61
	used for cap relief and/or FTEs that are nonprimary						
	care or general surgery. (see instructions)	Pro	gram Name	Program Code	Unweighted	Unwei ghted	
			g. a Hame	l og. a oodo	IME FTE Count	Direct GME	
						FTE Count	
1 10	06 the FTF- in Line /1 0F		1. 00	2. 00	3. 00	4. 00	/1
1. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0. 00	61
	for each new program. (see instructions) Enter in						
	column 1, the program name. Enter in column 2, the						
	program code. Enter in column 3, the IME FTE						
	unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
1. 20	Of the FTEs in line 61.05, specify each expanded				0. 00	0. 00	61
20	program specialty, if any, and the number of FTE				0.00	0.00	.
	residents for each expanded program. (see						
	instructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
	ACA Provisions Affecting the Health Resources and Ser	ryl coc	Admi ni strati o	n (UDCA)		1. 00	
2 00	Enter the number of FTE residents that your hospital				iod for which	0. 00	62
	your hospital received HRSA PCRE funding (see instruc	ctions)				0.00	"-
2. 01	Enter the number of FTE residents that rotated from a				your hospital	0.00	62
	during in this cost reporting period of HRSA THC prog			ons)			
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se			rost renorting	neriod? Enter	N	63
0.00	"Y" for yes or "N" for no in column 1. If yes, comple						
				Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Napprovi dos	FTEs in	1/ (col . 1 +	
				Nonprovider Site	Hospi tal	col. 2))	
				1.00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings-	!			
	period that begins on or after July 1, 2009 and before	re June	30, 2010.				
4. 00	Enter in column 1, if line 63 is yes, or your facilit			0.00	0. 00	0. 000000	64
	in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in						
	settings. Enter in column 2 the number of unweighted						
				I	i l		
	resident FTEs that trained in your hospital. Enter in	n columr	1 3 the ratio				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0146 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 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/ (col. 1 + col. 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 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 Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 N Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν 0 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 Ν 75.00 subprovider? Enter "Y" for yes and "N"

Ν

108.00

108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.

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

Health Financial Systems COMMUNITY HOSPITAL	OF NOBLE CTY,	I NC	In Lieu	of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 15-0146 Pe	eriod: rom 01/01/2019	Worksheet S- Part I Date/Time Pr 6/23/2020 3:	2 epared:
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 e N	2.00	3.00	4. 00	109. 00
			-	1. 00	
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Woapplicable.	"Y" for yes or	"N" for no. I	f yes,	N	110.00
			1. 00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this converge of the FCHIP demonstration for this converge of the FCHIP demonstration properties and the FCHIP demonstration properties of the FCHIP demonstration properties of the FCHIP demonstration properties of the FCHIP demonstration and the FCHIP demonstration of the FCHIP demonstration for this converge of the FCHIP demonstration for the FCHIP demons	cost reporting column 1 is Y, articipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2. 00	3. 00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heademonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable.	g period? is "Y", enter the	N N	2.00	3. 30	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of	or "N" for no	N			 0115.00
in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) "93" percent (includes				
116.00 Is this facility classified as a referral center? Enter "Y"	" for yes or	N			116. 00
"N" for no. 117.00 s this facility legally-required to carry malpractice insu	urance? Enter	Υ			117. 00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence point if the policy is claim-made. Enter 2 if the policy is occur		1			118. 00
		Premi ums	Losses	Insurance	
		1.00			
118.01 List amounts of mal practice premiums and paid losses:		1. 00 115, 270	2. 00 11, 807	3. 00 62 71	0118.01
There is a second of the production of the party of the p		1.07270		•	
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche			1. 00 Y	2. 00	118. 02
and amounts contained therein. 119.00D0 NOT USE THIS LINE	edure fratting e	ost conters			119. 00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	in column 1, "Y qualifies for t	" for yes or the Outpatient	N	Y	120. 00
121.00 Did this facility incur and report costs for high cost impl	lantable device	es charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	1 is "Y", ente	. , . ,	N		122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f	for yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.					126. 00
126.00 If this is a Medicare certified kidney transplant center,		fication date			
in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, er	2. nter the certif				127. 00
in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, er in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, er	2. nter the certif 2. nter the certif	ication date			
in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, er in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, er in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center the column 129.00 If this is a Medicare certified lung transplant center the column 129.00 If this is a Medicare certified lung transplant center the column 129.00 If this is a Medicare certified lung transplant center the column 129.00 If this is a Medicare certified lung transplant center the column 129.00 If t	2. nter the certif 2. nter the certif 2.	ication date			128. 00
in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, er in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, er in column 1 and termination date, if applicable, in column	2. nter the certif 2. nter the certif 2. ter the certifi , enter the cer	ication date ication date cation date in			127. 00 128. 00 129. 00 130. 00

Health Financial Systems	COMMUNITY HOSPITAL C	OF NOBLE CTY, INC	2	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CCN:		Peri od:	Worksheet S-	-2
				From 01/01/2019 To 12/31/2019	Part I Date/Time Pr	
					6/23/2020 3:	46 pm
				1.00	2.00	+
132.00 If this is a Medicare certified is in column 1 and termination date,			ation date			132. 00
133.00 Removed and reserved	i appircable, ili corullii z	۷.				133. 00
134.00 If this is an organ procurement or		ne OPO number in	column 1			134.00
and termination date, if applicabl	e, in column 2.					_
140.00 Are there any related organization	n or home office costs as o	defined in CMS Po	ub. 15-1,	Υ	15H032	140.00
chapter 10? Enter "Y" for yes or '						
are claimed, enter in column 2 the	e home office chain number.		ons)	3.00		
If this facility is part of a cha	n organization, enter on	lines 141 throug	h 143 the n		of the home	
office and enter the home office			N C	Normbara 0010	\1	141 00
141.00 Name: PARKVIEW HEALTH SYSTEM, IN		RVICES	Contracto	r s Number: 0810) [141. 00
142.00 Street: 10501 CORPORATE DRIVE	P0 Box: 560	00				142.00
143.00 Ci ty: FORT WAYNE	State: IN		Zi p Code:	4684	15-1700	143.00
					1.00	+
144.00 Are provider based physicians' cos	sts included in Worksheet A	4?			Υ	144.00
				1.00	2. 00	_
145.00 of costs for renal services are cl	aimed on Wkst. A, line 74,	are the costs	for	1.00	2.00	145. 00
inpatient services only? Enter "Y	' for yes or "N" for no in	column 1. If col	lumn 1 is			
no, does the dialysis facility inc period? Enter "Y" for yes or "N"		for this cost re	eporti ng			
146.00 Has the cost allocation methodolog		usly filed cost i	report?	N		146. 00
Enter "Y" for yes or "N" for no i	n column 1. (See CMS Pub.					
yes, enter the approval date (mm/o	dd/yyyy) in column 2.					
					1.00	\dashv
147.00 Was there a change in the statisti					N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi					N N	148. 00 149. 00
149.00 was there a change to the simpiff	ed Cost Trilding method? En	Part A	Part B	Title V	Title XIX	149.00
		1. 00	2. 00	3. 00	4.00	
Does this facility contain a provior charges? Enter "Y" for yes or						
155. 00 Hospi tal	N TO TO TO Each compon	N N	N	N N	N N	155.00
156.00 Subprovi der - IPF		N	N	N	N	156. 00
157. 00 Subprovi der – I RF 158. 00 SUBPROVI DER		N	N	N	N	157. 00 158. 00
159. 00 SNF		N	N	N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N	N	N	160.00
161. 00 CMHC 161. 10 CORF			N N	N N	N N	161.00
101. TO CORF			IN	IN	IN	161. 10
h					1.00	
Multicampus 165.00 s this hospital part of a Multica	ampus hospital that has one	or more campus	es in diffe	rent CRSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	· · · · · · · · · · · · · · · · · · ·	s or more campus				100.00
	Name	County		Code CBSA	FTE/Campus	
166.00 f line 165 is yes, for each	0	1. 00	2.00 3	. 00 4. 00	5. 00	00 166. 00
campus enter the name in column					0.0	701.00.00
0, county in column 1, state in						
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1. 00	
Health Information Technology (HI	T) incentive in the Americ	an Recovery and	Rei nvestmen	t Act	1.00	
167.00 Is this provider a meaningful user	under §1886(n)? Enter "	Y" for yes or "N'	" for no.		Y	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			167 is "Y"),	, enter the		168. 00
168.01 If this provider is a CAH and is			qualify for	a hardshi p		168. 01
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "N"	for no. (see ins	structions)	•		
169.00 If this provider is a meaningful transition factor. (see instruction		ıs not a CAH (li	ıne 105 is '	"N"), enter the	9. 9	99169.00
1. a.s	,				1	1

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC		In Lieu	of Form CM:	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-0146		i od:	Worksheet S	-2
			To	m 01/01/2019 12/31/2019		ranarad.
			10	12/31/2019	6/23/2020 3	
				Begi nni ng	Endi ng	. 10 piii
				1. 00	2. 00	
0.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170. 00
				1. 00	2. 00	
171.00 If line 167 is "Y", does this provid	er have any days for indi	viduals enrolled in		N		0 171. 00
section 1876 Medicare cost plans rep	orted 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, e	nter the number of secti	on			
1876 Medicare days in column 2. (see	instructions)					

	Financial Systems COMMUNITY HOSPITAL OF NOE AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Pr		TNC CN: 15-0146	Peri od: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/23/2020 3:4	2 epared
				Y/N	Date	
	5			1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N for mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	all NO re	esponses. En	ter all dates in	tne	
. 00	Has the provider changed ownership immediately prior to the beging reporting period? If yes, enter the date of the change in column			N S)		1. (
			Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare Progra yes, enter in column 2 the date of termination and in column 3, voluntary or "I" for involuntary.	"V" for	N			2.0
3. 00	Is the provider involved in business transactions, including man contracts, with individuals or entities (e.g., chain home office or medical supply companies) that are related to the provider or officers, medical staff, management personnel, or members of the of directors through ownership, control, or family and other sim relationships? (see instructions)	es, drug its board	N			3.0
			Y/N	Type	Date	
			1.00	2. 00	3. 00	
1. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Accountant? Column 2: If yes, enter "A" for Audited, "C" for Co or "R" for Reviewed. Submit complete copy or enter date available column 3. (see instructions) If no, see instructions.	ompiled, e in	Y	A	03/27/2020	4.0
5. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcil		N	Y/N	Legal Oper.	5.0
				1.00	2. 00	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: If y the legal operator of the program?		ne provider i	s N		6. (
. 00	Are costs claimed for Allied Health Programs? If "Y" see instructions were nursing school and/or allied health programs approved and/o cost reporting period? If yes, see instructions.		d during the	N N		7. (8. (
. 00	Are costs claimed for Interns and Residents in an approved gradu program in the current cost report? If yes, see instructions.					9. (
10.00	Was an approved Intern and Resident GME program initiated or ren cost reporting period? If yes, see instructions.			N		10.0
1. 00	Are GME cost directly assigned to cost centers other than I & R Teaching Program on Worksheet A? If yes, see instructions.	in an App	or oved	N	Y/N	11. (
					1. 00	
	Bad Debts					
2. 00 3. 00	Is the provider seeking reimbursement for bad debts? If yes, see If line 12 is yes, did the provider's bad debt collection policy period? If yes, submit copy.			cost reporting	Y N	12. (13. (
4. 00	If line 12 is yes, were patient deductibles and/or co-payments w Bed Complement	vai ved? I1	fyes, see in	nstructions.	N	14.0
5. 00	Did total beds available change from the prior cost reporting pe			structions.	N	15. (
		Par			t B	
		V /NI	Date	Y/N	Date	
		Y/N 1.00	2. 00	3. 00	4. 00	

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16.00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Υ	05/01/2020	Υ	05/01/2020	17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		Υ		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.				i '	

Heal th	Financial Systems COMMUNITY HOSPITAL	OF NOBLE CTY,	INC	In Lie	u of Form CMS-	-2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0146 F	eri od:	Worksheet S-		
				rom 01/01/2019 o 12/31/2019	Part II Date/Time Pr	epared.	
					6/23/2020 3:	46 pm	
			iption D	Y/N 1.00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		<i>y</i>	1.00 N	N	20.00	
	Report data for Other? Describe the other adjustments:						
		1. 00	<u>Date</u> 2.00	Y/N 3. 00	Date 4 00		
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4. 00	21.00	
	records? If yes, see instructions.						
				-	1 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS I	HOSPI TALS)		1. 00		
	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 apprais	sais made duri	ng the cost		23.00	
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost rep	orting period?		24.00	
05.00	If yes, see instructions			1.6		05.00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	it yes, see		25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period? If	yes, see		26.00	
27.00	instructions.					27.00	
27. 00	Has the provider's capitalization policy changed during th copy.	e cost reporti	ng period/it	yes, submit		27. 00	
	Interest Expense						
28. 00	. 33 3	ntered into du	ring the cost	reporti ng		28. 00	
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (D	eht Service Re	serve Fund)		29. 00	
27.00	treated as a funded depreciation account? If yes, see inst		CDE SCI VICC NC	serve runa)		27.00	
30. 00	Has existing debt been replaced prior to its scheduled mat	urity with new	debt? If yes,	see		30.00	
31. 00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	deht? If ves	See		31.00	
01.00	instructions.	33ddilee of flew	dobt. 11 yes,	300			
00.00	Purchased Services	6		I I I		20.00	
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ea through con	tractuai		32.00	
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competit	ive bidding? If		33.00	
	no, see instructions.						
34. 00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement wit	h provi der-bas	ed physicians?		34.00	
01.00	If yes, see instructions.	· ·		. ,		01.00	
35. 00	If line 34 is yes, were there new agreements or amended ex	isting agreeme	nts with the p	rovi der-based		35.00	
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date		
				1.00	2. 00		
27.00	Home Office Costs					24.00	
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?			36. 00 37. 00	
27.00	If yes, see instructions.					37.00	
38. 00	,					38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth					39.00	
57.00	see instructions.	o. onarn compo				37.00	
40. 00	, , , , , , , , , , , , , , , , , , ,	home office?	If yes, see			40.00	
	i nstructi ons.						
		1.00 2.00					
44 05	Cost Report Preparer Contact Information	EDI O		44 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	PARKVIEW HEALT	H SYSTEM, INC.			42.00	
43. 00	preparer. Enter the telephone number and email address of the cost	2603738406		ERI C. NI CKESON@F	PARKVIEW COM	43.00	
.0.00	report preparer in columns 1 and 2, respectively.					.5.55	

Heal th	Financial Systems COMM	IUNITY HOSPITAL C	OF NOBLE CTY,	INC		In Lieu	of Form CMS	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	IESTI ONNAI RE	Provi der (CCN: 15-0146	Peri From To	01/01/2019	Worksheet S Part II Date/Time P 6/23/2020 3	repared:
				00				
			3.	. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the titl	le/position D	DIRECTOR REIM	BURSEMENT				41.00
	held by the cost report preparer in columns	1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost	report						42.00
	preparer.							
43.00	Enter the telephone number and email address	s of the cost						43.00
	report preparer in columns 1 and 2, respecti	i vel y.						

31.00

32.00

32.01

33 00

33.01

0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm I/P Days / 0/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Avai I abl e 1.00 2.00 3.00 4.00 5.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 11, 315 0.00 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 HMO IRF Subprovider 4.00 4 00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 7.00 31 11, 315 0.00 0 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8 00 31 00 C 0 0.00 0 8 00 9.00 CORONARY CARE UNIT 32.00 0 0 0.00 0 9.00 10.00 BURN INTENSIVE CARE UNIT 33.00 0 0 0.00 10.00 SURGICAL INTENSIVE CARE UNIT 34.00 0.00 11.00 0 0 0 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 43.00 13.00 14.00 Total (see instructions) 31 11, 315 0.00 0 14.00 CAH visits 15.00 0 15.00 SUBPROVIDER - IPF 16.00 40.00 C 0 0 16.00 17.00 SUBPROVIDER - IRF 41.00 0 0 0 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0 0 19.00 44.00 20.00 NURSING FACILITY 45.00 0 0 0 20.00 OTHER LONG TERM CARE 46.00 21.00 0 21.00 22.00 HOME HEALTH AGENCY 101.00 0 22.00 AMBULATORY SURGICAL CENTER (D. P.) 115.00 23.00 23.00 HOSPI CE 116.00 24.00 0 0 24.00 24. 10 HOSPICE (non-distinct part) 30.00 24.10 99.00 25.00 CMHC - CMHC 0 25.00 CMHC - CORF 25. 10 99.10 0 25.10 RURAL HEALTH CLINIC 88.00 26.00 0 26.00 FEDERALLY QUALIFIED HEALTH CENTER 89.00 26 25 0 26 25 27.00 Total (sum of lines 14-26) 31 27.00 28.00 Observation Bed Days 0 28.00 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 30 00 30.00

31.00

32.00

32.01

33 00

Employee discount days - IRF

33.01 LTCH site neutral days and discharges

LTCH non-covered days

Labor & delivery days (see instructions)

Total ancillary labor & delivery room outpatient days (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0146

Peri od: Worksheet S-3 From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

6/23/2020 3:46 pm I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Component Total ALL Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 Hospital Adults & Peds. (columns 5, 6, 7 and 4, 365 1, 326 105 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, 472 745 2.00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4 00 0 4 00 0 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 105 7.00 1.326 4.365 beds) (see instructions) INTENSIVE CARE UNIT 8 00 0 C 0 8 00 9.00 CORONARY CARE UNIT 0 0 0 9.00 10.00 BURN INTENSIVE CARE UNIT 0 0 0 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 0 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 12 00 13.00 NURSERY 13.00 55 423 14.00 Total (see instructions) 1, 326 160 4, 788 0.00 196.00 14.00 CAH visits 15.00 0 C 0 15.00 SUBPROVIDER - IPF 0 0.00 16.00 0 C 0.00 16.00 17.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY C 0.00 0 0 0.00 19.00 20.00 NURSING FACILITY 0 0 0.00 0.00 20.00 OTHER LONG TERM CARE 0.00 21.00 0 0.00 21.00 22.00 HOME HEALTH AGENCY 0 0 0 0.00 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 0.00 0.00 23.00 HOSPI CE 0.00 24.00 0 0.00 24.00 24. 10 HOSPICE (non-distinct part) 0 24.10 0.00 CMHC - CMHC 0 C 0 0.00 25.00 25.00 0 25. 10 CMHC - CORF 0 C 0.00 0.00 25.10 RURAL HEALTH CLINIC 0 0 0.00 0.00 26.00 0 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 26 25 C 0 00 26 25 196.00 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 200 1, 651 28.00 29.00 Ambulance Trips 29.00 566 Employee discount days (see instruction) 30 00 30.00 43 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 57 93 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 0 32.01 33 00 LTCH non-covered days 0 33 00 33.01 LTCH site neutral days and discharges 33.01

Health Financial SystemsCOMMUNITY HOSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0146

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm

Full Time Equivalents Full Eq							6/23/2020 3:4	6 pm
Northern					Di sch	arges		
No		Component		Title V	Title XVIII	Title XIX		
Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospit ce days) (see instructions for col. 2 for the portion of LDP room available beds)				12. 00	13.00	14. 00		
MINO and other (see instructions) 504 230 2.00 3.00 4.00 4.00 1	1.00	8 exclude Swing Bed, Observation Bed and		C		43		1.00
MMO IRF Subprovider		HMO and other (see instructions)			504	230		
5.00		· ·				0		ł
6.00						U		
Total Adults and Peds. (exclude observation beds) See instructions)								1
8. 00 INTENSIVE CARE UNIT 9. 00 10. 00 1								
9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 10.00		· ·						
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 11								
11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 THER SPECIAL CARE (SPECIFY) 12. 00 12. 00 13. 00 14. 00 14. 00 15. 0								l
12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 14.00 10.10		·						
13.00 NURSERY 13.00 14.00 Total (see instructions) 0.00 0 503 43 1,674 14.00 15.00 15.00 16.40 15.00 16.00 16.00 16.00 16.00 17.00 18.00 17.00 18.00 1								
14.00 Total (see instructions) 0.00 CAH visits		1						
15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 19.00 ONURSING FACILITY 19.00 OTHER LONG TERM CARE 19.00 OTHER LONG TERM CARE 20.00 HOME HEALTH AGENCY 21.00 OMBULATORY SURGICAL CENTER (D.P.) 22.00 HOME Connected the strict part of th			0.00	(503	43	1 674	
16. 00 SUBPROVI DER - I PF		, ,	0.00		505	43	1,074	
17. 00 SUBPROVI DER - IRF 0. 00 0 0 0 17. 00 18. 00 18. 00 19. 00 18. 00 19. 00		· ·	0.00	C	ol	0	0	•
19. 00		1		C	o	0	0	
20.00 NURSING FACILITY 0.00 20.00 21.00 22.0	18.00	SUBPROVI DER						18.00
21.00 OTHER LONG TERM CARE 0.00 22.00 HOME HEALTH AGENCY 0.00 22.00 AMBULATORY SURGICAL CENTER (D.P.) 0.00 23.00 HOME HEALTH AGENCY 0.00 23.00 HOSPICE 0.00 HOSPICE (non-distinct part) 24.10 HOSPICE (non-distinct part) 24.10 CMHC - CORF 0.00 25.10 CMHC - CORF 0.00 25.10 CMHC - CORF 0.00 25.10 CMHC - CORF 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 27.00 Doservation Bed Days 29.00 Ambulance Trips 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 27.00 Employee discount days (see instruction) 27.00 CMBC 27.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days								
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.00 CMHC - CMHC 25.00 CMHC - CMHC 25.00 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 31.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0.00 20.00 21.00 22.00 23.00 24.00 25.10 0.00 0.00 0.00 0.00 0.00 0.00 0.00								
23.00 AMBULATORY SURGICAL CENTER (D.P.) 0.00 24.00 HOSPICE 0.00 24.10 HOSPICE (non-distinct part) 24.10 25.00 CMHC - CMHC 0.00 25.10 CMHC - CORF 0.00 26.00 RURAL HEALTH CLINIC 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 27.00 Total (sum of lines 14-26) 0.00 28.00 Observation Bed Days 28.00 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days							0	
24. 00 HOSPICE								
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 24. 10 25. 00 25. 00 25. 10 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20.								
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days			0.00					
25. 10 CMHC - CORF			0.00					
26. 00 RURAL HEALTH CLINIC								
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 28. 00 Observation Bed Days 28. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) Employee discount days - IRF 31. 00 Employee discount days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0. 00 33. 00 33. 00								-
27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 22.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 33.00								
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days 29.00 30.00 31.00 32.00 32.01								
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 32.01 LTCH non-covered days 30.00 31.00 32.01	28.00	Observation Bed Days						28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 32.01 LTCH non-covered days 31.00 Sacration in the properties of the pr	29.00	Ambul ance Trips						29. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 32.01								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.01								ı
outpati ent days (see i nstructions) 33.00 LTCH non-covered days 0 33.00								
33.00 LTCH non-covered days 0 33.00	32. 01							32. 01
	33 00							33 00
JOY OF LET OF STATE TIER THE ARAY SHING AT THE TOTAL OF THE TOTAL STATE AND THE TOTAL		LTCH site neutral days and discharges						33. 01

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col. 4 A-6)1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 200 00 5, 060, 354 1.00 Total salaries (see 14, 570, 306 19, 630, 660 577, 829. 00 33.97 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3 00 O 0 00 3 00 Non-physician anesthetist Part 0 00 0 4.00 Physician-Part A -30,000 30,000 305.00 98.36 4.00 Administrative 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 0 5.00 Physician and Non 0 0.00 0.00 5.00 Physician-Part B 6.00 Non-physician-Part B for 0 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 7.00 7.00 21.00 0 0.00 0.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 5.060.354 0 5.060.354 129, 447, 00 39.09 8.00 organization personnel 9 00 SNF 44.00 0.00 0.00 9 00 6, 473 10.00 Excluded area salaries (see 2, 031, 956 2, 038, 429 80, 564. 00 25.30 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 682, 387 682, 387 10, 110. 00 67. 50 11.00 Contract Labor: Top Level 0.00 12.00 0 0 0.00 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 0 0.00 0.00 13.00 0 A - Administrative 14.00 Home office and/or related 0 0 0.00 0.00 14.00 organization salaries and wage-related costs 129, 447. 00 14.01 Home office salaries 5,060,354 5, 060, 354 39.09 14.01 Related organization salaries 0.00 14.02 14.02 0.00 Home office: Physician Part A 15.00 0 0 0.00 0.00 15.00 - Administrative 0 16.00 Home office and Contract 0.00 0.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 - Teachi ng Home office contract 16.02 0 0.00 0.00 16.02 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 5, 513, 897 5, 513, 897 17.00 instructions) 18.00 Wage-related costs (other) 18 00 (see instructions) 19.00 Excluded areas 896, 888 896, 888 19.00 20.00 Non-physician anesthetist Part 0 20.00 21.00 Non-physician anesthetist Part 0 21.00 0 22.00 Physician Part A -О 22.00 Administrative 22.01 Physician Part A - Teaching 0 22.01 Physician Part B 0 23.00 0 23 00 24.00 Wage-related costs (RHC/FQHC) 0 0 24.00 25.00 Interns & residents (in an 25.00 approved program) 25.50 Home office wage-related 1,546,461 0 1, 546, 461 25.50 (core) 25.51 Related organization 0 0 25.51 wage-related (core)

0

0

25.52

Home office: Physician Part A

- Administrative - wage-related (core)

42.00

Social Service

43.00 Other General Service

In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL OF NOBLE CTY, INC HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 1, 915, 672 -1, 915, 672 0.00 0. 00 26.00 146, 477. 00 27.00 Administrative & General 5.00 615, 147 5, 985, 687 6, 600, 834 45.06 27.00 28.00 0.00 28.00 Administrative & General under 0.00 0 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 391, 774 36, 058 427, 832 15, 387.00 27.80 30.00 . Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 32.00 22, 624. 00 Housekeepi ng 9.00 298, 974 27, 517 326, 491 14. 43 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 379, 230 -180, 574 198, 656 10, 753. 00 18.47 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 207, 930 207, 930 13, 655. 00 15. 23 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 42. 80 38.00 38.00 13.00 400, 876 36, 895 437, 771 10, 229. 00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 598, 140 54. 95 40.00 Pharmacy 15.00 55, 051 653, 191 11, 886. 00 40.00 Medical Records & Medical Records Library 41.00 16.00 0 0 0.00 0.00 41.00

0

0

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

costs (see inst.)

(see inst.)

instructions)

COMMUNITY HOSPITAL OF NOBLE CTY, INC Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2019 To 12/31/2019 Part III Date/Time Prepared: 6/23/2020 3:46 pm Worksheet A Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Line Number Reported ion of Sal ari es Related to (col.2 ± col. Salaries in Sal ari es 3) (from col. 4 Worksheet A-6) 1. 00 2.00 3.00 4.00 5.00 6.00 PART III - HOSPITAL WAGE INDEX SUMMARY Net salaries (see 1.00 9, 509, 952 5, 060, 354 14, 570, 306 448, 382. 00 32. 50 1.00 instructions) 2.00 Excluded area salaries (see 2, 031, 956 6, 473 2, 038, 429 80, 564. 00 25.30 2.00 instructions) 3.00 Subtotal salaries (line 1 7, 477, 996 5, 053, 881 12, 531, 877 367, 818. 00 34.07 3.00 minus line 2)

5, 742, 741

7, 060, 358

20, 281, 095

4, 599, 813

5, 742, 741

7, 060, 358

25, 334, 976

8, 852, 705

5, 053, 881

4, 252, 892

139, 557. 00

507, 375. 00

231, 011. 00

0.00

4.00

5.00

6.00

7.00

41. 15

56. 34

49. 93

38. 32

4.00

5.00

6.00

0 19.00

0

0 22.00

37, 568

58, 984

6, 410, 787

20.00

21.00

23.00

24.00

25.00

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 HOSPITAL WAGE RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet S-3 From 01/01/2019 Part IV 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Amount Reported 1. 00 PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 1 00 1 00 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 334, 768 2.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 1, 160, 247 3.00 Qualified Defined Benefit Plan Cost (see instructions) 4.00 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 1, 685 6.00 7.00 Employee Managed Care Program Administration Fees 49,808 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 Health Insurance (Self Funded with a Third Party Administrator) 3, 329, 533 8.02 8.02 Heal th Insurance (Purchased) 8.03 0 8.03 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 10.00 Life Insurance (If employee is owner or beneficiary) 48, 699 11.00 11.00 Accident Insurance (If employee is owner or beneficiary) 12 00 Λ 12 00 Disability Insurance (If employee is owner or beneficiary) 67, 776 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 0 'Workers' Compensation Insurance 15.00 19, 727 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) 17.00 FICA-Employers Portion Only 1, 301, 992 17 00 Medicare Taxes - Employers Portion Only 18.00 0 18.00

Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see

19.00

20.00

21.00

22.00

23 00

24.00

OTHER

instructions))

Unemployment Insurance

Tuition Reimbursement

Day Care Cost and Allowances

25. 00 OTHER WAGE RELATED COSTS (SPECIFY)

State or Federal Unemployment Taxes

Part B - Other than Core Related Cost

Total Wage Related cost (Sum of lines 1 -23)

18.00 Other

0 18.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST Worksheet S-3 Part V Provider CCN: 15-0146 Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/23/2020 3: 46 pm Cost Center Description Contract Benefit Cost Labor 1.00 2.00 PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component Identification: 1.00 Total facility's contract labor and benefit cost 1.00 0 0 0 0 0 0 0 Hospi tal 2.00 0 2.00 Subprovi der - IPF Subprovi der - IRF Subprovi der - (Other) Swing Beds - SNF Swing Beds - NF 3.00 0 3.00 4.00 0 4.00 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 8.00 Hospital -Based SNF 0 8.00 Hospi tal -Based NF Hospi tal -Based OLTC 9.00 0 9.00 10.00 10.00 Hospi tal -Based HHA 11.00 0 0 0 0 0 0 0 0 11.00 12.00 Separately Certified ASC 0 12.00 13.00 Hospi tal -Based Hospi ce 0 13.00 14.00 Hospital-Based Health Clinic RHC 0 14.00 15.00 Hospital-Based Health Clinic FQHC 0 15.00 16.00 Hospi tal -Based-CMHC 0 16.00 16. 10 Hospital -Based-CMHC 10 0 16. 10 17.00 Renal Dialysis 0 17.00

	FINANCIAL SYSTEMS COMMUNITY HOSPITAL OF NOTICE OF NOTICE OF STATE		CN: 15-0146	In Lie Period: From 01/01/2019 To 12/31/2019		0 pared:	
					6/23/2020 3: 4	o pili	
					1. 00		
	Uncompensated and indigent care cost computation			>			
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by li	ne 202 colum	า 8)	0. 200606	1. 00	
2 00	Medicaid (see instructions for each line)				1 004 202	2.00	
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				1, 896, 293 Y	3.00	
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payment	s from Medic	ai d?	Ϋ́	4.00	
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fr				. 0	5.00	
6.00	Medicaid charges				17, 089, 187	6.00	
7.00	Medicaid cost (line 1 times line 6)				3, 428, 193	7.00	
8.00	Difference between net revenue and costs for Medicaid program ((line 7 mir	nus sum of li	nes 2 and 5; if	1, 531, 900	8. 00	
	< zero then enter zero)						
0.00	Children's Health Insurance Program (CHIP) (see instructions fo	or each lir	ne)		7 440	0.00	
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				7, 410 58, 689		
11.00	Stand-alone CHIP cost (line 1 times line 10)				11, 773		
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 mi	nus line 9	f < zero then	4, 363		
12.00	enter zero)						
	Other state or local government indigent care program (see inst	ructions f	or each line)			
13.00	Net revenue from state or local indigent care program (Not incl	9)	3, 094, 415	13.00			
14.00	00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or						
15.00	State or local indigent care program cost (line 1 times line 14	45	3, 694, 767				
16. 00	00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 600, 352) 13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and stat	ce/Local indi	gent care progra	nms (see		
17.00	Private grants, donations, or endowment income restricted to fu	ındi ng char	rity care		0	17.00	
18. 00 19. 00	Government grants, appropriations or transfers for support of hotal unreimbursed cost for Medicaid , CHIP and state and local			s (sum of lines	0 2, 136, 615	18. 00 19. 00	
	8, 12 and 16)		Uni nsured	Lnounod	Total (col. 1		
			pati ents	I nsured pati ents	+ col . 2)		
			1.00	2. 00	3. 00		
	Uncompensated Care (see instructions for each line)				0.00		
20. 00	Charity care charges and uninsured discounts for the entire fac	cility	3, 576, 75	0 1, 302, 215	4, 878, 965	20.00	
	(see instructions)						
21. 00	Cost of patients approved for charity care and uninsured discou	unts (see	717, 51	8 1, 302, 215	2, 019, 733	21.00	
22. 00	instructions) Payments received from patients for amounts previously written	off oc	50	0 1, 147	1, 647	22. 00	
22.00	charity care	UII as	30	1, 147	1,047	22.00	
23. 00			717, 01	8 1, 301, 068	2, 018, 086	23. 00	
			,	., ., ., .,	=/ 0.0/ 000		
					1. 00		
24. 00	Does the amount on line 20 column 2, include charges for patien		ond a Length	of stay limit	N	24.00	
	imposed on patients covered by Medicaid or other indigent care						
25. 00	If line 24 is yes, enter the charges for patient days beyond th	ne indigent	care progra	m's length of	0	25. 00	
24 00	stay limit	+min+! :			0 110 444	24 00	
26. 00 27. 00	Total bad debt expense for the entire hospital complex (see ins Medicare reimbursable bad debts for the entire hospital complex				8, 110, 446 112, 911		
27. 00							
	01 Medicare allowable bad debts for the entire hospital complex (see instructions) 173,709 00 Non-Medicare had debt expense (see instructions) 7,936,737						

7, 936, 737 28. 00 1, 652, 955 29. 00 3, 671, 041 30. 00 5, 807, 656 31. 00

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

28.00 Non-Medicare bad debt expense (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)
30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

		NITY HUSPITAL U	Provi der C			Washabaat A	2332-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JF EXPENSES	Provider C		Period: From 01/01/2019	Worksheet A	
					o 12/31/2019		
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	6/23/2020 3: 4 Reclassi fi ed	6 pm
	cost center bescription	Sai ai i es	Other	+ col . 2)	i ons (See	Tri al Bal ance	
				1 (01. 2)	A-6)	(col. 3 +-	
					,	col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT		2, 609, 184			1, 724, 974	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	C	1, 076, 140	1, 076, 140	2.00
3.00	00300 OTHER CAP REL COSTS	1 015 (70	U 5 120 217	7 052 000	1 015 (70	0	3.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 915, 672 615, 147	5, 138, 217 22, 571, 972			5, 138, 217 24, 048, 304	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	013, 147	22, 371, 472	23, 107, 119	001, 103	24, 048, 304	6.00
7. 00	00700 OPERATION OF PLANT	391, 774	826, 956	1, 218, 730	34, 276	1, 253, 006	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	, , _ , , , , , , , , , , , , , , , , ,		142, 230	8.00
9.00	00900 HOUSEKEEPI NG	298, 974	306, 796	605, 770	-114, 713	491, 057	9. 00
10.00	01000 DI ETARY	379, 230	248, 017	627, 247	-329, 212	298, 035	10.00
11. 00	01100 CAFETERI A	0	0	C	355, 055	355, 055	
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	C	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	400, 876	171, 319	572, 195	36, 895	609, 090	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	598, 140	101, 959	700, 099	55, 051	0 755, 150	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	390, 140	101, 939	700,099	05,051	755, 150	16.00
17. 00	01700 SOCIAL SERVICE		0			0	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	o	0	ď	o o	0	18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	O	0	d	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	d c	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	C	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	C	0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	<u> </u> C	0	0	23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 427, 876	1, 020, 493	3, 448, 369	-425, 526	3, 022, 843	30.00
31.00	03100 INTENSIVE CARE UNIT	2,427,670	1, 020, 493	3, 440, 309	-425, 526	3, 022, 643	31.00
32. 00	03200 CORONARY CARE UNIT		0			0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	Ö	0		o o	Ö	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	o	0	d	o o	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	c	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	C	0	0	41.00
43.00	04300 NURSERY	0	0	C	119, 672	119, 672	
44.00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	C	0	0	45.00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	<u></u>)	0	46. 00
50.00	05000 OPERATI NG ROOM	919, 590	470, 974	1, 390, 564	73, 645	1, 464, 209	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	c	560, 784	560, 784	52.00
53.00	05300 ANESTHESI OLOGY	0	1, 191, 254	1, 191, 254		1, 191, 254	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 393, 195	838, 504	1		2, 287, 496	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	1
56. 00 57. 00	05600 RADI OI SOTOPE	0	0		0	0	56. 00 57. 00
58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		0			0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0			0	59.00
60.00	06000 LABORATORY	Ö	2, 582, 336	2, 582, 336	ő	2, 582, 336	1
60. 01	06001 BLOOD LABORATORY	اً وَا	0	, , , , , , , , , , , , , , , , , , ,	o o	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	C	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(C	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	l c	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	75.000	1 (40 000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	564, 407	75, 802			688, 604	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 244, 191	199, 766 0	1, 443, 957	-521, 956 339, 606	922, 001 339, 606	66. 00 67. 00
68.00	06800 SPEECH PATHOLOGY		0		292, 328	292, 328	1
69.00	06900 ELECTROCARDI OLOGY	ا	0) 272, 320	272, 320	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	l c	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	959, 494	959, 494	-270, 883	688, 611	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	270, 883	270, 883	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 687, 952	3, 687, 952	0	3, 687, 952	
74.00	07400 RENAL DIALYSIS	0	0] _	2	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	1/1 7/0	E40.000	700 054	1 0	727 510	75.00
76. 98 77. 00	07698 HYPERBARIC OXYGEN THERAPY	161, 762	562, 089	723, 851	3, 659	727, 510 0	76. 98 77. 00
, , . 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	ا ا	0	ıı	U	U	1 / / . 00
88. 00	08800 RURAL HEALTH CLINIC	ol	Ω) 0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0			0	89.00
90.00	09000 CLI NI C	38, 733	14, 475	53, 208	11, 112	64, 320	1
91.00	09100 EMERGENCY	1, 188, 783	547, 770			1, 864, 787	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			<u> </u>			92.00

0

0

o

0 115.00

0 116.00

0

0

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

116. 00 11600 HOSPI CE

Heal th	Financial Systems COMM	JNITY HOSPITAL	OF NOBLE CTY, I	NC	In Lieu of	Form CMS-2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (Provi der CC		Peri od: Wor	ksheet A
					From 01/01/2019	o/Timo Droparod
					To 12/31/2019 Dat	:e/Time Prepared: 23/2020 3:46 pm
	Cost Center Description	Adjustments	Net Expenses			
	·	(See A-8)	For			
			Allocation			
	T	6. 00	7. 00			
1 00	GENERAL SERVI CE COST CENTERS	1 204 500	440.207			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	-1, 284, 588 0				1. 00 2. 00
3. 00	00300 OTHER CAP REL COSTS	0				3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 912, 148	1 -1			4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-9, 717, 747				5.00
6. 00	00600 MAI NTENANCE & REPAI RS	0	1			6.00
7. 00	00700 OPERATION OF PLANT	-7, 460				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	142, 230			8.00
9.00	00900 HOUSEKEEPI NG	0	491, 057			9.00
10.00	01000 DI ETARY	-156	297, 879			10.00
11. 00	01100 CAFETERI A	-249, 508	105, 547			11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	1 -1			12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-154, 146	454, 944			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0			14.00
15. 00	01500 PHARMACY	-755, 150	1			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0			16.00
17.00	01700 SOCIAL SERVICE	0	0			17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0			18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0				19.00
20. 00 21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0			20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0				22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0				23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>			25.00
30. 00	03000 ADULTS & PEDIATRICS	39, 288	3, 062, 131			30.00
31.00	03100 INTENSIVE CARE UNIT	0				31.00
32.00	03200 CORONARY CARE UNIT	0	o			32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	o			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	119, 672			43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0			44.00
45. 00	04500 NURSING FACILITY	0	1			45.00
46. 00	04600 OTHER LONG TERM CARE	0	0			46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	-1, 992	1 442 217			50.00
51.00	05100 RECOVERY ROOM	-1, 992				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		1			52.00
53.00	05300 ANESTHESI OLOGY	-1, 191, 254				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-13, 974				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0				55.00
56. 00	05600 RADI OI SOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	o			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0			59.00
60.00	06000 LABORATORY	0	2, 582, 336			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	0			64.00
65.00	06500 RESPIRATORY THERAPY	-2, 018				65.00
66.00	06600 PHYSI CAL THERAPY	-145, 242				66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	1 1 1 1 1 1 1 1 1			67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY		292, 328			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY					70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		688, 611			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-404				73.00
74. 00	07400 RENAL DIALYSIS	0				74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	1			75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	-973	1			76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0				77.00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0	0			88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00	09000 CLI NI C	-2, 861				90.00
91.00	09100 EMERGENCY	0	1, 864, 787			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	I	ı l			92.00

 Health Financial
 Systems
 COMMUNITY HOSPIT

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0146

| Peri od: | Worksheet A | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

			To 12/31/2019 Date/Ti	me Prepared: 20 3:46 pm
Cost Center Description	Adjustments	Net Expenses	0,20,20	20 0. 10 piii
·	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	-4, 733	2, 080, 235		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 ACQUISITION	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 INTEREST 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)	-15, 405, 066	43, 346, 356		118. 00
NONRE MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-40, 509			190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	42, 451		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194.00 07950 0THER 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	-57	213, 625		194. 03
194. 04 07954 PHYSI CI AN OFFI CES	0	0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	-110, 730	373, 697		194. 05
194. 06 07956 VACANT SPACE	0	1 9		194. 06
200.00 TOTAL (SUM OF LINES 118 through 199)	-15, 556, 362	43, 999, 582		200. 00

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146 | Peri od: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

					1	o 12/31/201	9 Date/lime Prepared: 6/23/2020 3:46 pm
	Cost Contor	Increases	Salamy	Othor			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
	B - REHAB THERAPY	0.00	1. 00	0.00			
1.00	OCCUPATI ONAL THERAPY	67. 00	292, 277	47, 329			1.00
2.00	SPEECH PATHOLOGY	6800	25 <u>1, 5</u> 88	<u>40, 7</u> 40			2.00
	0		543, 865	88, 069			
1. 00	C - INSURANCE CAP REL COSTS-BLDG & FIXT	1. 00	ol	29, 570			1.00
2.00	CAP REL COSTS-BEDG & TTXT	2. 00	0	19, 194			2.00
2.00	0		- — 	48, 764			2.00
	D - EQUIP LEASE	'	- 1				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	68, 434			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	74, 874			2.00
3. 00		0.00	0	0			3.00
4. 00		0.00	0	0			4.00
5. 00 6. 00		0. 00 0. 00	0	0			5. 00 6. 00
7. 00		0.00	0	0			7.00
8. 00		0.00	0	ő			8.00
9. 00		0. 00	Ö	Ö			9.00
10.00		0.00	0	0			10.00
11.00		0.00	0	0			11.00
12.00		0. 00	0	0			12.00
13.00		0. 00	0	0			13.00
14. 00		0.00	0	0			14.00
	F - CLINIC DIETICIAN		U	143, 308			
1. 00	CLINIC DIETICIAN	90. 00	7, 547	0			1.00
1.00	0		$-\frac{7,547}{7,547}$	0			1.00
	G - EMPLOYEE SALARY BENEFITS		7,017	<u> </u>			
1.00	ADMINISTRATIVE & GENERAL	5. 00	925, 333	0			1.00
2.00	OPERATION OF PLANT	7. 00	36, 058	0			2.00
3.00	HOUSEKEEPI NG	9. 00	27, 517	0			3.00
4. 00	DI ETARY	10.00	34, 903	0			4.00
5. 00 6. 00	NURSING ADMINISTRATION PHARMACY	13.00	36, 895	0			5.00
7. 00	ADULTS & PEDIATRICS	15. 00 30. 00	55, 051 259, 968	0			6.00
8. 00	OPERATING ROOM	50.00	86, 859	o			8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	128, 225	Ö			9.00
10.00	RESPI RATORY THERAPY	65. 00	51, 946	0			10.00
11.00	PHYSI CAL THERAPY	66. 00	114, 511	0			11.00
12.00	HYPERBARIC OXYGEN THERAPY	76. 98	14, 883	0			12.00
13.00	CLINIC	90. 00	3, 565	0			13.00
14.00	EMERGENCY	91.00	133, 485	0			14.00
16. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	3, 126	0			16.00
17. 00	CANTEEN PHYSICIANS' PRIVATE OFFICES	192. 00	3, 347	0			17. 00
17.00	0		1, 915, 672	<u>0</u>			17.00
	H - CAFETERIA		.,	-1			
1.00	CAFETERI A	11. 00	207, 930	147, 125			1.00
	0		207, 930	147, 125			
	I - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	976, 077			1.00
2. 00	OPERATION OF PLANT	<u> </u>		<u>142</u> 976, 219			2.00
	J - HOME OFFICE SALARIES		UU	970, 219			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	5, 060, 354	0			1.00
	0		5, 060, 354	0			
	K - LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	<u>142, 2</u> 30			1.00
	0		0	142, 230			
	M - IMPLANTS	70.00	ما	070 000			1.00
1. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	270, 883			1.00
	0	+		270, 883			•
	N - OB		U U	270,003			
1. 00	NURSERY	43. 00	106, 258	13, 414			1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	497, 928	62, 856			2.00
	0		604, 186	76, 270			
	P - OTHER						
1.00		0.00	•	0			1.00
	O DEDCOMAL PROPERTAY		0	0			
1 00	Q - PERSONAL PROP TAX CAP REL COSTS-MVBLE EQUIP	2 00	ما	E 00E			1 00
1. 00	O KEL COSTS-MARKE ECOLAL		위	<u>5, 995</u> 5, 995			1.00
500.00	Grand Total: Increases		8, 339, 554	1, 898, 863			500.00
			.,,,	, = . = , = = =			1 222.00

Heal th	Financial Systems	COMMU	JNITY HOSPITAL	OF NOBLE CTY,	I NC	In Lieu of Form C	MS-2552-10
RECLAS	SI FI CATI ONS			Provi der CC	CN: 15-0146 F	Period: Worksheet From 01/01/2019	A-6
						Γο 12/31/2019 Date/Time	Prepared:
		Daaraasaa				6/23/2020	3: 46 pm
	Cost Center	Decreases Li ne #	Sal ary	Other W	/kst. A-7 Ref.	l	
	6.00	7. 00	8. 00	9. 00	10.00		
	B - REHAB THERAPY						
1. 00	PHYSI CAL THERAPY	66. 00	543, 865	88, 069	0	l e	1.00
2. 00		0.00	0 543, 865	0_ 88, 069	0		2. 00
	C - INSURANCE		543, 805	88, 009			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	48, 764	12		1.00
2.00		0.00	О	0	12		2.00
	0		0	48, 764			
4.00	D - EQUIP LEASE	5 00	ما	45.004	4.0		4.00
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	15, 384 1, 924	10 10	l e	1.00
2. 00 3. 00	OPERATION OF PLANT DIETARY	7. 00 10. 00	0	1, 924	0	l	2. 00 3. 00
4. 00	ADULTS & PEDIATRICS	30.00	o	5, 038	0	l e	4.00
5. 00	OPERATI NG ROOM	50.00	O	13, 214	0	l e	5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54. 00	О	72, 428	0		6.00
7.00	RESPI RATORY THERAPY	65. 00	0	3, 551	0	1	7. 00
8.00	PHYSI CAL THERAPY	66.00	0	4, 533	0	l e	8.00
9. 00 10. 00	HYPERBARIC OXYGEN THERAPY EMERGENCY	76. 98 91. 00	0	11, 224 5, 251	0		9. 00 10. 00
11. 00	AMBULANCE SERVICES	95.00	0	4, 136	0	l e	11.00
12.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	827	0	l e	12.00
.2.00	CANTEEN	1,01.00	٩	02.	ŭ		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	1, 710	0		13.00
14.00	COMMUNITY & VOLUNTEER	194. 05	0	2, 575	0		14.00
	SERVICES	+					
	O		0	143, 308			_
1. 00	F - CLINIC DIETICIAN DIETARY	10. 00	7, 547	0	0		1.00
1.00	0	— — 10.00	$\frac{7,547}{7,547}$	— — ŏ			1.00
	G - EMPLOYEE SALARY BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 915, 672	0	0		1.00
2.00		0. 00	0	0	0	l .	2.00
3.00		0.00	0	0	0	l I	3.00
4. 00 5. 00		0. 00 0. 00	0	0	0		4. 00 5. 00
6. 00		0.00	o	0	0		6.00
7. 00		0. 00	o	0	0		7.00
8.00		0.00	О	0	0		8.00
9.00		0. 00	0	0	0		9. 00
10.00		0. 00	0	0	0	l	10.00
11. 00 12. 00		0.00	0	0	0		11. 00 12. 00
12.00		0. 00 0. 00	0	0	0		13.00
14. 00		0. 00	o	0	0	l e	14.00
16. 00		0.00	o	0	0		16.00
17.00		0.00	0_	0_	0		17.00
	0		1, 915, 672	0			
1 00	H - CAFETERIA	10.00	207 020	147 105	0		1.00
1. 00	DI ETARY		207, 930 207, 930	14 <u>7, 1</u> 25 147, 125_	0		1.00
	I - DEPRECIATION		207, 930	147, 125			
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	0	976, 219	9		1.00
2.00		0.00	O	0	0		2.00
	0 — — — — —		0	976, 219			
	J - HOME OFFICE SALARIES						
1. 00	ADMI NI STRATI VE & GENERAL		•	5, 060, 354	0		1.00
	K - LAUNDRY		U	5, 060, 354			
1. 00	HOUSEKEEPI NG	9. 00	0	142, 230	0		1.00
1.00	0	— — /. 00	— — ў	142, 230			1.00
	M - IMPLANTS		-1				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	270, 883	0		1.00
	PATI ENTS						
	0		0	270, 883			
1 00	N - OB ADULTS & PEDIATRICS	30.00	604 104	74 270	0		1 00
1. 00 2. 00	ADULIS & PEDIATRICS	0.00	604, 186	76, 270 0	0	l e e e e e e e e e e e e e e e e e e e	1. 00 2. 00
2.00		<u> </u>	604, 186	76, 270	9		2.00
	P - OTHER		20.7.00	, 3, 2, 0			
1.00		0.00	0	0	0		1.00
	0		0	0			

Heal th Financial Systems

COMMUNITY HOSPITAL OF NOBLE CTY, INC

In Lieu of Form CMS-2552-10

Provider CCN: 15-0146

Period:
From 01/01/2019
To 12/31/2019

Decreases

Decreases

						0/23/2020 3.	40 PIII
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	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	5, 995	13		1.00
	0		0	5, 995			
500.00	Grand Total: Decreases		3, 279, 200	6, 959, 217			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0146

						1 07 2 37 2 0 2 0 3. 4	O PIII
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	755, 392	0	0	0	0	2.00
3.00	Buildings and Fixtures	3, 871, 871	50, 148	0	50, 148	0	3. 00
4.00	Building Improvements	63, 781	0	0	0	0	4. 00
5.00	Fixed Equipment	405, 024	1, 333, 494	0	1, 333, 494	0	5. 00
6.00	Movable Equipment	13, 868, 647	648, 347	0	648, 347	2, 018, 748	6.00
7.00	HIT designated Assets	3, 209, 182	123, 444	0	123, 444	0	7.00
8.00	Subtotal (sum of lines 1-7)	22, 173, 897	2, 155, 433	0	2, 155, 433	2, 018, 748	8.00
9.00	Reconciling Items	1, 699, 086	1, 539, 345	0	1, 539, 345	0	9.00
10.00	Total (line 8 minus line 9)	20, 474, 811	616, 088	0	616, 088	2, 018, 748	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	755, 392	210, 579				2.00
3.00	Buildings and Fixtures	3, 922, 019	627, 069				3.00
4.00	Building Improvements	63, 781	7, 379				4.00
5.00	Fixed Equipment	1, 738, 518	58, 938				5.00
6.00	Movable Equipment	12, 498, 246	6, 429, 341				6. 00
7.00	HIT designated Assets	3, 332, 626	0				7.00
8.00	Subtotal (sum of lines 1-7)	22, 310, 582	7, 333, 306				8.00
9.00	Reconciling Items	3, 238, 431					9.00
10.00	Total (line 8 minus line 9)	19, 072, 151	7, 333, 306				10.00

Health Financial Systems C	OMMUNITY HOSPITAL OF NOBLE CTY, INC	In Lieu of Form (CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-0146	Period: Worksheet From 01/01/2019 Part II	A-7
		To 12/31/2019 Date/Time 6/23/2020	
	SUMMARY OF CA	PI TAL	

				Т	o 12/31/2019	Date/Time Pre 6/23/2020 3:4	
			SL	JMMARY OF CAPIT	ΓAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see instructions)	
					instructions)	ĺ	
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 609, 184	0	C	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	C	0	0	2.00
3.00	Total (sum of lines 1-2)	2, 609, 184		C	0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	· · · · · · · · · · · · · · · · · · ·				1
1.00	CAP REL COSTS-BLDG & FLXT	0	2, 609, 184				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2, 609, 184				3.00

Health Financial Systems	COMMUNITY HOSPITAL OF NOBLE CTY, INC		In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-0146	Peri od:	Worksheet A-7

Heal tr	n Financial Systems COMMU	JNITY HOSPITAL	OF NOBLE CIY,	INC	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2019	Worksheet A-7 Part III	
					Fo 12/31/2019		narod:
					10 12/31/2019	6/23/2020 3: 4	
		COME	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
				col. 2)			
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	6, 479, 710	0	6, 479, 710	0. 300234	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15, 830, 871	728, 408	15, 102, 463	0. 699766	0	2.00
3.00	Total (sum of lines 1-2)	22, 310, 581	728, 408	21, 582, 173	1. 000000	0	3.00
		ALLOCAT	TION OF OTHER C	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
			ed Costs	through 7)			
		6. 00	7.00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(348, 377	68, 434	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(976, 077	74, 874	2.00
3.00	Total (sum of lines 1-2)	0	0	(1, 324, 454	143, 308	3.00
			SU	IMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)			9 through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					_
1.00	CAP REL COSTS-BLDG & FIXT	0	29, 570			440, 386	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	19, 194	5, 995	5 0	1, 076, 140	2.00
3.00	Total (sum of lines 1-2)	0	48, 764	(0	1, 516, 526	3.00
						•	

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0146 Peri od: Worksheet A-8 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) 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 OPHARMACY 15.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 -187 ADMINISTRATIVE & GENERAL 5 00 7.00 Α stations excluded) (chapter 8.00 Television and radio service -1, 988 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 -1, 191, 254 10.00 Provi der-based physici an 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization -6, 940, 213 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -80, 152 CAFETERI A 11.00 14.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others 16.00 Sale of medical and surgical 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18.00 18.00 0.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A - 8 - 366.00 therapy costs in excess of limitation (chapter 14) Utilization review OUTILIZATION REVIEW-SNF 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant 28.00 ONONPHYSICIAN ANESTHETISTS 19.00 28.00 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 30.00 A-8-3 67.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions)

Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 Provider CCN: 15-0146 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for 32.00 0 0.00 32.00 Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY) 33.00 0 0.00 33.00 (3)OTHER ADJUSTMENTS (SPECIFY) 33.01 0.00 33.01 (3)TELEPHONE -39 EMPLOYEE BENEFITS DEPARTMENT 33.02 4.00 33.02 Α OTHER ADJUSTMENTS (SPECIFY) 33.03 0.00 33.03 33 04 PHYSICIAN RECRUITMENT -14, 918 ADMINISTRATIVE & GENERAL 5 00 33 04 Α -752, 644 PHARMACY PHARMACY SALES 0 33.05 В 15.00 33.05 33.06 SELF INSURANCE -1, 912, 109 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.06 OTHER ADJUSTMENTS (SPECIFY) 33.07 0.00 33.07 OTHER ADJUSTMENTS (SPECIFY) 33.08 0.00 33.08 33.09 LOBBY DUES Α -3, 236 ADMINISTRATIVE & GENERAL 5.00 33.09 33.10 LI QUOR -706 ADMINISTRATIVE & GENERAL 5.00 33.10 Α -57 FOUNDATION 33.11 LI OUOR Α 194.03 O 33.11 INTERUNIT SUBSIDY -132, 989 PHYSI CAL THERAPY 33.12 Α 66.00 33.12 33. 13 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.13 33 14 INTERUNIT SUBSIDY -1.284.588CAP REL COSTS-BLDG & FLXT 33 14 1 00 Α -47, 670 COMMUNITY & VOLUNTEER 33. 15 INTERUNIT SUBSIDY 194.05 33.15 Α SERVI CES INTERUNIT SUBSIDY -13, 675 RADI OLOGY-DI AGNOSTI C 33. 16 54.00 33.16 OTHER OPERATING REVENUE -33, 019 ADMINISTRATIVE & GENERAL 5.00 0 33.17 33.17 В 33. 18 OTHER OPERATING REVENUE В -5.472 OPERATION OF PLANT 7.00 33 18 OTHER OPERATING REVENUE -404 DRUGS CHARGED TO PATIENTS 33.19 33. 19 В 73.00 OTHER OPERATING REVENUE -156 DI ETARY 10.00 33. 20 33. 20 В -169, 356 CAFETERI A OTHER OPERATING REVENUE 33.21 33. 21 B 11.00 -154, 146 NURSING ADMINISTRATION 33. 22 OTHER OPERATING REVENUE В 13.00 33.22 OTHER OPERATING REVENUE -2, 506 PHARMACY 33. 23 В 15.00 -3,516 ADULTS & PEDIATRICS OTHER OPERATING REVENUE 33. 24 В 30.00 33.24 OTHER OPERATING REVENUE -299RADI OLOGY-DI AGNOSTI C 33 25 В 54.00 33 25 33. 26 OTHER OPERATING REVENUE -2, 018 RESPI RATORY THERAPY 65.00 33.26 В 33 27 OTHER OPERATING REVENUE В -12, 253 PHYSI CAL THERAPY 66.00 33.27 33. 28 OTHER OPERATING REVENUE -2, 861 CLI NI C 90.00 0 33, 28 В -4, 733 AMBULANCE SERVICES OTHER OPERATING REVENUE 33 29 B 95.00 33 29 OTHER OPERATING REVENUE -40,509 GIFT, FLOWER, COFFEE SHOP & 190.00 33.30 В 33.30 CANTEEN OTHER OPERATING REVENUE -63, 060 COMMUNITY & VOLUNTEER 194.05 33.31 33.31 В 0 SERVI CES TELEMETRY CHARGES 42, 804 ADULTS & PEDIATRICS 33.32 Α 30.00 0 33.32 ADMIN PHYS SALARIES Α 124, 499 ADMINISTRATIVE & GENERAL 5.00 33.33 33.34 LOBBYING EXPENSE 0.00 33.34 LOBBYING EXPENSE -1, 382 ADMI NI STRATI VE & GENERAL 33.35 33 35 Α 5.00 33. 36 HOSPITAL ASSESSMENT FEE Α -2, 848, 585 ADMINISTRATIVE & GENERAL 5.00 33.36 OTHER OPERATING REVENUE -1,992 OPERATING ROOM 33.37 33.37 В 50.00

-973 HYPERBARI C OXYGEN THERAPY

33.38

50.00

76.98

В

-15, 556, 362

TOTAL (sum of lines 1 thru 49)

OTHER OPERATING REVENUE

(Transfer to Worksheet A, column 6, line 200.)

33.38

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

⁽²⁾ Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

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

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

From 01/01/2019 OFFICE COSTS 12/31/2019 Date/Time Prepared:

						6/23/2020 3:4	46 pm
	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 ADJUST	MENTS REQUIRED AS A RESULT OF	F TRANS	SACTIONS WITH RELATED O	RGANIZATIONS OF	CLAIMED HOME	
	OFFICE COSTS:						
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME (OFFICE ALLOCATION	10, 941, 326	9, 192, 144	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	PPG SI	UBSI DY	0	8, 689, 395	2.00
3.00	0.00				0	0	3.00
4.00	0.00				0	0	4.00
5.00	TOTALS (sum of lines 1-4).				10, 941, 326	17, 881, 539	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 RELA	TED ORGANIZATION(S) AND/OR HO	OME 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
- 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 provi der.

Heal th	Financial Syste	ems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lieu	of Form CMS-	2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0146	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2019		
					To 12/31/2019	Date/Time Pro	
						6/23/2020 3: 4	46 pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1.00	1, 749, 182	0					1.00
2. 00	-8, 689, 395	0					2.00
3. 00	0	0					3.00
4.00	0	0					4.00
5. 00	-6, 940, 213						5.00
			bscripts as appropriate) are tra	nsferred in detail to Wo	rkshoot A column	6 lines as	
appropr	i ate. Posi ti ve	amounts increas	se cost and negative amounts dec	rease cost.For related o	rganization or ho	me office cos	t which
has not	been posted t	o Worksheet A,	columns 1 and/or 2, the amount	allowable should be indi	cated in column 4	of this part	
	Related Orga	ani zati on(s)					
		me Office (
]	5 66					

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
8. 00 9. 00			9.00
10.00			10.00
10. 00 100. 00		1	100.00

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

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

Type of Business 6. 00

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2019 To 12/31/2019 Date/Time Prepared: Provi der CCN: 15-0146

						-	Γο 12/31/2019	Date/Time Pre 6/23/2020 3:4	epared: 16 pm
	Wkst. A Line #	Cost	Center/Physi ci an	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
			ldentifier	Remuneration	Component	Component		ider Component	
								Hours	
	1. 00		2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	53. 00 DR.			1, 191, 254		0			1.00
2.00	91. 00 DR.	. В		30, 000		30, 000	211, 500		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			1 221 254	1 101 254	20.000	0	0	10.00
200.00	Wkst. A Line #	Coot	Center/Physi ci an	1, 221, 254 Unadj usted RCE		30,000 Cost of		305 Physician Cost	200.00
	WKSt. A LITTE #	COST	I denti fi er		Unadjusted RCE			of Malpractice	
			ruentiffei	LIIIII	Limit	Continuing	Share of col.	Insurance	
					Limit	Education	12	Trisul ance	
	1. 00		2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00	53. 00 DR.	. A		0					1.00
2.00	91. 00 DR.	. В		31, 013	1, 551	0	0	0	2.00
3.00	0.00			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	_	10.00
200.00				31, 013		0	0	0	200.00
	Wkst. A Line #	Cost	Center/Physi ci an	Provi der	Adjusted RCE	RCE	Adjustment		
			I denti fi er	Component	Limit	Di sal I owance			
				Share of col. 14					
	1.00		2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	53. 00 DR.	. A	2. 00	0	0				1. 00
2. 00	91. 00 DR.			l o	31, 013	0	0		2. 00
3. 00	0.00			0	0	0	0		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	0	0		9.00
10.00	0.00			0	0	0	0		10.00
200.00				0	31, 013	0	1, 191, 254		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC In Lieu of Form CMS-2552-10 Worksheet B Part I Date/Time Prepared: 6/23/2020 3:46 pm Provi der CCN: 15-0146 Peri od: From 01/01/2019 To 12/31/2019 CAPITAL RELATED COSTS

			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost contor boost pri on	for Cost	DEBG @ 11741		BENEFITS	oub to tu.	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)	1.00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS					*	
1.00	00100 CAP REL COSTS-BLDG & FIXT	440, 386	l	1			1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 076, 140 3, 226, 069		1, 076, 140 0	3, 226, 069		2.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	14, 330, 557	96, 409		1, 084, 776		5.00
6. 00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700 OPERATION OF PLANT	1, 245, 546	37, 249	42, 106	70, 309	1, 395, 210	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	142, 230	l	1	0	145, 434	8. 00
9.00	00900 HOUSEKEEPI NG	491, 057	4, 635	1	53, 655	549, 380	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	297, 879 105, 547	9, 542 6, 172		32, 647 34, 171	345, 770 145, 890	10.00 11.00
12. 00		0	0, 1,2	1	0 1, 171	0	12.00
13.00	01300 NURSING ADMINISTRATION	454, 944	1, 298	105, 781	71, 942	633, 965	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11, 921		0	11, 921	14.00
15.00	01500 PHARMACY	0	3, 515		107, 344	180, 105	15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	5, 370 0	1	0	5, 370 0	16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	Ö	0	0	18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	1 1	0	0	0	0	0	20. 00
21. 00		0	0	0	0	0	21.00
22. 00 23. 00	1 1	0	0	0	0	0	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0		<u> </u>	0	0	23.00
30.00		3, 062, 131	56, 067	62, 483	342, 424	3, 523, 105	30.00
31. 00	1 1	0	0	1	0	0	31.00
32.00		0	0	0	0	0	32.00
33. 00 34. 00		0	0	0	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	0	Ö	O	0	0	41.00
43.00	04300 NURSERY	119, 672	806	4, 192	17, 462	142, 132	43. 00
44. 00	I I	0	0	0	0	0	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0		0	0	0	45. 00 46. 00
10.00	ANCILLARY SERVICE COST CENTERS			, o		Ü	10.00
50.00		1, 462, 217	42, 000	133, 053	165, 398	1, 802, 668	50. 00
51.00		0	0	10 727	01 020	0	51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	560, 784	5, 176	19, 737	81, 828 0	667, 525 0	52.00 53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 273, 522	39, 375	396, 396	250, 027	2, 959, 320	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57. 00		0	0	0	0	0	57.00
58. 00 59. 00		0		0	0	0	58.00 59.00
60.00	06000 LABORATORY	2, 582, 336	1	_	0	2, 593, 169	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	1 1	0				0	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64. 00		0		0	0	0	63. 00 64. 00
65.00	1 1	686, 586	6, 910	26, 982	101, 290	821, 768	65.00
66.00		776, 759	29, 872	9, 920	133, 909	950, 460	66. 00
67.00		339, 606		1	48, 032	387, 638	1
68. 00 69. 00	i i	292, 328	0	0	41, 345	333, 673 0	68. 00 69. 00
70.00	+ I	0	0	0	0	0	70.00
71. 00	+ I	688, 611	Ö	o o	0	688, 611	71.00
72. 00	I I	270, 883	0	0	0	270, 883	
73.00		3, 687, 548	0	0	0	3, 687, 548	
74. 00 75. 00	I I	0	0	0	0	0	74.00 75.00
75. 00 76. 98	07698 HYPERBARIC OXYGEN THERAPY	726, 537	5, 502		29, 029	787, 146	1
77. 00	1 1	0	0,002		0	0	77. 00
a = -	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	88. 00 89. 00
	09000 CLINIC	61, 459	0		8, 191	_	1
	the state of the s		·	1	-,		·

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 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS DEPARTMENT** Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A 91. 00 09100 EMERGENCY 1, 864, 787 23, 479 21, 486 217, 299 2, 127, 051 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 09500 AMBULANCE SERVICES 2, 080, 235 95.00 143, 259 292, 902 2, 516, 396 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 0 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 09900 CMHC 0 0 0 99.00 99.00 C 0 99. 10 09910 CORF 0 0 0 0 0 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101 00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 0 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 107.00 Ω 108.00 10800 LUNG ACQUISITION 0 C 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 0 C 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 0 115.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 43, 346, 356 399, 335 1, 072, 686 3, 183, 980 43, 259, 762 118. 00 118.00 NONREI MBURSABLE COST CENTERS 34, 491 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 971 23.453 971 6.096 191. 00 19100 RESEARCH 0 191.00 C 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 21, 087 70, 691 192. 00 42, 451 627 6, 526 0 193.00 193. 00 19300 NONPALD WORKERS 0 0 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 C 0 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 194.02 0 0 0 194. 03 07953 FOUNDATI ON 213, 625 194. 03 0 0 213, 625 0 194. 04 07954 PHYSICIAN OFFICES 0 194.04 0 15, 993 29, 467 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 373, 697 1,856 421, 013 194. 05 194.06 07956 VACANT SPACE 0 194.06 200.00 Cross Foot Adjustments 0 200.00

43, 999, 582

440, 386

1, 076, 140

3, 226, 069

0 201.00

43, 999, 582 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part |
| To 12/31/2019 | Date/Time Prepared: 6/23/2020 3:46 pm

Control Cont						0 12/31/2019	6/23/2020 3:4	
		Cost Center Description			OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
1.00 0.000 CAP REL DOSTS-BLUE & FIXT							9. 00	
2.00 0000 CAP REL COSTS-AMBLE EDUP 2.00 0000 CAP REL COSTS CAP REL COST	1.00				1			
4.00 0.000 DEPROYEE FRIEFITS DEPARTMENT 15, 517, 974 0.0000 0.000 0.000 0.000 0.000 0.000 0.000								
5.00 DOSOD MANI BERMAN TEAR CE ACHEMAL 7.00 DOSOD MANI SERVINES 7.00 DOSO DOSOD MANI SERVINES 7.00 DOSO DOSOD MANI SERVINES 7.00 DOSOD MANI SERVIN								•
0.000 0.0000 MAINTENANCE & REPAIRS 0 0 2, 155, 379 247, 150 18, 00 0.000 1.00000 1.00000 1.00000 1.00000 1.00000 1.00000 1.00000 1.00000 1.00000 1.0000000			15, 517, 974					•
B. OD DOBING LANDREY S. LINEN SERVICE 79, 239 0 22, 577 1-41 194, 247 91 10.00 10.000 ILTERY 188, 390 0 67, 051 335 28.4 481 10.00 10.000 ILTERY 188, 390 0 67, 051 335 28.4 481 10.00 10.00 10.000 ILTERY 188, 390 0 67, 051 335 28.4 481 10.00 10.00 10.000 1.000			0	0				•
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.00000000	7.00	00700 OPERATION OF PLANT	760, 169	0	2, 155, 379			7. 00
10. DO 01000 DI FTARY 188, 390 0		1 1		0				•
11.00 01000 (AFFERRA			·	0				•
12.00 01200 IMA INTERNACE OF PERSONNEL 0 0 0 0 0 12.00 3.87 13.00 13.0			1	0				1
13.00 01300 NIRSS ING ADM IN STRATION 34.5, 411 0 9.121 0 3.871 13.00 13.0				0				1
14.00 01400 CENTRAL SERVICES & SUPPLY 6.495 0 83,765 74,802 35,553 14.00 16.0			_	0	1			1
15.00 OISCO PHABILACY 98, 129		l l		Ö			-	1
17.00 01700 SOCIAL SERVICE (SPECIFY) 0 0 0 0 0 0 17.00 19.00 1900 NORPHYSIC ANI AMESTHETISTS 0 0 0 0 0 0 0 19.00 21.00 0200 DURSIN KS SCHOOL 22.00 0200 DURSIN KS SCHOOL 23.00 0200 DURSIN KS SCHOOL 24.00 0400 DURSIN KS SCHOOL 24.00 0400 DURSIN KS SCHOOL 24.00 0400 DURSIN KS SCHOOL 25.00 0400 DURSIN KS SCHOOL 25.00 0500 DURSIN KSCHOOL 25.00 0500 DURSIN KSCHOOL 25.00 0500 DURSIN KSC	15.00			0				15.00
18. DO ORDINO OTHER CENERAL SERVICE (SPECIFY) O O O O O O O O O			2, 926	0	37, 733	0		1
19.00 01900 MOMPHYSI CI AM AMESTHEIT STS 0 0 0 0 0 0 0 0 0		1 1		0	0	0		1
20.00			0	0	0	0		1
21.00 02100 BAT SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 0 0 0 0 0			0	0	0	0		•
22.00 02200 RAS SERVICES-OTHER PROM COSTS APPRVD 0 0 0 0 0 22.00			0	0	0	0		
23.00			0	Ö	0	0	_	
30.00 03000 ADULTS & PEDI ATRICS 1,919,536 0 393,981 86,240 167,216 30,00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 0 33.00 33.00 33	23. 00		0	0	0	0	0	23. 00
33 00 03700 INTENSIVE CARE UNIT 0 0 0 0 0 32.00 330 00 330 OROMANY CARE UNIT 0 0 0 0 0 0 32.00 330 00 3300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 34.00 40.00 340 OR								
32 00 03200 COROMARY CARE UNIT 0 0 0 0 0 0 0 32.00 33.00 330 00 3300 BURN INTERISIVE CARE UNIT 0 0 0 0 0 0 0 33.00 34.00 40.00 4000 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0 40.00 41.00 41.00 5UBPROVIDER - IPF 0 0 0 0 0 0 0 0 0 0 41.00 41.00 41.00 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0 0 0 41.00 41.00 41.00 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I		0		86, 240		ı
33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 33.00 43. 00 03400 SUBGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 34.00 43. 00 03400 SUBGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 44.00 43. 00 04300 SUBFROYUBER - I PF 0 0 0 0 0 0 0 0 0 0 44.00 43. 00 04300 SUBFROYUBER - I PF 0 0 0 0 0 0 0 0 0 0 44.00 43. 00 04300 SUBFROYUBER - I PF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I	0	0	0	0	_	•
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0			0	0	0	0		1
40.00 0.0000 0.000 0.0			0	0	0	0		•
11.00 04100 SUBROVI DER - 1 IRF			0	0	0	0		•
43. 00 04300 NURSERY 77, 439 0 5, 663 249 2, 404 43. 00 44. 00 445. 00 04500 0500		l l	0	Ö	Ö	0	_	•
45.00 04500 OURS OUR TERM CARE			77, 439	0	5, 663	249	2, 404	•
A6. 00 0 0 0 0 0 0 0 0 0	44.00		0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS SO. 00 SO. 00 SO. 00 COST CENTERS S		1 1	0	0	0	0	_	•
50.00 050000 050000 050000 050000 050000 050000 050000 0500000 05000000 0500000000	46. 00		0	0	0	0	0	46.00
S1-00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0	50.00		982 169	0	295 132	64 995	125 262	50.00
15.200 0		l l	1	_		·		1
54.00 05400 RADI OLOGY-DI AGNOSTI C 1,612,362 0 276,686 24,636 117,433 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0		l l	363, 696	0	36, 368	249	15, 436	1
55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 55.00	53.00		0	0	0	0		53.00
56. 00 05600 RADIO I SOTOPE 0 0 0 0 0 0 0 0 0 57.00			1, 612, 362	0	276, 686	24, 636		1
57. 00 05700 05700 05700 05700 058			0	0	0	0		1
58. 00 05800 MACNETI C RESONANCE I MAGING (MRI) 0 0 0 0 0 0 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 60. 00 06000 LABORATORY 1, 412, 867 0 76, 126 611 32, 310 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 63. 00 06300 BLOOD STORI NO, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 447, 734 0 48, 559 1, 509 20, 610 65. 00 66. 00 06600 PHYSI CAL THERAPY 517, 851 0 209, 909 0 89, 901 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 211, 201 0 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 181, 799 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 67. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 375, 184 0 0 0 0 0 67. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 375, 184 0 0 0 0 0 67. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 147, 588 0 0 0 0 0 67. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,009, 129 0 0 0 0 0 67. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 67. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 67. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 67. 00 09000 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 67. 00 09000 09000 00 00 00 0			0	0	0	0		•
59,00 05900 CARDIAC CATHETERIZATION		i i	0	0	0	0		•
60.01 60.01 8L00D LABORATORY 0 0 0 0 0 0 60.01			0	Ö	0	0		•
61.00 06100 PRP CLINICAL LAB SERVICES-PRGM ONLY	60.00	06000 LABORATORY	1, 412, 867	0	76, 126	611	32, 310	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 447, 734 0 48, 559 1, 509 20, 610 65.00 06600 PHYSI CAL THERAPY 517, 851 0 209, 909 0 89, 091 66.00 06600 PHYSI CAL THERAPY 517, 851 0 209, 909 0 89, 091 66.00 06600 PHYSI CAL THERAPY 517, 851 0 209, 909 0 89, 091 66.00 06600 SPECHP ATHOLOGY 181, 799 0 0 0 0 0 68.00 06800 SPECHP ATHOLOGY 181, 799 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 375, 184 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 147, 588 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 76.98 07698 HYPERBARI C OXYGEN THERAPY 428, 870 0 38, 666 0 16, 411 76.98 77.00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0 0 0 0 0 89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 90.00 09000 CLINI C 0 0 0 0 0 91.00 09100 BERSENATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 0 91.00 09100 DIERGENCY 1, 158, 907 0 164, 988 47, 556 70, 026 91.00 91.00 094.00 DOSERVATION BEDS (NON-DI STINCT PART) 0 0 0 0 0 91.00 09100 DIERGENCY 1, 158, 907 0 164, 988 47, 556 70, 026 91.00 91.00 094.00 00 00 0 0 0 0 0 91.00 094.00 00 00 0 0 0 0 92.00 094.00 00 00 00 0 0 0 0 91.00 094.00 00 00 0 0 0 0 0 92.00 094.00 00 00 0 0 0 0 0 93.00 094.00 000 00 00 0 0 0 0 0	60. 01		0	0	0	0	0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 64. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 447, 734 0 48,559 1,509 20,610 65. 00 66. 00 06500 RESPIRATORY THERAPY 517,851 0 209,909 0 89,091 66. 00 67. 00 06600 PHYSICAL THERAPY 211,201 0 0 0 0 0 0 68. 00 06600 SPECCH PATHOLOGY 181,799 0 0 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 70. 00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 0 71. 00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 375,184 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 147,588 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 428,870 0 38,666 0 16,411 76.98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 0 89. 00 09000 CLINTATIENT SERVICE COST CENTERS 80. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 91. 00 09000 DSERVATION BEDS (NON-DISTINCT PART) 0 164,988 47,556 70,026 91.00 92. 00 09100 BMERGENCY 1,158,907 0 164,988 47,556 70,026 91.00 94. 00 094.00 O94.00 O94.00 O94.00 94. 00 094.00 O94.00 O94.00 O94.00 94. 00 094.00 O94.00 O94.00 95. 00 094.00 O94.00 O94.00 96. 00 094.00 O94.00 O94.00 97. 00 094.00 O94.00 O94.00 97. 00 094.00 O94.00 97. 00 094.00 O94.0		l l	_	_	_	_	_	1
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 447, 734 0 48, 559 1, 509 20, 610 65. 00 06600 PHYSI CAL THERAPY 517, 851 0 209, 909 0 89, 091 66. 00 06700 0CCUPATI ONAL THERAPY 211, 201 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 211, 201 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 181, 799 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 375, 184 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 147, 588 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 009, 129 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 76. 90 07698 HYPERBARI C OXYGEN THERAPY 428, 870 0 38, 666 0 16, 411 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 77. 00 00000 CENTRAL HEALTH CLINI C 0 0 0 0 79. 00 09000 CLINI C 0 0 0 0 79. 00 09000 DEMERGENCY 1, 158, 907 0 164, 988 47, 556 70, 026 91. 00 79. 00 094. 00 09400 BERGENCY 1, 158, 907 0 164, 988 47, 556 70, 026 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0			0	0	0	0		1
65. 00 06500 RESPIRATORY THERAPY 447, 734 0 48, 559 1, 509 20, 610 65. 00 66. 00 06600 PHYSI CAL THERAPY 517, 851 0 209, 909 0 89, 091 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 211, 201 0 0 0 0 0 0 0 67. 00 68. 00 6800 SPEECH PATHOLOGY 181, 799 0 0 0 0 0 0 68. 00 69. 00 0 0 0 0 0 0 0 68. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	_	•
66. 00 06600 PHYSI CAL THERAPY 517, 851 0 209, 909 0 89, 091 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 211, 201 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 181, 799 0 0 0 0 0 0 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0			447 734	0	48 559	1 509	_	1
67. 00 06700 0CCUPATI ONAL THERAPY 211, 201 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 181, 799 0 0 0 0 0 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0				Ö				1
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69. 00 70.	67.00			0	0	0		1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 375, 184 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 147, 588 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 009, 129 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 428, 870 0 38, 666 0 16, 411 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 09900 CLINIC 0 0 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 91. 00 09100 DMERGENCY 1, 158, 907 0 164, 988 47, 556 70, 026 91. 00 91. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 95. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 95. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 96. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 97. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 97. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 97. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 97. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 97. 00 09400	68. 00	I I	181, 799	0	0	0	0	
71. 00			0	0	0	0		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 147, 588 0 0 0 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75.		1 1	0	0	0	0		•
73. 00 07300 DRUGS CHARGED TO PATIENTS 2,009,129 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 76. 98 07698 HYPERBARIC OXYGEN THERAPY 428,870 0 38,666 0 16,411 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0UTPATIENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 37,948 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 1,158,907 0 164,988 47,556 70,026 91. 00 0THER REIMBURSABLE COST CENTERS 94. 00 0 0 0 0 94. 00 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94. 00				0	0	0		1
74. 00 07400 RENAL DI ALYSI S 0 07400 RENAL DI ALYSI S 0 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 75. 00 75. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 0 0 0 88. 00 89. 00 09900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 37, 948 0 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 1, 158, 907 0 164, 988 47, 556 70, 026 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 07400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			·	0	0	0		1
76. 98 07698 HYPERBARI C OXYGEN THERAPY 428, 870 0 38, 666 0 16, 411 76. 98 77. 00 0 0 0 0 0 0 0 0 0			1 ' ' '	Ö	Ö	0		1
77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0	75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
SERVICE COST CENTERS			428, 870	0	38, 666	0		
88. 00	77. 00		0	0	0	0	0	77. 00
89. 00	00.00		1 0		Ι ο			00.00
90. 00 09000 CLINIC 37, 948 0 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 094. 00 094		1 1	0	0	0	0	_	1
91. 00 09100 EMERGENCY 1, 158, 907 0 164, 988 47, 556 70, 026 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94. 00 0 0 0 0 0 0 0 0 0		1 1	37 948	0	0	0		1
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 O9400 HOME PROGRAM DIALYSIS O O O O O O O O O				Ö	164, 988	47, 556		
OTHER REI MBURSABLE COST CENTERS 0 0 0 0 94.00 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 94.00						, 230		1
		OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES 1,371,038 0 0 0 0 95.00			0					
	95.00	INADION WIRDITAINCE PEKALCEZ	1, 3/1, 038	0	1 0	0	0	95.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0146

			10) 12/31/2019	6/23/2020 3: 4	parea: 6 pm
Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	<u> </u>
,	E & 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	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	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 ACQUI SI TI ON	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	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 SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 114, 889	0	1, 866, 912	244, 379	768, 989	118. 00
NONREI MBURSABLE COST CENTERS	_					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18, 792	0	27, 907	0	11, 845	
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	38, 515	0	148, 180	2, 811	62, 892	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 00
194. 01 07951 PAIN CLINIC	0	0	0	0		194. 01
194. 02 07952 OCC HEALTH	0	0	0	0		194. 02
194. 03 07953 FOUNDATI ON	116, 392	0	0	0		194. 03
194. 04 07954 PHYSICIAN OFFICES	0	0	0	0		194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	229, 386	0	112, 380	0	47, 697	
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, 517, 974	0	2, 155, 379	247, 190	891, 423	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part |
| To 12/31/2019 | Date/Time Prepared: 6/23/2020 3:46 pm

				0 12/31/2019	6/23/2020 3: 4	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	
			OF PERSONNEL	N N	SUPPLY	
	10. 00	11. 00	12.00	13.00	14. 00	
GENERAL SERVICE COST CENTERS			I			1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						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	630, 021					10.00
11. 00 01100 CAFETERI A	0	287, 512	1			11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	7 074	0	1 000 242		12.00
13. 00 O1300 NURSING ADMINISTRATION 14. 00 O1400 CENTRAL SERVICES & SUPPLY	0	7, 974	0	1, 000, 342	145 210	13. 00 14. 00
15. 00 01500 PHARMACY		9, 265		0	145, 219 2, 577	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY		9, 200 N		0	2,577	16.00
17. 00 01700 SOCIAL SERVICE		0		0	0	17. 00
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)		0		o o	0	18. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	o	0	l c	Ö	0	19. 00
20. 00 02000 NURSI NG SCHOOL	0	0	l c	О	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	C	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS	(00.004	F0 407	1	400 045	40 775	
30. 00 03000 ADULTS & PEDI ATRI CS	630, 021	50, 427	0		13, 775	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0		0	0	34.00
40. 00 04000 SUBPROVI DER - PF		0			Ö	40. 00
41. 00 04100 SUBPROVI DER - RF		0		Ö	0	41. 00
43. 00 04300 NURSERY	o	2, 706		21, 674	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	l c	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00 O4600 OTHER LONG TERM CARE	0	0	C	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	24, 775			20, 024	50.00
51. 00 05100 RECOVERY ROOM	0	10 470	0	-	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	12, 679		101, 562	0	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		36, 957		0	5, 077	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		30, <i>7</i> 37		0	0,077	55. 00
56. 00 05600 RADI OI SOTOPE		0		Ö	0	56. 00
57. 00 05700 CT SCAN	o	0	l c	Ö	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	l c	О	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59.00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	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	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY		15, 960		0	0 3, 802	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY		15, 987		0	1, 219	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		6, 672	· · · · · ·		0	67. 00
68. 00 06800 SPEECH PATHOLOGY		5, 743		Ö	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0	l c	Ö	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	l c	o	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	65, 690	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	5, 819	73.00
74. 00 07400 RENAL DI ALYSI S	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	5, 606		44, 908	2, 126	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	م	_	_		_	00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 90. 00 09000 CLI NI C		1, 273			221	90.00
91. 00 09100 EMERGENCY		28, 687		229, 793	14, 259	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		20, 007		227, 175	17, 237	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94.00
•	<u>'</u>			·		

145, 219 202. 00

1,000,342

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Period: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Pi

Date/Time Prepared: 6/23/2020 3:46 pm Cost Center Description DI ETARY CAFETERI A MAI NTENANCE NURSI NG CENTRAL OF PERSONNEL ADMI NI STRATI O SERVICES & **SUPPLY** 10.00 11. 00 12.00 13 00 14.00 95.00 09500 AMBULANCE SERVICES 0 53, 225 0 0 8, 453 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 0 0 0 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 0 o 99.00 99.00 09900 CMHC 0 0 99. 10 09910 CORF 0 0 99.10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 106.00 0 0 0 0 0 107.00 10700 LIVER ACQUISITION 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 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 0 115.00 0 C 0 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 630, 021 1,000,342 118.00 277, 936 0 143, 042 118. 00 NONREI MBURSABLE COST CENTERS 1, 692 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 1,005 0 191. 00 19100 RESEARCH 0 0 191.00 00000000 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 70 192.00 1.673 0 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS C 0 194.00 194. 01 07951 PAIN CLINIC 0 0 194.01 0 0 0 194. 02 07952 OCC HEALTH 0 0 194, 02 194. 03 07953 FOUNDATION 0 0 194.03 2, 356 194. 04 07954 PHYSICIAN OFFICES 0 194.04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 415 194. 05 4, 542 0 194.06 07956 VACANT SPACE 0 0 194.06 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201.00

630, 021

287, 512

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

6/23/2020 3:46 pm OTHER GENERAL SERVI CE **PHARMACY** MEDI CAL SOCI AL NONPHYSI CI AN Cost Center Description (SPECIFY) RECORDS & SERVI CE ANESTHETI STS LI BRARY 15. 00 16. 00 17.00 18.00 19.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 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 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 325, 260 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 62, 044 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 0 19.00 0 02000 NURSING SCHOOL 0 20.00 0 20.00 ol 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 C 21.00 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 C 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 164 4,506 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 0 0 0 03300 BURN INTENSIVE CARE UNIT 33 00 33 00 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT C 0 34.00 04000 SUBPROVI DER - I PF 0 0 40.00 40.00 C 0 0 0 0 41.00 04100 SUBPROVI DER - I RF Ω 0 0 41.00 04300 NURSERY 0 43.00 43.00 187 0 0 0 o 44.00 04400 SKILLED NURSING FACILITY 0 44.00 C 04500 NURSING FACILITY 0 0 0 45.00 0 45.00 04600 OTHER LONG TERM CARE 0 0 0 0 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 363 7, 020 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 880 52.00 0 οĺ 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13 13, 175 0 0 0 0 0 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 55.00 0 0 56.00 05600 RADI 0I S0T0PE C 0 56.00 0 57.00 05700 CT SCAN C 0 0 57.00 58 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 0 0 60.00 06000 LABORATORY 7.915 0 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 C 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 0 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 0 0 0 06500 RESPIRATORY THERAPY 2,837 0 65.00 65.00 0 72 0 06600 PHYSI CAL THERAPY 0 66.00 1,056 0 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 358 0 67.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 285 0 68.00 0 06900 ELECTROCARDI OLOGY 0 69.00 C 0 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 420 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 524 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 315, 930 0 73 00 6,584 0 0 07400 RENAL DIALYSIS 74.00 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 75.00 76. 98 ol 07698 HYPERBARIC OXYGEN THERAPY 0 1,564 0 0 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 0 0 Ω OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 О 0 88.00 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89 00 C 0 0 90.00 09000 CLI NI C 0 69 0 0 90.00 09100 EMERGENCY 0 0 91.00 91.00 10.059 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 - GENERAL SERVICE COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm OTHER GENERAL SERVI CE SOCI AL NONPHYSI CI AN Cost Center Description **PHARMACY** MEDI CAL (SPECIFY) RECORDS & SERVI CE **ANESTHETISTS** LI BRARY 17.00 19.00 15. 00 16.00 18.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 0 95.00 95.00 09500 AMBULANCE SERVICES 3, 605 1, 194 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 97.00 0 0 0 0 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 98.00 0 0 99. 00 09900 CMHC 0 99.00 0 0 0 99. 10 09910 CORF 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 Ω 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 0 0 106.00 106.00 10600 HEART ACQUISITION 0 0 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 0 0 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110,00 111.00 11100 I SLET ACQUISITION C 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 C 0 0 0 115.00

SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 62, 044 0 118.00 118.00 324, 795 0 0 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 0 0 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 194. 01 07951 PAIN CLINIC 0 0 0 0 0 0 0 0 194. 01 0 194. 02 07952 OCC HEALTH 0 194. 02 0 0 0 0 194. 03 194. 03 07953 FOUNDATI ON 0 194. 04 07954 PHYSICIAN OFFICES 0 0 0 0 194. 04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 194.05 465 0 0 194.06 194.06 07956 VACANT SPACE 0 0 0 200.00 Cross Foot Adjustments 0 200, 00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 325, 260 62,044 0 0 202.00

0

0

0

116.00

116. 00 11600 HOSPI CE

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Ti me Prepared:

6/23/2020 3:46 pm INTERNS & RESIDENTS NURSI NG SERVI CES-SALA SERVI CES-0THE PARAMED ED Subtotal Cost Center Description RY & FRINGES R PRGM COSTS SCH00L PRGM 24.00 20.00 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 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 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 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 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 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 0 7, 192, 916 30.00 0 0 03100 INTENSIVE CARE UNIT 0 0 0 31.00 0 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 C 0 34.00 40.00 04000 SUBPROVI DER - I PF 0 0 0 0 40.00 0 41.00 04100 SUBPROVI DER - I RF 0 0 0 0 0 41.00 43 00 04300 NURSERY Ω O 0 252 454 43 00 0 04400 SKILLED NURSING FACILITY 0 44.00 0 0 44.00 04500 NURSING FACILITY 0 С 0 0 0 45.00 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 0 0 0 3, 527, 868 50.00 05100 RECOVERY ROOM 0 0 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 1, 198, 395 52.00 0 05300 ANESTHESI OLOGY 0 53 00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 5, 045, 659 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55.00 05600 RADI OI SOTOPE 0 0 0 56,00 56,00 0 0 57.00 05700 CT SCAN 0 0 0 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 59 00 05900 CARDI AC CATHETERI ZATI ON 0 0 O 59.00 0 0 06000 LABORATORY 0 4, 122, 998 60.00 0 60.00 0 60.01 06001 BLOOD LABORATORY C 0 0 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 0 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 C 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY C 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 1, 362, 779 65.00 0 0 0 06600 PHYSI CAL THERAPY 66.00 0 0 1, 785, 645 66,00 06700 OCCUPATI ONAL THERAPY 67.00 Ω 0 605, 869 67 00 06800 SPEECH PATHOLOGY 00000000 0 0 68.00 521, 500 68.00 0 06900 ELECTROCARDI OLOGY 69.00 69.00 0 70.00 07000 FLECTROENCEPHALOGRAPHY 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 1, 130, 905 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 418, 995 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 6, 025, 010 73.00 0 73.00 07400 RENAL DIALYSIS 0 0 74 00 C 74 00 0 75.00 07500 ASC (NON-DISTINCT PART) C 0 75.00 0 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 C 0 1, 325, 297 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 0 90 00 09000 CLINIC 0 0 109, 161 90 00 Ω 0 91.00 09100 EMERGENCY 0 C 0 0 3, 851, 385 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

| Period: | Worksheet B | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0146

			T	o 12/31/2019	Date/Time Prepare 6/23/2020 3:46 pr	
		INTERNS &	RESI DENTS		0/23/2020 3.40 pi	
Cost Center Description	NURSI NG	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	Subtotal	
	SCH00L	RY & FRINGES	R 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 94	. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	3, 953, 911 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	0	0 105	
106. 00 10600 HEART ACQUISITION	0	0	0	0	0 106	
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107	. 00
108.00 10800 LUNG ACQUI SI TI ON	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 ISLET ACQUISITION	0	0	0	0	0 111	
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	0	0 115	. 00
116. 00 11600 HOSPI CE	0			0	0 116	. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	42, 430, 747 118	. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	95, 732 190	
191. 00 19100 RESEARCH	0	0	0	0	0 191	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	324, 832 192	
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193	
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	
194. 02 07952 OCC HEALTH	0	0	0	0	0 194	
194. 03 07953 FOUNDATI ON	0	0	0	0	332, 373 194	
194. 04 07954 PHYSICIAN OFFICES	0	0	0	0	0 194	
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	815, 898 194	
194. 06 07956 VACANT SPACE	0	0	0	0	0 194	
200.00 Cross Foot Adjustments	0	0	0	0	0 200	
201.00 Negative Cost Centers	0	0	0	0	0 201	
202.00 TOTAL (sum lines 118 through 201)	0	0	0	0	43, 999, 582 202	. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0146 Peri od: Worksheet B From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 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 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00

MCRI F32 - 16. 1. 168. 0

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2019 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

			From 01/01/2019 Part I To 12/31/2019 Date/Time	Prepared:
			6/23/2020	3:46 pm
Cost Center Description	Intern &	Total		
	Resi dents			
	Cost & Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	3, 953, 911		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 KI DNEY ACQUI SI TI ON	0	0		105. 00
106.00 10600 HEART ACQUISITION	0	0		106.00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUI SITION	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 ISLET ACQUISITION	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	O		115.00
116. 00 11600 HOSPI CE	O	o		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	o	42, 430, 747		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	95, 732		190. 00
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	324, 832		192.00
193. 00 19300 NONPALD WORKERS	0	O		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	o	o		194.00
194. 01 07951 PAIN CLINIC	O	o		194. 01
194. 02 07952 OCC HEALTH	O	ol		194. 02
194. 03 07953 FOUNDATI ON	o	332, 373		194. 03
194. 04 07954 PHYSICIAN OFFICES	o	0		194.04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES	o	815, 898		194. 05
194. 06 07956 VACANT SPACE		0		194. 06
200.00 Cross Foot Adjustments		o		200.00
201.00 Negative Cost Centers		ō		201. 00
202.00 TOTAL (sum lines 118 through 201)	l ol	43, 999, 582		202. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	١	, ,		

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

				Ic) 12/31/2019	Date/lime Pre 6/23/2020 3:4	
			CAPI TAL REI	LATED COSTS		10, 20, 2020 0	, p
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	BLDG & TIXI	WVBLL LQUIF	Subtotal	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT		0		0	0	2.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 913, 738	96, 409	6, 232	2, 016, 379	0	1
6. 00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	1
7.00	00700 OPERATION OF PLANT	0	37, 249		79, 355	0	7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	3, 204 4, 635	1	3, 204 4, 668	0	
10. 00	01000 DI ETARY	O	9, 542	1	15, 244	0	1
11.00	01100 CAFETERI A	O	6, 172		6, 172	0	
12.00	01200 MAI NTENANCE OF PERSONNEL	0	1 200	_	107.070	0	12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY		1, 298 11, 921	105, 781	107, 079 11, 921	0	13. 00 14. 00
15. 00	01500 PHARMACY	0	3, 515	69, 246	72, 761	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	5, 370		5, 370	0	16.00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	_	0	0	17. 00 18. 00
	01900 NONPHYSI CI AN ANESTHETI STS	Ö	Ö	Ö	o	0	19.00
20. 00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	0	21. 00 22. 00
	02300 PARAMED ED PRGM-(SPECIFY)		0		0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS		-				
30.00	03000 ADULTS & PEDIATRICS	0	56, 067	62, 483	118, 550	0	
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T		0		0	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	o	0	Ö	Ö	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER	0	0	0	0	0	40. 00 41. 00
43. 00	04300 NURSERY		806	4, 192	4, 998	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	
45. 00 46. 00	04500 NURSING FACILITY	0	0	0	0	0	45.00
40.00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	ı o	0	<u> </u>		0	46.00
50.00	05000 OPERATING ROOM	0	42, 000	133, 053	175, 053	0	50.00
51.00	05100 RECOVERY ROOM	0	0 E 174	10.727	0	0	51.00
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY		5, 176 0	19, 737 0	24, 913 0	0	52.00 53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	39, 375	396, 396	435, 771	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 57. 00	05600	0	0	0	0	0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	Ö	Ö	Ö	Ö	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	10, 833	0	10, 833	0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	U	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	O	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		6, 910	26, 982	33, 892	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	29, 872		39, 792	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 69. 00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	o o	Ö	Ö	Ö	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	О	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07400 RENAL DIALYSIS		0		ol	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0	ō	o	0	75. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	5, 502		31, 580	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	ı O	0	0	0]	0	77. 00
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0	23, 479	21, 486	44, 965	0	
		<u>, </u>			,		

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** Cost Center Description Directly MVBLE EQUIP Subtotal Assi gned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 92.00 0 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 09500 AMBULANCE SERVICES 0 143, 259 143, 259 95.00 95.00 0 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 98.00 99. 00 09900 CMHC 0 0 0 99.00 0 99. 10 99. 10 09910 CORF 0 0 Ω 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 C 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105. 00 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107.00 0 0 0 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 0 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 399, <u>335</u> 1, 072, 686 1, 913, 738 3, 385, 759 0 118.00 118, 00 NONREI MBURSABLE COST CENTERS 3, 971 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 971 0 190. 00 0 4, 942 191. 00 19100 RESEARCH 0 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 21, 087 0 192.00 21, 714 627 0 193. 00 19300 NONPALD WORKERS 0 193.00 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 0 0 0 0 0 0 194. 01 194. 01 07951 PAIN CLINIC O 0 0 194. 02 07952 OCC HEALTH C 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 0 194. 03 0 0 0 194.04 194. 04 07954 PHYSICIAN OFFICES 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 15, 993 0 194. 05 0 1.856 17.849 194.06 07956 VACANT SPACE 0 194.06 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201, 00 TOTAL (sum lines 118 through 201) 1, 913, 738 440, 386 1, 076, 140 3, 430, 264 202.00 0 202.00 ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

6/23/2020 3:46 pm Cost Center Description ADMINISTRATIV MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **REPAIRS PLANT** LINEN SERVICE 7.00 9.00 5.00 6.00 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 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 2, 016, 379 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 98, 775 0 178, 130 7.00 00800 LAUNDRY & LINEN SERVICE 10 296 1,861 8 00 8 00 Ω 15.361 9.00 00900 HOUSEKEEPI NG 38, 894 C 2,692 631 46,885 9.00 1, 497 01000 DI ETARY 24, 479 10.00 5.541 22 10.00 11.00 01100 CAFETERI A 10.328 0 3,585 22 968 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 Ω C 0 0 0 12 00 13.00 01300 NURSING ADMINISTRATION 44, 882 754 0 204 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 844 6, 923 465 1,870 14.00 01500 PHARMACY 15.00 12, 751 0 2.041 551 15.00 0 01600 MEDICAL RECORDS & LIBRARY 0 16.00 380 C 3.118 842 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 18 00 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 19.00 0 0 0 02000 NURSING SCHOOL 0 20 00 0 C 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 C 0 0 0 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 249, 422 0 32, 561 5. 359 8, 796 30.00 03100 INTENSIVE CARE UNIT 31.00 C 0 0 31.00 32.00 03200 CORONARY CARE UNIT 0 C 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 33.00 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 0 04000 SUBPROVI DER - I PF 40.00 0 0 0 0 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 C 0 0 0 41.00 43.00 04300 NURSERY 10.062 468 15 126 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 44.00 04500 NURSING FACILITY 45.00 0 C 0 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 6, 588 50.00 05000 OPERATING ROOM 127, 622 0 24, 391 4.039 50.00 05100 RECOVERY ROOM 51.00 C 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 47, 258 C 3,006 15 812 52.00 05300 ANESTHESI OLOGY 53.00 0 0 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 209 508 0 1, 531 6, 176 54 00 22, 867 05500 RADI OLOGY-THERAPEUTI C 55.00 C 0 55.00 C 0 05600 RADI OI SOTOPE 56.00 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 ol 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 0 Ω 0 0 58 00 0 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 59.00 60.00 06000 LABORATORY 183, 586 6, 291 38 1, 699 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 0 0 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 C 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 ol 63.00 0 0 0 06400 I NTRAVENOUS THERAPY 0 64 00 Ω 64 00 0 0 65.00 06500 RESPIRATORY THERAPY 58, 178 C 4.013 94 1,084 65.00 06600 PHYSI CAL THERAPY 67, 289 66.00 17, 348 4,686 66.00 0 06700 OCCUPATI ONAL THERAPY 27, 443 67.00 C 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 23, 623 C 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 48. 751 71.00 0 0 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 177 C 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 261, 058 0 0 0 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) o 75.00 0 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 76.98 55, 727 C 3, 195 0 863 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 C 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER C 0 0 0 89.00 09000 CLI NI C 4, 931 90.00 0 0 0 90.00 91.00 09100 EMERGENCY 150, 587 C 13, 635 2, 955 3.683 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 178, 151 0 95.00 0 Ω

0 201.00

46, 885 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0146 Peri od: Worksheet B From 01/01/2019 Part II 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm ADMINISTRATIV MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **REPAIRS** LINEN SERVICE **PLANT** 8. 00 9. 00 5.00 6.00 7.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96, 00 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 99.00 99. 10 09910 CORF 0 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 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 0 0 107.00 108. 00 10800 LUNG ACQUISITION 0 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 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 0 113.00 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 0 116.00 C 0 SUBTOTALS (SUM OF LINES 1 through 117) 1, 964, 002 154, 290 15, 186 40, 445 118. 00 118.00 0 NONREIMBURSABLE COST CENTERS 0 2, 306 623 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 442 0 191. 00 19100 RESEARCH 0 191.00 0 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 5.005 0 12, 246 175 3, 308 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 0 0 0 194. 01 07951 PAIN CLINIC 0 0 194.01 0 0 194. 02 07952 OCC HEALTH 0 0 0 0 0 194. 02 194. 03 07953 FOUNDATI ON 0 0 0 194.03 15, 124 0 0 194.04 194. 04 07954 PHYSICIAN OFFICES 0 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 29, 806 0 9, 288 0 2, 509 194. 05 194.06 07956 VACANT SPACE 0 194.06 200.00 200.00 Cross Foot Adjustments

2,016,379

0

0

 \cap

15, 361

178, 130

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0146

Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

6/23/2020 3:46 pm Cost Center Description DI ETARY CAFETERI A MAI NTENANCE NURSI NG CENTRAL ADMI NI STRATI O SERVICES & OF PERSONNEL **SUPPLY** Ν 10. 00 12.00 11 00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 46, 783 10 00 01100 CAFETERI A 21,075 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 584 153, 503 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 22,023 14.00 01500 PHARMACY 0 679 15 00 0 391 0 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 17 00 01700 SOCIAL SERVICE 0 Ω 0 17.00 0 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 18.00 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19 00 C 0 19 00 02000 NURSING SCHOOL 0 0 20.00 20.00 0 0 0 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 C 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 46, 783 0 61, 985 2, 089 30.00 3.696 03100 INTENSIVE CARE UNIT 0 31 00 Ω 31.00 0 32.00 03200 CORONARY CARE UNIT 0 C 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 0 0 33.00 0 0 03400 SURGICAL INTENSIVE CARE UNIT ol 34.00 0 0 34.00 04000 SUBPROVI DER - I PF 0 40.00 C 0 0 40.00 04100 SUBPROVI DER - I RF 0 0 41.00 C 0 0 41.00 04300 NURSERY 0 43.00 0 0 198 3, 326 0 43.00 44 00 04400 SKILLED NURSING FACILITY 0 44 00 C 0 0 04500 NURSING FACILITY 45.00 C 0 0 45.00 04600 OTHER LONG TERM CARE 0 0 46.00 46.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 3, 037 50 00 0 1, 816 n 30, 454 05100 RECOVERY ROOM 0 51.00 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 929 15, 585 52.00 52.00 0 53 00 05300 ANESTHESI OLOGY 0 0 0 Ω 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2,709 0 770 54.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 55.00 0 56.00 05600 RADI 0I SOTOPE 0 0 0 0 0 56.00 0 0 0 05700 CT SCAN 57 00 57 00 0 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) C 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 59.00 06000 LABORATORY 0 0 60.00 0 60.00 0 06001 BLOOD LABORATORY 0 60.01 C 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 63.00 0 64 00 06400 INTRAVENOUS THERAPY 0 0 64 00 65.00 06500 RESPIRATORY THERAPY 0 o 577 65.00 1, 170 66.00 06600 PHYSI CAL THERAPY 1, 172 0 185 66.00 0000000000 0 0 06700 OCCUPATI ONAL THERAPY 0 67.00 489 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 421 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 0 9, 960 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 883 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 C 0 Ω 75.00 76. 98 0 0 07698 HYPERBARIC OXYGEN THERAPY 411 6,891 322 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0 77.00 C 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 Ω 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 C 0 0 89.00 90.00 09000 CLI NI C 0 93 0 34 90.00 0 09100 EMERGENCY 0 0 2, 162 91.00 2, 103 35, 262 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0146 Peri od: Worksheet B From 01/01/2019 Part II 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Cost Center Description DI ETARY CAFETERI A MAI NTENANCE NURSI NG CENTRAL OF PERSONNEL ADMI NI STRATI O SERVICES & Ν **SUPPLY** 10.00 11. 00 12.00 13 00 14.00 95.00 09500 AMBULANCE SERVICES 0 3, 902 0 0 1, 282 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 0 0 0 0 0 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 99.00 99.00 09900 CMHC 0 0 99. 10 09910 CORF 0 0 0 99.10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0000 0 0 0 106.00 0 107.00 10700 LIVER ACQUISITION 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 109.00

110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 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 0 115.00 C 0 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 20, 372 21, 692 118. 00 118.00 46, 783 0 153, 503 NONREI MBURSABLE COST CENTERS 257 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 74 0 191. 00 19100 RESEARCH 0 0 191.00

00000000 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 11 192.00 123 0 0 193.00 193. 00 19300 NONPALD WORKERS C 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 194. 01 07951 PAIN CLINIC 0 0 194.01 0 0 0 0 194. 02 07952 OCC HEALTH 0 0 194, 02 0 194. 03 07953 FOUNDATION 0 0 194. 03 173 194. 04 07954 PHYSICIAN OFFICES 0 194.04 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 o 63 194. 05 333 0 194.06 07956 VACANT SPACE 0 0 194.06 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 201.00 TOTAL (sum lines 118 through 201) 22, 023 202. 00 202.00 46, 783 21,075 153, 503

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

					10 12/31/2019	Date/lime Pre 6/23/2020 3:4	
					OTHER GENERAL		.
0+ 0+	D!+!	DUADMACY	MEDICAL	COCLAI	SERVI CE	NONDLIVEL CLAN	
Cost Cente	er Description	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	(SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
			LI BRARY	JERVICE		ANLSTILLITSTS	
		15. 00	16. 00	17. 00	18. 00	19. 00	
GENERAL SERVICE							
1 1	OSTS-BLDG & FLXT						1.00
1 1	OSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE 1	BENEFITS DEPARTMENT						4. 00 5. 00
6. 00 00600 MAI NTENAN	1						6.00
7. 00 00700 OPERATION	1						7.00
8. 00 00800 LAUNDRY &	1						8.00
9. 00 00900 HOUSEKEEP	NG						9.00
10. 00 01000 DI ETARY							10.00
11. 00 01100 CAFETERI A							11.00
12. 00 01200 MAI NTENANO							12.00
13. 00 01300 NURSI NG AI 14. 00 01400 CENTRAL SI	ERVICES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY	LKVICES & SUFFEI	89, 174		•			15.00
	ECORDS & LIBRARY	0	9, 710				16.00
17. 00 01700 SOCIAL SEI		0	0		0		17. 00
18. 00 01850 OTHER GENI	ERAL SERVICE (SPECIFY)	0	0		0 0		18. 00
	I AN ANESTHETI STS	0	0		0	0	
20. 00 02000 NURSI NG SO	1	0	0	1	0		20.00
	CES-SALARY & FRINGES APPRVD	0	0		0		21.00
	CES-OTHER PRGM COSTS APPRVD D PRGM-(SPECIFY)	0	0	1	0 0		22.00
	NE SERVICE COST CENTERS	<u> </u>	0	1	0 0		23.00
30. 00 03000 ADULTS & I		45	707		0 0		30.00
31. 00 03100 I NTENSI VE	CARE UNIT	О	0		0 0		31.00
32. 00 03200 CORONARY (0	0		0		32.00
33. 00 03300 BURN NTEI		0	0	1	0		33.00
	INTENSIVE CARE UNIT	0	0		0		34.00
40. 00 04000 SUBPROVI DI 41. 00 04100 SUBPROVI DI		0	0		0		40.00
43. 00 04300 NURSERY	LK - TKI	0	29		0 0		43.00
44. 00 04400 SKI LLED NI	JRSING FACILITY	o	0	1	o o		44.00
45. 00 04500 NURSING FA		О	0		0 0		45.00
46. 00 04600 OTHER LONG		0	0		0 0		46. 00
50. 00 ANCI LLARY SERVI		2 010	1 100	1			FO 00
50. 00 05000 OPERATI NG 51. 00 05100 RECOVERY I		2, 019	1, 102 0	1	0 0	l	50.00
	ROOM & LABOR ROOM	ő	138		o o		52.00
53. 00 05300 ANESTHESI		0	0		0		53.00
54. 00 05400 RADI OLOGY	-DI AGNOSTI C	3	2, 038		0 0		54.00
55. 00 05500 RADI OLOGY		0	0	1	0		55.00
56. 00 05600 RADI 01 SOT	OPE	0	0		0		56.00
57. 00 05700 CT SCAN	RESONANCE IMAGING (MRI)	0	0				57. 00 58. 00
59. 00 05900 CARDI AC CA		0	0		0 0		59.00
60. 00 06000 LABORATOR		o	1, 243		o o		60.00
60. 01 06001 BL00D LAB	DRATORY	О	0		0 0		60. 01
	CAL LAB SERVICES-PRGM ONLY						61.00
	OD & PACKED RED BLOOD CELLS	0	0	1	0		62.00
63. 00 06300 BLOOD STOI 64. 00 06400 I NTRAVENOI	RING, PROCESSING & TRANS.	0	0		0		63. 00 64. 00
65. 00 06500 RESPIRATOR		0	445				65.00
66. 00 06600 PHYSI CAL		20	166	1	o o		66.00
67. 00 06700 OCCUPATI O		0	56	l .	0 0		67.00
68.00 06800 SPEECH PA		О	45		0		68. 00
69. 00 06900 ELECTROCAI		0	0		0		69.00
70. 00 07000 ELECTROENG	1	0	0	1	0		70.00
	JPPLIES CHARGED TO PATIENTS CHARGED TO PATIENTS	0	223 82		0		71. 00 72. 00
	RGED TO PATIENTS	86, 617	1, 034	1	0 0		73.00
74. 00 07400 RENAL DI AI		00,017	0		o o		74.00
75. 00 07500 ASC (NON-I		0	0		0		75.00
76. 98 07698 HYPERBARI (C OXYGEN THERAPY	О	246		0 0		76. 98
	C STEM CELL ACQUISITION	0	0		0 0		77. 00
	I CE COST CENTERS			ı			00.00
88. 00 08800 RURAL HEAI 89. 00 08900 FEDERALLY	LIH CLINIC QUALIFIED HEALTH CENTER	0	0		0		88. 00 89. 00
90. 00 09000 CLI NI C	QUALITIED HEALIN CENTER	0	11		0 0		90.00
91. 00 09100 EMERGENCY		16	1, 579		o o		91.00
1 1	ON BEDS (NON-DISTINCT PART)	7	,				92.00
	<u> </u>	·					

TOTAL (sum lines 118 through 201)

0 202.00

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Worksheet B From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm OTHER GENERAL SERVI CE SOCI AL NONPHYSI CI AN Cost Center Description **PHARMACY** MEDI CAL (SPECIFY) RECORDS & SERVI CE **ANESTHETISTS** LI BRARY 17. 00 19.00 15. 00 16.00 18.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 0 0 0 09500 AMBULANCE SERVICES 327 95.00 566 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 97.00 0 0 0 0 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 98.00 0 99. 00 09900 CMHC 0 99.00 0 0 99. 10 09910 CORF 0 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 Ō 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0000 105.00 0 106.00 10600 HEART ACQUISITION 0 0 0 106.00 107. 00 10700 LI VER ACQUI SI TI ON 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 0 0 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION C 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 C 0 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 9, 710 0 118.00 118.00 89, 047 0 0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 0 0 0 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 0 0 0 0 0 0 0 0 0 0 0 193. 00 19300 NONPALD WORKERS 193. 00 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 194. 01 07951 PAIN CLINIC 0 0 194.01 0 194. 02 07952 OCC HEALTH 0 0 194. 02 οl 194. 03 07953 FOUNDATI ON 0 194. 03 194. 04 07954 PHYSICIAN OFFICES 0 0 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 194.05 127 194.06 07956 VACANT SPACE 0 0 194.06 0 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 201.00

89, 174

9, 710

0

202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146

MIRCHARD					10	0 12/31/2019	Date/lime Pre 6/23/2020 3:4	
SCHOOL PY A FRINGES R PROV COSTS PRON				INTERNS &	RESI DENTS			
SCHOOL PY A FRINGES R PROV COSTS PRON		Cost Contor Description	NUDCLNC	SEDVICES SALA	SEDVI CES OTHE	DADAMED ED	Subtotal	
BEMINDAL STRIVET CIST CINTIESS 20.00 21.00 22.00 23.00 24.00		Cost Center Description					Subtotal	
1.00 001001/GAP REL LOSIS-BUILD & FIRM							24. 00	
2.00 00000 CAR REL DOSTS-MPRIE EQUIP								
4.00 ODISCO IMPRILED SERVICE S GENERAL		1 1						1
5.00		1 1						1
6.00 00000 MAINTENANCE & REPAIRS 6.00 0								1
8.00 00000 LAUMORY & LI LINES SERVICE 8.00 0.0								1
9.00 00000 HOUSEKEEPING		00700 OPERATION OF PLANT						7.00
10.00 101000 DIETARY		1 1						
11.00 01100 CAFETERIA 11.00 01100 CAFETERIA 11.00 01100 CAFETERIA 12.00 11.00 01100 CAFETERIA 12.00 11.00 01100 CAFETERIA 13.00 01100 CAFE		1 1						1
12.00 10.1200 IAN INTERNIEC GF PERSONNEL 12.00 12.00 IANSIE NA ZAMIN ISTRATION 13.00 13.00 13.00 IANSIE NA ZAMIN ISTRATION 14.00 15.00 IANSIE NA ZAMIN ISTRATION 14.00 15.00 IANSIE NA ZAMIN ISTRATION 14.00 IANSIE NA ZAMIN ISTRATION 15.00 IANSI								1
13.00 0.1300 NURSI NA ZADAIN INSTRATION 13.00 1.00 O.1300 CONTRAL SERVICE S. SUPPLY 15.00 0.1500 PHARMACY 15.00 PHARMACY 15.00 0.1500 PHARMACY 15.00 P		1 1						1
15.00 101-00 PHARMACY							•	1
10.00 10-000 MEDICAL RECORDS & LIBRARY 10.00 17.00 1710		1 1						1
17.00 17.00 SOCIAL SERVICE 17.00 18.00 1		· · ·						1
18.00 101850 DTHER GENERAL SERVICE (SPECIFY) 18.00 1020 00200 000HRYSI CHA MESTINETISTS 19.00 1020 002000 001851 NS SCHOOL 22.00 2								1
19.00 101900 NONPHYSICIAN AMESTHETISTS		1 1						1
1.00 107100 ARR SERVICES-SALARY & FRINGES APPRVD 0 22.0 02200 02		1 1						1
22.00 2020 AR SERVICES-OTHER PROM COSTS APPRVD 0			0					20.00
23.00				0				1
IMPATIENT ROUTINE SERVICE COST CENTERS 10,000,000,000,000,000 (1) STAR POLI PATRICS 529,993 30,000 30,000 300,000 (3000,000 (2) STAR CHINT 0.000,000 32,000 33,000 300,000 (3000		1 1			0	0		1
30.00 30000 ADULTS & PEDIATRICS 529, 993 30.00 31.00 31.00 31.00 32.00	23.00					U		23.00
31.00	30. 00						529, 993	30.00
33.00		1 1						
34. 00 34.00 34.00 34.00 34.00 04.	32.00	03200 CORONARY CARE UNIT					0	32.00
40.00 04000 SUBPROVIDER - IPF		1 1					-	1
1.00 0.4100 SUBPROVI DER - I RF		1 1					-	
43.00 04300 NURSERY 19, 222 43.00 044.00 044.00 044.00 044.00 044.00 044.00 045.		1 1						1
44. 00 04400 SKILLED NURSING FACILITY 0 45. 00 45. 00 45. 00 46. 00		1 1						
46. 00 04600 OTHER LONG TERN CARE 0 40. 00		1 1						1
ANCIL LARY SERVICE COST CENTERS	45.00	04500 NURSING FACILITY					0	45.00
50.00	46. 00						0	46. 00
51.00 OSTOO RECOVERY ROOM	EO 00			Γ	<u> </u>		274 121	E0 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 92, 656 52. 00 05300 05300 05300 05300 05300 05300 05300 05400 RADI OLLOGY-DI AGNOSTI C 681, 373 54. 00 05500 05500 RADI OLLOGY-DI AGNOSTI C 0 55. 00 05500 RADI OLLOGY-DI AGNOSTI C 0 55. 00 05500 RADI OLLOGY-DI AGNOSTI C 0 05500 RADI OLLOGY-DI AGNOSTI C 0 05500 RADI OLLOGY-THERAPEUTI C 0 55. 00 05500 RADI OLLOGY-THERAPEUTI C 0 05500 RESPI RATORY THERAPEUT 0 05500 RESPI RATO		· · ·						1
54. 00 OS400 RADI OLOGY-DI AGNOSTIC 0.550.00 OS500 RADI OLOGY-THERAPEUTIC 0.550.00 OS500 RADI OLOGY-THERAPEUTIC 0.560.00 OS500 RADI OLOGY-THERAPEUTIC 0.560.00 OS500 OS500 CADI OLOGY-THERAPEUTIC 0.560.00 OS500 OS500 CADI OLOGY-THERAPEUTIC 0.570.00 OS500 OS500 OS500 ARDI OLOGY-THERAPEUTIC 0.570.00 OS500 OS500 OS500 ARDI OLOGY-THERAPEUTIC 0.570.00 OS500 OS50		· · ·						1
55. 00 05500 RADI OLOCY-THERAPEUTI C 0 55. 00 56. 00 05600 RADI OL SOTOPE 0 56. 00 57. 00 05700 CT SCAN 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 59. 00 60. 01 06000 LABURATORY 0 60. 01 61. 00 06010 IL BORNATORY 0 60. 01 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62. 00 63. 00 06300 BLOOD STORIN CR. PROCESSING & TRANS. 0 64. 00 64. 00 06400 INTRAVENOUS THERAPY 0 64. 00 65. 00 06500 PHYSI CAL THERAPY 99. 453 66. 00 06600 PHYSI CAL THERAPY 130. 658 66. 00 06600 PHYSI CAL THERAPY 130. 658 67. 00 06700 PHYSI CAL THERAPY 227. 988 67. 00 0700 OO 000 PHYSI CAL THERAPY 130. 658 68. 00 06800 PHYSI CAL THERAPY 24. 089 69. 00 06900 ELECTROCARDI OLOGY 24. 089 70. 00 0700 OLOGO PECH CHALGORAPHY 0 69. 00 70. 00 0700 OLOGO PECH CHALGORAPHY 0 70. 00	53.00	05300 ANESTHESI OLOGY					0	53.00
56. 00 05600 RADIO I SOTOPE 56. 00 57. 00 05700 CT SCAN 0 59. 00 05900 CARDIA C CATHETERI ZATI ON 0 60. 01 06000 LABORATORY 203.690 60. 01 06001 BLOOD LABORATORY 60. 01 61. 00 06100 DEBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62. 00 63. 00 06300 BLOOD STORING, PROCESSI NG & TRANS. 0 63. 00 64. 00 06400 I INTRAVENOUS THERAPY 0 64. 00 66. 00 06600 PHYSI CAL THERAPY 99. 453 65. 00 66. 00 06600 PHYSI CAL THERAPY 130.658 66. 00 67. 00 06700 CCUPATI ONAL THERAPY 130.658 66. 00 69. 00 06900 ELECTROCARDIO LOGY 27, 988 67. 00 69. 00 06900 ELECTROCARDIO LOGY 0 69. 00 70. 00 07000 ELECTROCARDIO LOGY 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 58, 934 71. 00 74. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 34, 59		1 1						1
57, 00 05700 CT SCAN 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 57, 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 59, 00 05900 CARDIAC CATHETERIZATION 0 59, 00 060, 00 06000 LABORATORY 203, 690 60, 00 61, 00 06000 LABORATORY 203, 690 60, 00 61, 00 06000 BLODO LABORATORY 0 60, 00 61, 00 62, 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62, 00 63, 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63, 00 63, 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 64, 00 06400 INTRAVENOUS THERAPY 0 64, 00 66, 00 06600 PHYSI CAL THERAPY 99, 453 66, 00 06600 PHYSI CAL THERAPY 99, 453 66, 00 06600 PHYSI CAL THERAPY 27, 988 67, 00 06600 PHYSI CAL THERAPY 27, 988 67, 00 06600 PHYSI CAL THERAPY 27, 988 67, 00 06900 ELECTROCARDIOLOGY 24, 089 68, 00 06900 ELECTROCARDIOLOGY 0 070, 0		1 1						1
58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 580 0 58. 00 05900 0 05900 0 0.2001 CARDI AC CATHETERI ZATI ON 0 59. 00 0.900 0 0.9		1 1					-	1
59. 00 OS900 CARDI AC CATHETERI ZATI ON 0 59. 00 60. 00 O600.00 O600.00 CALBORATORY 203.69 (a) 60. 00 61. 00 O6010 IBLOOD LABORATORY 0 60. 00 61. 00 61. 00 O6200 IBLOOD LABORATORY 0 60. 00 61. 00 62. 00 O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62. 00 63. 00 O6300 BLOOD STORI NG, PROCESSING & TRANS. 0 63. 00 64. 00 O6400 INTRAVENOUS THERAPY 0 64. 00 65. 00 O6500 RESPI RATORY THERAPY 99. 453 65. 00 66. 00 O6600 PHYSI CAL THERAPY 130. 658 66. 00 67. 00 O6700 OCCUPATI ONAL THERAPY 21. 09 68. 00 68. 00 O6800 SPEECH PATHOLOGY 24. 099 68. 00 68. 00 O6900 ELECTROCARDI OLOGY 0 70. 00 71. 00 O7000 ELECTROCARDI OLOGY 0 70. 00 72. 00 O7200 IMPL DEV. CHARGED TO PATI ENTS 58. 93.4 71. 00 73. 00 O7300 BRUGS CHARGED TO PATI ENTS 349. 592 73. 00 75. 00 O750		1 1						1
60. 01 06001 BLOOD LABORATORY 0 60. 01								
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 62. 00 64. 00 06400 INTRAVENOUS THERAPY 0 64. 00 06400 INTRAVENOUS THERAPY 99, 453 65. 00 06500 RESPIRATORY THERAPY 99, 453 65. 00 06600 RESPIRATORY THERAPY 130, 658 66. 00 06700 OCCUPATIONAL THERAPY 27, 988 67. 00 06700 OCCUPATIONAL THERAPY 27, 988 67. 00 06900 ELECTROCARDIOLOGY 24, 089 68. 00 06900 ELECTROCARDIOLOGY 0 09. 00 07000 ELECTROCARDIOLOGY 0 09. 00 07000 ELECTROCARDIOLOGY 0 09. 00 07. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 58, 934 71. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 19, 259 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 349, 592 73. 00 74. 00 07400 RENAL DI ALYSIS 349, 592 73. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 99, 235 76. 98 77. 00 07500 ALLOGENEIC STEM CELL ACQUISITION 97. 00 00000 CLUTENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 89. 00 09. 00 09000 EDERALLY QUALIFIED HEALTH CENTER 99. 00 09. 00 09000 EMERGENCY 256, 947 91. 00 91. 00 9100		1 1					203, 690	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00							0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 99. 453 65. 00 66. 00 06600 PHYSI CAL THERAPY 99. 453 65. 00 67. 00 06700 0CCUPATI ONAL THERAPY 27, 988 67. 00 68. 00 06800 SPECH PATHOLOGY 24, 089 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0.000 70. 00 07000 ELECTROCARDI OLOGY 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 58, 934 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 19, 259 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 349, 592 73. 00 74. 00 07300 ASC (NON-DI STI NCT PART) 0 75. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 99, 235 76. 98 76. 98 07698 HYPERBARI C OXYGEN THERAPY 99, 235 76. 98 77. 00 00T700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 00TPATI ENT SERVI CE COST CENTERS 88. 00 89. 00 08900 RURAL HEALTH CLINI C 0 88. 00 89. 00 09900 CLINI C 5, 669 90. 00 91. 00 09900 EMERGENCY 256, 947 91. 00							0	
64. 00 06400 INTRAVENOUS THERAPY 0 64. 00 65. 00 66500 RESPI RATORY THERAPY 99, 453 65. 00 66. 00 06600 PHYSI CAL THERAPY 130, 658 66. 00 66. 00 06700 OCCUPATI ONAL THERAPY 27, 988 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 27, 988 67. 00 68. 00 06800 SPEECH PATHOLOGY 24, 089 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 69. 00 07. 0								
65. 00 06500 RESPI RATORY THERAPY 99, 453 65. 00 66. 00 06600 PHYSI CAL THERAPY 130, 658 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 27, 988 67. 00 67. 00 06800 SPEECH PATHOLOGY 24, 089 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 70. 00 70. 00 70. 00 ELECTROCARDI OLOGY 0 70. 00 70. 00 70. 00 ELECTROCARDI OLOGY 0 70. 00 70. 00 70. 00 RESPIRATORY ELECTROCARDI OLOGY 0 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 19, 255 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 255 72. 00 73. 00 74. 00 74. 00 74. 00 74. 00 75. 00		1 1						
67. 00							99, 453	1
68. 00 06800 SPEECH PATHOLOGY 24,089 68.00 69. 00 06900 ELECTROCARDI OLOGY 0 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 58,934 71.00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 19,259 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 349,592 73.00 74. 00 07400 RENAL DI ALYSI S 0 74.00 74.00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 75.00 75.00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 99,235 76.98 77. 00 001700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 77.00 0UTPATI ENT SERVI CE COST CENTERS 0 88.00 88. 00 08800 RURAL HEALTH CLI NI C 0 89.00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 5,069 90.00 90. 00 09100 EMERGENCY 256,947 91.00		06600 PHYSI CAL THERAPY						
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 98 07698 HYPERBARI C OXYGEN THERAPY 77. 00 0700 ALLOGENEI C STEM CELL ACQUI SI TI ON 77. 00 00TPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 91. 00 09100 EMERGENCY								1
70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 71.00 70.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 58, 934 71.00 72.00 73.00		1 1					1	1
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 58, 934 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 259 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 349, 592 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 ASC (NON-DISTINCT PART) 0 75.00 75.00 ASC (NON-DISTINCT PART) 0 75.00 76.98 HYPERBARIC OXYGEN THERAPY 99, 235 76.98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 000 000 CLINIC COST CENTERS 0 88.00 89.00 RURAL HEALTH CLINIC 0 89.00 89.00 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLINIC 5, 069 90.00 91.00 09100 EMERGENCY 256, 947 91.00		1 1						
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 259 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 349, 592 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 07500 ASC (NON-DISTINCT PART) 99, 235 76.98 PYPERBARIC OXYGEN THERAPY 99, 235 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0		1 1						
73. 00 07300 DRUGS CHARGED TO PATIENTS 349, 592 73. 00 74. 00 07400 RENAL DIALYSIS 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 75. 00 76. 98 07698 HYPERBARIC OXYGEN THERAPY 99, 235 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77. 00 00179ATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 89. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89. 00 90. 00 09000 CLINIC 5, 069 90. 00 91. 00 09100 EMERGENCY 256, 947 91. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS						
75. 00 07500 ASC (NON-DISTINCT PART) 0 75. 00 76. 98 77. 00								
76. 98 07698 HYPERBARI C OXYGEN THERAPY 99, 235 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 77. 00 000 00000 0000 0000 0000 00000 00000 0000 00								
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 T7. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 89. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89. 00 90. 00 09000 CLINIC 5, 069 90. 00 91. 00 09100 EMERGENCY 256, 947 91. 00								
SERVICE COST CENTERS								
88. 00								1 55
90. 00 09000 CLI NI C 5, 069 90. 00 91. 00 9100 EMERGENCY 256, 947 91. 00	88. 00						0	88. 00
91. 00 09100 EMERGENCY 256, 947 91. 00								
		1 1						
72.00							250, 947	
	00	1	ı	ı	ı	l	1	, 55

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2019 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0146

				To 12/31/2019	Date/Time Pre	
					6/23/2020 3: 4	6 pm
		I NTERNS &	RESI DENTS			
			I			
Cost Center Description	NURSI NG		SERVI CES-OTHE		Subtotal	
	SCH00L	RY & FRINGES	R PRGM COSTS	PRGM		
OTHER RELABILISTANIE OCCT OFFITERS	20. 00	21. 00	22.00	23. 00	24. 00	
OTHER REIMBURSABLE COST CENTERS			1	1		04.00
94. 00 09400 HOME PROGRAM DIALYSIS					0	
95. 00 09500 AMBULANCE SERVICES					327, 487	1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED					0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD					0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS					0	98.00
99. 00 09900 CMHC					0	
99. 10 09910 CORF					0	
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM						100.00
101. 00 10100 HOME HEALTH AGENCY					0	101.00
SPECIAL PURPOSE COST CENTERS		1	1	1		1
105. 00 10500 KI DNEY ACQUI SI TI ON						105.00
106. 00 10600 HEART ACQUISITION						106.00
107. 00 10700 LI VER ACQUI SI TI ON						107.00
108. 00 10800 LUNG ACQUISITION						108.00
109. 00 10900 PANCREAS ACQUISITION						109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON						110.00
111. 00 11100 SLET ACQUISITION					0	111.00
113. 00 11300 NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)						115.00
116. 00 11600 HOSPI CE						116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	(0	3, 301, 766]118. 00
NONREI MBURSABLE COST CENTERS		1	1	1		1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					·	190.00
191. 00 19100 RESEARCH						191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES						192.00
193. 00 19300 NONPAI D WORKERS						193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS						194.00
194. 01 07951 PAIN CLINIC						194. 01
194. 02 07952 OCC HEALTH						194. 02
194. 03 07953 FOUNDATI ON					15, 297	1
194. 04 07954 PHYSI CI AN OFFI CES						194. 04
194. 05 07955 COMMUNITY & VOLUNTEER SERVICES						194. 05
194. 06 07956 VACANT_SPACE						194.06
200.00 Cross Foot Adjustments	0	0	(1		200.00
201.00 Negative Cost Centers	0	0	(0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	(0	3, 430, 264	202.00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: 6/23/2020 3:46 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF NOBLE CTY, INC Provi der CCN: 15-0146 Cost Center Description Intern & Total

	cost center bescription	Residents	Total		
		Cost & Post			
		Stepdown			
		Adjustments			
	Ta	25. 00	26. 00		
1 00	GENERAL SERVICE COST CENTERS	1	1	T	1 00
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				10.00
11. 00	01100 CAFETERI A				11.00
	01200 MAINTENANCE OF PERSONNEL				12. 00
	01300 NURSI NG ADMI NI STRATI ON				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
	01500 PHARMACY				15.00
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE				16.00 17.00
	01850 OTHER GENERAL SERVICE (SPECIFY)				18.00
	01900 NONPHYSI CI AN ANESTHETI STS				19. 00
	02000 NURSI NG SCHOOL				20.00
	02100 I&R SERVICES-SALARY & FRINGES APPRVD				21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS	C		•	30.00
	03100 INTENSIVE CARE UNIT	C	1		31.00
	03200 CORONARY CARE UNIT	C	1		32.00
	03300 BURN INTENSIVE CARE UNIT	C	_		33.00
	03400 SURGI CAL INTENSI VE CARE UNIT 04000 SUBPROVI DER - I PF			1	34. 00 40. 00
41.00	1 1			•	41.00
	04300 NURSERY		1	1	43.00
44. 00	1 1		1	l .	44.00
	04500 NURSING FACILITY		1	I .	45. 00
46.00	1	C	0		46. 00
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATI NG ROOM	C	1		50.00
51.00		C	_		51.00
52.00		C	1	l .	52.00
53.00		0	1		53.00
54. 00 55. 00		C	681, 373	1	54. 00 55. 00
	05600 RADI OLOGI - MERAPEUTI C				56.00
57.00					57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)		Ö		58. 00
	05900 CARDI AC CATHETERI ZATI ON	C	0		59.00
60.00	06000 LABORATORY	C	203, 690		60.00
60. 01	06001 BLOOD LABORATORY	C	0		60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	0	i e	62.00
63.00			0		63.00
	06400 I NTRAVENOUS THERAPY		99, 453		64.00
65. 00 66. 00	1 1		130, 658	i e	65. 00 66. 00
67.00	1 1		27, 988	1	67.00
68. 00			24, 089	·	68. 00
	06900 ELECTROCARDI OLOGY		0		69.00
	07000 ELECTROENCEPHALOGRAPHY		Ö	i e e e e e e e e e e e e e e e e e e e	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	58, 934		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	C	19, 259		72. 00
	07300 DRUGS CHARGED TO PATIENTS	C	349, 592		73.00
	07400 RENAL DI ALYSI S	0	0	•	74.00
	07500 ASC (NON-DISTINCT PART)	C	0	l .	75.00
	07698 HYPERBARI C OXYGEN THERAPY	C	1		76. 98
77. 00		C	0	<u> </u>	77. 00
88 NO	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC				88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
	09000 CLINIC		5, 069	I and the second	90.00
	09100 EMERGENCY		256, 947	·	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	[C	<u> </u>		92.00
	-				

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL OF NOBLE CTY, INC ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0146 Peri od: Worksheet B From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 00000000 09500 AMBULANCE SERVICES 327, 487 95.00 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 98.00 98.00 0 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0000 105.00 106.00 10600 HEART ACQUISITION 0 106.00 107. 00 10700 LI VER ACQUI SI TI ON 107.00 0 108.00 10800 LUNG ACQUISITION 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 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 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)
NONREI MBURSABLE COST CENTERS 0 3, 301, 766 118.00 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 10,644 0 191. 00 19100 RESEARCH 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.00 0000000000000 42, 582 193. 00 19300 NONPALD WORKERS 193. 00 0 194. 00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194. 01 07951 PAIN CLINIC 0 194.01 194. 02 07952 OCC HEALTH 194. 02 0 194. 03 07953 FOUNDATI ON 194. 03 15, 297 194. 04 07954 PHYSICIAN OFFICES 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 59, 975 194.05 194.06 07956 VACANT SPACE C 194.06 200.00 200.00 Cross Foot Adjustments

0

3, 430, 264

201.00

202.00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

		UNITY HOSPITAL (OF NOBLE CTY,	INC	In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-0146	Period: From 01/01/2019	Worksheet B-1	
						Date/Time Pre	
		CAPITAL REL	ATED COSTS			6/23/2020 3: 4	6 pm
		OALLIAE REE	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE		ADMI NI STRATI V	
		(SQUARE FEET)	(DOLLAR	BENEFITS	n	E & GENERAL	
			VALUE)	DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
		1. 00	2.00	4. 00	5A	5. 00	
4 00	GENERAL SERVI CE COST CENTERS	10/ 050		T			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	136, 058	1, 318, 199				1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 310, 177				4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	29, 785	7, 634			28, 481, 608	5. 00
6. 00	00600 MAINTENANCE & REPAIRS	0	0	(0	0	6. 00
7.00	00700 OPERATION OF PLANT	11, 508	51, 577	427, 832	2 0	1, 395, 210	1
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	990 1, 432	41	326, 49	1 0	145, 434 549, 380	1
10.00	01000 DI ETARY	2, 948	6, 984			1	
11.00	01100 CAFETERI A	1, 907	0	207, 930	0	145, 890	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	(0		12.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	401 3, 683	129, 575	437, 77	1		1
15. 00	01500 PHARMACY	1, 086	84, 822	653, 19°		11, 921 180, 105	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 659	0 1, 322	(0	l	1
17. 00	01700 SOCIAL SERVICE	0	0		0	0	
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	(0	0	18.00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	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	Ö	0		o o	Ö	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(0	0	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	17 222	7/ 520	2 002 450		2 522 105	20.00
30. 00 31. 00	03100 NTENSI VE CARE UNIT	17, 322	76, 538 0	2, 083, 658	0 0	3, 523, 105 0	30.00
32. 00	03200 CORONARY CARE UNIT	o	0		o o	·	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	34.00
40. 00 41. 00	04000 SUBPROVI DER		0			0	
43. 00	04300 NURSERY	249	5, 135	106, 258	0	142, 132	
44.00	04400 SKILLED NURSING FACILITY	o	0	(0	0	44.00
45. 00	04500 NURSING FACILITY	0	0	•	0 0	•	
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	ı o	0		<u> </u>	<u> </u>	46.00
50.00	05000 OPERATING ROOM	12, 976	162, 981	1, 006, 449	9 0	1, 802, 668	50.00
	05100 RECOVERY ROOM	0	0	(0	0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 599 0	24, 176 0		0 0		52.00
	05400 RADI OLOGY-DI AGNOSTI C	12, 165	485, 558		-	2, 959, 320	
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0		0	0	55.00
56. 00	05600 RADI OI SOTOPE	0	0	(0	0	56.00
57.00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0			0	57. 00 58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0			0	1
60.00	06000 LABORATORY	3, 347	0		0	2, 593, 169	
60. 01	06001 BLOOD LABORATORY	0	0	(0	0	
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	06300 BLOOD STORING, PROCESSING & TRANS.		0			0	63.00
	06400 I NTRAVENOUS THERAPY	Ö	0	į (0	0	
65.00	06500 RESPI RATORY THERAPY	2, 135	33, 051			821, 768	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	9, 229	12, 151			950, 460	
67. 00 68. 00	06800 SPEECH PATHOLOGY		0	292, 27 251, 588		387, 638 333, 673	1
69. 00	06900 ELECTROCARDI OLOGY	Ö	0	(0	0	1
70. 00		0	0	(0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9	0	688, 611	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0		0	270, 883 3, 687, 548	
	07400 RENAL DI ALYSI S		0			3, 007, 348	
75.00	07500 ASC (NON-DISTINCT PART)	0	0		o o	0	75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 700	31, 944				1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	1 (0	0	77.00
	08800 RURAL HEALTH CLINIC	O	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	l	89. 00
90. 00	09000 CLI NI C	0	0	49, 84	5 0	69, 650	90.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm CAPITAL RELATED COSTS Reconciliatio ADMINISTRATIV Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** (SQUARE FEET) (DOLLAR BENEFITS F & GENERAL n VALUE) DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1. 00 2.00 4.00 5A 5.00 91. 00 09100 EMERGENCY 7, 254 1, 322, 268 2, 127, 051 91.00 26, 319 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 09500 AMBULANCE SERVICES 0 0 95.00 175, 483 1, 782, 316 2, 516, 396 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 C 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 o 0 97.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 Ω 0 09900 CMHC 0 99.00 99.00 C 0 99. 10 09910 CORF 0 0 0 0 0 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 C 0 0 101.00 10100 HOME HEALTH AGENCY 0 Ω 0 0 01101 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 0 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 107.00 Ω 108.00 10800 LUNG ACQUISITION 0 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 o 0 110.00 Ω 111.00 11100 | 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 0 115.00 0 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 123, 375 1, 313, 969 19, 374, 547 -15, 517, 974 27, 741, 788 118.00 118.00 NONREI MBURSABLE COST CENTERS 34, 491 190. 00 1, 189 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1.227 37.094 o 191. 00 19100 RESEARCH 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 6, 515 0 70, 691 192. 00 768 39, 710 0 0 193.00 193. 00 19300 NONPALD WORKERS C 0 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 0 C 0 0 194. 01 07951 PAIN CLINIC 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 0 0 0 0 0 194.02 194. 03 07953 FOUNDATI ON 213, 625 194. 03 0 0 C 194. 04 07954 PHYSICIAN OFFICES 0 0 194.04 4, 941 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 2, 273 179, 309 421, 013 194. 05 194.06 07956 VACANT SPACE 0 194.06 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 440, 386 1, 076, 140 3, 226, 069 15, 517, 974 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 544842 203. 00 3. 236752 0.816371 0.164338 204.00 Cost to be allocated (per Wkst. B, 2, 016, 379 204. 00 Part II) 0.000000 0. 070796 205. 00 205.00 Unit cost multiplier (Wkst. B, Part II)206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

| Peri od: | Worksheet B-1 | To | 12/21/2019 | T Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL OF NOBLE CTY, INC Provider CCN: 15-0146

						rom 01/01/2019 o 12/31/2019	Date/Time Pre 6/23/2020 3:4	
		Cost Center Description	MAINTENANCE & REPAIRS	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS	Орш
			(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)		SERVED)	
	GENER	AL SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4. 00 5. 00
6.00	00600	MAINTENANCE & REPAIRS	106, 273	l e				6. 00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	11, 508 990					7. 00 8. 00
9. 00		HOUSEKEEPI NG	1, 432	ł				9.00
10.00		DIETARY	2, 948	l '			21, 003	10.00
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL	1, 907	1, 907 0			0	11. 00 12. 00
13.00	01300	NURSING ADMINISTRATION	401	401	0	401	0	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	3, 683 1, 086	· ·			0	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	1, 659				0	16.00
17. 00	01700	SOCIAL SERVICE	0	0		0	0	17. 00
18. 00 19. 00		OTHER GENERAL SERVICE (SPECIFY) NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00		NURSI NG SCHOOL	0	ő	Ö	0	0	20.00
21.00		I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM-(SPECIFY)	0	0			0	22. 00 23. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	17, 322	17, 322 0			21, 003 0	30. 00 31. 00
32. 00	1	CORONARY CARE UNIT	0	ő			0	32.00
33.00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	0	_	0	0	34. 00 40. 00
41. 00	04100	SUBPROVI DER - I RF	0	Ö			0	41.00
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	249	249			0	43. 00 44. 00
45. 00	1	NURSING FACILITY	0	ő			0	45.00
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50.00		OPERATING ROOM	12, 976	12, 976	50, 078	12, 976	0	50.00
51.00		RECOVERY ROOM	0 1, 599	0	1		0	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	1, 599	1, 599 0	192	1, 599 0	0	52. 00 53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	12, 165			12, 165	0	54.00
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	0	0	0	0	0	55. 00 56. 00
57.00	05700	CT SCAN	0	Ö	Ö	0	0	
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00 59. 00
60.00		CARDI AC CATHETERI ZATI ON LABORATORY	3, 347	3, 347	471	3, 347	0	60.00
60. 01	1	BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61. 00 62. 00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	ō	0	0	0	63.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0 2, 135	0	_	-	0	64. 00 65. 00
66. 00	1	PHYSICAL THERAPY	9, 229			9, 229	0	66.00
67.00		OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	ō	0	0	0	70. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00		RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 76. 98		ASC (NON-DISTINCT PART) HYPERBARIC OXYGEN THERAPY	1, 700	0 1, 700		1, 700	0	75. 00 76. 98
77. 00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		1		0	77. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	T 0	Ι ο	Ιο	O	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	ő			0	89. 00
90. 00 91. 00		CLINIC EMERGENCY	7, 254	7, 254	0 36, 641	0 7, 254	0	90. 00 91. 00
		OBSERVATION BEDS (NON-DISTINCT PART)	7,254	,, 254	30, 041	7,254		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 01/01/2019 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (SQUARE FEET) (MEALS REPAI RS PLANT (SQUARE FEET) (SQUARE FEET) (POUNDS OF SERVED) LAUNDRY) 6. 00 7. 00 9. 00 10.00 8.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 95 00 09500 AMBULANCE SERVICES 0 0 0 95.00 0 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 09900 CMHC 99.00 0 99 00 0 0 0 0 99. 10 09910 CORF 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 101.00 0 0 0 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 0 0 107. 00 10700 LIVER ACQUISITION 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 C 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 0 o 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 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 0 115.00 0 0 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 93, 590 82,082 188, 290 79,660 21, 003 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 227 1, 227 1, 227 0 190, 00 191. 00 19100 RESEARCH 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 6, 515 6, 515 2, 166 6, 515 0 192.00 193. 00 19300 NONPALD WORKERS 0 193.00 0 C 0 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194, 00 0 C 0 0 194. 01 07951 PAIN CLINIC 0 C 0 0 0 194. 01 194. 02 07952 OCC HEALTH 0 194.02 0 0 0 0 194. 03 07953 FOUNDATI ON 0 Ω 0 0 0 194.03 194. 04 07954 PHYSICIAN OFFICES 0 194.04 0 0 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 4, 941 4, 941 0 4, 941 0 194.05 194.06 07956 VACANT SPACE 0 194.06 200 00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 155, 379 247, 190 891, 423 630, 021 202. 00 0 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 1. 297885 29. 996715 203. 00 0.000000 22.744463 9.653390 204.00 Cost to be allocated (per Wkst. B, 178, 130 15, 361 46, 885 46, 783 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 1.879702 0.080654 0.507727 2. 227444 205. 00

206.00

207.00

II)

(per Wkst. B-2)

Parts III and IV)

206.00

207.00

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

	Financial Systems COMMU ALLOCATION - STATISTICAL BASIS	JNITY HOSPITAL			<u> </u>	u of Form CMS-2 Worksheet B-1	
COST	ALLUCATION - STATISTICAL BASIS		Provider C		om 01/01/2019	Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	6/23/2020 3: 4 PHARMACY	6 pm
		(MEALS SERVED)	OF PERSONNEL (NUMBER	ADMI NI STRATI O N	SERVI CES & SUPPLY	(COSTED REQUIS.)	
		SERVED)	HOUSED)	(DI RECT NURS.	(COSTED	KEQUI 3.)	
		11. 00	12. 00	HRS.) 13. 00	REQUIS.) 14.00	15. 00	
	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	15.00	
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE						8.00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL	368, 836	0				11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	10, 229	0	160, 203			13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	0 11, 886	0	0	2, 121, 136 37, 642	3, 687, 952	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0	o o	0	3,007,732	16.00
17.00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23. 00
	03000 ADULTS & PEDIATRICS	64, 691	0	64, 691	201, 207	1, 862	1
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0	0	0	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	Ö	o o	0	0	33.00
34. 00 40. 00	03400 SURGI CAL INTENSIVE CARE UNIT 04000 SUBPROVI DER - IPF	0	0	0	0	0	34. 00 40. 00
41.00	04100 SUBPROVI DER - I RF	0	Ö	o o	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	3, 471 0	0	3, 471	0	0	43. 00 44. 00
45.00	04500 NURSING FACILITY	0	Ö	o	0	0	45.00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50.00	05000 OPERATING ROOM	31, 783	0	31, 783	292, 481	83, 485	
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0 16, 265	0	16, 265	0	0	51. 00 52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	47, 410 0	0		74, 152 0		54. 00 55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57. 00 58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 60. 01	O6000 LABORATORY O6001 BLOOD LABORATORY	0	0	0	0	0	60. 00 60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 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	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 20, 474	0	0	0 55, 529	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	20, 509	0	0	17, 800	821	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	8, 559 7, 368	0	0	0	0	67. 00 68. 00
69. 00		0	Ö	o o	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0 959, 494	0	70. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	o o	757, 474	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0	0	0	84, 999 0	3, 582, 162 0	1
75.00	07500 ASC (NON-DISTINCT PART)	0	Ö	ő	0	0	75. 00
76. 98 77. 00	O7698 HYPERBARI C OXYGEN THERAPY O7700 ALLOGENEI C STEM CELL ACQUI SITION	7, 192 0	0	7, 192	31, 060 0	0	76. 98 77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90.00	09000 CLI NI C	1, 633	Ö	o o	3, 230	0	90.00
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	36, 801	0	36, 801	208, 267	665	91. 00 92. 00
	· · · · · · · · · · · · · · · · · · ·			'	'		

Health Finar	cial Systems COMMU	NITY HOSPITAL	OF NOBLE CTY,	INC	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der CCN: 15-0146 Peri od: Wor				
					From 01/01/2019 To 12/31/2019	Date/Time Pre	narad.
					10 12/31/2019	6/23/2020 3: 4	
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	<u> </u>
	, and the second	(MEALS	OF PERSONNEL	ADMI NI STRATI O		(COSTED	
		SERVED)	(NUMBER	N	SUPPLY	REQUIS.)	
		ŕ	HOUSED)	(DIRECT NURS.	(COSTED	Í	
			,	HRS.)	REQUIS.)		
		11. 00	12. 00	13.00	14.00	15. 00	
OTHER	REIMBURSABLE COST CENTERS						
	HOME PROGRAM DIALYSIS	0	0	(0	0	
	AMBULANCE SERVICES	68, 281	0	(123, 471	13, 543	95.00
96. 00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	(0	0	96.00
	DURABLE MEDICAL EQUIP-SOLD	0	0	(0	0	97. 00
	OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	98. 00
99. 00 09900		0	0	(0	0	99. 00
99. 10 09910		0	0	(0	0	99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	(0	0	100.00
	HOME HEALTH AGENCY	0	0	(0	0	101.00
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0	0		0		105.00
	HEART ACQUISITION	0	0		0		106. 00
	LIVER ACQUISITION	0	0	(0		107. 00
	LUNG ACQUISITION	0	0	(0	0	108. 00
	PANCREAS ACQUISITION	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	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	115. 00
116. 00 11600	HOSPI CE	0	0	(0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	356, 552	0	160, 203	2, 089, 332	3, 682, 680	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 289	0		24, 718		190. 00
191. 00 19100		0	0		0		191. 00
	PHYSICIANS' PRIVATE OFFICES	2, 146	0	(1, 021		192. 00
	NONPALD WORKERS	0	0	1	0		193. 00
	OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 00
	PAIN CLINIC	0	0		0		194. 01
194. 02 07952		0	0		0		194. 02
194. 03 07953	FOUNDATI ON	3, 022	0	•	0		194. 03
	PHYSICIAN OFFICES	0	0		0		194. 04
	COMMUNITY & VOLUNTEER SERVICES	5, 827	0	(6, 065	·	194. 05
	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,	287, 512	0	1, 000, 342	2 145, 219	325, 260	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 779512	0. 000000			0. 088195	
204. 00	Cost to be allocated (per Wkst. B,	21, 075	0	153, 503	3 22, 023	89, 174	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 057139	0. 000000	0. 958178	0. 010383	0. 024180	205. 00
201 62	11)						00/ 05
206. 00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2)						207.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
I	Parts III and IV)			I	1		I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146 In Lieu of Form CMS-2552-10

				1	o 12/31/2019	Date/lime Pre 6/23/2020 3:4	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	NURSI NG SCHOOL (ASSI GNED TI ME)	рш
	I	16. 00	17. 00	18. 00	19. 00	20. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY						1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00
11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSI NG ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	211, 512, 566 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0	0	C	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
30.00	03000 ADULTS & PEDIATRICS	15, 379, 729	0	0	0	С	30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0				
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	_	1	1
34.00	03400 SURGICAL INTENSIVE CARE UNIT	o	0	0	0	C	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0	0	0		
43.00	04300 NURSERY	637, 750	0	0	0		1
44.00	04400 SKILLED NURSING FACILITY	0	0	Ö	Ö	•	1
45.00	04500 NURSING FACILITY	0	0		_		
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	<u> </u>	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	23, 960, 173	0	0	0		50.00
51. 00	05100 RECOVERY ROOM	0	0		_		
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 002, 761	0	0	0	C	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	14 714 000	0	0	0		
	05500 RADI OLOGY-THERAPEUTI C	44, 716, 888 0	0	0	0		1
	05600 RADI OI SOTOPE	0	0	0			1
57.00	05700 CT SCAN	0	0	0	0	C	1
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0		1
60.00	06000 LABORATORY	27, 014, 302	0	0	0		1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	C	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	_	0		61.00
62. 00 63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0		1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	d	1
65.00	06500 RESPIRATORY THERAPY	9, 683, 400	0	0	0	C	
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	3, 603, 776 1, 223, 479	0	0	0		
68. 00	06800 SPEECH PATHOLOGY	972, 779	0	0	0		1
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	C	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	C	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	4, 845, 663 1, 789, 210	0	0	0		1
73.00	07300 DRUGS CHARGED TO PATIENTS	22, 472, 664	Ö	Ö	0		1
74.00	07400 RENAL DIALYSIS	0	0	0	0	C	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	C	
76. 98 77. 00	07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION	5, 338, 233 0	0	0	_		1
	OUTPATIENT SERVICE COST CENTERS	, o					
	08800 RURAL HEALTH CLINIC	0	0				1
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	234, 093	0		_		
70.00	10,000 001 111 0	234, 073	0	1 0	0	1	75.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0146 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm OTHER GENERAL SERVI CE NONPHYSI CI AN NURSI NG Cost Center Description MEDI CAL SOCI AL (SPECI FY) RECORDS & **SERVICE** (TIME SPENT) **ANESTHETISTS** SCHOOL (ASSI GNED (ASSI GNED LI BRARY (TIME SPENT) (GROSS TIME) TIME) CHARGES) 19.00 20.00 16. 00 17. 00 18.00 91. 00 09100 EMERGENCY 34, 332, 718 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 0 0 09500 AMBULANCE SERVICES 0 95.00 95.00 12, 304, 948 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 o 0 97.00 0 0 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 98 00 0 09900 CMHC 0 0 99.00 99.00 C 0 99. 10 09910 CORF 0 0 0 0 O 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 01101 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 0 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 107.00 Ω 108.00 10800 LUNG ACQUISITION 0 C 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 o 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 0 C 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 C 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 211, 512, 566 0 0 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 0 192.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194 00 0 194. 01 07951 PAIN CLINIC 0 194. 01 194. 02 07952 OCC HEALTH 0 194.02 0 0 0 0 0 194. 03 07953 FOUNDATI ON 0 194.03 0 194. 04 07954 PHYSICIAN OFFICES 0 0 194.04 194. 05 07955 COMMUNITY & VOLUNTEER SERVICES 0 0 0 0 194.05 194.06 07956 VACANT SPACE 0 194.06 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 62,044 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000293 0. 000000 203. 00 0.000000 0.000000 0.000000 204.00 Cost to be allocated (per Wkst. B, 9,710 0 204.00 Part II) 0.000000 0.000000 0.000000 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000046 II)0 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00

Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL OF NOBLE CTY, INC
Provider CCN: 15-0146

					10 12/31/2019 Date/lime F 6/23/2020 3	
		INTERNS &	RESI DENTS			
	Cook Cooker Docement of	CEDVILOEC CALA	CEDVI CEC OTHE	DADAMED ED		
	Cost Center Description	RY & FRINGES	SERVICES-OTHE R PRGM COSTS	PARAMED ED PRGM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED		
		TIME)	TIME)	TIME)		
	OFNEDAL CERVILOE COCT OFNITERS	21. 00	22. 00	23. 00		
1. 00	GENERAL SERVICE COST CENTERS 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 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION 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 12. 00	01100 CAFETERI A					11. 00 12. 00
13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION					13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)					17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS					19.00
20.00						20.00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	C				21.00
22. 00 23. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)		0	1	0	22. 00 23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		1	L	<u> </u>	
30.00	03000 ADULTS & PEDIATRICS	C	1		0	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T		0		0	31.00 32.00
33. 00	03300 BURN INTENSIVE CARE UNIT				Ö	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	C	0		0	34.00
40.00	04000 SUBPROVI DER - I PF	C	0		0	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY				0	41.00 43.00
44. 00	04400 SKILLED NURSING FACILITY				0	44.00
45. 00	04500 NURSING FACILITY	C	0		0	45.00
46. 00	04600 OTHER LONG TERM CARE	C) 0		0	46. 00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0		0	50.00
51.00	05100 RECOVERY ROOM	C	0	•	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	0		0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C				0	53.00 54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	l c	o o		0	55.00
	05600 RADI OI SOTOPE	C	0		0	56.00
	05700 CT SCAN	C	0		0	57.00
59.00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION		0		0	58. 00 59. 00
60.00	06000 LABORATORY	C	o o		o	60.00
60. 01	06001 BLOOD LABORATORY	C	0		0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	61. 00 62. 00
63. 00	1 1				o	63.00
	06400 I NTRAVENOUS THERAPY	C	0		0	64.00
65.00	06500 RESPI RATORY THERAPY	C	0		0	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY				0	66. 00 67. 00
	06800 SPEECH PATHOLOGY				0	68.00
69. 00	06900 ELECTROCARDI OLOGY	C	0		0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	C	0		0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS				0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS		Ö		ō	73.00
	07400 RENAL DI ALYSI S	0	0		0	74.00
75. 00 76. 98	07500 ASC (NON-DISTINCT PART) 07698 HYPERBARIC OXYGEN THERAPY		0		0	75. 00 76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION			1	0	76. 98
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC	C	1	1	0	88.00
90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		0	1	0	89. 00 90. 00
	09100 EMERGENCY		o o	1	o o	91.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0146

				10	6/23/2020 3:	
		INTERNS &	RESI DENTS			
	Cost Center Description		SERVI CES-OTHE	PARAMED ED		
		RY & FRINGES	R PRGM COSTS	PRGM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED		
		TIME)	TIME)	TIME)		
92 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	21. 00	22. 00	23. 00		92.00
	REIMBURSABLE COST CENTERS					72.00
	HOME PROGRAM DIALYSIS	1	0	0		94.00
	AMBULANCE SERVICES	0	0			95. 00
	DURABLE MEDICAL EQUIP-RENTED	0	0	o o		96.00
1	DURABLE MEDICAL EQUIP-SOLD	0	0	ő		97.00
4	OTHER REIMBURSABLE COST CENTERS	0	0	-		98.00
99.00 09900		0	0	0		99.00
99. 10 09910	CORF	0	0	0		99. 10
100. 00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101. 00 10100	HOME HEALTH AGENCY	0	0	0		101. 00
	AL PURPOSE COST CENTERS					
	KIDNEY ACQUISITION	0				105.00
	HEART ACQUISITION	0	0			106. 00
1	LIVER ACQUISITION	0	0			107. 00
1	LUNG ACQUISITION	0	0			108. 00
1	PANCREAS ACQUISITION	0	0	_		109.00
4	INTESTINAL ACQUISITION	0	0	0		110.00
	I SLET ACQUI SITI ON	0	0	0		111.00
	INTEREST EXPENSE					113.00
	UTILIZATION REVIEW-SNF AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		114. 00 115. 00
116. 00 11600		0	U	0		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0			118.00
	IMBURSABLE COST CENTERS					110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191. 00 19100		0	0	-		191.00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193. 00 19300	NONPALD WORKERS	0	0	0		193.00
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		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	l e e e e e e e e e e e e e e e e e e e	0	0	-		194. 03
4	PHYSICIAN OFFICES	0	0	0		194. 04
4	COMMUNITY & VOLUNTEER SERVICES	0	0	0		194. 05
4	VACANT SPACE	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, Part I)	0	0	0		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000		203. 00
204. 00	Cost to be allocated (per Wkst. B,	0	0	0		204.00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000		205. 00
200.00		0.00000	3. 000000	3.000000		
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)			0		206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,			0. 000000		207. 00
	Parts III and IV)					

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 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 192, 916 7, 192, 916 7, 192, 916 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 0 33 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 0 40 00 04000 SUBPROVI DER - I PF 0 0 0 O 40 00 0 04100 SUBPROVI DER - I RF 41.00 0 41.00 0 0 04300 NURSERY 252, 454 43.00 252, 454 252, 454 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 45.00 04500 NURSING FACILITY 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 3, 527, 868 3, 527, 868 3, 527, 868 50.00 05100 RECOVERY ROOM 51.00 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 1, 198, 395 1, 198, 395 1, 198, 395 52 00 53.00 05300 ANESTHESI OLOGY O 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 5, 045, 659 5, 045, 659 0 0 5, 045, 659 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 0 05600 RADI OI SOTOPE 56.00 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) o 58.00 0 0 58.00 0 0 59 00 05900 CARDI AC CATHETERI ZATI ON 0 O 59 00 0 60.00 06000 LABORATORY 4, 122, 998 4, 122, 998 4, 122, 998 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 0 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06400 INTRAVENOUS THERAPY 64.00 0 0 64.00 1, 362, 779 65 00 06500 RESPIRATORY THERAPY 1 362 779 1 362 779 65 00 06600 PHYSI CAL THERAPY 1, 785, 645 1, 785, 645 66.00 1, 785, 645 66.00 06700 OCCUPATI ONAL THERAPY 605, 869 605, 869 605, 869 67.00 67.00 0 0 0 68.00 06800 SPEECH PATHOLOGY 521, 500 521, 500 521,500 68.00 06900 FLECTROCARDLOLOGY 69 00 0 69 00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 130, 905 1, 130, 905 1, 130, 905 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 418, 995 418, 995 0 0 418, 995 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 6,025,010 6, 025, 010 6,025,010 73 00 74.00 07400 RENAL DIALYSIS 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 07698 HYPERBARI C OXYGEN THERAPY 0 1, 325, 297 76. 98 1, 325, 297 1, 325, 297 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER o 89.00 0 89.00 0 0 90.00 09000 CLI NI C 109, 161 109, 161 0 109, 161 90.00 91.00 09100 EMERGENCY 3, 851, 385 3, 851, 385 3, 851, 385 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 973, 985 1, 973, 985 1, 973, 985 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 95 00 09500 AMBULANCE SERVICES 3, 953, 911 3, 953, 911 0 3, 953, 911 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96,00 96.00 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 98.00 0 0 99.00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 0 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 105, 00 0 0 106.00 10600 HEART ACQUISITION 0 106.00 107. 00 10700 LIVER ACQUISITION 0 107.00 0 0 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 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00

0 115.00

0 116.00

0

0

116.00 11600 HOSPI CE

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

Health Financial Systems			HOSPI TAL	OF NOBLE CTY,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Provi der C		Peri od: From 01/01/2019	Worksheet C Part I	
						To 12/31/2019	Date/Time Pre 6/23/2020 3:4	pared: 6 pm
				Title	XVIII	Hospi tal	PPS	
						Costs		
	Cost Center Description	To-	tal Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(fr	om Wkst.	Adj .		Di sal I owance		
		В,	Part I,					
		C	ol. 26)					
			1. 00	2.00	3.00	4. 00	5. 00	
200.00	Subtotal (see instructions)	4	14, 404, 732	0	44, 404, 73	2 0	44, 404, 732	200.00
201. 00	Less Observation Beds		1, 973, 985		1, 973, 98	5	1, 973, 985	201.00
202. 00	Total (see instructions)		12, 430, 747	0	42, 430, 74	7 o	42, 430, 747	202. 00

Health Financial Systems

COMMUNITY HOSPITAL OF NOBLE CTY, INC

In Lieu of Form CMS-2552-10

Provider CCN: 15-0146

Period:
From 01/01/2019
To 12/31/2019

Title XVIII Hospital

PPS

		71.11	V0.01.1		6/23/2020 3: 4	6 pm
		litle Charges	e XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
Cost Center Bescription	Impatrent	outputtent	+ col . 7)	Ratio	Inpati ent	
			,		Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.507.007		0.504.00	. [
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	9, 506, 206		9, 506, 206			30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	0					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT						33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	o o					34.00
40. 00 04000 SUBPROVI DER - I PF	0					40.00
41. 00 04100 SUBPROVI DER - RF	0					41.00
43. 00 04300 NURSERY	637, 750		637, 750			43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
45. 00 04500 NURSING FACILITY 46. 00 04600 OTHER LONG TERM CARE	0					45. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>			/		40.00
50. 00 05000 OPERATING ROOM	7, 599, 642	16, 360, 531	23, 960, 173	0. 147239	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	0	25,755,176		0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 002, 761	0	3, 002, 76 ²		0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	(0. 000000	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 306, 189	40, 410, 699	44, 716, 888		0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0.000000	0.000000	55.00
56. 00 05600 RADI 01 SOTOPE	0	0		0.000000	0.000000	56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0. 000000 0. 000000	0. 000000 0. 000000	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0.000000	0. 000000	59.00
60. 00 06000 LABORATORY	5, 556, 502	21, 457, 800	27, 014, 302		0. 000000	60.00
60. 01 06001 BL00D LABORATORY	0	0	, , , , , ,	0. 000000	0.000000	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	O	0		0. 000000	0. 000000	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0. 000000	0. 000000	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0.000000	0.000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0 0/1 215	(022 105	0 (02 40)	0.000000	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 861, 215 219, 568	6, 822, 185 3, 384, 208			0. 000000 0. 000000	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	71, 266	1, 152, 213	1		0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY	37, 754	935, 025			0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1		0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0. 000000	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 446, 446	3, 399, 217			0. 000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	613, 432	1, 175, 778			0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS	5, 207, 981	17, 264, 683	22, 472, 664		0.000000	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0		0. 000000 0. 000000	0. 000000 0. 000000	75.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	16, 676	5, 321, 557	5, 338, 233		0. 000000	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	1		0. 000000	77. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	(88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 4//045	0.00000	89.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	495 4, 403, 849	233, 598			0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 403, 849	29, 928, 869 5, 873, 523			0. 000000 0. 000000	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	١	3, 073, 323	3,073,323	0. 330002	0.000000	72.00
94.00 O9400 HOME PROGRAM DIALYSIS	0	0	(0. 000000	0.000000	94.00
95. 00 09500 AMBULANCE SERVICES	O	12, 304, 948	12, 304, 948	0. 321327	0. 000000	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0. 000000	0. 000000	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(0.000000	0. 000000	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC	0	0		0. 000000	0. 000000	98.00
99. 00 09900 CMHC 99. 10 09910 CORF	0	0				99. 00 99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM	0	0				100.00
101. 00 10100 HOME HEALTH AGENCY	l o	0	1			101.00
SPECIAL PURPOSE COST CENTERS	,		•			
105.00 10500 KIDNEY ACQUISITION	0	0	()		105.00
106.00 10600 HEART ACQUISITION	0	0	1			106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	(107.00
108. 00 10800 LUNG ACQUISITION	0	0				108.00
109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION	0	0				109. 00 110. 00
111.00 11100 TNTESTINAL ACQUISITION		0		ń		111.00
113. 00 11300 I NTEREST EXPENSE		O				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 HOSPI CE	0	0	(116.00
200.00 Subtotal (see instructions)	45, 487, 732	166, 024, 834	211, 512, 566)		200. 00

Health Financial Systems	COMMUNITY HOSPITAL OF NOBLE CTY, INC			In Lieu of Form CMS-2552-10		
OMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: From 01/01/2019	Worksheet C Part I	
				To 12/31/2019	Date/Time Pro 6/23/2020 3:4	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7.00	8.00	9. 00	10.00	
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	45, 487, 732	166, 024, 834	211, 512, 56	6		202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Provi der CCN: 15-0146

		Title XVIII	Hospi tal	6/23/2020 3: 46 pm PPS
Cost Center Description	PPS Inpatient	i tie xviii	1105pi tai	FF3
	Ratio			
	11. 00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT				30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00 04000 SUBPROVI DER - I PF				40.00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY				41. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY				44. 00
45. 00 04500 NURSI NG FACILITY				45.00
46.00 O4600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 147239			50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 399098			51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 112836			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00 05600 RADI OI SOTOPE	0. 000000			56.00
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000 0. 000000			58. 00 59. 00
60. 00 06000 LABORATORY	0. 152623			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
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 65. 00 06500 RESPI RATORY THERAPY	0. 000000 0. 140734			64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 495493			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 495202			67.00
68.00 06800 SPEECH PATHOLOGY	0. 536093			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 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 233385 0. 234179			71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 268104			73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 248265			76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77.00
88.00 O8800 RURAL HEALTH CLINIC				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLINIC	0. 466315			90.00
91. 00 09100 EMERGENCY	0. 112178			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 336082			92.00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSIS	0. 000000			04.00
94. 00 09400 HOME PROGRAM DI ALYSIS 95. 00 09500 AMBULANCE SERVICES	0. 321327			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 I&R SERVICES-NOT APPRVD PRGM				99. 10 100. 00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				101.00
105. 00 10500 KI DNEY ACQUI SI TI ON				105.00
106. 00 10600 HEART ACQUISITION				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 NTESTINAL ACQUISITION				110.00
111. 00 11100 SLET ACQUISITION				111.00
113. 00 11300 NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-SNF				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds				200. 00 201. 00
202.00 Total (see instructions)				202. 00
	1			1

In Lieu of Form CMS-2552-10
Worksheet C
01/2019 Part I
31/2019 Date/Time Prepared:
6/23/2020 3: 46 pm
tal PPS Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES COMMUNITY HOSPITAL OF NOBLE CTY, INC Provi der CCN: 15-0146 Peri od: From 01/01/2019 To 12/31/2019 Hospi tal Costs Title XIX

						Costs		
		Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
			col. 26)					
	LNDAT	LENT DOUTLINE CEDITION COST CENTEDS	1. 00	2.00	3. 00	4. 00	5. 00	
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	7, 192, 916		7, 192, 916	ol	7, 192, 916	30.00
31.00		INTENSIVE CARE UNIT	7, 192, 910		7, 192, 910	0	7, 192, 910	31.00
32. 00		CORONARY CARE UNIT	0		0	ő	0	32.00
33. 00		BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
34.00		SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
40.00		SUBPROVI DER - I PF	0		0	0	0	40. 00
41.00		SUBPROVI DER - I RF	0		0	0	0	41.00
43.00	1	NURSERY	252, 454		252, 454	0	252, 454	43.00
44. 00 45. 00		SKILLED NURSING FACILITY NURSING FACILITY	0		0	0	0	44. 00 45. 00
46. 00		OTHER LONG TERM CARE	0		0	0	0	46.00
10.00		LARY SERVICE COST CENTERS				<u> </u>	0	10.00
50.00		OPERATI NG ROOM	3, 527, 868		3, 527, 868	0	3, 527, 868	50.00
51.00		RECOVERY ROOM	0		0	0	0	51.00
52.00		DELIVERY ROOM & LABOR ROOM	1, 198, 395		1, 198, 395	0	1, 198, 395	
53.00		ANESTHESI OLOGY	0		0	0	0	53.00
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	5, 045, 659		5, 045, 659	0	5, 045, 659 0	54. 00 55. 00
56. 00		RADI OLOGI - THERAPEUTI C	0		0	0	0	56.00
57. 00		CT SCAN	0		0	0	Ö	57.00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0		0	O	0	58. 00
59.00		CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60.00		LABORATORY	4, 122, 998		4, 122, 998	0	4, 122, 998	60.00
60. 01		BLOOD LABORATORY	0		0	0	0	60. 01
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62. 00 63. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	62.00
64. 00		INTRAVENOUS THERAPY	0		0	0	0	63. 00 64. 00
65. 00		RESPI RATORY THERAPY	1, 362, 779	0		0	1, 362, 779	
66. 00		PHYSI CAL THERAPY	1, 785, 645	l e		o	1, 785, 645	
67. 00		OCCUPATI ONAL THERAPY	605, 869	ł	605, 869	0	605, 869	
68. 00		SPEECH PATHOLOGY	521, 500	0	521, 500	0	521, 500	68. 00
69. 00		ELECTROCARDI OLOGY	0		0	0	0	69. 00
70.00		ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	1, 130, 905 418, 995		1, 130, 905	0	1, 130, 905	
73. 00		DRUGS CHARGED TO PATTENTS	6, 025, 010		418, 995 6, 025, 010	0	418, 995 6, 025, 010	
74. 00		RENAL DIALYSIS	0,025,010		0, 023, 010	0	0, 023, 010	74.00
75. 00		ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76. 98	07698	HYPERBARI C OXYGEN THERAPY	1, 325, 297		1, 325, 297	0	1, 325, 297	76. 98
77. 00		ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77. 00
00.00		TIENT SERVICE COST CENTERS	T .	I	1	ما		00.00
88. 00 89. 00	1	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	l	0 0	0	0	88. 00 89. 00
90.00		CLINIC	109, 161	l	109, 161	0	109, 161	
		EMERGENCY	3, 851, 385	l	3, 851, 385	o		
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	1, 973, 985		1, 973, 985		1, 973, 985	
	OTHER	REIMBURSABLE COST CENTERS						
94.00		HOME PROGRAM DIALYSIS	0	l	0	0	0	
95.00		AMBULANCE SERVICES	3, 953, 911	l	3, 953, 911	0	3, 953, 911	95.00
96.00		DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97. 00 98. 00		DURABLE MEDICAL EQUIP-SOLD OTHER REIMBURSABLE COST CENTERS	0		0	0	0	97. 00 98. 00
99. 00			0		0	o o	0	99.00
99. 10			0		0		0	99. 10
	1	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		AL PURPOSE COST CENTERS						
		KI DNEY ACQUISITION	0	ł	0			105.00
		HEART ACQUISITION LIVER ACQUISITION	0		0 0			106. 00 107. 00
107.00	10800	LUNG ACQUISITION	0		0			107.00
		PANCREAS ACQUISITION	0		1 0			109.00
		INTESTINAL ACQUISITION	0		Ö		0	110.00
		ISLET ACQUISITION	0		0			111. 00
	1	INTEREST EXPENSE						113.00
		UTILIZATION REVIEW-SNF						114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	0	l	0			115.00
116.00	טטסווןט	HOSPI CE	0	<u> </u>	0		0	116. 00

Health Financial Systems	COMMUNITY HOSPITAL	OF NOBLE CTY,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARG	ES			Peri od: Worksheet C		
				From 01/01/2019 To 12/31/2019		pared:
					6/23/2020 3: 4	6 pm
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
200.00 Subtotal (see instructions) 44, 404, 732	2 0	44, 404, 732	0	44, 404, 732	200.00
201.00 Less Observation Beds	1, 973, 98!	5	1, 973, 985	5	1, 973, 985	201.00
202.00 Total (see instructions)	42, 430, 74	7 C	42, 430, 747	7 O	42, 430, 747	202. 00

Provider CCN: 15-0146

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

From 01/01/2019 Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Title XIX Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 506, 206 9, 506, 206 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 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 34.00 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 04300 NURSERY 637, 750 43.00 43.00 637, 750 04400 SKILLED NURSING FACILITY 44.00 0 44 00 45.00 04500 NURSING FACILITY 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 599, 642 16, 360, 531 23, 960, 173 0.147239 0.000000 50.00 05100 RECOVERY ROOM 0.000000 51.00 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 399098 0.000000 52.00 3, 002, 761 52.00 3,002,761 0 05300 ANESTHESI OLOGY 0.000000 53 00 0.000000 53 00 05400 RADI OLOGY-DI AGNOSTI C 4, 306, 189 40, 410, 699 0.112836 0.000000 54.00 44, 716, 888 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 0 05600 RADI 01 S0T0PE 56,00 0 C 0 0.000000 0.000000 56,00 57.00 05700 CT SCAN 0 C 0 0.000000 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0.000000 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 59.00 06000 LABORATORY 27, 014, 302 60.00 5, 556, 502 21, 457, 800 0.152623 0.000000 60 00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0.000000 0.000000 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0.000000 0.000000 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 0 C 0 0.000000 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 2, 861, 215 6, 822, 185 9, 683, 400 0.140734 0.000000 65.00 66 00 06600 PHYSI CAL THERAPY 219, 568 3, 384, 208 3, 603, 776 0.495493 0.000000 66 00 06700 OCCUPATI ONAL THERAPY 1, 223, 479 0.495202 67.00 71, 266 1, 152, 213 0.000000 67.00 06800 SPEECH PATHOLOGY 37, 754 935, 025 972, 779 0.536093 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000000 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0 000000 0.000000 70 00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 446, 446 3, 399, 217 4, 845, 663 0.233385 0.000000 71.00 613, 432 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 175, 778 1, 789, 210 0. 234179 0.000000 72.00 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 5, 207, 981 17, 264, 683 22, 472, 664 0 268104 0.000000 73 00 07400 RENAL DIALYSIS 74.00 0.000000 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 75.00 76.98 07698 HYPERBARI C OXYGEN THERAPY 5, 321, 557 5, 338, 233 0.248265 0.000000 76.98 16.676 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0.000000 77 00 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0.000000 89.00 0 234, 093 495 90 00 09000 CLI NI C 233, 598 0.466315 0.000000 90 00 91.00 09100 EMERGENCY 4, 403, 849 29, 928, 869 34, 332, 718 0.112178 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 5, 873, 523 5, 873, 523 0.336082 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0.000000 09500 AMBULANCE SERVICES 0 12, 304, 948 12, 304, 948 0. 321327 0.000000 95.00 95.00 96 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0.000000 0.000000 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0.000000 97.00 97.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS C 0 0.000000 0.000000 98.00 09900 CMHC 0 0 99.00 99.00 99. 10 09910 CORF 0 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 KI DNEY ACQUI SI TI ON 0 0 0 105.00 106. 00 10600 HEART ACQUISITION 0 0 C 106,00 0 107. 00 10700 LIVER ACQUISITION 0 107.00 108. 00 10800 LUNG ACQUISITION 0 0 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 111.00 0 113.00 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.) 115.00 116. 00 11600 HOSPI CE 116.00 200.00 45, 487, 732 166, 024, 834 Subtotal (see instructions) 211 512 566 200.00

Health Financial Systems	COMMUNITY HOSPITAL OF NOBLE CTY, INC			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7.00	8. 00	9. 00	10.00	
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	45, 487, 732	166, 024, 834	211, 512, 56	6		202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Provi der CCN: 15-0146

INPATIENT ROUTINE SERVICE COST CENTERS 30.00 330.00			Ti tle XIX	Hospi tal	6/23/2020 3: 46 p	pm
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 330.00	Cost Center Description	PPS Inpatient	THE XIX	nospi tai	113	
IMPATLENT ROUTINE SERVICE COST CENTERS 30.00 31.	·					
30.00 03000 ADULTS & PEDI ATRICS 33.00 32.00 32.00 03200 CORONARY CARE UNIT 33.00 33.00 33.00 33.00 03400 SURN INTENSI VE CARE UNIT 33.00 33.00 33.00 33.00 33.00 50.00 SURN INTENSI VE CARE UNIT 34.00 41.00 41.00 50.00 SURPROVIDER - IPF 40.00 41.00 41.00 50.00 SURPROVIDER - IPF 44.00 41.00 41.00 50.00 SURPROVIDER - IRF 45.00 44.00 44.00 50.00 SURPROVIDER - IRF 45.00 45.00 45.00 45.00 50.00 MURSING FACILITY 44.00 44.00 44.00 50.00 ASSON INVESTOR FACILITY 45.00 46.00 60.00 50.00 MURSING FACILITY 45.00 60.00 60.00 MURSING FACILITY 45.00 60.00	LADATI FAIT POLITIAIS OF DAYLOS OCCURRATEDO	11. 00				
31.00 03100 INTERSIVE CARE UNIT 32.00 32.00 03200 02000 CORDNARY CARE UNIT 32.00 33.00 3					3,	20 00
33.00 03300 BURN INTENSIVE CAKE UNIT 33.0 0 40.00 04000 SURDIACH INTENSIVE CAKE UNIT 40.00 04000 SURDIACH INTENSIVE CAKE UNIT 5 40.00 41.00 04100 SURDIACH INTENSIVE AND 41.00 41.00 04100 SURDROVID ER - I PF 4 41.00 43.00 04300 NURSERY 42.00 44.00 04400 SKILLED NURSING FACILITY 42.00 045.00 04500 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY 45.00 NURSING FACILITY 45.00 04500 NURSING FACILITY 45.00 NURSIN					I	
33.00 03400 SURROVID BER - I PF						
40.00 04000 04000 SUBPROVI DER - I PF	33.00 03300 BURN INTENSIVE CARE UNIT				3.	3.00
41.00					I	
43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSI NG FACILITY 44. 00 04500 SKILLED NURSI NG FACILITY 45. 00 04500 NURSI NG FACILITY 45. 00 04500 NURSI NG FACILITY 46. 00 04600 OTHER LONG TERM CARE 45. 00 04600 OTHER LONG TERM CARE 46. 00 05500 DEPRATI NG ROOM 0. 147239 50. 00 05500 DEPRATI NG ROOM 0. 000000 51. 00 055. 00 05500 DEPRATI SERVICE COST CENTERS 50. 00 05500 OSEON ARCSTRESI OLGY 0. 000000 53. 00 055. 00 05500 OSEON ARCSTRESI OLGY 0. 000000 055. 00 05500 OSEON RADIOLOGY-THERAPEUTI C 0. 000000 055. 00 05500 RADIOLOGY-THERAPEUTI C 0. 000000 055. 00 05500 RADIOLOGY-THERAPEUTI C 0. 000000 057. 00 05700 CT SCAN 0. 000000 057. 0						
44. 00 04400 SKI LLED NURSING FACILITY 45. 00 046.00 04600 OTHER LONG TERM CARE 46. 00 05000 OPERATIN GROWN 0. 047239 50. 00 05000 OPERATIN GROWN 0. 047239 51. 00 051.00 051.00 051.00 051.00 05000 OPERATING ROWN 0. 399998 52. 00 052.00						
45. 00 46						
ANCI LLARY SERVICE COST CENTERS 50.00						
50.00	46.00 O4600 OTHER LONG TERM CARE				4	6.00
51. 00 05100 RECOVERY ROOM & LABOR ROOM 0. 000000 0. 399098 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 399098 52. 00 05300 ANESTHESI OLOGY 0. 000000 53. 00 54. 00 05400 RADI OLOGY-THERAPEUTI C 0. 000000 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 57. 00 05700 CT SCAN 0. 000000 57. 00 05700 CT SCAN 0. 000000 57. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0. 000000 57. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0. 000000 0. 000000 0. 000000 0. 00000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000						
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.399098 52.00 05300 ANESTHESI OLOGY 0.000000 53.00		1 1				
53. 00 05300 ARSTHESI OLOGY 0,000000 53. 00 54. 00 05400 RADI OLOGY-DIAGNOSTI C 0.112836 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0.000000 55. 00 57. 00 05700 CT SCAN 0.000000 55. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 58. 00 60. 01 06000 LABORATORY 0.152623 60. 00 60. 01 06000 BLOOD LABORATORY 0.000000 60. 01 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0.000000 62. 00 62. 00 06200 HOLDE BLOOD & PACKED RED BLOOD CELLS 0.000000 62. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 62. 00 64. 00 06400 INTRAVENOUS THERAPY 0.140734 65. 00 65. 00 06500 RESPI RATORY THERAPY 0.495493 66. 00 66. 00 06600 P						
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 112836 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 55. 00 05700 CT SCAN 0. 000000 57. 00 05700 CT SCAN 0. 000000 57. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0. 00000 LABORATORY 0. 000000 0. 00000 LABORATORY 0. 000000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000		1			I	
56, 00 05600 RADI OI SOTOPE 0,000000 56,00 57,00 05700 CT SCAN 0,000000 57,00 58,00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0,000000 58,00 59,00 05900 CARDI AC CATHETERI ZATI ON 0,000000 59,00 60,01 0,000 LABDRATORY 0,152623 60,00 61,00 0,001 BLODD LABDRATORY 0,000000 60,01 61,00 0,6001 BLODD LABDRATORY 0,000000 61,00 62,00 0,6200 WHOLE BLODD & PACKED RED BLODD CELLS 0,000000 62,00 63,00 0,6300 B.ODD STORI NG, PROCESSI NG & TRANS. 0,000000 62,00 64,00 0,6400 INTRAVENOUS THERAPY 0,000000 64,00 65,00 0,6500 RESPIRATORY THERAPY 0,140734 65,00 66,00 0,6500 RESPIRATORY THERAPY 0,495493 66,00 67,00 0,000 0,000 0,000 0,0000 0,000000 68,00 68,00 0,000 0,000 0,000 0,0000 0,000000 69,00 69,00 0,000 0,000 0,00000 0,000000 69,00 69,00 0,000 0,00000 0,000000 69,00 71,00 0,000 0,000000 0,000000 0,000000 0,000000		1				
57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.152623 60. 00 61. 00 06001 BLOD LABORATORY 0.000000 61. 00 62. 00 06200 WHOLE BLODD & PACKED RED BLOOD CELLS 0.000000 62. 00 63. 00 06300 BLOD STORI NG, PROCESSI NG & TRANS. 0.000000 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.140734 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.495493 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.495493 66. 00 68. 00 06800 SPECH PATIONAL THERAPY 0.495202 67. 00 69. 00 07000 ELECTROCARDI OLOGY 0.536093 68. 00 69. 00 07000 ELECTROCARDI OLOGY 0.00000 69. 00 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.283385 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0.286104 73. 00 75. 00 07500 ASC (NON-DI		0. 000000			5	5.00
58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.000000 59. 00 59. 00 05990 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 01 06000 LABORATORY 0.000000 60. 01 06000 L BOOD LABORATORY 0.000000 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0.000000 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 64. 00 06400 I NTRAVENOUS THERAPY 0.000000 65. 00 06500 RESPI RATORY THERAPY 0.140734 66. 00 06600 PHYSI CAL THERAPY 0.495493 66. 00 06700 O CCUPATI ONAL THERAPY 0.495202 67. 00 06700 O CCUPATI ONAL THERAPY 0.536093 68. 00 06900 ELECTROCARDI OLOGY 0.536093 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.233385 72. 00 07200 I MPL DEV. CHARGED TO PATI ENTS 0.2334179 73. 00 07400 RENAL DI ALYSI S 0.000000 74. 00 07500 ASC (NON-DI STI NCT PART) <td< td=""><td></td><td>1</td><td></td><td></td><td></td><td></td></td<>		1				
59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.152623 60. 00 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0.000000 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 63. 00 64. 00 06400 I NTRAVENOUS THERAPY 0.000000 64. 00 65. 00 06500 PHYSI CAL THERAPY 0.140734 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.495493 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.495202 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.536093 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.233385 71. 00 72. 00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0.234179 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.248265 73. 00 74. 00 07400 RENAL DI ALYSI S 0.000000 75. 00 70. 700 OLI		1				
60. 00 06000 LABORATORY 0. 152623 60. 00 60. 01 06001 BLOOD LABORATORY 0. 0.000000 60. 01 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0. 0000000 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 0000000 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0. 000000 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0. 140734 65. 00 65. 00 06500 RESPI RATORY THERAPY 0. 140734 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 495493 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 495202 67. 00 68. 00 06800 SPEECH PATHOLGGY 0. 536093 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 233385 70. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 234179 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 234179 72. 00 74. 00 07400 RENAL DI ALYSIS 0. 000000 75. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0. 000000 75. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 248265 76. 98 77. 00 00000 ALLOGENEIC STEM CELL ACQUI SI TI ON 0. 000000 77. 00 00000 ALLOGENEIC STEM CELL ACQUI SI TI ON 0. 000000 77. 00 00000 ALLOGENEIC STEM CELL ACQUI SI TI ON 0. 000000 77. 00 00000 ALLOGENEIC STEM CELL ACQUI SI TI ON 0. 000000 77. 00 00000 ALLOGENEIC STEM CELL ACQUI SI TI ON 0. 000000 77. 00 00000 ALLOGENEIC STEM CELL ACQUI SI TI ON 0. 0000000 77. 00 00000 ALLOGENEIC STEM CELL ACQUI SI TI ON 0. 000000 77. 00 00000 ALLOGENEIC STEM CELL ACQUI SI TI ON 0. 000000 77. 00 000000 77. 00 000000 77. 0000000 77. 00		1				
60. 01 06001 BLOOD LABORATORY 0. 0.000000 61. 00 610. 0 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0. 0000000 62. 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 0000000 62. 0 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0. 000000 63. 0 06400 INTRAVENOUS THERAPY 0. 0.000000 64. 0 06400 INTRAVENOUS THERAPY 0. 0. 140734 65. 0 06500 RESPI RATORY THERAPY 0. 1495493 65. 0 06600 PHYSI CAL THERAPY 0. 495493 66. 0 06600 PHYSI CAL THERAPY 0. 495493 66. 0 06600 SPEECH PATHOLOGY 0. 536093 68. 0 06900 ELECTROCARDI OLOGY 0. 536093 68. 0 06900 ELECTROCARDI OLOGY 0. 000000 69. 0 06900 ELECTROCARDI OLOGY 0. 000000 69. 0 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 233385 71. 0 07300 DRUGS CHARGED TO PATI ENTS 0. 234179 72. 0 07400 RENAL DI ALYSI S 0. 000000 75. 0 07500 ASC (NON-DI STI NCT PART) 0. 000000 77. 0 07700 ASC (NON-DI STI NCT PART) 0. 000000 77. 0 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 0 00000 0 00000 0 00000 0 00000 0		1				
61. 00						
62. 00						
64. 00 06400 INTRAVENOUS THERAPY 0.000000 65. 00 06500 RESPIRATORY THERAPY 0.140734 65. 00 06600 PHYSI CAL THERAPY 0.495493 66. 00 06700 0CCUPATI ONAL THERAPY 0.495202 67. 00 06800 SPEECH PATHOLOGY 0.536093 68. 00 06900 ELECTROCARDI OLOGY 0.000000 07000 ELECTROCARDI OLOGY 0.000000 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.233385 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.234179 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.268104 73. 00 74. 00 07400 RENAL DI ALYSIS 0.000000 74. 00 075. 00 075. 00 075. 00 075. 00 075. 00 075. 00 076. 98 HYPERBARI C OXYGEN THERAPY 0.248265 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000						
65. 00	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			6	3.00
66. 00		1				
67. 00	1 I	1			I	
68. 00 06800 SPEECH PATHOLOGY 0. 536093 68. 00 69. 00 69. 00 69. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 75. 00	1 I	1 1			I	
69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 70. 00		1 1			I	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 233385 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 234179 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 268104 73. 00 74. 00 07400 RENAL DI ALYSIS 0. 000000 74. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 75. 00 07500 ASC (NON-DISTINCT PART) 0. 248265 76. 98 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 000000 000000 000000 0000000 000000		1 1				
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 233385 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 234179 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 268104 73. 00 74. 00 07400 RENAL DI ALYSIS 0. 000000 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0. 000000 0. 248265 76. 98 HYPERBARI C OXYGEN THERAPY 0. 248265 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 0000000 0. 0000000 0. 000000 0.		1 1				
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 268104 73. 00 74. 00 07400 RENAL DI ALYSI S 0. 000000 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0. 0000000 75. 00 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0. 248265 76. 98 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 0. 000000 000000 000000 0000000 000000						
74. 00 07400 RENAL DI ALYSI S 0.000000 75. 00 07500 ASC (NON-DI STI NCT PART) 0.000000 75. 00 076.98 HYPERBARI C OXYGEN THERAPY 0.248265 76. 98 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1 1			7:	2.00
75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 75. 00 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 00TPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0.000000 0.000000 88. 00	1 I	1 1			I	
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 248265 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 0 0 0 0 0 0 0		1 1			I	
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 77. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0. 000000 88. 00		1 1				
OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0.000000 88.00		1				
88. 00 08800 RURAL HEALTH CLINIC 0. 000000 88. 00		0.000000				7.00
		0. 000000			8	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 89. 00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			8'	39.00
90. 00 09000 CLINI C 0. 466315 90. 00		1				
91. 00 09100 EMERGENCY					1 -	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 336082 92. 00 OTHER REIMBURSABLE COST CENTERS		0. 336082			9.	2.00
94. 00 09400 HOME PROGRAM DI ALYSIS 0. 000000 94. 00		0.000000			9.	94 00
95. 00 09500 AMBULANCE SERVI CES 0. 321327 95. 00					I	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00					9	6.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00					I	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0. 000000 98. 00		0. 000000			I	
99. 00 09900 CMHC 99. 00						
99. 10 09910 CORF 99. 10 100. 00 10000 1 &R SERVI CES-NOT APPRVD PRGM 100. 00					· ·	
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 101						
SPECIAL PURPOSE COST CENTERS					10	71.00
105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00					10	5.00
106. 00 10600 HEART ACQUISITION 106. 00						
107. 00 10700 LI VER ACQUI SI TI ON 107. 00	1 I					
108. 00 10800 LUNG ACQUI SI TI ON 108. 00 109. 0					•	
109. 00 10900 PANCREAS ACQUISITION 109. 00 110. 00 11000 INTESTINAL ACQUISITION 110. 00						
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON 111. 00 111. 0					•	
113. 00 11300 I NTEREST EXPENSE 113. 00					I	
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)						
116. 00 11600 HOSPI CE 116. 00					· · · · · · · · · · · · · · · · · · ·	
200.00 Subtotal (see instructions) 200.00					l	
201.00 Less Observation Beds 201.00						
202.00 Total (see instructions)	ZUZ. UU TUTAL (See ENSTRUCTIONS)	<u> </u>			J20:	ız. UU

Health Financial Systems COMMUNITY HOSPITAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Peri od: Worksheet C From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared: Provi der CCN: 15-0146

			10	12/31/2019	6/23/2020 3:4	
		Ti tl	e XIX	Hospi tal	PPS	<u>o p</u>
Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
'	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
	Part I, col.	Part II col.	Capital Cost		Reducti on	
	26)	26)	(col. 1 -		Amount	
		·	col . 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	3, 527, 868	376, 121	3, 151, 747	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 198, 395	92, 656	1, 105, 739	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 045, 659	681, 373	4, 364, 286	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI 01 SOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	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	0	59. 00
60. 00 06000 LABORATORY	4, 122, 998	203, 690	3, 919, 308	0	0	60.00
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 362, 779		1, 263, 326	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 785, 645			0	0	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	605, 869			0	0	67.00
68.00 06800 SPEECH PATHOLOGY	521, 500	24, 089	497, 411	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 130, 905		1, 071, 971	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	418, 995			0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 025, 010	349, 592	5, 675, 418	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	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	1, 325, 297			0	0	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS				ما		00 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC	109, 161		0 104, 092	U O	0	89. 00 90. 00
		· ·		U O	0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 851, 385 1, 973, 985			o O	0	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	1,973,900	140, 449	1, 020, 030	υĮ	0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S			0	O	0	94.00
95. 00 09500 AMBULANCE SERVICES	3, 953, 911	327, 487	_	Ö	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0,700,711	0277.07	0,020,121	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD				o O	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0	0	ol	0	98.00
99. 00 09900 CMHC		0	o o	ol	0	99.00
99. 10 09910 CORF		0	o o	ol	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	Ö	Ö	ol	-	100.00
101. 00 10100 HOME HEALTH AGENCY	0		- 1	ol		101.00
SPECIAL PURPOSE COST CENTERS	_	-		-,		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0	0	o	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	o	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	o	o		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	o	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	o	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	ol		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	o		115.00
116. 00 11600 H0SPI CE	0	0	0	o		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	36, 959, 362	2, 898, 000	34, 061, 362	o		200. 00
201.00 Less Observation Beds	1, 973, 985	145, 449	1, 828, 536	o		201.00
202.00 Total (line 200 minus line 201)	34, 985, 377	2, 752, 551	32, 232, 826	O	0	202. 00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

Provi der CCN: 15-0146

Peri od: Worksheet C From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

6/23/2020 3:46 pm

Title XIX Hospi tal PPS Total Charges Outpati ent Cost Center Description Cost Net of Capital and (Worksheet C, Cost to Operating Part I Charge Ratio Cost column 8) (col. 6 / Reducti on col. 7) 7.00 8.00 6.00 ANCILLARY SERVICE COST CENTERS 50 00 0. 147239 50 00 05000 OPERATING ROOM 3, 527, 868 23, 960, 173 05100 RECOVERY ROOM 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 399098 52.00 1, 198, 395 3, 002, 761 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 5, 045, 659 44, 716, 888 0.112836 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 0 05700 CT SCAN 57 00 0 0.000000 57.00 Ω 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 60.00 06000 LABORATORY 4, 122, 998 27, 014, 302 0.152623 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0 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 0 0 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 0 C 64.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 06500 RESPIRATORY THERAPY 9, 683, 400 0.140734 65.00 1, 362, 779 65.00 06600 PHYSI CAL THERAPY 1, 785, 645 3, 603, 776 0.495493 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.495202 67.00 605, 869 1, 223, 479 67.00 68.00 06800 SPEECH PATHOLOGY 521, 500 972, 779 0.536093 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000000 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 130, 905 4, 845, 663 71.00 0.233385 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 418, 995 1, 789, 210 0.234179 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 025, 010 22, 472, 664 0.268104 73.00 07400 RENAL DIALYSIS 74 00 0.000000 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 75.00 07698 HYPERBARIC OXYGEN THERAPY 1, 325, 297 5, 338, 233 0.248265 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 234, 093 90.00 09000 CLI NI C 109, 161 0.466315 90.00 91.00 09100 EMERGENCY 91.00 3, 851, 385 34, 332, 718 0.112178 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 973, 985 5, 873, 523 0.336082 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 94.00 09500 AMBULANCE SERVICES 3, 953, 911 12, 304, 948 0.321327 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 97.00 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 98.00 98.00 C 0.000000 99.00 09900 CMHC 0 0 0.000000 99.00 99. 10 09910 CORF 0 0.000000 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 0 0.000000 101.00 10100 HOME HEALTH AGENCY 0 0.000000 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0.000000 105.00 0 106.00 10600 HEART ACQUISITION 0.000000 C 106.00 107.00 10700 LIVER ACQUISITION 0 0.000000 107. 00 0 108.00 10800 LUNG ACQUISITION 0.000000 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0.000000 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0.000000 110.00 111.00 11100 I SLET ACQUISITION 0 C 0.000000 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.) 0.000000 0 115.00 116. 00 11600 HOSPI CE 0.000000 116.00 200.00 Subtotal (sum of lines 50 thru 199) 36, 959, 362 201, 368, 610 200.00 201 00 Less Observation Beds 1, 973, 985 201 00 202.00 Total (line 200 minus line 201) 34, 985, 377 201, 368, 610 202.00

Heal th Financial	Systems COMM	OF NOBLE CTY,	INC	In Lieu of Form CMS-2552-10			
APPORTI ONMENT OF	ORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part I Date/Time Pre 6/23/2020 3:4	
			Title	e XVIII	Hospi tal	PPS	
Cost	Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
		Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
		(from Wkst.		Related Cost		col. 4)	
		B. Part II.		(col. 1 -			

Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	529, 993	0	529, 993	6, 016	88. 10	30.00
31.00 INTENSIVE CARE UNIT	0		0	0	0. 00	
32.00 CORONARY CARE UNIT	0		0	0	0. 00	
33.00 BURN INTENSIVE CARE UNIT	0		0	0	0. 00	
34.00 SURGICAL INTENSIVE CARE UNIT	0		0	0	0. 00	
40. 00 SUBPROVI DER - I PF	0	0	0	0	0. 00	
41.00 SUBPROVI DER - I RF	0	0	0	0	0.00	
43. 00 NURSERY	19, 222		19, 222	423	45. 44	
44.00 SKILLED NURSING FACILITY	0		0	0	0.00	
45.00 NURSING FACILITY	0		0	0		45.00
200.00 Total (lines 30 through 199)	549, 215		549, 215	6, 439		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			T			
30. 00 ADULTS & PEDIATRICS	1, 326	116, 821				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				34.00
40. 00 SUBPROVI DER - I PF	0	0				40.00
41. 00 SUBPROVI DER - I RF	0	0				41.00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
45. 00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30 through 199)	1, 326	116, 821				200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Title XVIII Hospi tal Total Charges Ratio of Cost Capital Costs Cost Center Description Capi tal Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 376, 121 23, 960, 173 0.015698 752, 863 11.818 05100 RECOVERY ROOM 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 92, 656 3, 002, 761 0.030857 11, 690 361 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 681, 373 44, 716, 888 0.015237 1, 567, 559 23, 885 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 0 0 0.000000 57 00 05700 CT SCAN 0 0 57.00 Ω Ω 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 06000 LABORATORY 203, 690 27, 014, 302 0.007540 1, 879, 758 14, 173 60.00 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0.000000 O 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 0 C 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 9, 683, 400 0.010270 1, 192, 659 12, 249 65.00 99, 453 65.00 06600 PHYSI CAL THERAPY 130, 658 3, 603, 776 0.036256 3,010 66.00 83.027 66.00 06700 OCCUPATI ONAL THERAPY 27, 988 6, 917 67.00 1, 223, 479 0.022876 158 67.00 68.00 06800 SPEECH PATHOLOGY 24, 089 972, 779 0.024763 18, 381 455 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 0 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70 00 0 0 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 845, 663 359, 840 71.00 58, 934 0.012162 4, 376 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 259 1, 789, 210 0.010764 156, 238 1, 682 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 349, 592 22, 472, 664 0.015556 1, 559, 422 24, 258 73.00 07400 RENAL DIALYSIS 74 00 0.000000 74 00 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 99, 235 5, 338, 233 0.018589 0 0 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 0 0 234, 093 90.00 09000 CLI NI C 5,069 0.021654 0 90.00 11, 691 91.00 09100 EMERGENCY 91.00 256, 947 34, 332, 718 0.007484 1, 562, 183 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 145, 449 5, 873, 523 0.024764 92.00 0 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 0.000000 0 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0.000000 Ω 200.00 Total (lines 50 through 199) 2, 570, 513 189, 063, 662 9, 150, 537 108, 116 200. 00

1 :	Systems	COMMUNITY HOSPITA	L OF NOBLE	CTY. INC	In I

Heal th Financial Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2019 Part III Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Title XVIII Hospi tal Nursi ng Nursi ng Allied Health Allied Health All Other Cost Center Description Post-Stepdown Medi cal School School Cost Post-Stepdown Educati on Adjustments Adjustments Cost 1.00 2A 2. 00 3. 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 30 00 30.00 0 0 000000000 0 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34.00 0 04000 SUBPROVI DER - I PF 40.00 0 40.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 0 0 41.00 04300 NURSERY 0 43.00 43.00 0 0 04400 SKILLED NURSING FACILITY C 44.00 44.00 45.00 04500 NURSING FACILITY 0 0 0 45.00 200.00 Total (lines 30 through 199) 200.00 Total Patient Per Diem Cost Center Description I npati ent Swi ng-Bed Total Costs (sum of cols. Adjustment Days (col. 5 ÷ Program Days Amount (see 1 through 3, col. 6) nstructions) minus col. 4.00 5.00 6.00 7.00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 0 6,016 0.00 1, 326 30.00 31.00 03100 INTENSIVE CARE UNIT 0.00 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0.00 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 0.00 33.00 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0.00 0 34.00 04000 SUBPROVI DER - I PF 0 0 0.00 40.00 40.00 0 0 04100 SUBPROVI DER - I RF 0.00 41.00 0 0 0 0 41.00 04300 NURSERY 0 43.00 423 0.00 0 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0.00 0 44.00 04500 NURSING FACILITY 45.00 0 0.00 0 45.00 Total (lines 30 through 199) 1, 326 200.00 200.00 6, 439 I npati ent Cost Center Description Program Pass-Through Cost (col. 7 x col. 8) 9. 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0000000000 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 34.00 04000 SUBPROVI DER - I PF 40.00 40.00 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 Total (lines 30 through 199) 200.00 200.00

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 01/01/2019 | Part IV | To | 12/31/2019 | Date/Time Prepared: THROUGH COSTS

Cost Center Description						10 12/31/2019	6/23/2020 3: 4	
Anesthetist School Post-Stepdown Adjustments School Post-Stepdown Adjustments Adjust				Ti tl e	e XVIII	Hospi tal		
Cost		Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
ANGILLARY SERVICE COST CENTERS			Anesthetist	School	School	Post-Stepdown		
NOCILLARY SERVICE COST CENTERS			Cost	Post-Stepdown		Adjustments		
ANCILLARY SERVICE COST CENTERS				Adjustments				
50.00			1. 00	2A	2. 00	3A	3. 00	
51.00 OS100 RECOVERY ROOM ALBOR ROOM O O O O O O O O O O O O O O O O O								
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 5.2 .00		I I	0	-	1			
S3.00 08300 AMESTHESI OLOGY 0 0 0 0 0 0 0 53.00			0	(1
54. 00 05400 RADI OLOGY-DI AGNOSTIC 0 0 0 0 0 0 55. 00			0	C		-	_	1
55.00 05500 RADIO LOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0			0	(-	_	
56.00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 56.00		1 1	0	(-		
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0		I I	0	(-	_	
58.00 05900 CARDIA CA CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0			0	(-	_	
59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0		i i	0	(_	1
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0		1 1	0	(-	_	
60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0		I I	0	(-	_	
61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY		I I	0	(ŭ .	_	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62. 00 63. 00 06300 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 65. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 66. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 67. 00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 68. 00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 68. 00 06600 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 69. 00 066700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 69. 00 066700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 69. 00 066700 OCCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 066700 OCCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 066700 OCCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 066700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 066700 OCCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY OCCUPATIONAL THERAPY OCCUPATIONAL THERAPY OCCUPATIONAL THERAPY OCCUPATIONAL THERAPY OCCUPATIONAL THERAP		i i	0	(0 0	0	1
63.00 06300 BLODD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 71.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TION 0 0 0 0 0 79.00 08900 RURAL HEALTH CLINI C 0 0 0 0 0 0 79.00 09900 CLINI C 0 0 0 0 0 79.00 09900 CLINI C 0 0 0 0 79.00 09900 CLINI C 0 0 0 0 79.00 09900 CLINI C 0 0 0 79.00 09900 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 79.00 09700 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 79.00 09900 DURABLE MEDI CAL EQUIP-SOLD 0 0 0 79.00 09900 DURABLE MEDI CAL EQUIP-SOLD 0 0 0 79.00 09900 DURABLE MEDI CAL EQUIP-SOLD 0 0 0 79.00 09905 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 79.00 09905 OTHER REI MBURSABLE COST CENTERS 0 0 0 79.00 09905 OTHER REI MBURSABLE COST CENTERS 0 0 0 79.00 09905 OTHER REI MBURSABLE COST CENTERS 0 0 0 79.00 09905 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 79.00 09905 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 79.00 09905 OTHER REI MB		I I						
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 66. 00 06500 CASTOR THERAPY 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06000 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 70. 00 07000 CLECTROENCEPHALLOGRAPHY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 77. 00 0000 CLINIC 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 99. 00 09000 CLINIC 0 0 0 0 0 99. 00 09000 CLINIC 0 0 0 0 91. 00 09000 DRERGENCY 0 0 0 0 0 92. 00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 99. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 99. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENT		I I	0	(ŭ .		
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 88. 00 08900 FEDERALLY QUALIFIED EDERALLY QUALIFIED EDERALLY QUALIFIED 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0 92. 00 09100 EMERGENCY 0 0 0 0 0 94. 00 09500 AMBULANCE SERVI CES 95. 00 09500 OMBURABLE MEDI CAL EQUI P-ROTED 0 0 0 0 96. 00 09500 OMBABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0		I I	0	(0 0	0	
66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 77.00 07700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 0 88.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 89.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 90.00 09000 CLI NI C 0 0 0 0 0 91.00 09000 CLI NI C 0 0 0 0 92.00 09000 CLI NI C 0 0 0 0 94.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 998.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 998.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 998.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 998.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 998.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 998.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 998.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 998		I I	0	(0 0	0	
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 690. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 69. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 070. 00 0 0 0		1 1	0	(0 0	0	65. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 77. 00 00700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 79. 00 09000 CLINI C 0 0 0 0 79. 00 09000 CLINI C 0 0 0 0 79. 00 09000 CLINI C 0 0 0 0 79. 00 09000 DIRABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79. 00 09400 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-		i i	0	(0 0	_	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 0 75. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 75. 00 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	(-	_	1
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0		I I	0	(٩	_	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 0 91. 00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 95. 00 09500 MBULANCE SERVICES 95. 00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 998. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 998. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 998. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 998. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 998. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 998. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 998. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 998. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 999. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 999. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 999. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 999. 00 09900			0	(٥	_	
72. 00			0	(-	_	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 75. 00 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 0 0 75. 00 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 77. 00 000 000 00 0 0 0 0 0 0 0 0 0 0 0 0		I I	0	(-	_	1
74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 76. 98 78. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0 0 94. 00 95. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 0 97. 00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0	(-		
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 89. 00 99. 00 09900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 99. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 0 0 97. 00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 0 0 0 98. 00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS		I I	0	(-	0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0		I I	0	(٥	_	
77. 00			0	(0	
SECTION SUBSIDIAR SUBSTRICT SubsTr		I I	0	-	1			
88. 00	77. 00		0)	0 0	0	77. 00
89. 00							1	
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 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 0 98. 00		I I	0		1			
91. 00			0	(_	1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 92. 00		I I	0	(-	_	
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 95. 00 96. 00 0 0 0 0 0 0 96. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 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 REIMBURSABLE COST CENTERS 0 0 0 0 0 98. 00			0	(_	1
94. 00	92. 00		0			0	0	92.00
95. 00 09500 AMBULANCE SERVI CES 95. 00 96. 00 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 98. 00	o				.1		1	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 96. 00 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 98. 00			0	()	0	0	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00								
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00		1 1	0	(2	O C		1
		i i	0			0		
200.00 lotal (lines 50 through 199) 0 0 0 0 0 0 200.00		1 1	0)	2	U C		
	200.00		0	(기	U C	0	J200.00

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 01/01/2019 | Part IV | To | 12/31/2019 | Date/Time Prepared: THROUGH COSTS

				'	0 12/31/2019	6/23/2020 3: 4	
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(-,,	0.000000	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	(-	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(44, 716, 888		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 I MAGING (MRI)	0	0	(1		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(-	0.000000	59.00
60.00	06000 LABORATORY	0	0	(27, 014, 302		60.00
60. 01	06001 BLOOD LABORATORY	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	9	0	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	9	0	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 (00 100	0.00000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	(.,,		65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(-,,		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(., 220,		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		972, 779		68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	`	ή		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(ή	0.000000	ı
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(.,		71.00 72.00
72.00	07300 DRUGS CHARGED TO PATIENTS	0	0		., ,		72.00
74.00	07400 RENAL DI ALYSI S	0	0				74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		1	0.00000	l
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	`	1		76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0				1
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0) 0	0.000000	77.00
88. 00	08800 RURAL HEALTH CLINIC	٥	0) 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0				89.00
90.00	09000 CLINIC		0				90.00
91. 00	09100 EMERGENCY		0				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				ł
,2.00	OTHER REIMBURSABLE COST CENTERS	٥,			0,0,0,020	0.00000	72.00
94.00	09400 HOME PROGRAM DIALYSIS	O	0		0	0.000000	94.00
95. 00	09500 AMBULANCE SERVICES	l	0)		3.555666	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	o	0		o	0. 000000	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	l ol	0				1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	l ol	0		1		1
200.00	1 1	l	0				200.00
		· -1		'		'	

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2019 | Part IV |
| To 12/31/2019 | Date/Time Prepared: 6/23/2020 3:46 pm | Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 THROUGH COSTS

					.0 .2,0.,20.,	6/23/2020 3: 4	6 pm
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	· ·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	Ü	Costs (col.	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	752, 863		0 2, 874, 258	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	11, 690		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 567, 559		0 8, 511, 316	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00	05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	1, 879, 758		0 2, 392, 825	l o	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	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. 000000	0		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	-	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	1, 192, 659		0 1, 760, 904	_	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	83, 027	1	0 48, 050		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	6, 917		0 13, 651	l o	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	18, 381		0 4, 094		68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	l ő	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	359, 840		0 376, 915		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	156, 238	l .	0 397, 756		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 559, 422		0 8, 392, 523		73.00
74. 00	07400 RENAL DIALYSIS	0. 000000	1, 337, 422	1	0 0, 372, 323	1	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	1	0 0	•	75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	1	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	1	0 0	_	77.00
77.00	OUTPATIENT SERVICE COST CENTERS	0. 000000		l	0 0		77.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0		89.00
90.00	09000 CLINIC	0. 000000	0		0 0	l ő	90.00
91. 00	09100 EMERGENCY	0. 000000	1, 562, 183		0 5, 461, 675		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 302, 109		0 1, 268, 462		92.00
72.00	OTHER REIMBURSABLE COST CENTERS	0.000000		l .	0 1,200,402		72.00
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94.00
95. 00	09500 AMBULANCE SERVICES	3. 000000	0				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0		97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
200.00		0.000000	9, 150, 537		0 31, 502, 429	_	200.00
200.00	Total (Titles 50 till ough 177)	1	7, 150, 557	I	0 31, 302, 429	ı	1200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0146 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 147239 2, 874, 258 423, 203 50.00 05100 RECOVERY ROOM 0 0 0.000000 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0.399098 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112836 8, 511, 316 0 0 960, 383 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 55.00 Ω 0 56.00 05600 RADI OI SOTOPE 0.000000 C 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 0 0 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 Ω 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 00 0 59.00 60.00 06000 LABORATORY 0.152623 2, 392, 825 365, 200 60.00 06001 BLOOD LABORATORY 0 60.01 0.000000 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61 00 0.000000 61 00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 C 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 63.00 63.00 C 06400 I NTRAVENOUS THERAPY 0 64.00 0.000000 0 0 64.00 0 06500 RESPIRATORY THERAPY 0 65 00 0 140734 1 760 904 247, 819 65 00 0 06600 PHYSI CAL THERAPY 66.00 0.495493 48,050 23,808 66.00 0 06700 OCCUPATI ONAL THERAPY 0. 495202 6,760 13,651 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.536093 4,094 0 0 2, 195 68.00 06900 FLECTROCARDLOLOGY 0.000000 0 69 00 69 00 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 233385 376, 915 0 87, 966 71.00 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 397, 756 0 72.00 0.234179 93.146 72.00 07300 DRUGS CHARGED TO PATIENTS 0 2, 250, 069 0.268104 8, 392, 523 73.00 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 0 74.00 07500 ASC (NON-DISTINCT PART) o 75.00 0.000000 0 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 0 76.98 o 0.248265 76.98 0 0 77.00 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0. 000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 0 90.00 09000 CLI NI C 0.466315 0 90.00 0 09100 EMERGENCY 91.00 0.112178 5, 461, 675 0 0 612, 680 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 268, 462 92.00 92.00 0.336082 0 426, 307 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES 0. 321327 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0.000000 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 98.00 0 0 200.00 Subtotal (see instructions) 31, 502, 429 5, 499, 536 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 31, 502, 429 0 5, 499, 536 202. 00

0

00000

0

0

0

0

0

0

94.00

95.00

96.00

97.00

98.00

200.00

201.00

202.00

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

94.00

95.00

96.00

97.00

98.00

200.00

201.00

202.00

Health Financial Systems COMMU	u of Form CMS-2	2552-10				
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Peri od: Worksheet D From 01/01/2019 Part I To 12/31/2019 Date/Time Prepar 6/23/2020 3:46 p		
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	

APPORTIONWENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider C	F	From 01/01/2019 o 12/31/2019	Date/Time Pre 6/23/2020 3:4	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total_Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col . 1 -			
	col . 26)		col . 2)			
INDATIONT DOUTING CEDALCE COCT CENTEDS	1. 00	2. 00	3. 00	4. 00	5. 00	
30. 00 ADULTS & PEDIATRICS	529, 993	0	529, 993	(014	88. 10	30.00
31. 00 INTENSIVE CARE UNIT	529, 993	U	529, 993	6, 016	0.00	
	0					
32. 00 CORONARY CARE UNIT	0			0	0.00	1
33. 00 BURN INTENSIVE CARE UNIT	0			0	0.00	1
34. 00 SURGICAL INTENSIVE CARE UNIT	0			0	0.00	
40. 00 SUBPROVIDER - I PF	0	0		0	0.00	
41. 00 SUBPROVI DER - I RF	10 000	0	10.000	0	0.00	
43. 00 NURSERY	19, 222		19, 222		45. 44	
44.00 SKILLED NURSING FACILITY	0		C	0	0. 00	
45. 00 NURSING FACILITY	0		C	0	0. 00	
200.00 Total (lines 30 through 199)	549, 215		549, 215	6, 439		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col . 6)				
INDATIONE DOUTING CERVICE COST CENTERS	6. 00	7. 00				
30, 00 ADULTS & PEDIATRICS	105	0.051				30.00
	105	9, 251				30.00
	0	0				
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				34.00
40. 00 SUBPROVIDER - I PF	0	0				40.00
41. 00 SUBPROVI DER – I RF	0	0				41.00
43. 00 NURSERY	55	2, 499				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
45. 00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30 through 199)	160	11, 750				200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2019 Part II 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Title XIX Hospi tal Total Charges Ratio of Cost Capital Costs Cost Center Description Capi tal Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 376, 121 23, 960, 173 0.015698 432, 951 6, 796 05100 RECOVERY ROOM 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 030857 52.00 92, 656 3, 002, 761 88, 703 2,737 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 681, 373 44, 716, 888 0.015237 79, 504 1, 211 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 0 0 0 57 00 05700 CT SCAN 0 0.000000 0 57.00 Ω Ω 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 141, 273 06000 LABORATORY 203, 690 27, 014, 302 0.007540 1,065 60.00 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 0 60.01 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 C 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 9, 683, 400 0.010270 404 65.00 99, 453 39, 381 65.00 06600 PHYSI CAL THERAPY 130, 658 3, 603, 776 0.036256 112 66.00 3.082 66.00 06700 OCCUPATI ONAL THERAPY 27, 988 67.00 1, 223, 479 0.022876 1, 129 26 67.00 68.00 06800 SPEECH PATHOLOGY 24, 089 972, 779 0.024763 556 14 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 Ω 70 00 0 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 845, 663 71.00 58, 934 0.012162 51, 304 624 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 259 1, 789, 210 0.010764 39, 822 429 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 349, 592 22, 472, 664 0.015556 162, 588 2,529 73.00 07400 RENAL DIALYSIS 74 00 0.000000 74 00 0 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 99, 235 5, 338, 233 0.018589 0 0 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 0 0 234, 093 90.00 09000 CLI NI C 5,069 0.021654 0 90.00 0 91.00 09100 EMERGENCY 87,069 91.00 256, 947 34, 332, 718 0.007484 652 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 145, 449 5, 873, 523 0.024764 0 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0.000000 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 0.000000 0 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0.000000 Ω 200.00 Total (lines 50 through 199) 2, 570, 513 189, 063, 662 1, 127, 362 16, 599 200. 00

Health Financial Systems COMMU	JNI TY HOSPI TAL	OF NOBLE CIY,	INC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co		Period: From 01/01/2019 To 12/31/2019		
		Ti +I	e XIX	Hospi tal	PPS	o piii
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
oust deliter bescription	School	School	Post-Stepdown		Medi cal	
	Post-Stepdown	3011001	Adjustments	0031	Educati on	
	Adjustments		Adj d3 tillerits		Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	171	1.00	2,1	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	0	0		0 0	_	31.00
32. 00 03200 CORONARY CARE UNIT		0		0 0		32.00
I I	0					l
33. 00 03300 BURN INTENSIVE CARE UNIT	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 - I PF	0	0		0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44.00
45.00 O4500 NURSING FACILITY	0	0		0		45.00
200.00 Total (lines 30 through 199)	0	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	I npati ent	
· ·	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	,	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 01	6 0.00	105	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1	0		0.00	0	31.00
32. 00 03200 CORONARY CARE UNIT		0		0.00	Ö	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		0		0.00	ő	33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T		0		0.00	Ö	34.00
40. 00 04000 SUBPROVI DER - PF	0	0		0.00	0	40.00
41. 00 04100 SUBPROVI DER - 1FF	0			0.00	0	41.00
43. 00 04300 NURSERY	0	0	42		55	43.00
		0				
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44.00
45. 00 04500 NURSING FACILITY		0		0.00		45. 00
200.00 Total (lines 30 through 199)						
Cost Center Description		0	6, 43	9	160	200.00
COST CONTENT DESCRIPTION	Inpatient	0	6, 43	9	160	200.00
cost content bescription	Program	0	6, 43	9	160	200.00
oost center bescriptron	Program Pass-Through	0	6, 43	9	160	200. 00
COST CENTER DESCRIPTION	Program Pass-Through Cost (col. 7	0	6, 43	9	160	200. 00
oust center bescription	Program Pass-Through Cost (col. 7 x col. 8)	0	6, 43	9	160	200. 00
	Program Pass-Through Cost (col. 7	0	6, 43	9	160	200.00
INPATIENT ROUTINE SERVICE COST CENTERS	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00 32. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00 32. 00 33. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00 32. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00 32. 00 33. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00 32. 00 33. 00 34. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SUBGICAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 0300 04300 NURSERY	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00	Program Pass-Through Cost (col. 7 x col. 8) 9.00		6, 43	9	160	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2019 | Part IV |
| To 12/31/2019 | Date/Time Prepared: 6/23/2020 3:46 pm | Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0146 THROUGH COSTS

					10 12,01,201,	6/23/2020 3: 46 pm	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdow	า	Adjustments		
			Adjustments				
	ANOLILARY OF BUILDE COOT OF STATE DO	1. 00	2A	2.00	3A	3. 00	
F0 00	ANCILLARY SERVICE COST CENTERS						F0 00
50.00	05000 OPERATING ROOM	0		0	0	-	50.00
51.00	05100 RECOVERY ROOM	0		0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0	1	52.00
53.00	05300 ANESTHESI OLOGY	0				0	53.00
54.00	O5400 RADI OLOGY - DI AGNOSTI C	0				0	54.00
55.00	O5500 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 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	58. 00 59. 00
60.00	06000 LABORATORY	0			0 0	-	60.00
60.00	06001 BLOOD LABORATORY	0			0 0	1	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	U		٩		0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	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	-	64.00
65. 00	06500 RESPIRATORY THERAPY	0				1	65.00
66. 00	06600 PHYSI CAL THERAPY	0				-	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0				-	67.00
68. 00	06800 SPEECH PATHOLOGY	0			0 0		68.00
69. 00	06900 ELECTROCARDI OLOGY	0			0 0	1	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	1	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		ol .		Ö	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0	-	72.00
	07300 DRUGS CHARGED TO PATIENTS	0		o l	0	0	73.00
74. 00	07400 RENAL DIALYSIS	0		ol	0	ō	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0	0	ő	75.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		o	o o		76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		o	o c		77. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0		0	0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0 0	0	89. 00
90.00	09000 CLI NI C	0		o	0 0	0	90.00
91.00	09100 EMERGENCY	0		o	0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0 0	0	94.00
95.00	09500 AMBULANCE SERVICES					[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		98. 00
200.00	Total (lines 50 through 199)	0		0	0 0	0	200. 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 01/01/2019 | Part IV | To | 12/31/2019 | Date/Time Prepared: THROUGH COSTS

						6/23/2020 3: 4	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		23, 960, 173		50.00
51.00	05100 RECOVERY ROOM	0	0		0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		3, 002, 761	0.000000	52.00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	44, 716, 888		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0.000000	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	1	0		56. 00
57. 00	05700 CT SCAN	0	0	1	0	0.000000	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	1	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0.000000	59.00
60.00	06000 LABORATORY	0	0	1	27, 014, 302		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	1	0	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 (00 400	0.00000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		9, 683, 400		65.00
66.00	06600 PHYSI CAL THERAPY	0	0		3, 603, 776		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		1, 223, 479		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		972, 779		68.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		-	0. 000000 0. 000000	ı
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		4, 845, 663 1, 789, 210		71.00 72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		22, 472, 664		73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 22, 472, 664		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0			0.00000	l
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		5, 338, 233		76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0, 336, 233		1
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		<u> </u>	0.000000	77.00
88. 00	08800 RURAL HEALTH CLINIC	ام	0		0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	•	o o		89.00
90.00	09000 CLINIC		0		234, 093		90.00
91. 00	09100 EMERGENCY	0	0	•	34, 332, 718		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		5, 873, 523		ł
	OTHER REIMBURSABLE COST CENTERS	-1	-		., ., ., .,		
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0	0.000000	94.00
95. 00	09500 AMBULANCE SERVICES	١	O				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0. 000000	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0	•	o o		1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	l o	0		o o		1
200.00	1 1	l	0		189, 063, 662		200.00
		, -1		'		•	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 15-0146 Peri od: Worksheet D From 01/01/2019 THROUGH COSTS Part IV 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Title XIX Hospi tal PPS Outpati ent Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Charges Pass-Through Charges (col. 6 ÷ Costs (col. Costs (col. x col. 10) x col. 12) col. 13.00 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 432, 951 428, 892 50 00 05000 OPERATING ROOM 0 05100 RECOVERY ROOM 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 o 52.00 88, 703 0 52.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 0 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.000000 79, 504 671, 790 0 54.00 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 0 57 00 05700 CT SCAN 0.000000 0 0 57.00 Ω 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 59.00 60.00 06000 LABORATORY 0.000000 141, 273 0 418, 627 0 60.00 06001 BLOOD LABORATORY 0 60.01 0.000000 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 C 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63.00 C 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 0.000000 65.00 65.00 39, 381 86, 266 0 0 06600 PHYSI CAL THERAPY 0.000000 66.00 3.082 71, 421 0 66.00 06700 OCCUPATI ONAL THERAPY 1, 129 0 63, 224 67.00 0.000000 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 556 115, 111 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000000 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 Ω 70 00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 51, 304 55, 125 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 39, 822 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 162, 588 0 450, 620 0 73.00 07400 RENAL DIALYSIS 0 74 00 0.000000 0 74 00 C 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 C 0 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 0.000000 0 0 0 0 76.98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 89.00 0 0 90.00 09000 CLI NI C 0.000000 0 0 90.00 C 0 953, 457 09100 EMERGENCY 0.000000 91.00 91.00 87.069 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 159, 250 0 92.00

0.000000

0.000000

0.000000

0.000000

0 94.00

0 96.00

0

0 98.00

0

0

0

0

0

1, 127, 362

0

0

0

3, 473, 783

95.00

97.00

0 200.00

OTHER REIMBURSABLE COST CENTERS
09400 HOME PROGRAM DIALYSIS

09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

94.00

95. 00 96. 00

200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Title XIX Hospi tal Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 147239 428, 892 63, 150 50.00 05100 RECOVERY ROOM 0 0 0.000000 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0.399098 52.00 r 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112836 671, 790 0 0 0 75, 802 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 55.00 C Ω 0 56.00 05600 RADI OI SOTOPE 0.000000 C 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 0 0 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 C 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 00 0 59.00 60.00 06000 LABORATORY 0.152623 418, 627 63, 892 60.00 06001 BLOOD LABORATORY 0 60.01 0.000000 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61 00 0.000000 61 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 C 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 63.00 C 0 06400 I NTRAVENOUS THERAPY 0 64.00 0.000000 0 0 0 64.00 0 06500 RESPIRATORY THERAPY 0 65 00 0 140734 12, 141 65 00 86.266 0 06600 PHYSI CAL THERAPY 66.00 0.495493 71, 421 35, 389 66.00 06700 OCCUPATI ONAL THERAPY 0. 495202 63, 224 31, 309 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.536093 115, 111 0 0 61,710 68.00 06900 FLECTROCARDLOLOGY 0.000000 0 69 00 69 00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 233385 0 71.00 55, 125 0 0 12,865 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0.234179 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 120, 813 0.268104 73.00 450, 620 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 0 0 75.00 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 0 76. 98 0.248265 0 0 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0. 000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89 00 0 89.00 90.00 09000 CLI NI C 0.466315 0 90.00 09100 EMERGENCY 91.00 0.112178 953, 457 0 0 106, 957 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 159, 250 53, 521 92.00 92.00 0. 336082 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES 0. 321327 262, 938 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 C 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0.000000 C 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 98.00 0 0 200.00 Subtotal (see instructions) 3, 473, 783 722, 038 200. 00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 3, 473, 783 0 722, 038 202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF NOBLE CTY, INC APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0146 Peri od: Worksheet D From 01/01/2019 To 12/31/2019 Part V Date/Time Prepared: 6/23/2020 3:46 pm 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 50.00 05100 RECOVERY ROOM 00000000000000000000000000000000 51.00 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 57.00 05700 CT SCAN 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 06001 BLOOD LABORATORY 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 61 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 65 00 65 00 06600 PHYSI CAL THERAPY 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69 00 06900 FLECTROCARDLOLOGY 0 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC STEM CELL ACQUISITION 76.98 76. 98 0 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 0 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 92.00

0

00000

0

0

0

0

0

0

94.00

95.00

96.00

97.00

98.00

200.00

201.00

202.00

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

94.00

95.00

96.00

97.00

98.00

200.00

201.00

202.00

Health Financial Systems	COMMUNITY HOSPITAL OF NOBLE CTY, INC	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-014	6 Peri od: From 01/01/2019	Worksheet D-1	
			Date/Time Pre 6/23/2020 3:4	pared: 6 pm
	Title XVIII	Hospi tal	PPS	•
Cost Center Description				

DRIFT AIL PROVIDER COMPONENTS 1.00			Title XVIII	Hospi tal	6/23/2020 3: 4 PPS	о рііі		
INPATIENT IMPS INPATIENT IMPS INPATIENT IMPS Inpatient days (Including private room days, and safing bed days, excluding networm days, and control days) 1.00 Inpatient days (Including private room days, sociously graing-bed and deservation bed days) 17 you have only private room days and on to coepited this i inc. 3.00 1.00		Cost Center Description						
Inpart INT NAYS 1.00 Impart and days (including private room days and saing-bed days, excluding nemborn) 0.01 0		DADT I ALL DOOM DED COMPONENTO			1. 00			
Impattent days (including private room days and swing-bed days, excluding newborn)								
Impatient days (including private room days, excluding swing-bed and nesborn days) 0.00 2.00	1.00		s, excluding newborn)		6, 016	1.00		
do not complete this line. 4. 00 Semi-private room days (excluding swing-bed and observation bed days) 1. 00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost 2. 00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost 2. 00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost 2. 00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost 2. 00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost 2. 00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost 3. 00 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and newbord days) (see instructions) 3. 00 Swing-bed SW type inpatient days applicable to 11 the XVIII only (including private room days) 3. 01 through December 31 of the cost reporting period (see instructions) 3. 02 Swing-bed SW type inpatient days applicable to 11 the XVIII only (including private room days) 4. 00 Swing-bed SW type inpatient days applicable to 11 the XVIII only (including private room days) 4. 00 Swing-bed SW type inpatient days applicable to 11 the XVIII only (including private room days) 4. 00 Swing-bed SW type inpatient days applicable to 11 the XVIII only (including private room days) 4. 00 Swing-bed SW type inpatient days applicable to 11 the XVIII only (including private room days) 4. 00 Swing-bed SW type inpatient days applicable to 11 the XVIII only (including private room days) 5. 00 Swing-bed SW type inpatient days applicable to 11 the XVIII only (including private room days) 6. 00 Swing-bed BW type inpatient days applicable to 11 the XVIII only (including private room days) 7. 10 Swing-bed BW type inpatient days applicable to 11 the XVIII only (including private room days) 8. 10 Swing-bed BW type inpatient days applicable to 11 the XVIII only	2.00				6, 016	2.00		
3.00 Somi-p-rivate room days (excluding swing-bed and observation bed days) through December 31 of the cost on copriling period reporting period of the symptome and the sym	3.00		ys). If you have only pr	ivate room days,	0	3.00		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost operating period in the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost operating period (if callendar year, enter 0 on this line) 7.01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 9.01 Total inpatient days including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10.02 SNing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 11.00 SNing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 1, 320 on December 31 of the cost reporting period (if callendar year, enter 0 on this line) 12.00 SNing-bed SNF type inpatient days applicable to title SNF or XIX only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 13.00 SNing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) and through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 14.00 SNing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 SNing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Medicar rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including period period (including swing-bed sNF services applicable to services after Dece	4 00	· ·	ed days)		1 365	4.00		
reporting period (if cal endar year, including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 8.00 Total inpatient days including private room days after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00 Total inpatient days including private room days after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00 Swing-bed SNF type inpatient days applicable to the Program (excluding saing-bed and newborn days) (see instructions) 8.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 8.01 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 8.01 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 8.01 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.02 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.03 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.04 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.05 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.06 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.07 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.08 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.0				er 31 of the cost		•		
reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 9.00 Swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10.00 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (see instructions) 11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWF type services applicable to the Program (excluding swing-bed days) 0 14.00 Swing-bed SWF type services applicable to services through December 31 of the cost 0.00 15.00 Swing-bed cost applicable SWF type services applicable to services after December 31 of the cost reporting period (line 5 XVIII only (including type type type type type type type type		reporting period	3 .					
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Potal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	6. 00							
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Wedically necessary private room days applicable to titles V or XIX only (including private room days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 17. 00 Wedically necessary private room days applicable to the Program (excluding swing-bed days) 18. 00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 18. 00 Swing-bed NF swing-bed SNF services applicable to services through December 31 of the cost 18. 00 Wedicaler rate for swing-bed SNF services applicable to services through December 31 of the cost 19. 00 Wedicaler rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Wedical or rate for swing-bed NF services through December 31 of the cost reporting period (line or swing-bed NF services through December 31 of the cost reporting period (line or swing-bed NF services through December 31 of the cost reporting period (line or swing-bed NF services through December 31 of the cost reporting period (lin	7 00		m days) through December	31 of the cost	0	7 00		
reporting period (if Calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through becember 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through becember 31 of the cost reporting period 12.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) after through becember 31 of the cost reporting period 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) after becember 31 of the cost reporting period (if calendary ear, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX o	7.00		iii days) tiii dagii beceiibei	31 01 the cost		7.00		
9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and nays) 1,320 9.00 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0 10.00 11.00 Swing-bed SNF type inpatient days applicable to instructions) 0 11.00 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0 12.00 12.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 0 12.00 13.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 0 13.00 14.00 Medical In pressny private room days applicable to title SV or XIX only (including private room days) 0 14.00 15.00 Total nursery days (title V or XIX only) 0 16.00 16.00 Nursery days (title V or XIX only) 0 16.00 17.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 0 0 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0 0	8.00		m days) after December 3	31 of the cost	0	8. 00		
newborn days) (see instructions) 0 10 00	0.00		a the Dragram (avaludina	, owing had and	1 224	0.00		
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Including the private room days applicable to the Program (excluding swing-bed days) 16.00 Including the XIX only (including private room days) 16.00 Including the XIX only (including private room days) 16.00 Including the XIX only (including private room days) 16.00 Including the XIX only (including private room days) 16.00 Including the XIX only (including private room days) 17.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including private room days) 18.00 Including the XIX only (including the XIX only (including private room days) 18.00 Including the XIX only (including the XIX only (including the XIX only (including the XIX only (including the XIX on	9.00		o the Program (excluding	g Swing-bed and	1, 320	9.00		
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including private room days) 13.00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (Including private room days) 16.10 North nursery days (title V or XIX only) 16.10 North nursery days (title V or XIX only) 17.00 North nursery days (title V or XIX only) 18.00 Swing-Bed ADJINSTRINI 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Swing-Bed Swing-bed SNF services applicable to services after December 31 of the cost 18.00 Swing-Bed Swing-bed SNF services applicable to services after December 31 of the cost 18.00 Swing-Bed Swing-bed SNF services applicable to services after December 31 of the cost 18.00 Swing-Bed Swing-bed SNF services applicable to services after December 31 of the cost 18.00 Swing-Bed Swing-bed SNF services applicable to services after December 31 of the cost 18.00 Swing-Bed Swing-bed SNF services applicable to services after December 31 of the cost 18.00 Swing-Bed Swing-Bed SNF services applicable to services after December 31 of the cost 18.00 Swing-Bed Swing-Bed SNF services applicable to services after December 31 of the cost 18.00 Swing-Bed Swing-Bed SNF services after December 31 of the cost reporting period (line of the Swing-Bed SNF services) 18.00 Swing-Bed Swing-Bed SNF services after December 31 of the cost reporting period (line of Swing-Bed SNF services) 18.00 Swing-Bed Swing-Bed SNF services after December 31 of the cost reporting period (line of Swing-Bed SNF services) 18.00 Swing-Bed Swing-Bed SNF services after December 31 of the cost reporting period (line of Swing-Bed SNF services) 18.00 Swing-Bed Swing-Bed SNF services after December	10.00		nly (including private r	oom days)	0	10.00		
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 13.00 14.00 15.00	44.00					44.00		
12.00 Swing-bed NF Type Inpatient days applicable to titles \$\tilde{V}\$ or XIX only (including private room days) 0 12.00	11.00			room days) after	0	11.00		
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 13.00 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 0 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 17.00 Nursery days (title V or XIX only) 0 16.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19.	12. 00			e room days)	0	12.00		
after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 14,00 15.00 16.00 17.00 1		through December 31 of the cost reporting period	3 .	,				
14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 16.00 16.00 Nursery days (title V or XIX only) 16.00 17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00 18.00 18.00 19.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 19.00	13. 00				0	13. 00		
15.00 Total nursery days (title V or XIX only) 0 15.00	14 00				0	14 00		
SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 reporting period Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 21.00 Total general inpatient routine service cost (see instructions) 7, 192, 916 7, 192, 916 5 x line 17) 7, 192, 916 7, 192, 91			am (exertaining swring bea	udy3)		1		
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 reporting period 0.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 reporting period 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 0.00 Medicaid rate for swing-bed SNF type services through December 31 of the cost reporting period 0.00 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period 0.00 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period 0.00 20.00 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period 0.00 2	16. 00				0	16. 00		
reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 19.00 19.00 Total general inpatient routine service cost (see instructions) 7, 192, 916 21.00 19.00 Total general inpatient routine services after December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 19.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 2 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 2 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 2 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 2.00 Swing-bed cost applicable to NF type services	17.00		+b	£ 111	0.00	17.00		
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 19.	17.00		es inrough becember 31 c	or the cost	0.00	17.00		
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service cost net of swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 31.00 Average per diem private room per diem charge (line 30 + line 4) 32.00 Average per diem private room per diem charge (line 30 + line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room charge differential (line 32 minus line 33) 35.00 Average per diem private room charge differential (line 32 minus line 33) 36.00 Private room cost differential adjustment (line 3 x line 31) 37.00 Program general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 3 x line 31) 38.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 3	18. 00	3	es after December 31 of	the cost	0. 00	18. 00		
reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (1.0.00 20.00 reporting period (2.0.00 Total general inpatient routine service cost (see instructions) 2.0.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 2.0.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 17) 2.0.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 2.0.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 2.0.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 2.0.00 Total swing-bed cost (see instructions) 2.0.00 Decental inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2.0.00 Private room charges (excluding swing-bed charges) 2.0.00 Semi-private room charges (excluding swing-bed charges) 2.0.00 Semi-private room charges (excluding swing-bed charges) 2.00 Average private room per diem charge (line 29 + line 3) 2.01 Average per diem private room per diem charge (line 20 + line 3) 2.01 Average per diem private room cost differential (line 34 x line 31) 2.01 Average per diem private room cost differential (line 34 x line 31) 2.01 Average per diem private room cost differential (line 34 x line 31) 2.01 Average per diem private room cost differential (line 34 x line 31) 2.01 Average per diem private room cost differential (line 34 x line 31) 2.01 Average per diem private room cost differential (line 34 x line 31) 2.01 Average per diem private room cost differential (line 3								
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 20.0	19. 00							
reporting period Total general inpatient routine service cost (see instructions) 21.00 22.00 22.00 23.00 24.00 25. I ine 17) 25.00 26.00 27. Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 28.00 29. Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 29. Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 20. Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 20. Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 20. Total swing-bed cost (see instructions) 21. Obstacl swing-bed cost (see instructions) 22. Obstacl swing-bed cost (see instructions) 23. Obstacl swing-bed cost (see instructions) 24. Obstacl swing-bed cost (see instructions) 25. Obstacl swing-bed cost (see instructions) 26. Obstacl swing-bed cost (see instructions) 27. Obstacl swing-bed cost (see instructions) 28. Obstacl swing-bed cost (see instructions) 29. Obstacl swing-bed cost (see instructions) 20. Obstacl swing-bed cost (see instructions) 21. Obstacl swing-bed cost (see instructions) 22. Obstacl swing-bed cost (see instructions) 23. Obstacl swing-bed cost (see instructions) 24. Obstacl swing-bed cost (see instructions) 25. Obstacl swing-bed cost (see instructions) 26. Obstacl swing-bed cost (see instructions) 27. Obstacl swing-bed cost (see instructions) 28. Obstacl swing-bed cost (see instructions) 29. Obstacl swing-bed cost (see instructions) 20. Obstacl swing-	20. 00							
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 32.00 Average perivate room per diem charge (line 29 * line 3) 33.00 Average semi-private room per diem charge (line 29 * line 3) 34.00 Average per diem private room cost differential (line 30 * line 4) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 34 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		reporting period						
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 Private ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 32.00 Average private room per diem charge (line 29 * line 3) 33.00 Average semi-private room per diem charge (line 30 * line 4) 34.00 Average per diem private room charge differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost ret of swing-bed cost and private room cost differential (line 7, 192, 916) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				ing ported (line		1		
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 X line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charges (line 29 + line 3) 30.00 Average per diem private room charge (line 29 + line 3) 30.00 Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) 27.00 Average per diem private room cost differential (line 34 x line 35) 38.00 Average per diem private room cost differential (line 34 x line 35) 39.00 Private room cost differential dijustment (line 3 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 37 x line 35) 30.00 Average per diem private room cost differential (line 3	22.00		er 31 of the cost report	ing period (iine	U	22.00		
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Deneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32.00 Average per diem private room per diem charge (line 30 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 35.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 Private room cost differential adjustment (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916) 38.00 Algiusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	,	31 of the cost reportin	ng period (line 6	0	23. 00		
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 1, 195. 63 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					_			
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per diem private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cos	24.00] 3 11 31	r 31 of the cost reporti	ng period (line	0	24.00		
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Pri vate room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average pri vate room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Private room cost differential adjustment (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 33) Average per diem private room cost differential (line 3 x line 33) Average per diem private room c	25. 00	,	31 of the cost reporting	period (line 8	0	25. 00		
27. 00 Concernation patient routine service cost net of swing-bed cost (line 21 minus line 26) 7, 192, 916 27. 00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28. 00 Pri vate room charges (excluding swing-bed charges) 0 29. 00 Semi-pri vate room charges (excluding swing-bed charges) 0 30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0 0.000000 Average pri vate room per diem charge (line 29 + line 3) 0 0.000000 Average semi-pri vate room per diem charge (line 30 + line 4) 0 0.000000 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 0 0.000000 Average per diem pri vate room cost differential (line 34 x line 31) 0 0.0000000 Average per diem pri vate room cost differential (line 34 x line 31) 0 0.000000000000 Average per diem pri vate room cost differential (line 34 x line 35) 0 0.000000000000000000000000000000		·		, ,				
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 1, 195.63 38.00 Ado.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, ,	(line 21 minus line 24)					
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00	27.00		(TTHE 21 III HUS TTHE 26)		7, 192, 910	27.00		
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 30.00 30.00 30.00 31.00 0.00 32	28. 00		d and observation bed ch	narges)	0	28. 00		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 31.00 0.00 32.00 0.00 33.00 0.00 33.00 0.00 0	29. 00	Private room charges (excluding swing-bed charges)						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 32.00 32.00 32.00 32.00 33.00 34.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00			Line 20)					
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 7, 192, 916 27 minus line 36) Program general inpatient routine service cost per diem (see instructions) 88.00 Adjusted general inpatient routine service cost (line 9 x line 38) 9, 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	÷ Tine 28)			1		
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 192, 916 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 35.00 36.00 37.00 3						1		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 192, 916) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 195.63 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 38.00 39.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 39.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00		Average per diem private room charge differential (line 32 mi	nus line 33)(see instrud	ctions)		1		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 192, 916) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 195.63 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 40.00		,	ne 31)			1		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 195.63 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	and private room cost di	fferential (line		1		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 195.63 38.00 Program general inpatient routine service cost (line 9 x line 38) 1, 585, 405 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00	,	ana private room cost ur	Troncinciai (TITIE	7, 172, 710	37.00		
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,195.63 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 1,195.63 38.00 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY						
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,585,405 39.00 40.00	20.00				4 405 /5	20.00		
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			•			1		
		,	*					
	41.00	, , , , , , , , , , , , , , , , , , , ,	•		1, 585, 405			

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-0146	Period: From 01/01/2019	Worksheet D-1	
					To 12/31/2019	6/23/2020 3:4	
	Cost Center Description	Total	Ti tl Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpati ent Cost	Inpatient Days	Di em (col. + col. 2)		(col . 3 x col . 4)	
42.00	NUDCEDY (+; +1 - 1/ 0 VIV1 -)	1. 00	2.00	3.00	4.00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0. 0	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	(0.0	00 0	0	43.00
44. 00	CORONARY CARE UNIT	0		0.0		0	44.00
45.00	BURN INTENSIVE CARE UNIT	0		0.0		0	45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	,	0.0	00 0	0	46. 00 47. 00
47.00	Cost Center Description						47.00
40.00	December 1 and 1 a		11			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS			ons)		1, 515, 452 3, 100, 857	48. 00 49. 00
50. 00							50.00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (1	from Wkst. D,	sum of Parts II	108, 116	51.00
52. 00 53. 00	· · · · · · · · · · · · · · · · · · ·						52. 00 53. 00
33.00	medical education costs (line 49 minus line 52)						33.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
56.00							56.00
57. 00	7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00							58.00
59. 00	Lesser of lines 53/54 or 55 from the cost repmarket basket	porting period	ending 1996,	updated and c	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines					0	61.00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54)	x 60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	iisti ucti oiis)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	ıcti ons)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine costinstructions)(title XVIII only)	ts through Dece	ember 31 of th	ne cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decemb	oer 31 of the	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after [ecember 31 of	f the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient m PART III – SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facili)		70. 00
71.00	Adjusted general inpatient routine service co	ost per diem (I	ine 70 ÷ line	e 2)			71.00
72.00	Program routine service cost (line 9 x line 7	•		05)			72.00
73. 00 74. 00	Medically necessary private room cost application Total Program general inpatient routine servi						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient i	•		,	Part II, column		75.00
	26, line 45)		,				
76.00	Per diem capital-related costs (line 75 ÷ lin	,					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		provi den irecon	rds)			79.00

42. 00	NURSERY (title V & XIX only)	0	O	0. 00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units			0.00	ما		40.00
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45. 00	BURN I NTENSI VE CARE UNI T	0	0	0.00	0	0	45.00
46. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0. 00	0	0	46.00
47. 00							47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3. line 2	(00)			1, 515, 452	48. 00
49. 00	Total Program inpatient costs (sum of lines					3, 100, 857	49. 00
	PASS THROUGH COST ADJUSTMENTS	<u> </u>					
50.00	Pass through costs applicable to Program inpa	atient routine services	(from Wkst	D, sum of Par	ts I and	116, 821	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillary servio	es (from Wk	st. D, sum of P	arts II	108, 116	51.00
	and IV)						
52. 00	Total Program excludable cost (sum of lines !					224, 937	52.00
53. 00	Total Program inpatient operating cost exclude		on-physi ci a	in anesthetist,	and	2, 875, 920	53.00
	medical education costs (line 49 minus line !	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0. 00	55.00
56. 00	Target amount (line 54 x line 55)					0.00	56. 00
57. 00	Difference between adjusted inpatient operati	ng cost and target amo	unt (lino E	64 minus Lino 52	,	o	57.00
58. 00	Bonus payment (see instructions)	ing cost and target and	unt (inte s	oo iiii iius TTHE 55	' l	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting ported anding 1	006 undate	nd and compounded	d by the	0. 00	59.00
37.00	market basket	borting perrod endring	990, upuate	a and compounder	a by the	0.00	37.00
60. 00	Lesser of lines 53/54 or 55 from prior year	rost report undated by	the market	hasket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of lines				int by	0.00	61.00
01.00	which operating costs (line 53) are less than					ĭ	01.00
	amount (line 56), otherwise enter zero (see i		01 X 00),	or the cu	get		
62.00	Relief payment (see instructions)	,				0	62.00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instructions)				0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST				'		
64.00	Medicare swing-bed SNF inpatient routine cos	ts through December 31	of the cost	reporting peri	od (See	0	64.00
	instructions)(title XVIII only)	-					
65.00	Medicare swing-bed SNF inpatient routine cos-	ts after December 31 of	the cost r	eporting period	(See	0	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 64 plus	line 65)(ti	tle XVIII only)	For	0	66.00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through Decembe	r 31 of the	e cost reporting	peri od	0	67.00
(0.00	(line 12 x line 19)	t -	21 -6		:	0	(0.00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after December	31 or the c	cost reporting p	eri oa	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient i	routine costs (line 67	+ line 68)			0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU					-	
70.00	Skilled nursing facility/other nursing facili			line 37)			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 (line 1	4 x line 35	i)			73.00
74.00	Total Program general inpatient routine servi	ce costs (line 72 + li	ne 73)				74.00
75.00	Capital-related cost allocated to inpatient i	routine service costs (from Worksh	neet B, Part II,	col umn		75.00
	26, line 45)						
76. 00	Per diem capital-related costs (line 75 ÷ lin	•					76.00
77. 00	Program capital-related costs (line 9 x line	•					77. 00
78. 00	Inpatient routine service cost (line 74 minus	*					78. 00
79. 00	Aggregate charges to beneficiaries for excess	•					79. 00
80. 00	Total Program routine service costs for compa		tation (lir	ne 78 minus line	79)		80.00
81. 00	Inpatient routine service cost per diem limi						81.00
82. 00	Inpatient routine service cost limitation (li	•					82.00
83.00	Reasonable inpatient routine service costs (83.00
84.00	Program inpatient ancillary services (see ins						84.00
85.00	Utilization review - physician compensation		`				85.00
86. 00	Total Program inpatient operating costs (sum)				86. 00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1 / [1	07 00
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of					1, 651 1, 195. 63	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	,				1, 195, 63	
07.00	Topservation bed cost (Time of X Time 66) (Set	. That detrolla)			1	1, 7/3, 700	07.00

Health Financial Systems COMM	UNITY HOSPITAL	OF NOBLE CTY,	I NC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		pared: 6 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	529, 993	7, 192, 916	0. 07368	3 1, 973, 985	145, 449	90.00
91.00 Nursing School cost	0	7, 192, 916	0.00000	0 1, 973, 985	0	91.00
92.00 Allied health cost	0	7, 192, 916	0.00000	0 1, 973, 985	0	92.00
93.00 All other Medical Education	0	7, 192, 916	0. 00000	0 1, 973, 985	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0146	Peri od: From 01/01/2019	Worksheet D-1	
			To 12/31/2019	Date/Time Pre 6/23/2020 3:4	
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	

		Title XIX	Hospi tal	6/23/2020 3: 4 PPS	6 pm_
	Cost Center Description	TI LI C XIX	nospi tai	113	
	DART I ALL PROVIDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	bed and newborn days)	rivate room days,	6, 016 6, 016 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 b Total swing-bed SNF type inpatient days (including private ro reporting period		er 31 of the cost	4, 365 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro 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 rooreporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)		, ,	105	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc	tions)	,	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period			0	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this lir	ne)	0	13.00
14. 00 15. 00	Total nursery days (title V or XIX only)	alli (excluding Swing-bed	days)	423	
16. 00 17. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 (of the cost	55	16. 00 17. 00
18. 00	reporting period	3		0.00	
19. 00	reporting period				19. 00
20. 00	reporting period				
21. 00	reporting period Total general inpatient routine service cost (see instruction		ine cost	0. 00 7, 192, 916	
22. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ting period (line		22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December \mathbf{x} line 20)	31 of the cost reporting	g 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	(line 21 minus line 26)		0 7, 192, 916	26. 00 27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	30. 00 31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	. 1116 20)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x li	, ,	· · · · /	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	7, 192, 916	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 195. 63	
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•		125, 541 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			125, 541	

	Financial Systems COMMU ATION OF INPATIENT OPERATING COST	INITY HOSPITAL (OF NOBLE CTY, Provi der C	CN: 15-0146	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
			T; +1	e XIX	Hospi tal	6/23/2020 3: 4 PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
42.00	NURSERY (title V & XIX only)	252, 454	423	596. 8	55	32, 825	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43.00
44. 00	CORONARY CARE UNIT	0	0	•		0	44. 00
45.00	BURN INTENSIVE CARE UNIT	0	0				45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0.0	0	0	46. 00 47. 00
47.00	Cost Center Description						47.00
40.00	December 1 and 1 a	-+	1 1: 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		212, 263 370, 629	•
50.00	Pass through costs applicable to Program inp.	atient routine	services (fro	m Wkst. D, su	m of Parts I and	11, 750	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	16, 599	51.00
52. 00 53. 00	52.00 Total Program excludable cost (sum of lines 50 and 51)					28, 349 342, 280	52. 00 53. 00
	medical education costs (line 49 minus line : TARGET AMOUNT AND LIMIT COMPUTATION			,	<u> </u>		
54.00	Program di scharges					0	54.00
55.00						0.00	•
56. 00 57. 00						0	56. 00 57. 00
58. 00						0	58.00
59. 00						0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					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					0	61.00
	amount (line 56), otherwise enter zero (see	instructions)			-		,,,,,,
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	· ·		·		0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00		e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00						0	68. 00
69. 00						0	69. 00
70.00	Skilled nursing facility/other nursing facil)		70. 00
71.00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		ı (line 14 x li	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74.00
75.00	Capital-related cost allocated to inpatient	•			Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77.00	Program capital-related costs (line 73 = 11)						77.00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00						79. 00	

Health Financial Systems COMM	MUNITY HOSPITAL	OF NOBLE CTY,	I NC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		pared: 6 pm
	_	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	529, 993	7, 192, 916	0. 07368	3 1, 973, 985	145, 449	90.00
91.00 Nursing School cost	0	7, 192, 916	0.00000	0 1, 973, 985	0	91.00
92.00 Allied health cost	0	7, 192, 916	0.00000	0 1, 973, 985	0	92.00
93.00 All other Medical Education	0	7, 192, 916	0.00000	0 1, 973, 985	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF N	NOBLE CTY, INC	In Lieu	u of Form CMS-2552-10

	ncial Systems COMMUNITY HOSPITAL OF NOBL				u of Form CMS-2	
I NPATI ENT A	ANCILLARY SERVICE COST APPORTIONMENT Pro	vider C		Peri od: From 01/01/2019	Worksheet D-3	
				To 12/31/2019		pared:
					6/23/2020 3: 4	6 pm
	Coot Contan Decement on	litle	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
			10 charges	Charges	(col. 1 x	
				onal goo	col. 2)	
			1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDIATRICS			2, 976, 045		30.00
	O I NTENSI VE CARE UNI T			0		31.00
	O CORONARY CARE UNIT O BURN INTENSIVE CARE UNIT			0		32. 00 33. 00
	O SURGICAL INTENSIVE CARE UNIT					34.00
	O SUBPROVI DER - I PF			0		40.00
	O SUBPROVI DER - I RF			0		41.00
	0 NURSERY					43.00
	LLARY SERVICE COST CENTERS					
	O OPERATING ROOM		0. 14723		110, 851	50.00
	O RECOVERY ROOM		0.00000		0	51.00
	O DELIVERY ROOM & LABOR ROOM O ANESTHESIOLOGY		0. 39909 0. 00000		4, 665 0	52. 00 53. 00
	O RADI OLOGY-DI AGNOSTI C		0. 11283		-	54.00
	O RADI OLOGY-THERAPEUTI C		0. 00000		0	55.00
	O RADI OI SOTOPE		0. 00000		0	56.00
	O CT SCAN		0. 00000		0	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)		0. 00000	0	0	58. 00
	O CARDI AC CATHETERI ZATI ON		0. 00000		0	59. 00
	O LABORATORY		0. 15262			60.00
1	1 BLOOD LABORATORY		0.00000		0	60.01
	O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 00000 0. 00000		0	61. 00 62. 00
	O BLOOD STORING, PROCESSING & TRANS.		0. 00000		0	63.00
	O I NTRAVENOUS THERAPY		0. 00000		Ö	64.00
	RESPI RATORY THERAPY		0. 14073		167, 848	65.00
	O PHYSI CAL THERAPY		0. 49549		41, 139	66.00
	O OCCUPATI ONAL THERAPY		0. 49520	6, 917	3, 425	67.00
	O SPEECH PATHOLOGY		0. 53609		9, 854	68. 00
	O ELECTROCARDI OLOGY		0.00000		0	69.00
1	O ELECTROENCEPHALOGRAPHY O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000 0. 23338		0 83, 981	70. 00 71. 00
	O IMPL. DEV. CHARGED TO PATIENTS		0. 23330			72.00
	O DRUGS CHARGED TO PATIENTS		0. 26810		418, 087	73.00
	O RENAL DI ALYSI S		0.00000		0	74.00
75. 00 0750	O ASC (NON-DISTINCT PART)		0. 00000	0 0	0	75.00
	8 HYPERBARIC OXYGEN THERAPY		0. 24826		-	76. 98
	O ALLOGENEIC STEM CELL ACQUISITION		0. 00000	0	0	77. 00
	ATIENT SERVICE COST CENTERS		1 0 00000	اما	1 0	00.00
	O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	88.00
	O CLINIC		0. 00000 0. 46631			89. 00 90. 00
	O EMERGENCY		0. 40031		-	
	O OBSERVATION BEDS (NON-DISTINCT PART)		0. 33608			
	R REIMBURSABLE COST CENTERS					
	O HOME PROGRAM DIALYSIS		0. 00000	0 0	0	94.00
	O AMBULANCE SERVICES					95.00
	O DURABLE MEDI CAL EQUI P-RENTED		0.00000			96.00
	O DURABLE MEDICAL EQUIP-SOLD O OTHER REIMBURSABLE COST CENTERS		0.00000		1	97.00
98. 00 0985 200. 00	Total (sum of lines 50 through 94 and 96 through 98)		0.00000	9, 150, 537	0 1, 515, 452	98.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (Li	ne 61)		9, 150, 557 N		200.00
202.00	Net charges (line 200 minus line 201)	01)		9, 150, 537		202.00
1			•		•	

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In L	ieu of Form CMS-2552-10

Health Financial Systems COMMUNITY HOSPITAL OF	NOBLE CTY,	INC	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0146	Peri od:	Worksheet D-3	
			From 01/01/2019		
			To 12/31/2019		
		\(\(\)\(\)		6/23/2020 3: 4	6 pm
		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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			210, 788		30.00
31. 00 03100 NTENSIVE 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 INTENSI VE CARE UNI T			0		34.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 04300 NURSERY			74, 197		43.00
ANCI LLARY SERVI CE COST CENTERS			71,177		10.00
50. 00 05000 OPERATI NG ROOM		0. 14723	432, 951	63, 747	50.00
51. 00 05100 RECOVERY ROOM		0. 00000	· ·	05,747	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 39909		l .	
		1	· ·		1
		0.00000		0 071	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 11283			
55. 00 O5500 RADI OLOGY-THERAPEUTI C		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 IMAGING (MRI)		0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
60. 00 06000 LABORATORY		0. 15262	23 141, 273	21, 562	60.00
60. 01 06001 BL00D LABORATORY		0.00000	0 0	0	60. 01
61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000	0 0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	0 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	1
65. 00 06500 RESPI RATORY THERAPY		0. 14073		5, 542	1
66. 00 06600 PHYSI CAL THERAPY		0. 49549		1, 527	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 49520			
68. 00 06800 SPEECH PATHOLOGY		0. 53609			1
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	
		1			
		0. 23338			1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 23417		9, 325	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 26810			1
74. 00 07400 RENAL DI ALYSI S		0.00000		0	1
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000		0	75.00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 24826		-	1
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000			
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0 0	0	89. 00
90. 00 09000 CLI NI C		0. 46631	5 0	0	90.00
91. 00 09100 EMERGENCY		0. 11217	87, 069	9, 767	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 33608	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 SERVICES					95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	1
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 127, 362		
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		., 127, 302	212,200	201.00
202.00 Net charges (line 200 minus line 201)	. (11110 01)		1, 127, 362		202.00
		1	., 127, 302	1	,_02.00

Health Financial Systems	COMMUNITY HOSPITAL OF N	IOBLE CTY, INC	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	ŧ	Provider CCN: 15-0146	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared:

			To 12/31/2019	Date/Time Pre 6/23/2020 3:4	
		Title XVIII	Hospi tal	PPS	о рііі
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	2, 132, 083	
1. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	785, 428	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or discharges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			0	2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	
2. 02	Outlier payments for discharges occurring prior to October 1	•		0	1
2. 04	Outlier payments for discharges occurring on or after October			0	1
3. 00	Managed Care Simulated Payments	. (555 51. 451. 51.5)		0	1
4. 00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instr	uctions)	26. 48	1
5. 00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.00
6. 00	or before 12/31/1996 (see instructions) FTE count for allopathic and osteopathic programs that meet t	he criteria for an add-	on to the can for	0.00	6. 00
7. 00	new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified			0. 00	
7. 00	ACA § 5503 reduction amount to the IME cap as specified under			0.00	1
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa	thic and osteopathic pro	ograms for	0.00	8.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.	79(c)(2)(iv), 64 FR 263	40 (May 12,		
8. 01					8. 01
8. 02					8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	es (8, 8,01 and 8,02)	(see	0. 00	9. 00
10. 00	<pre>instructions) FTE count for allopathic and osteopathic programs in the curr</pre>	ent vear from vour reco	rds	0.00	10.00
	FTE count for residents in dental and podiatric programs.				11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Se	otember 30, 1997,	0. 00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital clo	sure		0.00	17. 00
18. 00	Adjusted rolling average FTE count			0. 00	
	Current year resident to bed ratio (line 18 divided by line 4).		0. 000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0.000000	1
	IME payment adjustment - Managed Care (see instructions)			0	
	Indirect Medical Education Adjustment for the Add-on for § 42				
23. 00	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$.	ent cap slots under 42 (JFR 412.105	0. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	1
25. 00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0. 00	25. 00
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
	IME add-on adjustment amount (see instructions)			0	1
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	1
	Total IME payment (sum of lines 22 and 28)	4)		0	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	1)		0	29. 01
30 OO	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instru	rtions)	3. 20	30.00
	Percentage of Medicaid patient days (see instructions)	acronic days (see riisti u	0110110)	19. 54	1
	Sum of lines 30 and 31			22. 74	1
	Allowable disproportionate share percentage (see instructions)		7. 97	
	Disproportionate share adjustment (see instructions)				34.00

Heal th	Financial Systems COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0146	Peri od:	Worksheet E	
			From 01/01/2019 To 12/31/2019		pared:
				6/23/2020 3:4	
		Title XVIII	Hospi tal	PPS	
			Pri or to 10/1 1.00	2. 00	
	Uncompensated Care Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)			8, 350, 599, 096	35. 00
35. 01	Factor 3 (see instructions)		0. 000083315	0. 000107027	
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente instructions)	r zero on this line) (se	e 689, 254	893, 740	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amo	unt (see instructions)	515, 524	224, 656	35. 03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		740, 180	,	36. 00
	Additional payment for high percentage of ESRD beneficiary di				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40. 00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	83 684 an 685 (see	0		41.00
00	instructions)	55, 55. a 555. (555			00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0		41. 01
42.00	an 685. (see instructions)	£. £.,!:	0.00		40.00
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68		0.00		42. 00 43. 00
43.00	instructions)				43.00
44.00					44.00
45.00	days)				45.00
45. 00 46. 00	Average weekly cost for dialysis treatments (see instructions Total additional payment (line 45 times line 44 times line 41		0.00		45. 00 46. 00
47. 00	Subtotal (see instructions)	. 01)	3, 715, 823		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	mall rural hospitals	4, 789, 729		48. 00
	only. (see instructions)	<u> </u>			
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions)		4, 521, 253	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I an			233, 549	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	
54. 00 54. 01	Special add-on payments for new technologies			0	
55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	
56. 00	Cost of physicians' services in a teaching hospital (see intr			0	
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt.		3 ,	0	58. 00
59.00	Total (sum of amounts on lines 49 through 58)			4, 754, 802	
60.00	Primary payer payments			17, 995	
61.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		4, 736, 807	
62.00	Deductibles billed to program beneficiaries			449, 039	
63. 00 64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			1, 782 53, 359	
65. 00	Adjusted reimbursable bad debts (see instructions)			34, 683	
66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		13, 521	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	/		4, 320, 669	
68.00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	68. 00

69.00

70.00

70.50

70.88

70.89

70.90

70. 91

0 70.92

70.93

0 70.95

0 70.87

0

0

0 70.94

4, 284

-602

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

70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)

70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

70.93 HVBP payment adjustment amount (see instructions)

70.94 | HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

Demonstration payment adjustment amount before sequestration

Pioneer ACO demonstration payment adjustment amount (see instructions)

SCH or MDH volume decrease adjustment (contractor use only)

HSP bonus payment HVBP adjustment amount (see instructions)
HSP bonus payment HRR adjustment amount (see instructions)
Bundled Model 1 discount amount (see instructions)

70. 92

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

<u>Heal t</u> h	Financial Systems COMMUNITY HOSPITAL OF	NOBLE CTY,	I NC	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0146	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre	
		T: ±1 -		11! +-1	6/23/2020 3: 4	6 pm
			XVIII	Hospi tal	PPS	
			FFY	(yyyy) 0	Amount 1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		2019	455, 296	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i			2020		
	the corresponding federal year for the period ending on or af		,	2020	183, 606	
70. 98 70. 99	Low Volume Payment-3 HAC adjustment amount (see instructions)				0	70. 98 70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			4, 963, 253	•
71.00	Sequestration adjustment (see instructions)	07 & 70)			99, 265	
71. 02	Demonstration payment adjustment amount after sequestration				0	1
71. 03	Sequestration adjustment-PARHM pass-throughs				J.	71. 03
72. 00	Interim payments				4, 730, 628	•
72. 01	Interim payments-PARHM				.,,	72. 01
73.00	Tentative settlement (for contractor use only)				0	73.00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.073)	2, 72, and			133, 360	74. 00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	nce with			63, 833	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	
94.00	The rate used to calculate the time value of money (see instr	uctions)			0. 00	1
95. 00	Time value of money for operating expenses (see instructions)				0	95. 00
96. 00	Time value of money for capital related expenses (see instruc	tions)		D.1	0 (4.6) - 10 (1	96. 00
				Pri or to 10/1 1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
100.00	HSP bonus amount (see instructions)			602, 418	203, 012	100.00
	HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			1. 0073999417	0. 9991448819	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	s)		4, 458	-174	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0. 9990	1. 0000	1
104.00	HRR adjustment amount for HSP bonus payment (see instructions			-602	0	104. 00
000 00	Rural Community Hospital Demonstration Project (§410A Demonst					000
200.00	Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	erioa unaer	tne 21st			200. 00
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	ie 49)				201. 00
	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A in period)	first year	of the curre	ent 5-year demons		
	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
206. 00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
207.00	Adjustment to Medicare Part A Inpatient Reimbursement					207 22
	Program reimbursement under the §410A Demonstration (see inst	,				207.00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	111le 59)				208.00
	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use					209. 00 210. 00
	Total adjustment to Medicare IPPS payments (see instructions)					210.00
Z11.00	Comparision of PPS versus Cost Reimbursement					j∠ 1 1. UU
212 00	Total adjustment to Medicare Part A IPPS payments (from line	211)				212. 00
	Low-volume adjustment (see instructions)	2.17				213.00
	Net Medicare Part A IPPS adjustment (difference between PPS a	nd cost rei	mbursement)			218. 00
5. 50	(line 212 minus line 213) (see instructions)					

Health Financial Systems	COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-014	From 01/01/2019	Worksheet E Part B Date/Time Prepared:

6/23/2020 3:46 pm Title XVIII Hospi tal 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions) 5, 499, 536 2.00 2.00 OPPS payments 3.00 4, 436, 150 3 00 4.00 Outlier payment (see instructions) 0 4.00 4.01 Outlier reconciliation amount (see instructions) 0 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.864 5.00 4, 751, 599 6.00 Line 2 times line 5 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 93.36 7.00 8.00 Transitional corridor payment (see instructions) 8.00 9 00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 0 10.00 Organ acquisitions 0 10.00 Total cost (sum of lines 1 and 10) (see instructions) 0 11.00 11.00 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, line 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 payment for services on a charge basis 0 15.00 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 16.00 had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 0.000000 17.00 18.00 Total customary charges (see instructions) 0 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00 instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20 00 Ω 20 00 instructions) 21.00 Lesser of cost or charges (see instructions) 0 21.00 22.00 Interns and residents (see instructions) 0 22.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 0 23.00 Total prospective payment (sum of lines 3, 4, 436, 150 24.00 4. 4.01. 8 and 9) 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 849, 513 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 26.00 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 3, 586, 637 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 29.00 0 30.00 Subtotal (sum of lines 27 through 29) 3, 586, 637 30.00 31.00 Primary payer payments 1, 391 31.00 32.00 Subtotal (line 30 minus line 31) 3, 585, 246 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 120, 350 34.00 78. 228 35.00 Adjusted reimbursable bad debts (see instructions) 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 36.00 50, 452 36,00 37.00 Subtotal (see instructions) 3, 663, 474 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39 00 39 00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39. 97 Demonstration payment adjustment amount before sequestration 39.97 0 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 0 RECOVERY OF ACCELERATED DEPRECIATION 39 99 0 39 99 40.00 Subtotal (see instructions) 3, 663, 474 40.00 73, 269 40.01 Sequestration adjustment (see instructions) 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 Sequestration adjustment-PARHM pass-throughs 40 03 40 03 41.00 Interim payments 3, 611, 655 41.00 41.01 Interim payments-PARHM 41.01 Tentative settlement (for contractors use only) 42.00 0 42.00 Tentative settlement-PARHM (for contractor use only) 42.01 42.01 -21, 450 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.00 §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) n 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00 94.00 Total (sum of lines 91 and 93) 94.00 ol

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 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 4.00 1.00 2.00 3.00 1.00 Total interim payments paid to provider 4, 730, 628 3, 611, 655 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 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 3.01 0 3.02 0 3.02 0 3 03 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4, 730, 628 3, 611, 655 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 5.52 0 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5. 50-5. 98)

6.00

6.01

6.02

7.00

8.00

21, 450

3, 590, 205

NPR Date

(Mo/Day/Yr)

2.00

133, 360

Contractor

Number

1.00

4, 863, 988

6.00

6.01

6.02

7.00

the cost report. (1)

SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Determined net settlement amount (balance due) based on

Total Medicare program liability (see instructions)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0146 Period: From 01/01/2019 To 12/31/2019 Provider CCN: 15-0146 Provider CC	Heal th	Financial Systems COMMUNITY HOSPITAL OF	NOBLE CTY, INC	In Lieu	u of Form CMS	-2552-10
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wks	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		From 01/01/2019 To 12/31/2019	Part II Date/Time Pr 6/23/2020 3:	epared:
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I, col. 8 line 20 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00			Title XVIII	Hospi tal	PPS	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I, col. 8 line 20 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00						
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of c					1. 00	
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 30.00 31.00						
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)						
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 30.00 31.00				e 14		
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)		1	8-12			
Total hospital charges from Wkst C, Pt. I, col. 8 line 200 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I in 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify)						
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I in 168 Calculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions) Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 6.00 7.00 7.00 7.00 8.00 9.00 9.00 9.00 10.0						
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 7.00 8.00 8.00 9.00 10.00 30.00 31.00	5.00					
Iine 168	6.00					6. 00
9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify)	7. 00		certified HIT technology	Wkst. S-2, Pt. I		7.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify)	8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00	9.00	Sequestration adjustment amount (see instructions)				9. 00
30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00	10.00	.00 Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
31.00 Other Adjustment (specify)		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.00	31.00	Other Adjustment (specify)				31.00
	32.00	Balance due provider (line 8 (or line 10) minus line 30 and I	line 31) (see instructio	ns)		32.00

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

Provi der CCN: 15-0146

Period: Worksheet G From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/23/2020 3:46 pm

					6/23/2020 3: 4	6 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	7, 952	O	0	0	1.00
2. 00	Temporary investments	7, 732	0	0	l	
3. 00	Notes recei vabl e	Ö	Ö	0	Ö	
4.00	Accounts receivable	22, 383, 929	0	0	0	4.00
5.00	Other recei vabl e	0	0	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	1	0	0	0	
7.00	Inventory Proposid expenses	399, 902	0	0	0	
8. 00 9. 00	Prepaid expenses Other current assets	6, 000, 569	0	0		
10.00	Due from other funds	0		0	Ö	
11. 00	Total current assets (sum of lines 1-10)	15, 352, 532	Ö	0	1	
	FIXED ASSETS					
12.00	Land	0	0	0		
13.00	Land improvements	755, 392	0	0	1	
14.00	Accumulated depreciation	-526, 017	0	0		
15. 00 16. 00	Buildings Accumulated depreciation	3, 922, 018 -1, 854, 924	0	0	0	
17. 00	Leasehold improvements	63, 781	0	0	0	
18. 00	Accumulated depreciation	-32, 142	o o	0	Ö	
19. 00	Fi xed equipment	1, 151, 710	Ö	0	Ō	
20.00	Accumulated depreciation	-131, 886	0	0	0	20.00
21. 00	Automobiles and trucks	517, 697	0	0	0	
22. 00	Accumulated depreciation	-234, 532	0	0	0	
23.00	Major movable equipment	11, 191, 911	0	0	0	1
24. 00	Accumulated depreciation	-8, 608, 393	0	0	0	
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	1, 646, 686 -793, 697	0	0	0	
27. 00	HIT designated Assets	-793, 097 0		0	0	
28. 00	Accumulated depreciation	Ö	o o	0	ő	
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	
30.00	Total fixed assets (sum of lines 12-29)	7, 067, 604	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	5, 000	0	0	1	
32. 00 33. 00	Deposits on leases Due from owners/officers	0	0	0	0	
34. 00	Other assets	1, 233, 869	-	0		
35. 00	Total other assets (sum of lines 31-34)	1, 238, 869		0	1	
36.00	Total assets (sum of lines 11, 30, and 35)	23, 659, 005	0	0	l .	
	CURRENT LIABILITIES					
37.00	Accounts payable	1, 704, 010		0		
38. 00	Salaries, wages, and fees payable	879, 171	0	0		
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	0	0	0	0	
41. 00	Deferred income	0	0	0		
42. 00	Accel erated payments	0		O	Ŭ	42.00
43. 00	Due to other funds	Ö	0	0	0	
44.00	Other current liabilities	172, 852	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2, 756, 033	0	0	0	45.00
	LONG TERM LIABILITIES	_			_	
46.00	Mortgage payable	0	0	0	0	
47. 00 48. 00	Notes payable Unsecured Loans	0	0	0		
49. 00	Other long term liabilities	170, 265	-	0		
50.00	Total long term liabilities (sum of lines 46 thru 49)	170, 265		0	l	•
51.00	Total liabilities (sum of lines 45 and 50)	2, 926, 298		0	l	
	CAPI TAL ACCOUNTS					
52.00	General fund balance	20, 732, 707				52.00
53.00	Specific purpose fund		0	_		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
57. 00	Plant fund balance - invested in plant			U	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					55.50
00.00						1
59. 00	Total fund balances (sum of lines 52 thru 58)	20, 732, 707	0	0	0	
		20, 732, 707 23, 659, 005		0	0	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

				T ₁	o 12/31/2019	Date/Time Pre 6/23/2020 3:4	
		General	Fund	Speci al Pu	rpose Fund	Endowment Fund	БШ
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) HOME OFFICE INTEREST EXPENSE	654, 875 0 0	13, 387, 867 6, 700, 698 20, 088, 565	0 0 0 0 0 0	0	0 0 0 0	5. 00 6. 00 7. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ASSET TRANSFERS	10, 733 0 0 0	654, 875 20, 743, 440	0 0 0 0 0	0	0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	10, 733 20, 732, 707	0	0	0	17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) HOME OFFICE INTEREST EXPENSE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ASSET TRANSFERS	0 0	0 0 0 0 0	0 0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	,	0	0 0 0 0 0	0			13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Peri od:

From 01/01/2019 Parts I & II Date/Time Prepared: 12/31/2019 6/23/2020 3:46 pm Cost Center Description Outpati ent Inpati ent Total 1.00 2.00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 8, 537, 806 8, 537, 806 1.00 2.00 SUBPROVIDER - IPF 2.00 0 0 3.00 SUBPROVIDER - IRF 0 0 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 5.00 6.00 0 0 6.00 SKILLED NURSING FACILITY 0 7.00 0 7.00 8.00 NURSING FACILITY 0 0 8.00 9.00 OTHER LONG TERM CARE 0 0 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 8.537.806 8, 537, 806 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 0 0 11.00 12.00 CORONARY CARE UNIT 0 0 12.00 BURN INTENSIVE CARE UNIT 0 13 00 13 00 0 SURGICAL INTENSIVE CARE UNIT 14.00 0 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16,00 0 0 16.00 11 - 15) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 8, 537, 806 8, 537, 806 17 00 18.00 Ancillary services 37, 437, 338 37, 437, 338 18.00 Outpatient services 156, 864, 615 19.00 0 156, 864, 615 19.00 RURAL HEALTH CLINIC 0 20.00 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 0 12, 378, 191 12, 378, 191 23.00 24.00 CMHC 0 24.00 24. 10 CORF 0 0 0 24.10 AMBULATORY SURGICAL CENTER (D. P.) 0 o 25.00 0 25.00 0 26.00 HOSPI CE 0 0 26,00 OTHER (SPECIFY) 27.00 0 0 27.00 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 45, 975, 144 169, 242, 806 215, 217, 950 28.00 line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 59, 555, 944 29.00 30.00 PROVISION FOR BAD DEBT 7, 822, 225 30.00 31.00 HOME OFFICE INTEREST EXPENSE 654, 875 31.00 32 00 0 32 00 0 33.00 33.00 34.00 0 34.00 35.00 0 35.00 Total additions (sum of lines 30-35) 8, 477, 100 36.00 36.00 37.00 DEDUCT (SPECIFY) 37.00 38.00 0 38.00 39.00 0 39.00 40.00 40.00 41.00 0 41.00 42.00 Total deductions (sum of lines 37-41) 42.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 68, 033, 044 43.00

43.00

to Wkst. G-3, line 4)

552-10
pared: 5 pm
<i>y</i> piii
1. 00
2.00
3.00
4.00
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
20.00
21. 00
22. 00
23. 00
24.00

-31, 532 24. 00 297, 314 532, 998

0 24.03

966, 389

6, 700, 698 0 24.01

24.02

25.00 26. 00 27. 00

28.00 0 6, 700, 698 29.00

24. 01 EMS SUBSIDY

24. 02 OTHER REVENUE

24. 03 OTHER (SPECIFY)

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

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

	Financial Systems	COMMUNITY HOSPITAL OF			u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT		Provi der CCN: 15-0146	Peri od: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Pre 6/23/2020 3:4	
			Title XVIII	Hospi tal	PPS	<u> </u>
	PART I - FULLY PROSPECTIVE METHOD				1. 00	
	CAPITAL FEDERAL AMOUNT					
1. 00	Capital DRG other than outlier				233, 549	1.00
1. 01	Model 4 BPCI Capital DRG other than o	utlier			0	
2.00	Capital DRG outlier payments				0	2.00
2. 01	Model 4 BPCI Capital DRG outlier paym	ents			0	2. 01
3.00	Total inpatient days divided by numbe	r of days in the cost re	eporting period (see ins	structions)	12. 33	3.00
4.00	Number of interns & residents (see in				0.00	4.00
5.00	Indirect medical education percentage				0. 00	
6. 00	<pre>Indirect medical education adjustment 1.01)(see instructions)</pre>	(multiply line 5 by the	e sum of lines 1 and 1.0)1, columns 1 and	0	6.00
7. 00	Percentage of SSI recipient patient d	ays to Medicare Part A p	oatient days (Worksheet	E, part A line	0. 00	7. 00
	30) (see instructions)					
8.00	Percentage of Medicaid patient days t	o total days (see instru	uctions)		0. 00	8.00
9. 00	Sum of lines 7 and 8				0. 00	
10.00	Allowable disproportionate share perc		5)		0. 00	
11.00	Disproportionate share adjustment (se				0	
12. 00	Total prospective capital payments (s	ee Instructions)			233, 549	12.00
					1. 00	
	PART II - PAYMENT UNDER REASONABLE CO					
1.00	Program inpatient routine capital cos				0	
2. 00	Program inpatient ancillary capital c				0	2.00
3.00	Total inpatient program capital cost				0	
4.00	Capital cost payment factor (see inst				0	4.00
5. 00	Total inpatient program capital cost	(ITNE 3 X ITNE 4)			U	5.00
					1. 00	
	PART III - COMPUTATION OF EXCEPTION P.					
1.00	Program inpatient capital costs (see				0	1.00
2.00	Program inpatient capital costs for e		ces (see instructions)		0	2.00
3. 00	Net program inpatient capital costs (0	3.00
4.00	Applicable exception percentage (see				0. 00	
5.00	Capital cost for comparison to paymen				0	
6.00	Percentage adjustment for extraordina			v line ()	0.00	
7.00	Adjustment to capital minimum payment		y circumstances (iine 2	x rine 6)	0	7. 00 8. 00
8.00						0.00

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

Current year allowable operating and capital payment (see instructions)

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

16.00 Current year operating and capital costs (see instructions)

17.00 Current year exception offset amount (see instructions)

Worksheet L, Part III, line 14)

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

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

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

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

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

0 9.00

0 10.00

0 12.00

0 13.00

0 14.00

0 15.00

0 16.00

0 17.00

11.00

9.00

12.00

13.00

14.00

15.00